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Subject: Additional Comments on Clinical lab data submission

Thank you for the opportunity to submit additional comments on the revised draft methodology discussed at the stakeholder meeting on 1/15/13. The revisions to date have dealt in a substantive manner with the comments from the laboratory community and we appreciate DHCS making these changes. We would reiterate some comments made to previous drafts and the suggestions we voiced at the stakeholder meeting.

- (1) We reiterate our concern on the wisdom of collecting data from hospital based pathologists who submit claims for clinical and anatomic pathology codes for hospital in and outpatients by billing

for the professional component only. They submit claims using the appropriate CPT or HCPCS using a -26 modifier indicating the claim is only for the professional component, i.e. a specified percentage of the allowable global payment. Hospitals depending upon the per diem contracts that exists with DHCS might submit a charge for the technical component using a -27 TC only modifier. There are also likely situations where the hospital bills on behalf of the hospital based pathologist and submits a global charge and then pays the hospital based pathologist their professional.

We would encourage DHCS to only request data on global payments. As the representative from the Ca. Hospital Assoc. confirmed at the stakeholder meeting hospital typically receive payment for a lump sum for all clinical laboratory tests for that specific insured patient without a breakdown of payment per test. Even if they were able to provide the reimbursement for the technical component of the lab service DHCS would have no easy way to link up to the payment of the professional component to the pathology group. If you limited the data to global payments to labs that could also include outreach labs that may be based in a hospital but are providing services to community patients and not registered outpatients of the hospitals. That is the more meaningful data for comparison of payment information.

- (2) There was also a good discussion of the fact that many large plans have multiple products, e.g. Blue Shield may offer 9 or more different types of plans that offer different menus of covered services, service dollar caps etc. It is likely that most lab providers would not track their payments from different insurance products from the same insurer on a separate basis. It may be best to ask for the average from that specific insurer. The fee schedules may in fact always be the same across product lines but it's difficult to confirm.
- (3) DHCS has been extending the timeline for provider submission of data based upon the ongoing stakeholder discussions. We encourage you to consider another extension on the deadline for submission to allow providers sufficient time to digest what data is being requested and to complete their response. Not all laboratories are active in professional or trade organizations and they may not be aware of this impending request.