

Fact Sheet on the Resource Based Relative Value Scale (RBRVS) Fee Schedule Effective January 1, 2014

1. *When did the new RBRVS-based fee schedule become effective?*

- 1.1. The RBRVS-based physician and non-physician practitioner fee schedule is effective for *services rendered* on or after January 1, 2014.
- 1.2. The rule as initially adopted through rulemaking was based upon Medicare's 2013 policies and RVUs. After reviewing Medicare's Physician Fee Schedule 2014 Final Rule (issued November 27, 2013), the Division updated the workers' compensation Physician Fee Schedule regulations in accordance with Labor Code §5307.1 by issuing and posting an Administrative Director update Order adopting relevant changes from the 2014 Medicare Physician Fee Schedule. Although the Medicare Physician Fee Schedule Final Rule is usually issued approximately November 1st, it was delayed in 2013 due to the federal government shutdown.
- 1.3. The Update Order and regulations are posted on the Division's Official Medical Fee Schedule (OMFS) web page: <http://www.dir.ca.gov/dwc/OMFS9904.htm#7> .
 - 1.3.1. As part of that Order, the Administrative Director updates the links and documents incorporated by reference into title 8, Cal. Code Regs. §9789.19. The Order also updates the conversion factors to account for inflation in accordance with the Medicare Economic Index and the relative value scale adjustment, if any.
 - 1.3.2. The Physician Fee Schedule uses the Medicare 2014 relative value units and 2014 CPT codes.
 - 1.3.3. The posted regulations include provisions adopted in the initial rulemaking action, in the "clean up" rulemaking (to eliminate use of federal Office of Workers' Compensation Program values), and in the Administrative Director's Update Order.

2. **How does the RBRVS fee schedule work?**

- 2.1. The fee schedule has three components:
 - 2.1.1. *Relative Value Units (RVUs)* for each medical service measure the relative resources associated with the physician's work (the time and skill required for the procedure), practice expenses (the staff time and costs of maintaining an office), and malpractice expenses. The RVUs compare the resources required for one service to those required for other services. Relative to the pre-2014 OMFS, the RBRVS tends to provide lower relative values for surgical and other technical procedures and higher relative values for E&M services. Most RVUs will be based on Medicare's RVUs. If Medicare has not established RVUs for a reimbursable procedure code the services will be priced By Report.
 - 2.1.1.1. The pre-2014 OMFS set one RVU for each procedure, and did not list separate RVUs for physician work, practice expense and malpractice. The RBRVS-based fee schedule adopts the Medicare relative value scale file which sets forth separate RVUs for work, practice expense and malpractice.
 - 2.1.1.2. The pre-2014 OMFS set the same fee for a physician service regardless of where the service was rendered, e.g. the physician received the same fee if the procedure was performed in a physician office or at an inpatient facility. The RBRVS-based fee

schedule adopts the Medicare approach which has different RVUs for physician services in a “facility” vs. a “non-facility.” Generally the physician “non-facility” practice expense RVU is higher than the “facility” practice expense RVU. In the non-facility setting such as the physician’s office, the physician bears higher overhead/practice costs than if the physician performed the service in a facility.

2.1.1.3. The RBRVS-based fee schedule sets out a table designating “facility” or “non-facility” status for various “place of service” codes.

2.1.2. A *conversion factor* (CF) is a dollar amount that is used in a formula to convert the RVUs into a payment amount for a service. The CF determines overall fee schedule payment levels. The fee schedule starts with separate conversion factors for surgery, radiology, and “all other services” in 2014 and transitions to a single CF beginning 2017, for all services except anesthesia. Anesthesia is priced under a different scale (using base units and time units) and will continue to have a separate conversion factor. The Anesthesia conversion factor also transitions during the period 2014 through 2017.

2.1.3. A *geographic adjustment factor* (GAF) adjusts for geographic differences in the costs of maintaining a physician practice. Medicare uses adjustment factors for nine geographic areas or localities in California, but for California workers’ compensation the regulations adopt statewide average GAFs. For services other than Anesthesia, the RBRVS-based regulation reduces administrative complexity by using statewide average geographic adjustment factors for each RVU component, instead of Medicare’s nine locality adjustments. For Anesthesia, there is one statewide GAF for all anesthesia procedures since anesthesia “base units” are not broken down into work, practice expense and malpractice components.

2.2. The RBRVS-based fee schedule will be updated annually, and will have mid-year updates as needed. The conversion factor will be updated based on the increase in the Medicare Economic Index and any relative value scale adjustment adopted by Medicare. These updates are mandated by SB 863 (Labor Code section 5307.1(b) (2) (A) (iii), (g)). The inflation adjustment, which does NOT include any adjustments for the Medicare sustainable growth rate (SGR) measure, should provide predictable and equitable annual adjustments based on changes in the costs of maintaining a medical practice. SB 863 does not include the SGR as an update factor, and evidences intent to disallow the SGR to impact workers’ compensation fees by specifying the July 2012 Medicare payment (which did not utilize SGR) as the benchmark. The SGR formula has been severely criticized, and for many years, Congress has passed bills to prevent the SGR from going into effect.

2.2.1. The RBRVS will be phased in over a four-year period through changes in the conversion factor applicable to each type of service. The conversion factors (set forth in 8 CCR §9789.12.5), *before adjustment for inflation and relative value scale adjustment*, are shown in Table 1. (Since they must be adjusted for inflation and relative value scale adjustment, the conversion factors in Table 1 are not the adjusted conversion factors that will be used in calculating payments.)

Table 1. Transition Conversion Factors Before Adjustments for Inflation/RV Scale Adjustment

Type of Service	RAND Budget-Neutral CF	120% 2012 Medicare ^a	2014 CF 75/25 Blend	2015 CF 50/50 Blend	2016 CF 25/75 Blend	2017 CF 120% Medicare
Anesthesia	34.5903	25.6896	32.3651	30.1400	27.9148	25.6896
Surgery	55.6849	40.8451	51.9750	48.2650	44.5551	40.8451
Radiology	52.9434	40.8451	49.9188	46.8943	43.8697	40.8451
All other services	34.4566	40.8451	36.0537	37.6509	39.2480	40.8451

^a The Medicare 2012 CFs for anesthesia and all other services are \$21.408 and \$34.042, respectively.

2.2.2. The Conversion Factors for each year will be updated with the published inflation factor and the Medicare relative value scale adjustment, if any. The updated conversion factors will be adopted by use of an Administrative Director Order posted on the DWC website as specified in Labor Code section 5307.1 subdivision (g). For 2014, the updated conversion factors (set forth in 8 CCR §9789.19) are shown in Table 2.

Table 2. 2014 Conversion Factors, Adjusted for Inflation and Relative Value Scale Budget Neutrality Adjustments

Type of Service	2014 CF
Anesthesia	33.8190
Surgery	55.2913
Radiology	53.1039
All other services	38.3542

2.3. The maximum fee for a workers' compensation medical service performed in 2014 is calculated by applying the appropriate formula and ground rules.

Example: Injured worker is a new patient who is examined in the physician's office. Physician bills CPT® 99205 Office or other outpatient visit for evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; comprehensive examination; medical decision making of high complexity.

Step 1: Determine if place of service is "facility" or "non-facility" (§9789.12.2(d). Physician's Office is Place of Service code 11 Office, a "non-facility" setting.

Step 2: Select formula for non-facility site of service calculation (§9789.12.2(a)).

Non-facility site of service fee calculation:

$$[(\text{Work RVU} * \text{Statewide Work GAF}) + (\text{Non-Facility PE RVU} * \text{Statewide PE GAF}) + (\text{MP RVU} * \text{Statewide MP GAF})] * \text{Conversion Factor (CF)} = \text{Base Maximum Fee}$$

Key: RVU = Relative Value Unit
 GAF = Average Statewide Geographic Adjustment Factor
 Work = Physician Work
 PE = Practice Expense
 MP = Malpractice Expense

Step 3: Open the CMS' 2014 Medicare National Physician Fee Schedule Relative Value File (Zip Folder "RVU14A", then the file "PPRRVU14_V1219" (Link is set forth in §9789.19)) to identify the Non-Facility RVUs for Practice Expense, and the RVUs for Work and Malpractice.

Work RVU	Column F	3.17
Non-facility PE	Column G	2.35
Malpractice	Column K	0.26

Step 4: Identify the Average Statewide Geographic Adjustment Factors to use (set forth in §9789.19).

Statewide GAFs (Other than anesthesia)	Average Statewide Work GAF: 1.040 Average Statewide Practice Expense GAF: 1.1606 Average Statewide Malpractice Expense GAF: 0.6636
---	--

Step 5: Identify the 2014 Conversion Factor to use (set forth in §9789.19).

The "Evaluation and Management" code is not "anesthesia", "surgery" or "radiology"; rather it falls within the "other services". Therefore the Conversion Factor to use is \$38.3542.

Conversion Factors adjusted for MEI and Relative Value Scale adjustment factor, if any	Anesthesia Conversion Factor: \$33.8190 Surgery Conversion Factor: \$55.2913 Radiology Conversion Factor: \$53.1039 Other Services Conversion Factor: \$38.3542
--	---

Step 6: Apply the formula for non-facility site of service calculation (§9789.12.2(a)).

$$[(\text{Work RVU} * \text{Statewide Work GAF}) + (\text{Non-Facility PE RVU} * \text{Statewide PE GAF}) + (\text{MP RVU} * \text{Statewide MP GAF})] * \text{Conversion Factor (CF)} = \text{Base Maximum Fee}$$

$$[(3.17 * 1.040) + (2.35 * 1.1606) + (0.26 * 0.6636)] * \$38.3542 = \$237.67$$

Step 7: Apply relevant ground rules, if any, to the Base Maximum Fee to determine the payable fee (e.g., the Health Professional Shortage Area 10% bonus payment.) Note, however, that certain ground rules are applied during the initial calculations rather than being applied at the end of the formula. For example, the Physical Therapy Multiple Procedure Payment Reduction is applied to reduce the practice expense RVU component of multiple procedures during the initial calculations using the formula; the Physical Therapy MPPR is not applied at the end of the calculations as that would result in an incorrect reduction.

3. What are the biggest changes in ground rules?

3.1. The ground rules adopted in the RBRVS-based fee schedule adopt Medicare ground rules, with some exceptions. The exceptions address WC-specific programmatic needs such as WC-required reports. Unless there was a compelling policy reason for retaining a pre-2014 OMFS rule, the Division adopted Medicare payment rules.

3.1.1. Adopting the Medicare rules simplifies the administration of the fee schedule and brings WC policies in conformance to how the RBRVS rates are set.

3.1.2. Aggregate payments under the RBRVS are limited to 120 percent of Medicare aggregate payments. If different policies were adopted for Medicare-covered services that increase aggregate payments, an offsetting adjustment would be required.

3.2. *Coding.* The RBRVS-based fee schedule regulation adopts the American Medical Association's *Current Procedural Terminology*[®] and incorporates it by reference into the regulations. The new edition of the CPT will be adopted each year through an Administrative Director update Order. The regulations specify certain CPT codes that are not to be used.

3.3. *Supplies and reports.* The pre-2014 OMFS provided separate allowances for certain reports and supplies. The RBRVS-based fee schedule generally bundles payment for reports and supplies into the payment for E&M and other services. Certain WC-required reports that are separately reimbursable continue to be paid separately, including progress reports, permanent and stationary PR-4 reports, consultation reports requested by the QME or AME in the context of a medical-legal evaluation and consultation reports requested by the WCAB or Administrative Director.

3.4. *Consultations.* The pre-2014 OMFS utilized consultation codes. The RBRVS-based fee schedule does not use consultation codes, but follows the Medicare rule which uses visit codes to report consultation services.

- 3.4.1. The rule generally follows Medicare, using the visit codes and bundling consultation reports, however separate payment is allowed for workers' compensation required consultation reports requested by the Workers' Compensation Appeals Board or requested by a QME or AME during a medical-legal evaluation. In 2010, Medicare stopped recognizing CPT codes for consultation services and instead pays for consultations using the E&M visit codes. Medicare found that distinguishing between consultations and patient referrals was problematic and subject to abuse. To make the change budget neutral, CMS increased the payment for E&M visits (CMS, 2009) so that the E+M visit codes account for consultations.
- 3.5. *Surgical global periods.* Under both the pre-2014 OMFS and the RBRVS-based fee schedule, a single global surgical fee covers a package of services including the surgical procedure itself, immediate pre and post-surgical services, and E&M services routinely delivered after the surgery in a fixed period of time. Surgical procedures are assigned a global period length of zero, 10, or 90 days. The global period is indicated for each surgical procedure in the Physician Fee Schedule Relative Value file on the CMS website.
- 3.5.1. Post-surgical E&M visits account for a considerable proportion of the total time and work associated with surgical procedures in the RBRVS but there is some concern regarding whether the global billing rules provide sufficient recognition of work-related components of follow-up care. Because both Medicare and WC use global periods, data are not available to determine the intensity and frequency of visits during the global periods.
- 3.5.2. WC patients have a shorter length of stay than Medicare patients for surgical admissions and are generally younger and healthier than Medicare patients. *Implementing a Resource-Based Relative Value Scale Fee Schedule for Physician Services*, Wynn et al., 2013. As a result, they are likely to require fewer follow-up visits for *medical* reasons. However, there is some concern regarding whether WC patients require more follow-up visits for workers' compensation-specific reasons.
- 3.5.3. To provide protection when a patient requires additional visits, the rule allows for a surgeon to submit documentation and be paid for medically necessary visits during the global period that exceed the number of visits incorporated into the global payment as indicated in the Medicare Physician Time File.
- 3.6. *Physical medicine.* Many of the pre-2014 OMFS ground rules are eliminated and new ground rules based on the Medicare payment rules are adopted.
- 3.6.1. The RBRVS-based rule eliminates the pre-2014 OMFS "cascade" for multiple physical therapy procedures, and instead follows Medicare's rules for discounting multiple physical medicine procedures. The rule adopts the Medicare Multiple Procedure Payment Reduction ("MPPR") for "Always Therapy" codes and applies the discounting to chiropractic and acupuncture codes as well as therapy services provided to the same patient on the same day. Pursuant to the MPPR, full payment is made for the procedure with the highest practice expense payment. For additional procedures or additional units of the same procedure, full payment is made for the work and malpractice components of each procedure and 50 percent payment is made for the *practice expense* component of each procedure.

- 3.6.2. The pre-2014 OMFS limits on the number of procedures and time billed during an encounter will continue as “presumed reasonable limits on reimbursement.” Medically necessary procedures above the limits must be preauthorized and subject to a pre-negotiated fee agreement in order to be paid.
- 3.7. *Non-physician practitioners.* The pre-2014 OMFS does not differentiate between physicians and non-physician practitioners acting within their scope of practice for purposes of determining the maximum allowable fee for a procedure. The RBRVS-based fee schedule adopts the Medicare rules relating to non-physician practitioner fees.
- 3.7.1. Unless their services are billed “incident to” a physician’s service, the RBRVS-based fee schedule: a) pays services furnished by nurse practitioners and physician assistants at 85 percent of the allowed amount for physician services; b) pays clinical social workers at 75 percent of the allowed amount. The rule follows the Medicare ground rules and pays for non-physician practitioners at the discounted rate when they bill directly for their services (rather than a physician billing for their services “incident to” the physician’s service).
- 3.8. *Physician-administered vaccines and drugs.* The pre-2014 OMFS contains outdated allowances for physician-administered vaccines and drugs that are injected or infused during an E&M visit or other procedure.
- 3.8.1. The new rule follows the MediCal fee schedule for drug ingredients because it provides broader drug coverage than Medicare. The fee schedule is contained in the Medi-Cal Rates file.
- 3.8.2. The MediCal Rates file follows Medicare for most drugs, which sets the maximum rate at the Average Sales Price (ASP) plus 6 percent. If a drug does not have a Medicare ASP price, MediCal’s pharmacy pricing methodology for outpatient prescription drugs applies.
- 3.8.3. The “Basic Rate” price listed on the Medi-Cal rates page includes an injection administration fee of \$4.46. This injection administration fee should be subtracted from the published rate because payment for the injection administration will be determined under the RBRVS.
- 3.8.4. The Medi-Cal Rates file applies to the *physician-administered* drugs, not to *physician-dispensed* drugs (which are governed by Labor Code section 5307.1 and title 8, Cal. Code Regs. §9789.40.)
- 3.9. *Health Professional Shortage Area (HPSA) Bonus.* The RBRVS-based fee schedule adopts the Medicare HPSA bonus payments. Physicians who provide professional services in a Primary Care or Mental Health HPSA are eligible for a 10-percent bonus payment.
- 3.9.1. Only psychiatrists are eligible for the Mental Health HPSA, and if the service is performed in a zip code that is both a primary and mental health HPSA, only one 10-percent bonus is payable.
- 3.9.2. Eligibility for the HPSA bonus is determined by the location services were rendered, not where the physician maintains his/her office.
- 3.9.3. The rule provides that the claims administrator must automatically pay the 10% bonus along with the underlying payment for the service, if the service is performed in a zip code that fully falls within the HPSA. For services rendered in a zip code that does not fall within

a fully county HPSA, the physician must use the “AQ” modifier to request the HPSA bonus payment if the site of service falls within the HPSA.

4. Why is the RB-RVS a major reform in physician payment?

- 4.1. The pre-2014 OMFS for physician services used outdated procedure codes to describe medical services. This presented an administrative burden on providers, who needed to maintain a separate coding system for WC patients, and increased fee disputes between providers and payers over services that are not described in the OMFS. The Resource Based Relative Value Scale (RBRVS) replaces more than 980 outdated codes. The percentage of payments that will be using fee schedule rates rather than “By Report” increases from 90 percent to at least 96 percent. This will improve the system by providing certainty about fees and reducing disputes.
- 4.2. The relative values in the pre-2014 fee schedule were based on historical charges, which tended to undervalue Evaluation & Management (E&M) services relative to surgical or other technical procedures. Overvaluing a service provides an incentive for unnecessary utilization while undervaluing a service could raise access issues. The RBRVS reflects the resources (costs) required to furnish services and provides neutral incentives for providing services.
- 4.3. The pre-2014 fee schedule had not been updated with new codes and relative value units since 1999. Linking the OMFS to the Medicare Physician Fee Schedule (MPFS) provides a mechanism for annual updates for changes in coding, practice patterns and inflation. In the future, the OMFS will be more consistent with the payment policies and processes used by other payers.

5. How will the RBRVS fee schedule affect administrative burden?

- 5.1. Annual updates in the procedure codes and relative values will reduce administrative burden on providers since they will no longer need to maintain two separate sets of procedure codes.
- 5.2. The fee schedule should reduce frictional costs for providers and payers:
 - 5.2.1. Fewer services will be priced By Report (BR). For the most part, supplies that were previously priced BR will be bundled into the payment for the service.
 - 5.2.2. The ground rules are clearly delineated, including correct coding policies and documentation requirements for evaluation and management services.

6. What are the implications of the RBRVS on spending for physician services?

- 6.1. Total allowances under the RBRVS are projected to increase 11.9 percent by the end of the transition in 2017. Regular annual updates are projected to increase spending by 8 percent over this period. The rest of the increase is attributable to transitioning from pre-2014 OMFS payment levels to 120 percent of July 2012 Medicare payment levels. (The pre-2014 OMFS anesthesia payments are 161% and the pre-2014 OMFS “all other services” are 116% of July 2012 Medicare.)
- 6.2. Changes in total allowances are in accordance with the provisions of SB 863 which mandates the transitioned RBRVS to be no more than 120% of July 2012 Medicare, plus inflation adjustments in accordance with the MEI, and relative value scale adjustments, if any.
- 6.3. On average, the RBRVS will:
 - 6.3.1. Increase allowances for E&M services and services that are classified as medicine.
 - 6.3.2. Reduce allowances for surgery, radiology, anesthesiology, and pathology.

6.4. Because most providers furnish a range of services, most impacts by provider specialty are less than the impacts by type of service. Table 2 compares the estimated impacts by type of service and selected specialties at the end of the transition period in 2017 when allowances will be based on 120 percent of the Medicare 2012 rate updated for inflation.

Table 3: Summary of Impacts by Type of Service and By Specialty in 2017 Relative to Pre-2014 OMFS

	By Type of Service	By Specialty
Surgery	-20.1 percent	-8.7 percent
Radiology	-15.9 percent	-23.3 percent
Pathology	-29.0 percent	-6.9 percent
E&M	+39.5 percent	
Anesthesiology	-19.6 percent	-15.3 percent
Medicine	+17.3 percent	
Chiropractic		+22.3 percent
Family and general medicine	---	+12.0 percent
Physical therapy	---	+64.7 percent
Physical medicine and rehab	---	+51.7 percent
Psychiatry	---	+2.6 percent
Occupational medicine	---	+29.2 percent