State of California—Health and Human Services Agency
Department of Health Care Services

TOBY DOUGLAS
Director

EDMUND G. BROWN JR.
Governor

AUG 22 2014

Hye Sun Lee, M.P.H
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

STATE PLAN AMENDMENT 10-020: MEDI-CAL REIMBURSEMENT METHODOLOGY FOR RADIOLOGY SERVICES

Dear Ms. Lee:

The Department of Health Services (DHCS) is resubmitting State Plan Amendment (SPA) 10-020 for your review and approval. SPA 10-020 adjusts Medi-Cal rates for radiology services to not exceed 80 percent of the Medicare rate for the same or similar service. The 90-day clock stopped for this SPA so that DHCS could conduct additional research to provide comprehensive responses to various Requests for Additional Information (RAI) requested by the Centers for Medicare and Medicaid Services (CMS).

Assembly Bill 853 (Chapter 717, Statutes of 2010) added Welfare & Institutions Code, section 14105.08, which mandates that Medi-Cal reimbursement rates for radiology services may not exceed 80 percent of the corresponding Medicare rate, effective October 1, 2010. This SPA adds page 3k to add this new rate methodology, with an effective date of October 1, 2012.

SPA 10-020 was originally submitted in December 2010. The SPA packet included amendments to pages 3a, 3d, and 3f in Attachment 4.19-B to add the reimbursement methodology for radiology services and a rate reduction chart reflecting the Medi-Cal codes and rates exceeding 80 percent of the Medicare rate for the same or similar service. The rate adjustments were based on the 2010 Medicare rates, and the effective date of the SPA was October 1, 2010. CMS responded with various RAIs, but DHCS requested to stop the 90-day clock in order to allow necessary time to prepare more comprehensive responses, despite the collaborative efforts of CMS and DHCS.

This SPA submission no longer amends pages 3a, 3d, and 3f in Attachment 4.19-B and replaces those pages with a new page 3k to describe the reimbursement methodology for radiology services. In addition to this change, the radiology codes and rates specified in the rate reduction chart in Enclosure 1 have been updated. The radiology codes and rates that were based on the 2010 Medicare rates have been updated to the 2012 Medicare rates, and the effective date of SPA 10-020 has been changed from October 1, 2010 to October 1, 2012.

The following updated SPA documents included for your review and approval are:

- HCFA 179 Transmittal Form
- Attachment 4.19-B, Pages 3a, 3d, and 3f, striking out the language to add the reimbursement methodology for radiology services to these pages
- Attachment 4.19-B, Page 3k - Reimbursement Methodology for Radiology Services
- Radiology Rate Reduction Chart (Enclosure 1)

DHCS appreciates the guidance CMS has provided on SPA 10-020. If you have any questions regarding this SPA, please contact Ms. Connie Florez, Chief, Fee-For-Service Rates Development Division, at (916) 552-9589.

Sincerely,

ORIGINAL SIGNED

Toby Douglas
Director

Enclosures

cc: Ms. Connie Florez, Chief
Fee-For-Service Rates Development Division
1501 Capitol Avenue, MS 4600
Sacramento, CA 95814

Ms. Lupe Martinez, Chief
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **10-020**

2. STATE: **California**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **October 1, 2012**

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: **42 CFR 435.831**

7. FEDERAL BUDGET IMPACT:
a. FFY **2013-14** **$ 10,666,419**
b. FFY **2014-15** **$ 10,666,419**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19B-Added page 3K**

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT:

Revised Medi-Cal Reimbursement Methodology for Radiology Services

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:

ORIGINAL SIGNED

Toby Douglas

14. TITLE: **Director, Department of Health Services**

15. DATE SUBMITTED:

16. RETURN TO:

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

REIMBURSEMENT METHODOLOGY FOR ESTABLISHING REIMBURSEMENT RATES FOR DURABLE MEDICAL EQUIPMENT, ORTHOTIC AND PROSTHETIC APPLIANCES, AND LABORATORY SERVICES

1. The methodology utilized by the State Agency in establishing reimbursement rates for durable medical equipment as described in State Plan Attachment 3.1-A, paragraph 2a, entitled "Hospital Outpatient Department Services and Organized Outpatient Clinic Services", and Paragraph 7c.2, entitled "Home Health Services Durable Medical Equipment", will be as follows:

   (a) Reimbursement for the rental or purchase of durable medical equipment with a specified maximum allowable rate established by Medicare, except wheelchairs, wheelchair accessories, wheelchair replacement parts, and speech-generating devices and related accessories, shall be the lesser of the following:

      (1) The amount billed in accordance with California Code of Regulations, Title 22, section 51008.1, entitled "Upper Billing Limit", that states that bills submitted shall not exceed an amount that is the lesser of the usual charges made to the general public or the net purchase price of the item (as documented in the provider's books and records), plus no more than a 100 percent mark-up. (Refer to Reimbursement Methodology table at page 3e.)

      (2) An amount that does not exceed 80 percent of the lowest maximum allowance for California established by the federal Medicare program for the same or similar item or service. (Refer to Reimbursement Methodology Table at page 3e.)

   (b) Reimbursement for the rental or purchase of a wheelchair, wheelchair accessories, wheelchair replacement parts, and speech-generating devices and related accessories, with a specified maximum allowable rate established by Medicare shall be the lowest of the following:

      (1) The amount billed in accordance with California Code of Regulations, Title 22, Section 51008.1 entitled "Upper Billing Limit", that states that bills submitted shall not exceed an amount that is the lesser of the usual charges made to the general public, or the net purchase price of the item (as documented in the provider's books and records),

schedule and any annual or periodic adjustments to the fee schedule are published in the provider manual and on the California Department of Health Services Medi-Cal website.

3. Reimbursement rates for orthotic and prosthetic appliances as described in State Plan Attachment 3.1-A, paragraph 12c, entitled "Prosthetic and Orthotic Appliances," shall not exceed 80 percent of the lowest maximum allowance for California established by the federal Medicare program for the same or similar item. (Refer to Reimbursement Methodology Table at page 3f.)

4. Reimbursement rates for clinical laboratory or laboratory services as described in State Plan Attachment 3.1-A, paragraph 3, entitled "Laboratory, Radiological, and Radioisotope Services," shall not exceed 80 percent of the lowest maximum allowance for California established by the federal Medicare program for the same or similar service. (Refer to Reimbursement Methodology Table at page 3f.)

Reimbursement Methodology Table

Paragraph	Effective Date	Percentage	Authority
1(d)(3)	January 1, 2004	The manufacturer's suggested retail purchase price reduced by a percentage discount of 20%, or by 15% if the provider employs or contracts with a qualified rehabilitation professional	California Welfare and Institutions Code section 14105.48
1(e)(2)	October 1, 2003	The acquisition cost plus a 23% markup	California Welfare and Institutions Code section 14105.48
3	October 1, 2003	May not exceed 80% of the lowest maximum allowance for California established by the federal Medicare program for the same or similar services	California Welfare and Institutions Code section 14105.21
4	October 1, 2003	May not exceed 80% of the lowest maximum allowance established by the federal Medicare program for the same or similar services	California Welfare and Institutions Code section 14105.22

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: California

REIMBURSEMENT METHODOLOGY FOR RADIOLOGY SERVICES

1) Except as otherwise noted in the State Plan, state-developed fee schedules are the same for both governmental and private providers of radiological services. The agency's fee schedule rates were set as of October 1, 2012 and are effective for services provided on or after that date. All rates are published at http://files.medi-cal.ca.gov/pubsdoco/rates/rateshome.asp.

Radiology Rate Reduction

Procedure Code*	2012 Medi-Cal Rate*	2012 Medicare Rate**	New Medi-Cal Rate	New Medi-Cal Technical Rate (TC) (left blank if not split billable)	New Medi-Cal Professional Rate (26) (left blank if not split billable)	Difference Between 2012 Medi-Cal Rate and New Medi-Cal Rate
70010	$173.47	$99.81	$79.85			$93.62
70030	$33.62	$32.54	$26.03	$19.26	$6.77	$7.59
70110	$38.20	$45.12	$36.09	$25.63	$10.47	$2.11
70220	$37.32	$44.73	$35.78	$25.40	$10.38	$1.54
70260	$45.84	$53.75	$43.00	$28.81	$14.19	$2.84
70332	$94.62	$85.01	$68.01	$46.24	$21.76	$26.61
70355	$38.20	$23.45	$18.76	$9.94	$8.82	$19.44
70450	$196.84	$207.37	$165.89	$131.06	$34.84	$30.95
70460	$230.16	$270.91	$216.72	$171.21	$45.51	$13.44
70496	$552.79	$635.67	$508.53	$437.34	$71.19	$44.26
70498	$562.38	$652.84	$522.27	$449.16	$73.12	$40.11
70540	$509.78	$526.33	$421.06	$366.32	$54.74	$88.72
70542	$522.77	$590.50	$472.40	$406.26	$66.14	$50.37
70543	$941.21	$746.57	$597.25	$507.67	$89.59	$343.96
70546	$861.22	$901.87	$721.50	$649.35	$72.15	$139.72
70549	$861.22	$904.41	$723.53	$651.17	$72.35	$137.69
70551	$509.78	$548.86	$439.09	$377.62	$61.47	$70.69
70552	$615.10	$612.34	$489.87	$416.39	$73.48	$125.23
70553	$953.01	$743.05	$594.44	$499.33	$95.11	$358.57
71101	$42.78	$44.65	$35.72	$25.00	$10.72	$7.06
71110	$38.20	$46.21	$36.97	$25.88	$11.09	$1.23
71111	$54.24	$60.46	$48.37	$35.31	$13.06	$5.87
71250	$232.71	$265.47	$212.38	$169.90	$42.48	$20.33
71550	$575.75	$605.14	$484.12	$426.02	$58.09	$91.63
71552	$943.35	$869.10	$695.28	$604.89	$90.39	$248.07
72072	$34.42	$42.50	$34.00	$25.16	$8.84	$0.42
72110	$49.66	$57.00	$45.60	$32.83	$12.77	$4.06
72114	$61.12	$75.12	$60.09	$46.27	$13.82	$1.03
72125	$232.71	$269.57	$215.66	$172.53	$43.13	$17.05
72128	$232.71	$265.55	$212.44	$172.07	$40.36	$20.27
72131	$232.71	$264.77	$211.81	$171.57	$40.24	$20.90
72141	$575.75	$489.87	$391.90	$325.27	$66.62	$183.85
72142	$682.98	$621.56	$497.25	$417.69	$79.56	$185.73
72146	$575.75	$493.77	$395.02	$327.87	$67.15	$180.73
72147	$682.98	$553.64	$442.92	$363.19	$79.72	$240.06
72148	$575.75	$487.59	$390.08	$327.66	$62.41	$185.67

Procedure Code*	2012 Medi-Cal Rate*	2012 Medicare Rate**	New Medi-Cal Rate	New Medi-Cal Technical Rate (TC) (left blank if not split billable)	New Medi-Cal Professional Rate (26) (left blank if not split billable)	Difference Between 2012 Medi-Cal Rate and New Medi-Cal Rate
72149	$682.25	$606.87	$485.50	$412.67	$72.82	$196.75
72156	$971.24	$741.09	$592.87	$486.15	$106.72	$378.37
72157	$971.24	$693.47	$554.78	$449.37	$105.41	$416.46
72158	$970.24	$729.79	$583.83	$484.58	$99.25	$386.41
72191	$421.42	$517.96	$414.37	$339.78	$74.59	$7.05
72192	$232.71	$255.84	$204.67	$159.64	$45.03	$28.04
72193	$253.53	$311.79	$249.43	$202.04	$47.39	$4.10
72195	$442.70	$545.05	$436.04	$374.99	$61.05	$6.66
72196	$562.23	$605.30	$484.24	$411.60	$72.64	$77.99
72197	$948.74	$762.54	$610.03	$518.53	$91.51	$338.71
72220	$26.70	$32.93	$26.35	$19.23	$7.11	$0.35
72285	$277.22	$149.40	$119.52	$70.52	$49.00	$157.70
72295	$163.76	$132.89	$106.32	$70.17	$36.15	$57.44
73200	$211.13	$260.87	$208.70	$166.96	$41.74	$2.43
73206	$401.90	$457.83	$366.27	$293.01	$73.25	$35.63
73218	$436.28	$541.35	$433.08	$376.78	$56.30	$3.20
73219	$522.77	$596.35	$477.08	$410.29	$66.79	$45.69
73222	$522.77	$558.10	$446.48	$379.51	$66.97	$76.29
73223	$941.21	$715.73	$572.59	$486.70	$85.89	$368.62
73530	$61.12	$38.80	$31.04	$19.55	$11.48	$30.08
73550	$25.98	$32.16	$25.73	$18.27	$7.46	$0.25
73700	$211.13	$261.26	$209.01	$167.21	$41.80	$2.12
73706	$442.36	$507.27	$405.82	$328.71	$77.11	$36.54
73718	$436.28	$534.14	$427.31	$371.76	$55.55	$8.97
73719	$522.77	$597.91	$478.33	$411.36	$66.97	$44.44
73722	$522.77	$570.79	$456.63	$388.14	$68.49	$66.14
73723	$941.21	$716.51	$573.21	$487.23	$85.98	$368.00
74022	$45.84	$54.61	$43.69	$30.58	$13.11	$2.15
74150	$232.71	$260.54	$208.43	$160.49	$47.94	$24.28
74175	$447.63	$550.80	$440.64	$361.32	$79.32	$6.99
74181	$562.23	$484.93	$387.94	$329.75	$58.19	$174.29
74183	$948.74	$764.49	$611.60	$519.86	$91.74	$337.14
74475	$103.83	$120.14	$96.11	$74.00	$22.11	$7.72
74480	$129.80	$120.53	$96.42	$74.24	$22.18	$33.38
74485	$108.98	$120.14	$96.11	$74.00	$22.11	$12.87
74710	$43.28	$42.43	$33.95	$20.37	$13.58	$9.33
75600	$245.13	$278.80	$223.04	$202.96	$20.07	$22.09
75605	$259.00	$208.04	$166.43	$119.83	$46.60	$92.57

Procedure Code*	2012 Medi-Cal Rate*	2012 Medicare Rate**	New Medi-Cal Rate	New Medi-Cal Technical Rate (TC) (left blank if not split billable)	New Medi-Cal Professional Rate (26) (left blank if not split billable)	Difference Between 2012 Medi-Cal Rate and New Medi-Cal Rate
75625	$258.38	$209.42	$167.54	$120.63	$46.91	$90.84
75630	$282.99	$244.42	$195.53	$123.19	$72.35	$87.46
75635	$451.64	$564.52	$451.62	$343.23	$108.39	$0.02
75650	$265.83	$229.95	$183.96	$123.25	$60.71	$81.87
75658	$263.66	$238.04	$190.43	$139.01	$51.42	$73.23
75660	$262.24	$254.80	$203.84	$148.80	$55.04	$58.40
75662	$271.11	$300.92	$240.73	$170.92	$69.81	$30.38
75665	$262.20	$262.84	$210.27	$155.60	$54.67	$51.93
75671	$269.62	$309.72	$247.77	$178.40	$69.38	$21.85
75676	$262.36	$247.62	$198.09	$142.63	$55.47	$64.27
75680	$269.62	$282.77	$226.22	$158.35	$67.87	$43.40
75685	$261.86	$252.09	$201.67	$147.22	$54.45	$60.19
75705	$281.00	$300.88	$240.70	$151.64	$89.06	$40.30
75710	$258.77	$233.79	$187.03	$140.27	$46.76	$71.74
75716	$261.90	$274.36	$219.49	$166.81	$52.68	$42.41
75726	$258.23	$232.44	$185.95	$139.46	$46.49	$72.28
75731	$258.23	$225.00	$180.00	$133.20	$46.80	$78.23
75733	$262.05	$270.03	$216.03	$162.02	$54.01	$46.02
75736	$258.23	$229.49	$183.60	$137.70	$45.90	$74.63
75741	$261.71	$214.23	$171.38	$118.25	$53.13	$90.33
75743	$269.42	$243.35	$194.68	$126.54	$68.14	$74.74
75746	$258.12	$224.04	$179.23	$132.63	$46.60	$78.89
75756	$392.20	$243.44	$194.76	$144.12	$50.64	$197.44
75774	$241.27	$149.70	$119.76	$105.39	$14.37	$121.51
75825	$258.23	$201.21	$160.97	$114.29	$46.68	$97.26
75827	$258.04	$205.31	$164.24	$118.26	$45.99	$93.80
75842	$494.23	$244.38	$195.50	$134.90	$60.61	$298.73
75870	$480.40	$205.70	$164.56	$118.48	$46.08	$315.84
75885	$492.05	$220.76	$176.61	$118.33	$58.28	$315.44
75902	$94.00	$87.73	$70.18	$54.04	$16.14	$23.82
75945	$158.61	$185.10	$148.08	$131.79	$16.29	$10.53
75960	$447.40	$180.36	$144.29	$111.10	$33.19	$303.11
75961	$533.69	$374.72	$299.78	$128.91	$170.87	$233.91
75962	$565.17	$202.88	$162.31	$141.21	$21.10	$402.86
75964	$304.03	$130.78	$104.62	$89.98	$14.65	$199.41
75966	$598.14	$244.47	$195.58	$142.77	$52.81	$402.56
75978	$564.52	$207.57	$166.05	$144.47	$21.59	$398.47
75989	$156.81	$146.17	$116.93	$68.99	$47.94	$39.88

Procedure Code*	2012 Medi-Cal Rate*	2012 Medicare Rate**	New Medi-Cal Rate	New Medi-Cal Technical Rate (TC) (left blank if not split billable)	New Medi-Cal Professional Rate (26) (left blank if not split billable)	Difference Between 2012 Medi-Cal Rate and New Medi-Cal Rate
76010	$26.43	$30.55	$24.44	$17.11	$7.33	$1.99
76098	$27.89	$20.48	$16.38	$9.83	$6.55	$11.51
76802	$60.97	$75.71	$60.57	$26.65	$33.92	$0.40
76810	$187.91	$109.87	$87.90	$47.47	$40.43	$100.01
76811	$205.06	$213.33	$170.66	$90.45	$80.21	$34.40
76813	$115.13	$141.32	$113.06	$63.31	$49.74	$2.07
76814	$72.24	$89.93	$71.94	$30.22	$41.73	$0.30
76820	$81.37	$48.46	$38.77	$17.83	$20.93	$42.60
76821	$90.38	$110.55	$88.44	$59.25	$29.19	$1.94
76827	$82.09	$71.96	$57.57	$33.39	$24.18	$24.52
76946	$54.82	$38.77	$31.01	$15.20	$15.82	$23.81
76950	$57.57	$60.27	$48.21	$24.11	$24.11	$9.36
76965	$239.44	$111.85	$89.48	$34.00	$55.48	$149.96
77003	$64.10	$71.12	$56.89	$31.86	$25.03	$7.21
77011	$443.46	$408.57	$326.86	$277.83	$49.03	$116.60
77012	$289.63	$163.25	$130.60	$83.59	$47.02	$159.03
77014	$152.15	$160.53	$128.42	$93.75	$34.67	$23.73
77021	$445.56	$469.96	$375.97	$315.82	$60.16	$69.59
77031	$272.52	$158.93	$127.14	$61.03	$66.11	$145.38
77032	$61.88	$59.17	$47.34	$24.61	$22.72	$14.54
77051	$15.36	$11.88	$9.51	$7.03	$2.47	$5.85
77052	$15.36	$11.88	$9.51	$7.03	$2.47	$5.85
77053	$91.26	$71.24	$56.99	$42.74	$14.25	$34.27
77054	$131.37	$97.06	$77.65	$59.01	$18.64	$53.72
77057	$72.16	$89.67	$71.74	$43.04	$28.70	$0.42
77058	$726.68	$798.50	$638.80	$574.92	$63.88	$87.88
77059	$899.00	$813.72	$650.98	$585.88	$65.10	$248.02
77073	$37.32	$43.30	$34.64	$22.52	$12.12	$2.68
77077	$48.13	$46.66	$37.33	$19.41	$17.92	$10.80
77080	$100.66	$64.04	$51.23	$43.04	$8.20	$49.43
77081	$35.72	$31.96	$25.57	$16.36	$9.20	$10.15
77261	$134.85	$74.39	$59.51			$75.34
77262	$145.92	$111.12	$88.89			$57.03
77263	$210.10	$164.62	$131.69			$78.41
77295	$813.13	$550.71	$440.57	$251.12	$189.44	$372.56
77300	$126.06	$74.55	$59.64	$34.00	$25.65	$66.42
77305	$81.14	$68.01	$54.40	$25.57	$28.83	$26.74
77310	$89.54	$96.74	$77.39	$34.05	$43.34	$12.15

Procedure Code*	2012 Medi-Cal Rate*	2012 Medicare Rate**	New Medi-Cal Rate	New Medi-Cal Technical Rate (TC) (left blank if not split billable)	New Medi-Cal Professional Rate (26) (left blank if not split billable)	Difference Between 2012 Medi-Cal Rate and New Medi-Cal Rate
77315	$121.13	$150.23	$120.19	$55.29	$64.90	$0.94
77321	$179.20	$108.24	$86.59	$47.62	$38.97	$92.61
77328	$258.12	$300.86	$240.69	$154.04	$86.65	$17.43
77331	$53.75	$66.78	$53.42	$17.10	$36.33	$0.33
77333	$95.19	$58.31	$46.64	$12.13	$34.52	$48.55
77336	$55.08	$53.28	$42.63			$12.45
77372	$806.21	$959.62	$767.70			$38.51
77373	$1,517.88	$1,828.87	$1,463.10			$54.78
77401	$32.93	$25.18	$20.14			$12.79
77417	$57.30	$16.20	$12.96			$44.34
77418	$523.76	$545.47	$436.38			$87.38
77421	$144.97	$97.28	$77.82	$62.26	$15.56	$67.15
77435	$543.09	$634.32	$507.46			$35.63
77470	$253.65	$189.02	$151.22	$65.02	$86.19	$102.43
77761	$382.00	$403.12	$322.49	$164.47	$158.02	$59.51
77762	$458.40	$534.28	$427.42	$188.07	$239.36	$30.98
77763	$660.86	$754.39	$603.52	$247.44	$356.07	$57.34
77776	$649.40	$453.42	$362.74	$166.86	$195.88	$286.66
77777	$764.00	$611.02	$488.81	$175.97	$312.84	$275.19
77778	$1,069.60	$898.73	$718.99	$251.65	$467.34	$350.61
77786	$502.28	$627.67	$502.14	$366.56	$135.58	$0.14
77790	$152.80	$99.27	$79.42	$36.53	$42.88	$73.38
78122	$176.94	$116.58	$93.26	$75.54	$17.72	$83.68
78205	$232.68	$252.80	$202.24	$173.93	$28.31	$30.44
78216	$115.98	$142.28	$113.82	$91.06	$22.76	$2.16
78320	$246.24	$269.31	$215.45	$174.51	$40.93	$30.79
78494	$280.04	$282.20	$225.76	$176.09	$49.67	$54.28
78496	$82.89	$70.71	$56.57	$35.64	$20.93	$26.32
78708	$176.94	$194.50	$155.60	$107.36	$48.24	$21.34
78808	$40.19	$47.93	$38.34			$1.85
78811	$2,027.00	$1,205.01	$964.01	$896.53	$67.48	$1,062.99
78812	$2,027.00	$1,222.50	$978.00	$899.76	$78.24	$1,049.00
78813	$2,027.00	$1,226.71	$981.37	$902.86	$78.51	$1,045.63
78814	$2,127.00	$1,236.01	$988.81	$899.82	$88.99	$1,138.19
78815	$2,127.00	$1,247.39	$997.91	$898.12	$99.79	$1,129.09
78816	$2,127.00	$1,248.28	$998.63	$898.77	$99.86	$1,128.37
79005	$172.66	$148.93	$119.14	$47.66	$71.49	$53.52
79101	$180.07	$169.01	$135.21	$51.38	$83.83	$44.86

Procedure Code*	2012 Medi-Cal Rate*	2012 Medicare Rate**	New Medi-Cal Rate	New Medi-Cal Technical Rate (TC) (left blank if not split billable)	New Medi-Cal Professional Rate (26) (left blank if not split billable)	Difference Between 2012 Medi-Cal Rate and New Medi-Cal Rate
79403	$239.80	$210.09	$168.07	$77.31	$90.76	$71.73
79445	$200.50	$247.23	$197.78	$104.82	$92.96	$2.72

REIMBURSEMENT METHODOLOGY FOR ESTABLISHING REIMBURSEMENT RATES FOR DURABLE MEDICAL EQUIPMENT, ORTHOTIC AND PROSTHETIC APPLIANCES, ~~AND~~ LABORATORY~~, AND RADIOLOGY~~ SERVICES

1. The methodology utilized by the State Agency in establishing reimbursement rates for durable medical equipment as described in State Plan Attachment 3.1-A, paragraph 2a, entitled "Hospital Outpatient Department Services and Organized Outpatient Clinic Services", and Paragraph 7c.2, entitled "Home Health Services Durable Medical Equipment", will be as follows:

   (a) Reimbursement for the rental or purchase of durable medical equipment with a specified maximum allowable rate established by Medicare, except wheelchairs, wheelchair accessories, wheelchair replacement parts, and speech-generating devices and related accessories, shall be the lesser of the following:

      (1) The amount billed in accordance with California Code of Regulations, Title 22, section 51008.1, entitled "Upper Billing Limit", that states that bills submitted shall not exceed an amount that is the lesser of the usual charges made to the general public or the net purchase price of the item (as documented in the provider's books and records), plus no more than a 100 percent mark-up. (Refer to Reimbursement Methodology table at page 3e.)

      (2) An amount that does not exceed 80 percent of the lowest maximum allowance for California established by the federal Medicare program for the same or similar item or service. (Refer to Reimbursement Methodology Table at page 3e.)

   (b) Reimbursement for the rental or purchase of a wheelchair, wheelchair accessories, wheelchair replacement parts, and speech-generating devices and related accessories, with a specified maximum allowable rate established by Medicare shall be the lowest of the following:

      (1) The amount billed in accordance with California Code of Regulations, Title 22, Section 51008.1 entitled "Upper Billing Limit", that states that bills submitted shall not exceed an amount that is the lesser of the usual charges made to the general public, or the net purchase price of the item (as documented in the provider's books and records),

schedule and any annual or periodic adjustments to the fee schedule are published in the provider manual and on the California Department of Health Services Medi-Cal website.

3. Reimbursement rates for orthotic and prosthetic appliances as described in State Plan Attachment 3.1-A, paragraph 12c, entitled "Prosthetic and Orthotic Appliances," shall not exceed 80 percent of the lowest maximum allowance for California established by the federal Medicare program for the same or similar item. (Refer to Reimbursement Methodology Table at page 3f.)

4. Reimbursement rates for clinical laboratory or laboratory services as described in State Plan Attachment 3.1-A, paragraph 3, entitled "Laboratory, Radiological, and Radioisotope Services," shall not exceed 80 percent of the lowest maximum allowance for California established by the federal Medicare program for the same or similar service. (Refer to Reimbursement Methodology Table at page 3f.)

~~5. Reimbursement rates for radiology services as described in State Plan Attachment 3.1-A, paragraph 3, entitled "Laboratory, Radiological, and Radioisotope Services," shall not exceed 80 percent of the lowest maximum allowance for California established by the federal Medicare program for the same or similar service. (Refer to Reimbursement Methodology Table at page 3f.)~~

Reimbursement Methodology Table

Paragraph	Effective Date	Percentage	Authority
1(d)(3)	January 1, 2004	The manufacturer's suggested retail purchase price reduced by a percentage discount of 20%, or by 15% if the provider employs or contracts with a qualified rehabilitation professional	California Welfare and Institutions Code section 14105.48
1(e)(2)	October 1, 2003	The acquisition cost plus a 23% markup	California Welfare and Institutions Code section 14105.48
3	October 1, 2003	May not exceed 80% of the lowest maximum allowance for California established by the federal Medicare program for the same or similar services	California Welfare and Institutions Code section 14105.21
4	October 1, 2003	May not exceed 80% of the lowest maximum allowance established by the federal Medicare program for the same or similar services	California Welfare and Institutions Code section 14105.22
~~5~~	~~October 1, 2010~~	~~May not exceed 80% of the lowest maximum allowance established by the federal Medicare program for the same or similar services~~	~~California Welfare and Institutions Code section 14105.08~~