

**AB 1494 – Data Collection for New Rate Setting Methodology  
Clinical Laboratory and Laboratory Services  
March 2013**

The Department of Health Care Services (DHCS) has developed the following data collection request to be used to implement a new rate methodology for clinical laboratory or laboratory services, as specified in Assembly Bill (AB) 1494. The data collection request includes four areas: Fee Schedules, Procedure Codes, Data Elements, and Criterion for Providers that Will Need to Submit Data. DHCS has developed this request after considering stakeholder input.

**Background**

AB 1494 authorizes DHCS to develop a rate methodology for clinical laboratory or laboratory services that are comparable to payment amounts received by other payers. For the purpose of establishing this methodology, AB 1494 directs clinical laboratory and laboratory service providers to submit data reports based on the previous calendar year specifying the lowest amounts other payers are paying, minus discounts and rebates, within six months after the bill was chaptered. This request presents the parameters of the data elements and format for the data submission. To ensure providers have adequate time to prepare and submit the data, the submission date has been extended to May 31, 2013.

**Fee Schedules**

DHCS is requesting clinical laboratory and laboratory services data from providers listed on Table 1 that billed Medi-Cal for calendar year 2011. The requested data from these providers needs to be for clinical laboratory and laboratory services provided in California and consists of third-party payer information. Third-party payers are defined as insurers such as Anthem Blue Cross and Aetna, and other payers and programs comparable to Medi-Cal.

DHCS is requesting providers submit their calendar year 2011 third-party payer fee schedules from their top 5 third-party payers by Current Procedural Terminology (CPT) code volume. If the provider's fee schedules for the top 5 third-party payers do not constitute 80 percent of their business for each respective procedure code, the provider must submit additional fee schedules until the total fee schedules submitted equals at least 80 percent of their business, per code. These providers will only need to submit fee schedules for their top 10 third-party payers per code even if the fee schedules do not constitute 80 percent of their business. DHCS will count each fee schedule individually. For example, if a laboratory has 5 separate fee schedules for Payer XYZ, this would count as 5 fee schedules. However, providers will need to submit fee schedules for a minimum of at least 3 separate payers. To be clear, the top third-party payer fee schedules should be determined by aggregate volume (measured by CPT code), not by aggregate reimbursement dollars.

Under this request, the term “fee schedule” refers to the actual amount a provider receives in payment from the third party payer, and does not refer to a single set of usual and customary charges charged to all payers.

Below is additional information regarding data submittal:

- Providers will not include payer data from Medi-Cal and Medicare in their 80 percent calculation.
- DHCS is requiring data from providers for the listed procedure codes in Attachment A.
- DHCS will allow redaction of payer names; however, providers will need to maintain a clear audit trail that ties the fee schedules/data to a provider. DHCS may request the audit trail at any time.
- DHCS is requesting “global” rates and not split bill (modifiers TC and 26) rates.
- Hospitals will be excluded from submitting data. However, hospital outreach clinics and labs will be required to submit data. By definition, “hospital outreach clinics and labs” are labs that operate within the confines of a hospital yet they accept community patients/specimens from people outside of the hospital’s outpatient/inpatient population.

### **Procedure Codes**

DHCS is only requesting data for procedure codes listed in Attachment A. DHCS determined the procedure codes requiring data submittal by analyzing Medi-Cal paid claims data for calendar year 2011. DHCS based the decision on total paid claims volume and total paid claims amount. A threshold of 1,000 total paid claims volume was set based on an analysis of the codes most often billed to Medi-Cal in order to ensure that data is collected on those claims that represent the vast majority of Medi-Cal claims. The 1,000 paid claims threshold represents 99.58 percent of all paid claims and 98.50 percent of all reimbursements dollars for the listed codes in Attachment A. In addition, a total paid claims amount was set with a threshold of \$500,000. This threshold was set to capture codes that may be lower volume but represent significant dollars. Only two codes (S3820 and S3854) had total paid claims volume less than 1,000 but with total paid claims amount above \$500,000. For codes not listed on Attachment A and for new Healthcare Common Procedure Coding System (HCPCS) updated codes, DHCS will use the current rate setting methodology and set rates at 80 percent of the Medicare rate.

### **Data Elements**

Table 2 below demonstrates the claims data elements that DHCS requires providers supply to the Department. As noted, DHCS is asking for information on volume-based adjustments. These adjustments may or may not be a factor in the

development of the new rate methodology depending on how the final payments, after adjustments are made, compare against the payments made by other providers for the same CPTs that do not include adjustments.

Providers will submit fee schedules using the data table listed on Table 2. The Department will post the spreadsheet electronically via the following Web page: <http://www.dhcs.ca.gov/provgovpart/Pages/CLLS.aspx>.

### **Criterion for Providers that Will Need to Submit Data**

Table 1 indicates the providers by National Provider Identifier (NPI) number that are required to submit data reports to DHCS. Providers in Table 1 were determined by analyzing 2011 Medi-Cal paid claims data. The Department determined that providers with either a total paid claims amount totaling \$XXXXXX or greater or a total paid claims amount of XXXX or greater will need to submit data.

**(DHCS continues its work on determining the appropriate thresholds for this area and expects to make that information available before the March 20, 2013, stakeholder meeting. Therefore, Table 1 will be included once the parameters are established.)**

**TABLE 2**  
**Data Elements of Fee Schedules Required for Submission**

<b>CPT Code</b>	<b>CPT Desc</b>	<b>Fee Schedule</b>	<b>Number of Units Billed under this Fee Schedule for Calendar Year Ending on 12/31/2011</b>	<b>Insurer's Fee Schedule Rate for Calendar Year Ending on 12/31/2011</b>	<b>Any Volume-based Adjustments? (Yes or No) If Yes, Provide Details in Text Box Below</b>
00001	Desc 1	FS1	5,353	\$ 4.98	N
00002	Desc 2	FS1	5,000	\$ 6.25	N
00003	Desc 3	FS1	3,000	\$ 3.00	N
00004	Desc 4	FS1	1,200	\$ 8.00	N
00005	Desc 5	FS1	600	\$ 9.00	N
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00439	Desc 439	FS1	1,600	\$ 7.25	N
00001	Desc 1	FS2	5,500	\$ 5.50	N
00002	Desc 2	FS2	3,500	\$ 6.50	N
00003	Desc 3	FS2	865	\$ 3.50	N
00004	Desc 4	FS2	1,256	\$ 8.50	N
00005	Desc 5	FS2	900	\$ 9.50	N
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00439	Desc 439	FS2	1,400	\$ 8.00	N
00001	Desc 1	FS3	4,230	\$ 6.35	N
00002	Desc 2	FS3	1,253	\$ 4.25	N
00003	Desc 3	FS3	6,532	\$ 2.52	N
00004	Desc 4	FS3	652	\$ 9.26	N
00005	Desc 5	FS3	5,683	\$ 8.50	N
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00439	Desc 439	FS3	2,266	\$ 7.32	N
00001	Desc 1	FS4	3,615	\$ 6.35	N
00002	Desc 2	FS4	1,652	\$ 4.25	N
00003	Desc 3	FS4	6,223	\$ 2.52	N
00004	Desc 4	FS4	8,500	\$ 9.26	N
00005	Desc 5	FS4	566	\$ 8.50	N
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00439	Desc 439	FS4	158	\$ 7.32	N
00001	Desc 1	FS5	2,546	\$ 4.52	N
00002	Desc 2	FS5	3,551	\$ 6.12	N
00003	Desc 3	FS5	4,653	\$ 9.54	N
00004	Desc 4	FS5	859	\$ 8.46	N
00005	Desc 5	FS5	5,968	\$ 5.14	N
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00439	Desc 439	FS5	544	\$ 6.95	N

00001	Desc 1	FS6	12,345	\$	5.65	N
00002	Desc 2	FS6	4,567	\$	5.21	N
00003	Desc 3	FS6	6,541	\$	8.47	N
00004	Desc 4	FS6	9,854	\$	9.25	N
00005	Desc 5	FS6	4,532	\$	4.45	N
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00439	Desc 439	FS6	1,235	\$	5.50	N
00001	Desc 1	FS7	1,456	\$	4.56	N
00002	Desc 2	FS7	6,541	\$	1.23	N
00003	Desc 3	FS7	9,874	\$	3.65	N
00004	Desc 4	FS7	4,568	\$	6.25	N
00005	Desc 5	FS7	3,574	\$	6.25	N
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00439	Desc 439	FS7	9,535	\$	1.35	N
00001	Desc 1	FS8	785	\$	4.85	N
00002	Desc 2	FS8	658	\$	1.58	N
00003	Desc 3	FS8	4,856	\$	7.42	N
00004	Desc 4	FS8	6,554	\$	6.65	N
00005	Desc 5	FS8	1,235	\$	4.58	N
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00439	Desc 439	FS8	987	\$	9.58	N
00001	Desc 1	FS9	7,865	\$	5.45	N
00002	Desc 2	FS9	14,235	\$	4.78	N
00003	Desc 3	FS9	6,524	\$	7.65	N
00004	Desc 4	FS9	626	\$	6.96	N
00005	Desc 5	FS9	657	\$	3.65	N
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00439	Desc 439	FS9	9,853	\$	5.24	N
00001	Desc 1	FS10	4,562	\$	7.85	N
00002	Desc 2	FS10	1,234	\$	5.00	N
00003	Desc 3	FS10	6,535	\$	8.41	N
00004	Desc 4	FS10	456	\$	4.54	N
00005	Desc 5	FS10	4,663	\$	6.52	N
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00439	Desc 439	FS10	652	\$	4.32	N
If Yes in Column F, please describe the contractual volume-based adjustment in sufficient detail to enable DHCS to determine if it would apply to the number or dollar value of your laboratory's aggregate CPTs that are reimbursed by Medi-Cal.						

**ATTACHMENT A**  
**Procedure Codes Requiring Fee Schedules and Data Elements Submission**

80047	82055	82670	83735	84305	85060	86317	86803	87340	88150
80048	82085	82728	83789	84311	85097	86318	87015	87350	88164
80051	82103	82731	83874	84376	85240	86331	87040	87390	88172
80053	82105	82746	83880	84402	85300	86334	87045	87400	88173
80055	82108	82747	83883	84403	85347	86353	87046	87420	88174
80061	82139	82776	83890	84425	85362	86355	87070	87425	88175
80069	82140	82784	83891	84432	85378	86357	87071	87427	88184
80074	82150	82785	83892	84436	85379	86359	87075	87430	88185
80076	82172	82800	83894	84439	85380	86360	87076	87449	88189
80100	82232	82803	83896	84443	85384	86361	87077	87480	88230
80101	82239	82805	83897	84445	85460	86376	87081	87490	88235
80102	82247	82945	83898	84446	85520	86403	87086	87491	88237
80154	82248	82947	83900	84450	85576	86430	87088	87493	88262
80156	82261	82948	83901	84460	85610	86431	87101	87496	88267
80158	82270	82950	83903	84466	85613	86480	87102	87497	88271
80162	82272	82951	83908	84478	85651	86580	87106	87510	88275
80164	82274	82952	83909	84479	85652	86592	87110	87517	88280
80170	82306	82962	83912	84480	85660	86593	87116	87521	88291
80178	82310	82977	83914	84481	85670	86635	87147	87522	88300
80184	82330	82980	83921	84484	85730	86644	87149	87529	88302
80185	82340	83001	83925	84510	86003	86645	87150	87530	88304
80195	82374	83002	83930	84512	86021	86663	87177	87536	88305
80196	82375	83010	83935	84520	86038	86664	87181	87590	88307
80197	82378	83013	83970	84540	86039	86665	87184	87591	88309
80198	82379	83020	83986	84550	86060	86677	87185	87621	88311
80200	82390	83021	84030	84590	86063	86689	87186	87641	88312
80202	82397	83036	84075	84630	86077	86694	87205	87653	88313
80299	82435	83050	84100	84681	86140	86695	87206	87660	88321
81000	82436	83090	84132	84702	86141	86696	87209	87798	88329
81001	82465	83498	84133	84703	86146	86701	87210	87799	88331
81002	82491	83516	84134	85004	86147	86702	87220	87800	88342
81003	82520	83518	84144	85007	86160	86703	87230	87801	88346
81005	82533	83519	84146	85008	86171	86704	87252	87802	88347
81015	82542	83520	84153	85013	86200	86705	87254	87804	88360
81025	82550	83525	84154	85014	86225	86706	87255	87807	88361
81050	82552	83540	84155	85018	86235	86707	87260	87880	88368
82003	82553	83550	84156	85025	86255	86708	87275	87899	88720
82009	82565	83605	84157	85027	86256	86709	87276	87902	G0431
82010	82570	83615	84165	85041	86294	86756	87279	88104	G0434
82024	82575	83655	84166	85044	86300	86762	87280	88108	Q0111
82040	82607	83690	84244	85045	86301	86777	87324	88112	Q0112
82042	82627	83701	84270	85046	86304	86780	87328	88141	S3820
82043	82652	83718	84295	85048	86308	86787	87329	88142	S3854
82044	82668	83721	84300	85049	86316	86800	87338	88148	