Rates: Maximum Reimbursement

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This section describes the maximum reimbursement rates for physicians, podiatrists, nurse anesthetists, physician groups and hospital outpatient departments. For additional information about room charges for facilities, refer to *Rates: Maximum Reimbursement for Outpatient Room Rates*, in the appropriate Part 2 manual.

Reimbursement Calculation for Physician Services

Effective August 1, 2000, Medi-Cal's physician fee schedule is no longer based upon the 1969 California Relative Value Studies (CRVS). Medi-Cal assigns its own unit values for all physician services, except pathology (which generally uses 1974 CRVS values or Medicare's Maximum Allowance), and anesthesia (which uses 90.3 percent of the Uniform Relative Value Guide values).

To determine the basic reimbursement rate for a service, multiply the assigned unit value by the conversion factor on the following pages. Anesthesia reimbursement is calculated differently as noted in the following sections. The Medi-Cal website has the unit value for each procedure. It also provides the actual dollar figure resulting from this computation. The website location is *www.medi-cal.ca.gov*.

"By Report" and unlisted procedures are priced individually based on information included on or with the claim form.

Anesthesia: Physician

The maximum reimbursement rates allowed for anesthesiologist services (CPT® codes 00100 thru 01999) are derived by adding the base unit (for the procedure code) plus the time units (15 minutes per unit) and multiplying by a conversion factor. An additional time unit may be billed only if the fractional time equals or exceeds five minutes, or if total anesthesia time is less than five minutes (*California Code of Regulations* [CCR], Title 22, Section 51505.2). See the *Anesthesia* section in this manual for additional billing instructions.

Anesthesia: Certified Registered Nurse Anesthetist (CRNA)

The maximum reimbursement rates allowed for Certified Registered Nurse Anesthetist (CRNA) services are derived by multiplying a per unit conversion factor by the sum of anesthesia basic units, minus one, and anesthesia time units. One anesthesia time unit represents each 15 minutes of anesthesia time, except when the anesthesia time is a fraction of 15 minutes. An additional time unit may be billed only if the fractional time equals or exceeds five minutes, or if total anesthesia time is less than five minutes (*California Code of Regulations* [CCR], Title 22, Section 51505.2).

Type of Service	**Conversion Factor**
Non-Obstetrical Anesthesia	$11.02
Obstetrical Anesthesia	$13.42

Note: CRNA services must be billed with an appropriate modifier. For more information regarding modifiers and CRNA services, see the *Anesthesia* section of this manual.

Anesthesia Supervision

The reimbursement rate for anesthesia supervision, when used by an anesthesiologist for billing the supervision of nurse anesthetist services, is the dollar difference between the anesthesiologist allowance and the CRNA allowance for the same procedure and time units.

The principle behind this reimbursement method is that the combined fee should not be greater than the total amount reimbursable if the physician were to personally provide the complete anesthesia.

- Anesthesia supervision must be performed by an anesthesiologist.
- Anesthesia supervision excludes the simultaneous administration of anesthesia services while supervising.
- The supervising anesthesiologist can medically direct up to four concurrent procedures.
- The supervising anesthesiologist must:
  - Perform and document a pre-anesthetic examination and evaluation.
  - Prescribe the anesthesia plan.
  - Personally participate in and document performance of the most demanding procedures in the anesthesia plan, including induction and emergence.

- Ensure that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist.
- Monitor the course of anesthesia administration at frequent intervals.
- Remain physically present and available for immediate diagnosis and treatment of emergencies.
- Provide and document indicated post-anesthesia care.

For more information regarding anesthesia, refer to the *Anesthesia* section of this manual.

Physician Services Chart: Unit Value Conversion Factors

The following chart shows the unit value conversion factors for CPT and HCPCS codes. CPT codes also are described in the *Current Procedural Terminology* (CPT) code book.

Evaluation and Management (E&M), Medicine

E&M, Medicine Codes Table

Code	Service	Conversion Factor By Age of Recipient (0-17 years)‡	Conversion Factor By Age of Recipient (18+ years) ‡
See *Table 1*, on a following page	Primary Care I	$10.91*	$10.00*
See *Table 2*, on a following page	Primary Care II	$10.91*	$10.00*
Primary Care I & II services with Place of Service “23” (*CMS-1500*) or facility type “14” with admit type “1” (*UB-04*)	Primary Care I and II in ER	$12.42	$12.42
99281 thru 99285 and most other codes with Place of Service “23” (*CMS-1500*) or facility type “14” with admit type “1” (*UB-04*)	Other Medicine in ER	$1.04	$1.04
99381 thru 99384, 99391 thru 99394	Well Child Visits	$1.21	N/A
99222, 99223, 99232, 99233, 99291, 99292, 99468, 99469, 99471, 99472, 99475 thru 99480, Z0301 thru Z0314, Z1032 and most other Medicine, E&M codes	Other Medicine, E&M	$0.82*	$0.82*
S0265	Other Medicine	$1.00	$1.00

Anesthesia

Anesthesia Codes Table

Code	Service	Conversion Factor All Ages
01958, 01960 thru 01969	OB Anesthesia	$17.06
00100 thru 01953, 01990 thru 01999	Other Anesthesia	$14.01

Surgery

Surgery Codes Table

Code	Service	Conversion Factor All Ages ‡
58600, 58605, 58611, 58615	Tubal Sterilizations	$55.74
56405 thru 58999 (except tubal sterilizations)	GYN Surgery	$50.67*
59000 thru 59350, 59870,59871, 59899	Other OB	$50.67*
59400, 59409, 59414, 59610, 59612	OB (vaginal delivery)	$120.15
59510, 59514, 59525, 59618, 59622	OB (cesarean section)	$82.16
59812 thru 59830, 59841, 59852, 59857	Abortion	$37.23
59840 (regardless of Place of Service)	Abortion	$26.35*
59850, 59851, 59855, 59856(regardless of Place of Service)	Abortion	$34.46
Other surgery codes with Place of Service “23” (*CMS-1500*) or facility type “14” with admit type “1” (*UB-04*)	Emergency Room	$46.95
10000 thru 55999, 60000 thru 69999	Other Surgery	$37.23*

Radiology, Nuclear Medicine

Radiology, Nuclear Medicine Codes Table

Code	Service	Conversion Factor All Ages ‡
70010 thru 79999	Radiology, Nuclear Medicine	$3.82

Primary Care Procedure Codes

***Table 1*. Procedures Considered "Primary Care I" for Reimbursement.**

90951 thru 90966	99221 thru 99223	99316	99429
90967 thru 90970	99231 thru 99233	99336	99460 thru 99462
91105	99238	99341	99464
94772	99239	99342	99465
95115	99291	99344	
96110	99292	99345	
99202 thru 99205	99304 thru 99309	99347 thru 99351	
99211 thru 99215	99315	99417*	

***Table 2*. Procedures Considered "Primary Care II" for Reimbursement.**

91100	94642 thru 94645	95056	96360
92551 thru 92553	94660 thru 94668	95060	99360
92555	95004	95065	96361
92556	95017	95070	‹‹99242 thru 99245››
92587	95018	95076	
92950	95024	95079	‹‹99252 thru 99255››
94002	95028	95180	
94003	95044	95199	
94640	95052	96116	

Podiatry

The following chart shows the unit value conversion factors as they apply to podiatry procedure codes listed in the *Current Procedural Terminology* (CPT) code book.

CPT Section	Adult Conversion Factor	Child Conversion Factor
Primary Care I and II	$10.00	$10.91
Medicine	$0.82	$0.82
Anesthesia	$14.01	$14.01
Surgery	$37.23	$37.23
Radiology/Nuclear Medicine	$3.82	$3.82
Pathology (see "Pathology" in this section)		

Pathology

Medi-Cal covers laboratory services when ordered by a licensed practitioner, except as noted in the *California Code of Regulations* (CCR), Title 22, Section 51311. Reimbursement is made in accordance with CCR, Title 22, Section 51529 at the least of:

- The amount billed
- The charge to the general public
- Per *Welfare and Institutions Code* (W&I Code), Section 14015.22, 80 percent of the lowest maximum allowance established by the federal Medicare program for the same or similar services
- Medi-Cal's maximum allowance

Newborn Metabolic Screening Test

‹‹Newborn metabolic screening test (HCPCS code S3620), mandated by law for heritable disorders, shall be reimbursed at the rate of $211.00 as provided in CCR, Title 17, Sections 6508 and 6520.››

Individual Laboratory Tests

Per *Welfare and Institutions Code* (W&I Code), Section 14015.22, individual laboratory tests are reimbursed at an amount not to exceed 80 percent of the Medicare rate.

Medi-Cal will pay for laboratory tests or groups of tests only when billed by the provider who actually performed the pathology service, except as noted below. Services will be considered performed by the provider if an employee of the provider or the provider personally performs the service.

Exceptions are:

- Hospital outpatient departments billing for pathology services that are referred to and performed by an outside laboratory (excludes the hospital laboratory)
- A licensed clinical laboratory billing for pathology services that are referred to and performed by another licensed clinical laboratory
- A licensed clinical laboratory billing pathology services that are performed at a different location owned and operated by the billing licensed clinical laboratory (modifier 90 must be used)
- Physicians billing for newborn screening (HCPCS code S3620)

Other Services and Supplies

Payment information for the professional services and supplies listed below is in the appropriate Part 2 Allied Health provider manual.

- Acupuncture
- Chiropractic
- Durable Medical Equipment (DME)
- Hearing Aids
- Medical Supplies
- Medical Transportation
- Occupational Therapy
- Orthotic and Prosthetic Appliances and Services
- Physical Therapy
- Psychology
- Respiratory Care Practitioners
- Speech Pathology and Audiology

Note: For required claim information, refer to policy sections in the appropriate Part 2 Allied Health provider manual. For HCPCS billing codes, refer to the billing codes and reimbursement rates sections.

Outpatient facilities must use the *UB-04* claim form when billing for these services and supplies.

Payment information for optometric services and eye appliances is contained in the Vision Care provider manual.

Payment information for radiology services is contained in the Part 2 *Radiology* section.

‹‹Legend››

‹‹Symbols used in the document above are explained in the following table.››

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.
*	Procedures performed in a hospital outpatient department (Place of Service “22” on the *CMS-1500* claim and facility type “13” on the *UB-04* claim) are subject to 20 percent reduction of the maximum allowable where appropriate.
‡	Listed conversion factors are for physicians, physician groups and hospital outpatient departments. Other provider types may have different conversion factors.