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California Department of Insurance

AB 72:1

Average Contracted Rate Form Instructions

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Insurance Code § 10112.81(i)

INTRODUCTION

The Average Contracted Rate Form (“Form”) provides tabs for four sets of procedure codes, as follows:

- 1) **Anesthesia:** Provides a list of procedure codes pertaining to common anesthesia services.
- 2) **Pathology:** Provides a list of procedure codes pertaining to common pathology services.
- 3) **Radiology:** Provides a list of procedure codes pertaining to common radiology services.
- 4) **Other Codes:** Provides a blank worksheet for insurers to provide information on the top 100 other most frequently used services subject to Insurance Code section 10112.8 which are not otherwise listed on the Anesthesia, Pathology, or Radiology tabs.

The Form is separated into three versions, one for each market segment: individual, small group, and large group. Insurers should complete the applicable Form for each market segment in which the insurer currently offers commercial health coverage in California. For example, if an insurer offers coverage in the individual and large group markets, the insurer should submit two completed Forms—the designated Form for the individual market, and that for the large group market.

A. DATA SOURCE

The Average Contracted Rate Form requests total payment and claim volume data for specified procedures. The data fields are defined below. The source of the underlying claims data for the requisite information shall be limited to claims incurred in calendar year 2015 in California under the insurer’s commercial health coverage in all market segments.

B. DATA FIELD DEFINITIONS

1. **CPT Code:** This field is preset on the Anesthesia, Pathology, and Radiology tabs, and provides the applicable Current Procedural Terminology code for each listed procedure.

2. **Procedure Code:** This field applies to the Other Codes tabs only. Provide the applicable procedure code in the Procedure Code column for each procedure identified on the tab. Please use the procedure code that is customarily used to bill for each listed procedure.
3. **Code Type:** This field applies to the Other Codes tabs only. Indicate the type of procedure code (such as CPT) for each code listed under the Procedure Code column.
4. **Description:** Provides the description of the listed procedure. This field is preset on the Anesthesia, Pathology, and Radiology tabs. On the Other Codes tabs, the insurer must provide the applicable procedure description for each of the listed procedure codes.
5. **Modifier (if applicable):** To the extent the insurer modifies its reimbursement rates for a listed procedure based on modifier codes or conversion factors, provide any applicable modifier codes and/or conversion factors for each listed procedure. Each listed procedure must include at least the global payment amount, in addition to any applicable modifiers.

On the Anesthesia, Pathology, and Radiology tabs, up to four modifiers may be provided for each listed procedure. If no modifiers or fewer than four modifiers apply to a procedure, leave any unnecessary modifier rows for that procedure blank. Do not attempt to delete any rows. If more than four modifier codes apply to a listed procedure, please list the four most common modifiers (including the global payment) applicable to that procedure.
6. **Regions:** The information provided in the sub-columns of each region must be limited to the payment and claim volume data specific to services provided in that region.
7. **Physicians:** Provide the payment and claim volume data for payments made for services provided by a physician and surgeon licensed by the state to provide health care services, including a holder of a physician's and surgeon's certificate, a doctor of podiatric medicine's certificate, or an osteopathic physician's and surgeon's certificate pursuant to the Business and Professions Code, for claims involving the listed procedure (and modifier, if applicable).
8. **Other Licensed Health Professionals:** Provide the payment and claim volume data for payments made for services provided by other health professionals licensed by the state to provide health care services (excluding dentists licensed pursuant to the Dental Practice Act (Business and Professions Code section 1600 et seq.)), for claims involving the listed procedure (and modifier, if applicable).
9. **Total Payments:** For each listed procedure (and modifier, if applicable), provide the total dollar amount of all payments made by the insurer and insured for all claims incurred in calendar year 2015 in each applicable geographic region for that procedure provided by contracted individual health professionals, as defined in Insurance Code section 10112.8(f)(3). The payment data must be specific to services provided by the indicated provider category (Physicians or Other Licensed Health Professionals).
10. **Total No. Paid Claims:** For each listed procedure and applicable modifier code, provide the total number of all paid claims incurred in calendar year 2015 in each applicable geographic region. The claim volume data must be specific to services provided by the indicated provider category (Physicians or Other Licensed Health Professionals).

11. Average Contracted Rate: This field is automatically calculated by the form using the information in the Total Payments and Total No. Paid Claims columns.

C. REGIONS

- 1. Individual market** regions are the 19 geographic rating regions defined in Insurance Code § 10965.9(a)(2)(A).
- 2. Small group market** regions are the 19 geographic rating regions defined in Insurance Code § 10753.14(a)(2)(A).
- 3. Large group market** regions shall be insurer-specific and based on the geographic regions the insurer uses to rate its commercial large group health coverage in California. If an insurer offers large group market coverage in California, complete the Regions tab in the large group market-specific Form to provide the insurer-specific large group geographic region definitions.

D. REGIONS TAB – LARGE GROUP MARKET FORM

- 1. Region Methodology:** Describe the method(s) and geographic unit(s) by which the insurer defines its large group rating regions. Please define any uncommon acronyms in the description. If additional space is needed to describe the insurer’s methodology, the description may be submitted as a separate attachment.
- 2. Region #:** Regions should be consecutively numbered starting with Region 1. The form is pre-numbered for up to 35 regions. These numbers will correspond to the regional data columns on the procedure tabs. Only complete rows for as many geographic regions as the insurer uses for the large group market. Any unnecessary rows may be deleted or left blank.

If the insurer uses more than 35 large group rating regions in California, please contact the Department at Bruce.Hinze@insurance.ca.gov to obtain a customized Average Contracted Rate Form. Please include the number of large group regions in the email.
- 3. Insurer’s Large Group Region Definition:** Describe the geographic regions that comprise each numbered region.

E. OTHER MOST FREQUENTLY USED CODES

- 1. Other Codes Tab:** Under the Other Codes tab, list the other services most frequently subject to Insurance Code section 10112.8 not otherwise listed in the Anesthesia, Pathology, or Radiology tabs. If an insurer offers commercial health coverage in multiple market segments, the same list of procedures should be used on the Other Codes tab for each market segment.

The list should include 100 distinct procedure codes, exclusive of any applicable modifiers or conversion factors. A procedure code listed multiple times with different modifiers will count as one procedure code for this purpose.

For each service, provide the applicable procedure code, standard description, plus any applicable modifiers for each identified procedure. Complete the rest of the fields on the Other Codes tab consistent with the instructions above.

The 100 procedure codes identified by the insurer should represent the services represent the most frequently used services in calendar year 2015 which required payments by the insurer and/or insured to noncontracting individual health professionals for services provided in a contracting health facility. These procedures can involve any category of individual health professional, and are not limited to anesthesia, radiology, or pathology services.

- 2. Methodology/Criteria for Most Frequently Used Codes:** On a separate attachment, describe the methodology and criteria the insurer used to develop the list of services most frequently subject to Insurance Code section 10112.8 for inclusion on the Other Codes tab.
- 3. Justification to Provide Fewer than 100 Procedure Codes:** If the insurer believes that the other services most frequently subject to section 10112.8 would be appropriately encompassed by fewer than 100 procedure codes, please provide, on a separate attachment with the Form, a narrative justification explaining why providing data for fewer than 100 distinct procedure codes provides, in combination with the three specialty-specific tabs, the range of services most frequently subject to section 10112.8. This explanation should include the percentage of total payments to such noncontracting individual health professionals represented by the proposed number of “other most frequently used codes,” in combination with the three specialty-specific tabs.

F. INTERIM METHODOLOGY FOR CALCULATION OF AVERAGE CONTRACTED RATES

Please provide the following as a separate attachment to the SERFF filing:

- 1.** A narrative description of the insurer’s methodology for determining the average contracted rate for services subject to Insurance Code section 10112.8 not otherwise listed in the Average Contracted Rates Form, including the highest and lowest contracted rates.
- 2.** A copy of the insurer’s policies and procedures used to implement this methodology.