# Medi-Cal Notes to Rates

Medi-Cal Rates are updated and effective as of the 15th of the month and published to the Medi-Cal website on the 16th of the month.

The following information is provided to help you use the Rates worksheet.

This file reflects Medi-Cal fee-for-service rate policy for the listed procedure codes. Medi-Cal’s major rate changes, if they occur, are usually initiated after enactment of the budget act in June, and are effective for dates of service on or after August 1. In general, Medi-Cal reimbursement may be lower than the rates shown if the provider’s charge is lower than the rate. Additionally, certain modifiers cause Medi-Cal reimbursement to be higher or lower than the rates shown.

Rates for the majority of California Children’s Services (CCS)-authorized physician services are 39.7 percent greater than the rate which would otherwise apply. To be reimbursed at the higher rate, providers billing the service must ensure that the service is authorized by the CCS program for a particular child. Augmented rates for CCS-authorized services are not specifically listed on the Rates worksheet.

## Proc Type:

Denotes the procedure or record type. In this worksheet, records are uniquely defined by a combination of procedure type and procedure code. For example, this file contains three records for procedure code 10180, one record for procedure types K, O, and P.

| **Procedure Type** | **Procedure** |
| --- | --- |
| "E" | Local Educational Agency |
| "F" | EAPC |
| "G" | Medi-Cal Waiver |
| "I" | Injection |
| "J" | Anesthesia |
| "K" | Primary Surgeon |
| "L" | Radiology |
| "M" | Pathology and Clinical Laboratory |
| "N" | Medicine |
| "O" | Assistant Surgeon |
| "P" | Podiatrist |
| "Q" | Psychology Services for Mental Health Expansion |
| “T”  | EPSDT |
| “U” | EPSDT |
| “V” | Palliative Care |
| “X” | Targeted Rate Increase |
| “Y” | Justice Involved |
| "1" | Allied Health and other programs |
| "3" | Vision Care |

## Proc Code:

Includes Current Procedural Terminology (CPT) and alpha-numeric Health Care Financing Common Procedure Coding System (HCPCS) codes for covered benefits only. Codes for dental procedures are not included. CPT codes and descriptors are copyright 2000 American Medical Association. All rights reserved. Applicable Federal Acquisition Regulation System (FARS) and Defense Federal Acquisition Regulation Supplement (DFARS) apply.

## Procedure Description:

Lists abbreviated or truncated procedure descriptions. Refer to the current CPT book, HCPCS code book or Medi-Cal provider manuals for complete descriptions. Medi-Cal descriptors for several CPT codes differ from those in the CPT book. Examples are 47135, 90853, and 95115.

## Unit Value:

Lists the relative unit values used to compute the allowable rate, as follows:

* Unit value X dollar conversion factor equals maximum rate.
* Unit values listed for anesthesia services (procedure type “J”) represent base values only.
* Anesthesia time units are computed by allowing one unit for each 15 minutes of anesthesia time spent in attendance with the patient.
* Base unit values for nurse anesthetists are determined by subtracting one unit from the listed anesthesia base unit value.

## Basic Rate:

List of Medi-Cal’s basic rates. The listed rates are exact. Rates for physician services are reimbursable to physicians, physician groups, and non-physician medical practitioners, and, for procedure type “P”, podiatrists. A value of “0.00” or “0.01” means the procedure is priced by the fiscal intermediary.

## Child Rate:

Selected primary care and preventive medicine services are reimbursed at a higher rate for children aged 17 years or under than adults. For these services, rates for child patients are about 9 percent higher than rates for adult patients. For these services, the rates for adults are included in the “Basic Rate” column and the higher rates for children are listed in the “Child Rate” column. The rates are correct to within plus or minus 1 cent.

## ER Rate:

Selected medical and surgery services are reimbursed at a higher rate when performed in a hospital emergency room. The higher emergency room rates for these services are listed in the “Emergency Room Rate” column. The listed rates are correct plus or minus 1 cent. Caution: the rates in this column apply only if the procedure is a Medi-Cal benefit for an emergency room place of service.

## Conv Ind:

Conversion indicators are associated with dollar conversion factors which are used in the Medi-Cal pricing system to compute rates. In the case of physician services, the conversion indicators listed in the Rates worksheet are for services provided by physicians, non-physician medical practitioners, hospital outpatient departments and podiatrists. To compute rates for other provider types such as clinics and nurse practitioners, see the Conversion Factors worksheet for correlating conversion indicators and conversion factors.

## ER Ind:

Indicates the rates for medical and surgery services which exceed the basic rate when provided in an emergency room place of service. The higher emergency room conversion factor for these services is used when the service is provided in a hospital emergency room. A “1” in this column signifies that the higher rate is reimbursable, if this procedure is otherwise a Medi-Cal benefit in this place of service.

Use these rules to price services provided in a hospital emergency room:

1. If “ER Indicator” equals “1” and “Conversion Indicator” on the Rates worksheet equals “07”, use conversion factor $1.04 to compute the maximum rate;
2. If “ER Indicator” equals “1” and “Conversion Indicator” on the Rates worksheet equals “04”, use conversion factor $46.95 to compute the maximum rate;
3. If “ER Indicator” equals “1” and “Conversion Indicator” on the Rates worksheet equals “01”or “53”, use conversion factor $12.42 to compute the maximum rate;
4. If “ER Indicator” equals “1” and “Conversion Indicator” does not equal “07”, “04”, “01” or “53”, or if “ER Indicator” equals “0”, use the “Basic Rate” or the “Child Rate” listed in the Rates worksheet.

## Cutback Ind:

This field identifies medical services which are subject to a 20 percent rate reduction when performed in a hospital outpatient department or, for surgical procedures, in a surgical clinic. The cutback does not apply to an emergency room place of service. A “1” means the procedure is subject to the 20 percent place of service reduction. A “0” means the procedure is not subject to the reduction.

## Prof %:

This percentage is the maximum rate reimbursable as the professional component. The balance of the rate is reimbursable as the technical component. This field applies mainly to pathology, radiology, and certain other diagnostic procedures. A “0” means not applicable.

## Rental Rate:

The rental rate for durable medical equipment.

## Non-Physn Med Prac Ind:

A “Y” in this column signifies the procedure may be reimbursable if performed by a non-physician medical practitioner. An “N” in this column signifies the procedure is not reimbursable if performed by a non-physician medical practitioner.

## Hospital Outpatient Services:

In accordance with the federal and state court judgments in the cases of Orthopaedic Hospital, et al. v. Belshe; San Bernardino County, et al. v. Department of Health Services; and Barlow Respiratory Hospital, et al. v. Department of Health Services, the Medi-Cal Program began reimbursing hospital outpatient department claims an additional amount equal to 30% of the reimbursement rate in effect on June 30, 2001. Rates in effect on June 30, 2001, are considered the base rate for purposes of this calculation. During the period July 1, 2001, through July 1, 2004, the percentage amount will increase as follows:

* Effective July 1, 2001, through June 30, 2002, the additional amount will equal 30.00 percent of the base rate.
* Effective July 1, 2002, through June 30, 2003, the additional amount will equal 34.30 percent of the base rate.
* Effective July 1, 2003, through June 30, 2004, the additional amount will equal 38.81 percent of the base rate.
* Effective July 1, 2004, the additional amount will equal 43.44 percent of the base rate.

This additional reimbursement will **only** apply to claims for hospital outpatient services from hospitals billing with a currently active hospital outpatient department provider number and to services provided on or after July 1, 2001. It will not apply to amounts payable for drugs or medical supplies reimbursed in accordance with Title 22, Sections 51513 & 51520, services that are currently paid a cost based rate, and services for which no rate was established as of June 30, 2001. Also, the additional reimbursement will not be paid for a clinical diagnostic laboratory test in an amount that exceeds the difference between the rate established as of June 30, 2001, and the payment rate recognized for the test under title 42 United States Code, Section 1395(h) under Part B of the Medicare program.

Comprehensive Family Planning Services:

Pursuant to Welfare and Institutions Code section 14105.181 and State Plan,

Attachment 4.19-B, page 3g, reimbursement rates for Evaluation and Management

(E&M) codes for qualifying comprehensive family planning services are

calculated using the unit value for each qualifying E&M code times the applicable

conversion factor plus 90.9 percent.

E&M Current Procedural Terminology (CPT) codes and Primary Family Planning

Diagnosis Codes that qualify as Comprehensive Family Planning Services are

listed below:

E&M CPT codes 99202, 99203, 99204, 99211, 99212, 99213, or 99214 billed with a

primary family planning diagnosis code of Z30.011-Z30.019; Z30.02; Z30.09, Z30.2,

Z30.40-Z30.42; Z30.430-Z30.431; Z30.44-Z30.46; Z30.49; Z30.8-Z30.9 ; Z31.430;

Z31.438; Z31.440-Z31.441; Z31.5; Z71.83.

Procedure type X is not eligible for the above-mentioned reimbursement rate

adjustments associated with Comprehensive Family Planning Services.