Working Paper

Implementing a RB-RVS Fee Schedule for Physician Services

An Assessment of Policy Options for the California Workers' Compensation Program

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Preface

Senate Bill 863 requires that the administrative director (AD) of the Division of Workers' Compensation implement a resource-based relative value scale fee schedule to establish maximum allowable fees for physician and other practitioner services under the California workers' compensation system. The Department of Industrial Relations asked RAND to provide technical assistance in implementing the fee schedule. This working paper is designed to inform the rulemaking process by modeling the impact of the proposed policies. It also examines alternative policies that might be considered but does not make specific recommendations on those policies. The final product will be a formally edited and peer-reviewed RAND report. The report should be of interest to the California provider and payer communities and to policymakers in California and other states that are considering implementing a resource-based physician fee schedule for medical services provided to injured workers.

This research was conducted under the umbrella of the RAND Center for Health and Safety in the Workplace.

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The RAND Center for Health and Safety in the Workplace conducts research and analysis that help improve worker health and safety and reduce the economic costs of workplace accidents and illnesses. The center provides rigorous, objective analysis and a neutral venue in which to convene stakeholders from government, industry, and labor.

The center is part of the RAND Safety and Justice Program, which addresses all aspects of public safety and the criminal justice system, including violence, policing, corrections, courts and criminal law, substance abuse, occupational safety, and public integrity. Program research is supported by government agencies, foundations, and the private sector.

Questions or comments about this report should be sent to the project leader, Barbara Wynn (Barbara_Wynn@rand.org). For more information on the RAND Center for Health and Safety in the Workplace, see http://www.rand.org/jie/centers/workplace-health-safety.html or contact the director (chsw@rand.org).

Abstract

The study uses 2011 medical data to examine the impact of implementing a resource-based relative value scale to pay for physician services under the California worker's compensation system. Current allowances under the Official Medical Fee Schedule are approximately 111 percent of Medicare allowed amounts and will transition to 120 percent of Medicare over four-years. Using Medicare policies to establish the fee schedule amounts, aggregate allowances will decrease for four types of service by the end of the transition in 2017: anesthesia (-16.5 percent), surgery (- 13.4 percent), radiology (-9.6 percent) and pathology (-19.5 percent). Aggregate allowances for evaluation and management visits and for medicine will increase by 49.0 percent and 23.3 percent respectively.

Table of Contents

Preface ii
Abstract iii
Figures vi
Tables vii
Summary ix
Background ix
Impact Analyses x
Acknowledgments xviii
Abbreviations xix
1. Introduction 1
Description of OMFS and Its Shortcomings 1
A Brief Description of the RB-RVS 2
History of RB-RVS in California 3
Overview of RAND Analysis 4
Organization of This Report 6
2. Data 7
WCIS Data 7
Additional Data Sources 10
3. Analytical Approach 11
Cross-walking to 2013 Codes 11
Pricing under OMFS 12
Baseline pricing under RB-RVS 14
Pricing Anesthesia Services 20
4. Descriptive Results 22
Services and Payments under the OMFS Fee Schedule 22
Services under the RB-RVS 25
5. Impact analysis 28
6. Alternative Ground Rules 31
Geographic Adjustments 32
Alternative Conversion Factors 36
Non-physician Practitioners 37
Bundling Policies 44
Consultations 50
Global fees 55
Physician-administered Drugs 62
Hospital Outpatient Services 69

Ambulatory Surgery Center Services 76
Coding and Documentation Policies 76
E&M guidelines 80
Incorporating Pay-for-performance Elements into the OMFS 83
7. Summary 90
Appendix A 92
Physician Fee Schedule Payment Ground Rules: A Comparison of the OMFS and Medicare 92
Appendix B OMFS to 2013 CPT Crosswalk 100
Appendix C OMFS Codes with No 2013 CPT Equivalent Codes 160
Appendix D Analysis of Alternative PAD Pricing Policies 162
References 164

Figures

Figure 4.1 Distribution of Payments for Physician and Other Practitioner Services by Type of Payment 22
Figure 4.2 Distribution of Services by OMFS Type of Service 23
Figure 4.3 Distribution of Total OMFS Paid Amounts by Type of Service Category 23
Figure 4.4 Distribution of 2011 OMFS Payments by Locality 25
Figure 6.1 Services and Payments by Provider Type 40
Figure 6.2 Global Period Definitions 55

Tables

Table S.1 Revised Transition CF after Adjustment for Inflation and before Geographic Adjustment xi
Table S.2 Impact of RBRVS Implementation on Maximum Allowable Fees, by Service Type and Transition Year xiii
Table S.3 Impact of RBRVS Implementation on Maximum Allowable Fees, by Provider Specialty and Transition Year xiv
Table S.4 Impact of Using a Statewide GAF on Aggregate Allowances xv
Table 2.1 Nature of Injury in 2011 (All Claims with FROI vs. Only Claims with Medical Data) 8
Table 2.2 Percentage of Payments by Physician Specialty (WCIS and WCIRB) 9
Table 3.1 Modifications Based on DWC Ground Rules 13
Table 3.2 Pricing Based on Medicare Ground Rules 14
Table 3.4 Default Transition CFs Specified in Labor Code Section 5307.1(a)(2) 19
Table 3.5 Estimated Increases in the Medicare Economic Index 2012-2017 20
Table 4.1 OMFS 2011 Paid Amounts by Provider Specialty 24
Table 4.2 Service Volume and Total Maximum Allowable Fees under RBRVS by Status Code 26
Table 4.3 Components of Budget Neutral CF Calculations 27
Table 4.4 Revised Transition CF after Adjustment for Inflation and before Geographic Adjustment 27
Table 5.1 Impact of RBRVS Implementation on Maximum Allowable Fees, by Service Type and Transition Period 29
Table 5.2 Impact of RBRVS Implementation on Maximum Allowable Fees, by Provider Specialty and Transition Period 30
Table 6.1 GPCI Values, Cost Shares and GAF by Type of CF 33
Table 6.2 Comparison of Total Allowances under the OMFS and RB-RVS Using Nine Payment Localities and Statewide GAF, by Locality and HPSA Designation 35
Table 6.3 Impact of Alternative Transition CFs on Aggregate Allowances by Type of Service Relative to the Default CF 37
Table 6.4 WC Non-physician Practitioner Payment Policies 39
Table 6.5 Top Five Codes Billed Directly by Nurse Practitioners, Clinical Nurse Specialists, and Physician Assistants 41
Table 6.6 Comparison of Allowances for CPT 99214 under Current OMFS and RB-RVS during the Transition 42
Table 6.7 Comparison of Total Allowances for Non-Practitioner Services under Proposed Policy and Current Policy ($ millions) 44
Table 6.8 Bundling of CPT Code 99070 for Select Comparison States Using RB-RVS 45

Table 6.9 OMFS Payments for Supplies Related to Diagnostic and Therapeutic Procedures 47
Table 6.10 Distribution of Total Payments for CPT 99070 across Types of Service with the Same Patient and Date of Service 48
Table 6.11 OMFS Payments for Reports by CPT Code 50
Table 6.12 Comparison of Allowances under Current OMFS and Alternatives under the RB-RVS 53
Table 6.13 Summary of Selected State Policies on Consultation Codes 54
Table 6.14 Service Components Included in Work Component of the Global Fee for CPT 29881 Arthroscopy of the Knee with Medial or Lateral Meniscectomy (90 day global period)..... 57
Table 6.15 Comparison of Global Periods under the OMFS and MPFS for High Volume Procedures 58
Table 6.16 Summary Comparison of OMFS and MPFS Global Periods for Surgical Procedures 58
Table 6.17 Payment Approaches Related to Physician-administered Drugs..... 64
Table 6.18 Comparison of CMS and Medi-Cal Maximum Allowed Fees for PAD Ingredients[1] in Aggregate and for the Top 25 HCPCS Codes Ranked by 2011 OMFS Paid Amount 68
Table 6.19 Comparison of OMFS, CMS, and Medi-Cal Administration Fee Approaches 69
Table 6.20 Comparison of Allowances for Highest Expenditure Diagnostic Procedures 73
Table 6.21 Non-diagnostic High Volume Hospital Outpatient Services 75
Table 6.22 Distribution of NCCI Edits by CPT Code Ranges 77
Table 6.23 Selected NCCI Edits 77
Table 6.24 General Principles of Documentation for Medical Records 81
Table 6.25 Clinical History Matrix 82
Table 6.26 Medical Decision Making Matrix 83
Table 6.27 Example Performance Indicators 87
Table C.1 OMFS Codes with No 2013 CPT Counterpart That Were Priced under the RB-RVS at OMFS Allowances 160
Table C.2 OMFS Special Services with No 2013 CPT Counterpart That Were Priced with No Payment under the RB-RVS 161

Summary

Background

The Division of Workers' Compensation (DWC) maintains an Official Medical Fee Schedule (OMFS) for medical services provided under California's workers compensation (WC) program. The OMFS establishes the maximum allowable fee for services unless the payer and provider contract for a different payment amount. The OMFS for physician services applies to all services performed by physicians and other practitioners. The last major revision occurred in 1999, so that the procedure codes are outdated. Further, the allowable amounts are based on historical charges which tend to undervalue evaluation and management services relative to procedures and do not reflect changes in practice patterns and new medical technology.

Senate Bill (SB) 863 requires that the administrative director of DWC implement a resource-based relative value scale (RB-RVS) fee schedule to establish maximum allowable fees for physician and other practitioner services. As amended by SB 863, Labor Code Section 5307.1(a)(2) requires a four-year transition from the estimated aggregate maximum allowable amounts under the OMFS for physician services prior to January 1, 2014 to the maximum allowable amounts based on the RB-RVS. The maximum allowable fees are not to exceed 120 percent of estimated annualized aggregate fees prescribed in the Medicare payment system for physician services. The fee schedule is to be updated annually to reflect changes in procedure codes, relative values, and inflation and is to include as appropriate payment ground rules that differ from Medicare payment ground rules.

The RB-RVS fee schedule, which is maintained by the Centers for Medicare & Medicaid Services, has three basic elements:

- Relative value units (RVUs) for each medical service based on the 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. For some procedures, the RVUs for practice expenses vary based on whether the procedure is performed in the physician's office or at a facility. The RVUs compare the resources required for one service to those required for other services. Relative to the current OMFS, the RB-RVS tends to provide lower relative values for procedures and higher relative values for E&M services. The RB-RVS bundles values for supplies and reports into the RVUs for the primary procedure.
- A conversion factor (CF) that converts the RVUs into a payment amount for the procedure. The CF determines overall fee schedule payment levels. The Medicare program uses a single CF for all services except anesthesia. Anesthesia is priced under a different scale (using base units and time units) and has a separate conversion factor.

- A geographic adjustment factor (GAF) that adjusts for geographic differences in the costs of maintaining a physician practice. There are adjustment factors for nine geographic areas or payment localities in California.

Until the administrative director has adopted a RB-RVS fee schedule, Section 5307.1(a)(2) provides as a default that a RB-RVS fee schedule for physician and non-physician practitioner services will be effective January 1, 2014 in accordance with the fee-related structure and rules of the Medicare payment system for physician and non-physician practitioner services. Under the default provision, initial CFs for anesthesia, surgery, radiology, and all other services transition to a single conversion factor effective January 1, 2017 for all services other than anesthesia. A statewide geographic adjustment factor is applied to the CF in lieu of Medicare locality-specific factors.

Impact Analyses

Data and Methods

We used 2011 Workers' Compensation Information System (WCIS) medical data to model the impact of implementing the RB-RVS over a four-year transition period. Consistent with the policies that DWC proposes to implement, our impact analysis assumes that except for a few WC-required services and reports, the fee schedule would follow Medicare ground rules. For certain issues, we separately analyzed the impact of alternative policies.

Following the framework for the transition specified in Section 5307.1(a)(2), we computed separate CFs for anesthesia, surgery, radiology, and all other services based on current OMFS allowances and assessed the impact by comparing estimated total aggregate allowances under the OMFS to estimated allowances under the RB-RVS during 2014-2017.

Transition Conversion Factors

We computed "budget neutral" conversion factors for anesthesia, surgery, radiology and all other services combined that would result in estimated aggregate allowances under the RB-RVS that equal estimated aggregate allowances under the OMFS. Under the transition framework established in Section 5307.1(a)(2), the RB-RVS is to be phased-in over a four-year period by transitioning from multiple conversion factors in 2014 to a single CF for all services other than anesthesia (which continues to have its own CF) in 2017. The 2014 CFs are based on 75 percent of the budget neutral CFs and 25 percent of 1.2 x the Medicare 2012 CF. The 2017 single CF for all services other than anesthesia is based on 1.2 x the Medicare 2012 CF. The CFs will be further adjusted for inflation and geographic location. The inflation adjustment is based on the cumulative increase in the Medicare Economic Index between 2012 and the payment year.

Table S.1 provides the CF that we used for each year of the transition to model the impact of the RB-RVS. The amounts shown are appropriate blend of the revised budget neutral conversion factors and 1.2 x the Medicare CF updated for inflation.

Table S.1 Revised Transition CF after Adjustment for Inflation and before Geographic Adjustment

Type of Service	RAND budget neutral CF before inflation	120% 2012 Medicare	2014 75/25 Blend adjusted for inflation	2015 50/50 Blend adjusted for inflation	2016 25/75 Blend adjusted for inflation	2017 120 % Medicare adjusted for inflation
Anesthesia	34.490	25.69	32.645	30.571	28.531	27.817
Surgery	55.594	40.85	52.478	48.993	45.56	44.233
Radiology	52.458	40.85	50.101	47.4	44.758	44.233
All other services	33.782	40.85	35.94	37.913	39.981	44.233

Impact by Type of Service

Table S.2 summarizes the impact during the transition (2014-2017) by type of service. Over the 4-year period, total allowable fees are estimated to increase 19.6 percent. The increase represents that combined effect of estimated inflation (which increases the rates 8 percent over the period) and the transition from current OMFS payment levels in the aggregate for all services other than anesthesia at 111 percent of Medicare to 120 percent of Medicare in 2017. For anesthesia, allowable fees decline 16.5 percent over the transition. There are also declines in surgery (-13.4 percent) and radiology (-9.6 percent). Within the "all other services" category, there are significant increases for medicine (23.3 percent)[1] and evaluation and management (49.0 percent). In contrast, there are significant reductions in pathology (-19.5 percent). Because pathology is grouped with other services that have low OMFS payments relative to Medicare payments, the transition policy does not work as intended for pathology services. The reduction is greatest in the first year (-38.1percent) and lessens over the transition as the conversion factor increases.

Procedures are assigned in Table S.2 consistent with how they are classified in the CPT codebook. For example, reports and supplies are classified as "medicine" so that the changes in ground rules for bundling these services under the RB-RVS are included in the medicine rather

[1] Medicine (CPT 90281–99199, 99500–99607) includes noninvasive or minimally invasive services such as drug infusions/injections, physical medicine, psychiatric and neurologic medicine, reports, supplies and other special services.

than E&M service category. As a result, the percentage change in allowances for specialties that predominately furnish E&M services (see Table S.3) is lower than the increase for E&M services and the percentage change for physical medicine specialties is higher than the increase for the medicine category. Because surgeons furnish a substantial amount of E&M services as well as surgical services, the percentage change in allowances for the surgical specialties is -2.2 percent compared to the -13.4 percent change for surgery.

Table S.2 Impact of RBRVS Implementation on Maximum Allowable Fees, by Service Type and Transition Year

Type of service	OMFS		RBRVS 2014		RBRVS 2015		RBRVS 2016		RBRVS 2017	
	Total allowable fees ($ millions)	Percent of total	Total allowable fees ($ millions)	Percent change	Total allowable fees ($ millions)	Percent change	Total allowable fees ($ millions)	Percent change	Total allowable fees ($ millions)	Percent change
Anesthesia	24.81	2.5	24.47	-1.4	23.17	-6.6	21.97	-11.4	20.71	-16.5
Surgery	164.86	16.7	158.70	-3.7	150.72	-8.6	143.58	-12.9	142.69	-13.4
Radiology	104.34	10.5	100.33	-3.8	96.49	-7.5	93.26	-10.6	94.30	-9.6
Pathology	1.93	0.2	1.19	-38.1	1.28	-33.7	1.38	-28.6	1.55	-19.5l
Medicine	425.08	42.9	409.88	-3.6	436.49	2.7	468.02	10.1	523.96	23.3
E&M	268.95	27.2	306.90	14.1	328.75	22.2	354.46	31.8	400.79	49.0
Total	989.96	100	1,001.48	1.2	1,036.89	4.7	1,082.68	9.4	1,184.00	19.6

Table S.3 Impact of RBRVS Implementation on Maximum Allowable Fees, by Provider Specialty and Transition Year

Provider specialty	OMFS		RBRVS 2014		RBRVS 2015		RBRVS 2016		RBRVS 2017	
	Total allowable fees ($ millions)	Percent of total	Total allowable fees ($ millions)	Percent change	Total allowable fees ($ millions)	Percent change	Total allowable fees ($ millions)	Percent change	Total allowable fees ($ millions)	Percent change
Practice groups										
Multi-specialty	45.96	4.6	50.84	10.6	52.73	14.7	55.15	20.0	60.48	31.6
Single-specialty	2.94	0.3	2.88	-2.1	2.95	0.3	3.05	3.6	3.30	12.2
Individual providers										
Family medicine or general practice	211.16	21.3	213.12	0.9	221.00	4.7	231.11	9.4	253.29	20.0
Surgery	135.15	13.7	122.79	-9.1	123.19	-8.8	124.64	-7.8	132.16	-2.2
Physical therapy	63.16	6.4	86.61	37.1	92.42	46.3	99.30	57.2	111.93	77.2
Radiology	56.72	5.7	48.69	-14.2	47.07	-17.0	45.76	-19.3	46.57	-17.9
Physical medicine & rehabilitation	46.27	4.7	58.19	25.8	62.10	34.2	66.72	44.2	75.16	62.4
Psychiatry	37.96	3.8	35.55	-6.3	38.08	0.3	41.05	8.1	46.40	22.2
Occupational medicine	36.50	3.7	41.54	13.8	43.44	19.0	45.80	25.5	50.57	38.5
Chiropractic providers	34.69	3.5	35.19	1.4	37.56	8.3	40.36	16.3	45.46	31.0
Anesthesiology	27.49	2.8	26.02	-5.4	25.36	-7.8	24.86	-9.6	24.80	-9.8
Internal medicine	19.96	2.0	19.02	-4.7	19.65	-1.6	20.47	2.6	22.38	12.1
Neurology	13.53	1.4	9.76	-27.9	10.35	-23.6	11.05	-18.4	12.37	-8.6
Acupuncture	11.84	1.2	10.88	-8.1	11.60	-2.0	12.45	5.2	13.97	18.0
Occupational therapy*	7.99	0.8	11.16	39.7	11.93	49.4	12.84	60.8	14.50	81.6
Emergency medicine	7.46	0.8	8.11	8.6	8.48	13.6	8.93	19.7	9.88	32.3
Podiatry	4.58	0.5	5.42	18.4	5.51	20.2	5.64	23.2	6.07	32.5
Pathology	1.28	0.1	1.02	-20.1	1.09	-15.3	1.16	-9.5	1.30	1.3
Other	225.32	22.8	215.31	-11.5	222.83	-1.1	232.55	3.2	253.41	12.5
Total	989.96	100.0	1,001.48	1.2	1,036.89	4.7	1,082.68	9.4	1,184.00	100.0

Alternative Policies

In addition to modeling the impact of implementing the RB-RVS based on Medicare ground rules, we examined alternative policies that might be considered. Below is a summary of key findings from these analyses. To the extent an alternative policy would increase aggregate allowances, an offsetting adjustment would be required so that estimated aggregate allowances do not exceed 120 percent of Medicare allowances.

GAFs. The OMFS uses a single statewide fee schedule with no adjustment for geographic differences in the costs of maintaining an office. Medicare has different geographic adjustment factors for eight urban areas (e.g., Los Angeles, San Francisco, Oakland/Berkeley) and a "rest of state" locality comprised of 14 urban counties (including San Diego, Monterey, and Sacramento) and all rural counties. Our baseline impact analysis used the Medicare locality structure, but we also examined the impact of using a single statewide GAF. Using the 2011 WCIS data, the statewide GAF was 1.021 for anesthesia and 1.082 for all other services. If the statewide GAF were used in lieu of the locality-specific GAF, the effect would be to redistribute allowances determined using RVUs from localities with relatively high GAFs to the urban and rural counties that are classified in a "rest of state" locality (Table S.4).

Table S.4 Impact of Using a Statewide GAF on Aggregate Allowances

Payment Locality	% OMFS Allowances[1]	Locality -specific GAF		Percent Change in RB-RVS Allowances Using Statewide GAF Relative to Locality-specific[1]	
		All services other than anesthesia	Anesthesia	All services other than anesthesia (1.082 GAF)	Anesthesia (1.021 GAF)
Marin/Napa/Solano	1.8	1.119	1.032	-3.3	-1.9
San Francisco	3.5	1.185	1.071	-8.7	-5.5
San Mateo	1.2	1.182	1.07	-8.5	-5.4
Oakland/Berkeley	6.6	1.128	1.043	-4.1	-3.0
Santa Clara	3.5	1.176	1.071	-8.0	-5.5
Ventura	1.7	1.091	1.023	-0.8	-1.1
Los Angeles	34.3	1.075	1.021	0.7	-0.9
Anaheim/Santa Ana	10.4	1.111	1.04	-2.6	-2.7
Rest of California	30.6	1.032	0.993	4.8	1.9
Unknown	6.4				
All localities	100.0	1.082	1.021	0.0	0.0

[1]Does not include services priced BR.

Non-physician practitioners. The OMFS does not differentiate between physicians and non-physician practitioners acting within their scope of practice and sets the maximum allowable fees for similar services at the same amount. Unless their services are billed "incident to" a physician's service, Medicare pays services furnished by nurse practitioners and physician assistants at 85 percent of the allowed amount for physician services. Medicare pays clinical social workers at 75 percent of the allowed amount. Our baseline impact follows the Medicare policies but we also modeled the impact of setting the allowances at 100 percent of the amounts paid to physicians. Paying non-physician practitioners based on 100 percent of the amounts payable to physicians would increase total RB-RVS aggregate allowances 0.36 percent.

Alternative conversion factors. We calculated two alternative conversion factors that grouped pathology with other services that are projected to have reductions in allowances under the RB-RVS. One combined pathology with radiology and the second combined surgery, radiology, and pathology into a single grouping. Because physician pathology services represent only 0.2 percent of OMFS allowances, a change in the transition conversion factor for these services has little impact on the conversion factors for other services but increases the first year payments for pathology 42-46 percent relative to combining pathology with E&M and medicine.

Bundling payment for supplies and reports. The OMFS establishes separate allowances for certain reports and supplies. Medicare bundles payment for reports and supplies into the payment for E&M and other services. Our impact analysis generally follows Medicare's rules and bundles supplies and most reports, including consultation reports. We assumed that certain WC-required reports that are separately reimbursable would continue to be paid separately. Since these reports are not Medicare-covered reports, separate payment for these reports does not require an adjustment to remain within 120 percent of Medicare allowances.

Consultations. The OMFS has separate higher allowances for consultations while Medicare does not. In 2010, Medicare stopped recognizing CPT codes for consultation services and instead pays for consultations using the E&M visit codes. To make the change budget neutral, CMS increased the compensation for E&M visits (CMS, 2009). Following the Medicare ground rules (using the E&M visit codes and bundling consultation reports), estimated RB-RVS allowances are 57 percent of current OMFS allowances for consultations and reports. Allowances for consultations are 27 percent higher using RVUs for the consultation codes instead of the RVUs for the E&M visit codes. Using the consultation RVUs would increase E&M allowances 3.73 percent and total aggregate allowances by 0.96 percent.

Global periods. Under both the OMFS and the Medicare 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 definitions used by the OMFS and the RB-RVS are nearly identical. Post-surgical E&M visits account for a considerable proportion of the total time and work associated with surgical procedures in the RB-RVS 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 whether WC patients require more follow-up visits and what the impact would be of eliminating the global periods. However, WC patients have a shorter length of stay than Medicare patients for surgical admissions and are younger and healthier than Medicare patients. As a result, they are likely to require fewer follow-up visits for *medical* reasons.

Physical medicine. The OMFS has a complex set of rules concerning payment for physical medicine codes, including discounting of multiple procedures furnished during the same encounter and limits on the number of procedures or time billed during the encounter. When more than one unit of therapy services is furnished during the same encounter, Medicare pays 100 percent for the service with the highest allowance and discounts the practice expense component of the remaining units by 50 percent. The baseline impact analysis follows Medicare's rules for discounting the practice expense component and applies the discounting to chiropractic and acupuncture codes as well as therapy services. By including only bills for which payment was made, the impact analyses implicitly assumes that current limits on the number of procedures and time billed during an encounter will continue.

Physician-administered vaccines and drugs. The OMFS contains outdated allowances for physician-administered vaccines and drugs that are injected or infused during an E&M visit or other procedure. Our baseline impact analysis includes the physician-administration codes but does not include drug ingredient costs. Currently, the OMFS uses the MediCal fee schedule for outpatient prescription drugs. Either the Medicare or MediCal fee schedule would provide a vehicle to establish reasonable allowances for drug ingredient costs that would be updated on a regular basis. The MediCal fee schedule for physician-administered drugs would provide broader coverage for vaccines than the Medicare fee schedule.

Site-of-service differentials. The OMFS sets the same allowance for all sites of service. (Separate facility fees are allowed for hospital inpatient services, hospital emergency room and for operating rooms for ambulatory surgery but otherwise there are no differences in payment across different care settings). The practice expense component of the Medicare fee schedule distinguishes between services that are furnished in non-facility settings (i.e., physician offices) and facility-settings (e.g., hospitals and ambulatory surgery centers (ASCs) where Medicare makes a separate payment for the costs of the facility services. We do not include services furnished by ASCs or hospitals that are currently paid under the OMFS for physician services in our baseline impact analyses. Medicare ground rules would pay for any non-surgical services provided to hospital outpatients under its prospective payment system for hospital outpatient services. Hospital outpatient services account for about 2.2 percent of OMFS payments. Paying for these services under the RB-RVS would result in a 20 percent reduction in allowances while paying for these services at 1.2 times the Medicare rate for hospital outpatient services would increase allowances 40 percent. Only a small volume of non-surgical services are furnished by ASCs. Under Medicare, these services would be paid under the RB-RVS fee schedule.

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Abbreviations

AAOS	American Association of Orthopedic Surgeons
ACA	Affordable Care Act
AD	Administrative Director of the Division of Workers' Compensation
AMA	American Medical Association
ASA	American Society of Anesthesiologists
ASC	Ambulatory Surgery Center
ASP	Average Sales Price
AWP	Average Wholesale Price
BR	By Report
CF	Conversion Factor
CMS	Centers For Medicare and Medicaid Services
CPT®	Current Procedural Terminology
CRVS	California Relative Value Scale
CWCI	California Workers' Compensation Institute
DF	Discounting Factor
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics and Supplies
DWC	Division Of Workers' Compensation
E&M	Evaluation and Management
EDI	Electronic Data Interchange
FROI	First Reports of Injury
GAF	Geographic Adjustment Factor
GPCI	Geographic Practice Cost Index
HCPCS	Healthcare Common Procedure Coding System
HOPD	Hospital Outpatient Department
HPSA	Health Professional Shortage Areas
HRSA	Health Resources and Services Administration
ICD-9-CM	International Classification of Diseases, Clinical Modification
MCO	Medical Care Organization
MedPAC	Medicare Payment Advisory Commission
MEI	Medicare Economic Index
MPFS	Medicare Physician Fee Schedule
MRA	Maximum Reimbursement Amounts
MUE	Medically Unlikely Edits
NCCI	National Correct Coding Initiative
NDC	National Drug Codes

OMFS	Official Medical Fee Schedule
OPPS	Outpatient Prospective Payment System
OWCP	Office Of Workers' Compensation Program (Federal)
PAD	Physician-Administered Drugs
PC	Professional Component
PE	Practice Expense
PPRC	Physician Payment Review Commission
RB-RVS	Resource-Based Relative Value System
RVU	Relative Value Unit
SROI	Subsequent Reports of Injury
TC	Technical Component
WCAB	Workers' Compensation Appeals Board
WCIRB	Workers' Compensation Insurance Rating Board
WCIS	Workers' Compensation Information System

1. Introduction

Senate Bill 863 requires that the administrative director (AD) of the Division of Workers' Compensation (DWC) implement a resource-based relative value scale fee schedule to establish maximum allowable fees for physician and other practitioner services under the California workers' compensation (WC) system. This report models the impact of the proposed policies and selected alternative policies.

Description of OMFS and Its Shortcomings

DWC maintains an Official Medical Fee Schedule (OMFS) for medical services provided under California's workers compensation (WC) program. The OMFS establishes the maximum allowable fee for services unless the payer and provider contract for a different payment amount. The OMFS for physician services applies to all services performed by physicians and other practitioners regardless of type of facility in which the services are performed.[2] The OMFS primarily uses 1997 Common Procedural Terminology (CPT) codes to describe medical services. 1994 CPT codes are used for anesthesia services and physical medicine and there are a few WC-specific codes or definitions.[3]

The fee schedule consists of two components:

- Relative value units (RVUs) for each procedure. The relative value scale is based on the California Relative Value Scale (CRVS), which was developed by the California Medical Association in 1956 and adopted by DWC in 1965. The CRVS was last revised in 1974 and used historic physician charges to develop its relative values for services. The American Society of Anesthesiologists (ASA) 1993 *Relative Value Guide* is used for anesthesia services.
- A dollar conversion factor (CF) converts the RVUs into an allowance. Separate CFs apply to each type of service and have not been updated regularly.

The general formula for determining the maximum allowable fee is: Maximum fee = RVU x CF. Under current law, the AD has the authority to revise the physician fee schedule no less than biennially. However, the last major revision was completed in April 1999. SB 228 (2003) reduced allowances for services that exceed the Medicare fee schedule five percent (but not

[2] Separate facility fees are allowed for hospital inpatient services, hospital emergency room and for operating suites for ambulatory surgery but otherwise there are no differences in allowances across different care settings.

[3] The CPT code set is maintained and copyrighted by the American Medical Association (AMA). The code set is designated under the Health Insurance Portability and Accountability Act (HIPAA) as the national coding standard for physician and other health care professional services.

below Medicare rates) and froze allowances until the AD establishes a new fee schedule for physician and practitioner services. Administratively, the OMFS allowances for some evaluation and management (E&M) codes were increased to no less than Medicare fee schedule levels in 2007.

There are three major shortcomings in the current fee schedule. First, the OMFS uses outdated procedure codes to describe medical services. This poses an administrative burden on providers, who must maintain a separate coding system for WC patients. Also, because the OMFS does not include codes for new technology that has been developed since 1997, fee disputes between providers and payers are likely to occur over these typically high cost services. Second, the relative values in the current fee schedule are based on historical charges, which tended to undervalue E&M services relative to procedures. Overvaluing a service provides an incentive for unnecessary utilization while undervaluing a service could raise access issues. In contrast, a resource-based relative value scale (RB-RVS) reflects the resources (costs) required to furnish services and provides neutral incentives for providing services. Third, the current fee schedule does not provide for regular updates for changes in coding, practice patterns and inflation. These problems have led to efforts to adopt a fee schedule based on the Medicare RB-RVS Physician Fee Schedule (MPFS) over the last decade.

A Brief Description of the RB-RVS

The MPFS was implemented in January 1992 and incorporates a RB-RVS that values services based on the relative resources required to furnish them. The fee schedule is maintained by the Centers for Medicare & Medicaid Services (CMS) and is updated annually through a rulemaking process to take into account changes in the coding system, practice patterns, and inflation. The RB-RVS fee schedule has three basic elements:

- RVUs for each medical service based on the 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. For most procedures, the RVUs for practice expenses vary based on whether the procedure is performed in the physician's office or at a facility. The RVUs compare the resources required for one service to those required for other services. Relative to the current OMFS, the RB-RVS tends to provide lower relative values for procedures and higher relative values for E&M services.
- A CF that converts the RVUs into a Medicare payment amount for the procedure. The CF determines overall fee schedule payment levels. The Medicare program uses a single CF for all services except anesthesia. Anesthesia is priced under a different scale (using base units and time units) and has a separate conversion factor.
- A geographic adjustment factor (GAF) that adjusts for geographic differences in the costs of maintaining a physician practice. Separate geographic practice cost indices (GPCIs)

are applied to the RVUs for the three components constituting the service: physician work, malpractice expense, and practice expense. There are adjustment factors for nine geographic areas or localities in California.

History of RB-RVS in California

For more than a decade, DWC has considered replacing the current OMFS with a fee schedule based on RB-RVS. SB 228 (2003) postponed an effort initiated in 2001 to revise the fee schedule. The SB 228 provisions specified that the existing physician fee schedule would remain in place (except that fees would be reduced by 5% but not below the Medicare payment amount) until the AD adopted a physician fee schedule no earlier than January 1, 2006. As amended by SB 228, Section 5307.1 of the Labor Code did not specify the type of fee schedule that the AD should adopt but required that it be revised no less frequently than biennially. Most other components of the OMFS (other than pharmaceuticals) are based on Medicare fee schedules and are limited in the aggregate to 120 percent of the amounts that would be payable under Medicare for comparable services.

The most recent effort to adopt a RB-RVS fee schedule was initiated with a pre-rulemaking proposal to issue draft regulations in March 2010 and a revised draft proposal in July 2010 that responded to comments on the March proposal. Major issues were the adequacy of the overall payment levels (which are among the lowest of WC state programs) and the redistribution of payments across specialties. The March draft proposed to transition from multiple CFs to a single CF with total expenditures "budget neutral" to estimated expenditures under the OMFS. The July draft increased the total level of funding used to determine the CF, proposed higher CFs for surgery and radiology than for other services, and left the question of a transition to a single CF to future rulemaking. The pre-rulemaking proposals were supported by impact analyses prepared by The Lewin Group (Welch et al., 2008; Welch et al., 2010).

SB 863 was enacted on Sept. 18, 2012. The legislation made wide-ranging changes to California's WC system, one of which was to require the AD to adopt and periodically review an OMFS based on the RB-RVS for physician and non-physician practitioner services. As amended by SB 863, Labor Code Section 5307.1(a)(2) requires that the AD adopt a RB-RVS based fee schedule for physician and non-practitioner services with a four-year transition from the estimated aggregate maximum allowable amounts under the OMFS for physician services prior to January 1, 2014 to the maximum allowable amounts based on the RB-RVS. The maximum allowable fees are not to exceed 120 percent of estimated annualized aggregate fees prescribed in the Medicare payment system for physician services. The fee schedule is to be updated annually to reflect changes in procedure codes, relative values, and inflation and is to include as appropriate payment ground rules that differ from Medicare payment ground rules.

Until the AD has adopted a RB-RVS fee schedule, Section 5307.1(a)(2) provides as a default that a RB-RVS fee schedule for physician and non-physician practitioner services in

accordance with the fee-related structure and rules of the Medicare payment system for physician and non-physician practitioner services will be effective January 1, 2014. Under the default provision, initial CFs for anesthesia, surgery, radiology, and all other services transition to a single CF effective January 1, 2017 for all services other than anesthesia. A statewide GAF is applied to the CF in lieu of Medicare locality-specific factors.

Overview of RAND Analysis

Generally, our baseline impact analysis in Chapter 5 reflects the differences in the allowances under current OMFS rules and Medicare rules.[4] For certain issues, we separately analyzed the impact of alternative policies and discuss the results of those analyses in Chapter 6. Below we summarize our approach.

Coding System. The OMFS primarily uses 1997 CPT codes (1994 for physical medicine) to describe physician and other practitioner services, National Drug Codes (NDC) to bill for physician-administered pharmaceuticals, and some California-specific codes. Medicare uses the Healthcare Common Procedure Coding System. Level I is comprised of current CPT codes and Level II is alpha-numeric codes assigned to services (mostly non-professional), medications, supplies and equipment. For the impact analysis, we crosswalked the OMFS procedure codes into their 2013 CPT code equivalents (see Section 3.1). We also crosswalked NDC drugs codes into Medicare's J-codes for pharmaceuticals to analyze alternative drug pricing policies in Chapter 6. We did not assign services to the alpha-numeric codes because the AD proposed to adopt only CPT codes for professional services.

CFs. The OMFS has separate CFs for E&M services, medicine, surgery, radiology, pathology, and anesthesia. Medicare uses a single CF for all services other than anesthesia, which has its own CF. The default option in Section 5307.1(a)(2) provides for separate CFs for anesthesia, surgery, radiology and all other services combined that transition to a single CF for all services other than anesthesia over four years. We used the structure of the default option transition but recalculated budget neutral conversion factors for the OMFS portion of the transition CFs.

GAFs. The OMFS uses a single statewide fee schedule with no adjustment for geographic differences in the costs of maintaining an office. Medicare uses nine localities to adjust for geographic differences. Our baseline impact analysis uses the Medicare locality structure but we also examine the impact of using a single statewide GAF in Chapter 6.

Non-physician practitioners. The OMFS does not differentiate between physicians and non-physician practitioners acting within their scope of practice and sets the maximum allowable fees for similar services at the same amount. Unless their services are billed "incident to" a

[4] Appendix A contains a detailed comparison of the two fee schedules.

physician's service, Medicare pays services furnished by nurse practitioners and physician assistants at 85 percent of the allowed amount for physician services. Medicare pays clinical social workers at 75 percent of the allowed amount. Our baseline impact follows the Medicare policies but we also examine the impact of setting the allowances at 100 percent of the amounts paid to physicians in Chapter 6.

Site-of-service differentials. The OMFS sets the same allowance for all sites of service. (Separate facility fees are allowed for hospital inpatient services, hospital emergency room and for operating rooms for ambulatory surgery but otherwise there are no differences in payment across different care settings). The practice expense component of the Medicare fee schedule distinguishes between services that are furnished in non-facility settings (i.e., physician offices) and facility-settings (e.g., hospitals and ambulatory surgery centers (ASCs) where Medicare makes a separate payment for the costs of the facility services. We did not include services furnished by ASCs or hospitals that are currently paid under the OMFS for physician services in our baseline impact analyses. Instead, we separately examine the impact of alternative policies to pay for these services in Chapter 6.

Consultations. The OMFS has separate higher allowances for consultations while Medicare does not. In 2010, Medicare stopped recognizing CPT codes for consultation services and instead pays for consultations using the E&M visit codes. To make the change budget neutral, CMS increased the compensation for E&M visits (CMS, 2009). Our baseline impact analysis follows the Medicare pricing rules but we examine the impact of using the consultation code RVUs in Chapter 6.

Bundling payment for supplies and reports. The OMFS establishes separate allowances for certain reports and supplies. Medicare bundles payment for reports and supplies into the payment for E&M services. Our impact analysis generally follows Medicare's bundling rules and bundles supplies and most reports, including consultation reports. We assumed that certain WC-required reports that are separately reimbursable would continue to be paid separately. Since these reports are not Medicare-covered reports, separate payment for these reports does not require an adjustment to remain within 120 percent of Medicare allowances.

Physical medicine. The OMFS has a complex set of rules concerning payment for physical medicine codes, including discounting of multiple procedures furnished during the same encounter and limits on the number of procedures or time billed during the encounter. When more than one unit of therapy services is furnished during the same encounter, Medicare pays 100 percent for the service with the highest allowance and discounts the practice expense component of the remaining units by 50 percent. The baseline impact analysis follows Medicare's rules for discounting the practice expense component and applies the discounting to chiropractic and acupuncture codes as well as therapy services. By including only bills for which payment was made, the impact analyses implicitly assumes that current limits on the number of procedures and time billed during an encounter will continue.

Physician-administered vaccines and drugs. The OMFS contains outdated allowances for physician-administered vaccines and drugs that are injected or infused during an E&M visit or other procedure. Our baseline impact analysis includes the physician-administration codes but does not include drug ingredient costs. However, we examine alternative policies for paying for the drug ingredient costs in Chapter 6.

Organization of This Report

The remainder of this report is organized as follows:

- Chapter 2 describes the data used in the analyses.
- Chapter 3 discusses our methodology for conducting the impact analyses.
- Chapter 4 contains descriptive results.
- Chapter 5 presents impact results from the baseline model.
- Chapter 6 discusses alternative ground rules, including results from alternative policy simulations.

2. Data

WCIS Data

The primary data source for the impact analysis is the Workers' Compensation Information System (WCIS) database maintained by DWC. The WCIS uses electronic data interchange to collect comprehensive information from claims administrators[5] to help the Department of Industrial Relations oversee the state's WC system. Historically the data was collected in paper form but starting in 2000, electronic transmission of first reports of injury (FROI) became required. In 2006, the WCIS was expanded to include medical transmissions. Data is transmitted to DWC within 90 calendar days of the bill payment or the date of final determination that payment for billed medical services would be denied. By law, claims administrators with at least 150 total claims per year are required to report medical data for all services provided on or after September 22, 2006.

We chose the WCIS as our primary data source because it is the most complete and representative dataset available. In its pre-rulemaking impact analyses cited previously, The Lewin Group used data furnished by the California Workers' Compensation Institute (CWCI). The CWCI database includes medical data from a sample of insurers and self-insured employers. Given the self-selected nature of the sample because reporting is voluntary, its representativeness is uncertain. The CWCI database used in the earlier RB-RVS study included services with estimated OMFS allowances (including BR services) totaling $210 million. (Welch et al., 2010). Our WCIS data has estimated OMFS allowances totaling $1 billion for physician and practitioner services furnished in 2011. Further, the CWCI data do not include certain information needed to model payments under the RB-RVS, such as whether a service was provided in a facility or office setting. The WCIS includes this information. It includes actual payments to providers, which can be used as a tool in pricing algorithms where data may not be reliably reported and to determine payments for services and items priced BR

Even though the WCIS is the best data available, it has limitations: first, not all claims are reported into the system,[6] and among reported claims there is further underreporting of medical data.[7] Because the WCIS does not include all claims with medical expenditures, representativeness is a potential issue. If the distribution of services in the available data diverges from the "true" distribution (for all claims), this has implications for our policy simulations.

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[5] A claims administrator is an insurer, a self-insured self-administered employer, or a third-party administrator.

[6] According to the DWC, there is thought to be about 20% underreporting.

[7] About 21% of FROI claims have no medical claims data. When we exclude denied claims, the percentage of claims without medical data decreases to 14%.

Given the absence of a gold standard dataset to which we can compare the WCIS, we adopted several different approaches to assess the representativeness of the 2011 WCIS medical claims data. First, we compared the distribution of the nature of worker injury based on the First Report of Injury (FROI)[8] to the distribution for the claims with medical data (Table 2.1). If the distributions are similar, this suggests that, at a minimum, the medical claims data are representative of all claims with a FROI.

Table 2.1 Nature of Injury in 2011 (All Claims with FROI vs. Only Claims with Medical Data)

Code	Nature of Injury	All Claims (FROI)	Claims with Medical Data
52	Strain	30.7%	37.6%
49	Sprain	10.7%	11.0%
10	Contusion	11.4%	9.3%
59	All Other Specific Injuries, NOC	8.3%	7.5%
40	Laceration	10.6%	6.6%
80	All Other Cumulative Injuries, NOC	3.5%	5.2%
28	Fracture	2.6%	3.8%
37	Inflammation	2.8%	3.1%
90	Multiple Physical Injuries Only	3.1%	3.1%
43	Puncture	3.4%	2.0%
78	Carpal Tunnel Syndrome	0.7%	1.4%
77	Mental Stress	1.7%	1.3%
25	Foreign Body	2.2%	1.3%
04	Burn	1.5%	0.9%
16	Dislocation	0.3%	0.8%
13	Crushing	0.8%	0.7%
34	Hernia	0.6%	0.6%
91	Multiple Injuries Including Both Physical and Psychological	0.3%	0.4%
07	Concussion	0.3%	0.3%
01	No Physical Injury	0.8%	0.3%
71	All Other Occupational Disease Injury, NOC	0.4%	0.3%
68	Dermatitis	0.6%	0.3%
36	Infection	0.5%	0.3%
	All others	2.1%	2.0%
	TOTAL	100.0%	100.0%

[8] These figures were obtained from DWC tables available online at: http://www.dir.ca.gov/dwc/wcis/WCIS_Reports.html

Second, we compared the distribution of payments by physician specialty in the WCIS to the distribution of payments reported by the Workers' Compensation Insurance Rating Bureau (WCIRB). The WCIRB includes only insurer claims while the WCIS includes both insurer and self-insured claims. To increase comparability between the two datasets, we included only WCIS insurer data and reclassified the specialty designations to be consistent with the WCIRB to the extent feasible. However, important distinctions remain. The WCIRB data categorizes services according to the provider who received the payment. For example, payments for physician-dispensed pharmaceuticals, supplies and equipment are included in the WCRIB physician payments but are not captured in our WCIS physician file; instead, our file includes only items that are physician-administered during an encounter. If we are willing to assume that the WCIRB represents the universe of insurer claims, i.e. it captures most claims not reported to the WCIS, and the distribution of specialty payments are similar between the WCIS and the WCIRB, this increases our confidence that our claims are representative of all claims in California (Table 2.2).

Table 2.2 Percentage of Payments by Physician Specialty (WCIS and WCIRB)

Specialty	WCIS	WCIRB
General & Family Practice	22.4%	20.5%
Surgery[1]	14.9%	13.8%
Physical Therapist	7.4%	9.1%
Physical Medicine & Rehabilitation	5.7%	4.8%
Occupational Medicine	4.2%	2.3%
Chiropractic Providers	3.9%	4.7%
Anesthesiology	3.3%	2.9%
Radiology	3.1%	5.4%
Psychology	2.0%	1.8%
Internal Medicine[2]	2.0%	1.3%
Acupuncturist	1.3%	1.1%
Neurology	1.3%	1.2%
Emergency Medicine	0.9%	0.9%
Psychiatry	0.7%	1.6%
Podiatrist	0.5%	0.4%
Pathology	0.4%	0.8%
Marriage, Family, and Child Counselors	0.1%	0.1%
Ophthalmology	0.1%	0.1%
Dental Providers	0.1%	1.0%
Dermatology	0.1%	0.1%
Optometrists	0.0%	0.1%
Clinical Social Workers	0.0%	0.0%
All Other Providers[3]	25.5%	26.0%
Total	100%	100%

[1] We aggregated the following specialties in the WCIRB table to create the surgery category: orthopedic surgery, general surgery, hand surgery, plastic surgery, and neurosurgery.
[2] In the WCIRB, we included Osteopaths in the Internal Medicine category to make it comparable to the WCIS.
3 Specialties that we could not match in both datasets were folded into this "All other" category. 15% of payments in the WCIRB table were to unknown or unclassified specialties.

Overall, the evidence in Tables 2.1 and 2.2 suggest that the WCIS data can be assumed to be broadly representative of all WC claims in California.

Additional Data Sources

Data on 2013 Medicare RVUs is publicly available on the CMS website.[9] The zipped file contains a Microsoft Word document with an overview of the pricing methodology, an Excel spreadsheet with RVUs and Medicare Status indicators, and a separate file with GPCI locality values for the 3 components of the Medicare Fee Schedule: work, practice expense, and malpractice. For data on 2013 anesthesia base units we used another publicly available CMS dataset.[10] To model bonus payments for services provided in health professional shortage areas (HPSAs), we used information on HPSA designations in California available on the Health Resources and Services Administration website. [11] The Texas Department of Insurance Division of Workers Compensation provided us with a line item distribution of CPT 2011 codes for services provided under the Texas Workers' Compensation Program. We used this distribution to estimate how OMFS codes that crosswalk to multiple CPT codes will be distributed under the RB-RVS.[12] For codes without a Medicare assigned RVU (status codes C, I, N, and R), we used a supplementary file containing RVUs assigned under the Federal Workers' Compensation Program.[13] The most recent year available was 2012.

[9] Available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU13B.html.

[10] Available at http://www.cms.gov/Center/Provider-Type/Anesthesiologists-Center.html.

[11] Available at http://bhpr.hrsa.gov/shortage/hpsas/designation criteria/index.html.

[12] A public use data file is available at http://www.tdi.texas.gov/wc/topics.html#d.

[13] Available at http://www.dol.gov/owcp/regs/feeschedule/accept.htm.

3. Analytical Approach

Cross-walking to 2013 Codes

To model the impact of moving from the current OMFS to the RB-RVS fee schedule, we needed to reconcile CPT codes in both fee schedules. As we have discussed, the OMFS codes are based primarily on the 1997 CPT codes (1994 codes for physical medicine), some of which have been deleted, modified, or otherwise updated. We therefore needed to "crosswalk" the outdated OMFS CPT codes to their CPT 2013 equivalents. There were also some "California-specific" OMFS codes that were not in either the 1997 or 2013 CPT codebooks or that were in the 2013 CPT codebook but had a different code description. In addition, we found that some providers were using more recent CPT codes that did not have OMFS RVUs but did have 2013 CPT RVUs. We discuss how we handled these in a separate section.

We built on an earlier crosswalk developed by The Lewin Group for its earlier impact analysis that assigned OMFS codes to their 2010 CPT equivalents (Welch et al., 2008; Welch et al., 2010). Since 2010, other OMFS codes have been revised, and some of The Lewin Group replacement codes have themselves changed. In general, revised codes fell into one of two groups: (1) codes that were deleted (with or without replacement) – for example, Code A is deleted and replaced with Codes B and C, and (2) codes that were revised without being deleted – for example, Code A was revised and Code B was added. In other words, Code A is now "split" into Codes A and B.

We used Appendix B of the CPT codebooks to identify codes that underwent revisions. For codes that were deleted, replacements were usually specified within the text of the CPT codebook. Where the replacements were not clearly specified, and the OMFS codes had significant volume, we used our clinical judgment to identify the most suitable replacement.[14] Identifying codes that were revised without being deleted was more challenging and we often had to resort to manually comparing code descriptions between codebooks. The final crosswalk is contained in Appendix B.

In total, 983 OMFS codes were revised between 1997 and 2013. The Lewin Group originally crosswalked 538 of these codes. We crosswalked the remaining 445 OMFS codes and updated 42 of the Lewin replacement codes that had been revised. In total, 91 OMFS codes were deleted without replacement, 429 OMFS codes were deleted and replaced with a single code, 343 codes were deleted and replaced with multiple codes, and 120 codes were revised without being deleted.

[14] We did this for 10 codes: 01995, 76375, 90745, 90841, 93875, 99025, 99052, 99054, 99185, and 99186.

To carry out the impact analysis, we had to also crosswalk the service volume for modified OMFS ("old") codes to their 2013 replacements ("new" codes). In the simple case of a code that was deleted and replaced by another code, we simply assigned the service volume for the old code to its replacement. For example, old CPT 29815 was replaced by new CPT 29805 in our crosswalk. If the service volume for CPT 29815 was 500, we assigned CPT 29805 a volume of 500. For cases where a single OMFS code was split into multiple codes, we had to determine how to apportion the service volume for the old code across the new codes. We discuss our approach below.

We obtained 2011 utilization data[15] from the Texas Workers Compensation Program. We used the observed distribution of service volume in the Texas data to create weights that allowed us to replicate this distribution in the WCIS data when assigning service volume from old OMFS codes to new CPT codes. For example CPT 64443 was replaced by CPT 64494 and CPT 64495. Service volume for these two CPT codes in the Texas utilization file was 1,969 and 623 respectively. The distribution weights are therefore equal to 0.76 and 0.24. In other words, we assigned 76% of the volume for CPT 64443 to CPT 64494, and the remaining 24% to CPT 64495. For codes that were revised after 2011, and therefore did not appear in the Texas file, we turned to a CMS utilization file. CMS releases a crosswalk to provide guidance on the expected distribution of Medicare service volume from old to new CPT codes when codes are revised.[16] We used the CMS 2011 to 2013 crosswalk to fill in the gaps left by the Texas WC data.

Of the 463 OMFS codes that crosswalked to multiple CPT codes,[17] service volume for 271 codes (58.5%) was redistributed using weights constructed from the Texas WC file, and volume for 119 codes (25.7%) was redistributed using weights constructed from the CMS file. For the remaining 73 codes (15.8%), we either had missing service volume data for at least one of the new CPT codes,[18] or all the replacement codes had zero volume; we therefore redistributed the service volume for these OMFS codes equally across the new CPT codes.

Pricing under OMFS

The OMFS establishes the maximum allowable fee for services under California's workers compensation program. The fee schedule consists of two main components: (1) RVUs for each procedure, and (2) a CF. Separate CFs apply to E&M services, medicine, surgery, radiology,

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[15] This was the latest year available.

[16] Available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1590-FC.html

[17] This includes expanded codes.

[18] The majority of these were codes not paid under the MPFS. With missing data for at least one of the codes, it was not possible to construct the weights.

pathology, and anesthesia. The general formula used in determining the maximum allowable fee is:

$$\text{RVU x CF x DF}$$

Where DF is a discounting factor equal to $1 - \delta$ where δ is a reduction percentage required by SB 228 (2003). In most cases $\delta = 0.05$.[19] We modified this payment formula in certain situations based on DWC ground rules. These modifications are summarized in Table 3.1 below.

Table 3.1 Modifications Based on DWC Ground Rules

Category	Pricing Rules
Surgical procedures	For multiple procedures furnished on the same day the procedure with the highest allowance was valued at 100%, the next highest at 50%, and additional procedures at 25%.
Bilateral surgical procedures	Bilateral procedures were valued at 100% for the first procedure and 50% for the second.
Co-Surgeons	A procedure with co-surgeons was valued at 125% of the standard amount.
E&M	E&M visits requiring an interpreter (modifier 93) were valued at 110% of the standard amount.
Diagnostic tests with professional and technical components	Modifiers for the professional and technical components are not reliably reported. We developed a pricing algorithm that compared paid amounts to the allowances for the technical, professional and complete service and took into account other factors to identify technical and professional components for which a modifier was missing.
Laboratory tests	We treated any pathology/laboratory code that is payable under the MPFS as a physician service. Drug testing codes that were misclassified in the OMFS as clinical diagnostic laboratory tests were reclassified and valued at 95 % of the allowance applicable prior to 2004.
Physical therapy, acupuncture and chiropractic manipulative treatment	The procedure with the highest allowed amount was valued at 100%, the 2nd highest at 75%, the 3rd highest at 50%, and the 4th highest at 25%. Additional procedures were valued using the actual paid amount. Services with no payments that exceeded limits on the number of minutes or number of procedures that are payable during an encounter were excluded.
Arthroscopic procedures	The procedure with the highest allowed amount was valued at 100 percent while additional procedures were valued at 10%.
Assistants-at-surgery	Procedures requiring a physician assistant surgeon were valued at 20% of the standard amount while procedures with non-physician assistants were valued at 10%.
Microsurgery	Spinal procedures (code 61712) were valued at 25% of the allowed amount for the primary procedure. Nerve dissection or repair (code 64830) was valued at 50% of the allowed amount for the primary procedure.
By Report services	Some services under the OMFS are priced on a case-by-case basis based on a report submitted by the provider. These “by report” (BR) services include unlisted procedure codes, unusual services, and CPT 99070 for supplies. Because there is no standard pricing for these services, they were valued at the paid amounts.

[19] SB 228 (2003) reduced OMFS payments 5 percent but not below Medicare fee schedule amounts in 2004 and 2005. These reductions remain in effect.

Baseline pricing under RB-RVS

Most procedures under the Medicare PFS are assigned three relative values: work (W), practice expense (PE), and malpractice expense (MP).[20] Each of these three values is multiplied by a related geographic practice cost index values (GPCI), and the resulting value is multiplied by a CF to convert it into a dollar amount. Medicare has not established RVUs for all the codes that are covered under the WC system. We discuss how we handle pricing for these codes separately. In general the formula used in calculating payments is:

$$\text{CF x} \sum_{i} (RVU \text{ x } GPCI)_i$$

where *i* takes on three values denoting W, PE, and MP. (For the baseline analyses we applied the Medicare locality-specific GAFs consistent with the proposed rule). We adjusted this basic formula in certain situations to conform to Medicare's ground rules. See Table 3.2 below.

Table 3.2 Pricing Based on Medicare Ground Rules

Category	Pricing Rules
Surgical procedures	For multiple procedures furnished on the same day the procedure with the highest RVU was valued at 100% and additional procedures were valued at 50%.
Bilateral surgical procedures	Bilateral procedures were valued at 100% for the first procedure and 50% for the second.
Radiology	The discount policy applies separately to the professional component (the highest value code was valued at 100% while additional codes were valued at 75%) and the technical component (the highest value code was valued at 100% while additional codes were valued at 50%).
Physical therapy	The unit or procedure with the highest PE RVU was valued at 100 percent while additional units/procedures were valued at 50%. Full payment is made for work and malpractice expenses.
Diagnostic cardiovascular procedures	The discount applies to the only to the technical component of the procedure. The code with the highest technical component RVU was valued at 100 percent while additional procedures were valued at 75%.
Ophthalmology	The discount applies to the only to the technical component of the procedure. The code with the highest technical component RVU was valued at 100 percent while additional procedures were valued at 80%.
Global surgical period adjustments	If the surgeon does not furnish care throughout the global period, only a percentage of the fee is payable. Depending on the modifier reported, we applied the relevant portion of the payment. For example if modifier 56 was reported, we applied only the pre-operative portion of the RVU.
Assistants-at-surgery	Assistant surgeon services were valued at 16%.
Non-physician practitioners	Services provided by a physician assistant or nurse practitioner were valued at 85%, while services provided by a clinical social worker were valued at 75%.
Endoscopic procedures	The highest value endoscopy was valued at 100%. For the endoscopy procedure with the next highest amount, Medicare pays the marginal difference above the payment amount for the base endoscopy.

[20] Anesthesia services are handled differently and we discuss this in a separate section.

Pricing 2013 CPT Codes with No Medicare RVUs

There are several reasons codes for physician and other practitioner services may not have assigned RVU values under the Medicare fee schedule. The reason applicable to a given code is identified through its status code, which indicates whether the CPT code is included in the fee schedule and if it is covered, whether it is separately payable (see Table 3.3). The codes that always have RVUs are status codes A and T. Non-covered services are designated by status code N. Some of these services, including chiropractic and acupuncture codes, have RVUs assigned to them. The AMA establishes the RVUs for these services and CMS publishes them as a courtesy in Addendum B of the annual fee schedule update. Status code I services are not valid for Medicare purposes because Medicare uses another code for the reporting and payment of the services. Some status code I services have RVUs assigned to them but most do not.

Table 3.3 Definition of Status Codes in Medicare National Payment File for Physician Services

Status Code	Definition	RVU?
A	Active codes	Yes
B	Bundled codes	Some
C	Contractor priced codes	No
I	Priced under a different code under Medicare	Some
J	Anesthesia	Yes*
N	Non-covered service	Some
R	Restricted coverage	No
T	Injection codes payable only when another service is not provided	Yes

* Have base unit RVUs

We used different approaches to value services described by the different status codes that do not have RVUs that are used by the Medicare RB-RVS.

Bundled services: Status code B services are always bundled into the payment for the primary procedure. Except with respect to certain WC-required reports that are separately reimbursable under the OMFS, we assumed that these services would also be bundled under the RB-RVS.

- We assumed that reports billed under CPT 99080 in conjunction with a medical consultation for a primary treating physician would be bundled but that WC-required consultation reports performed in the context of medical-legal evaluations (OMFS modifier=30) or other mandated consultations (OMFS modifier =32) would be paid separately. We also assumed that the Primary Treating Physician's Permanent and Stationary Report [PR-3] would be paid separately.
- We assumed that reports billed under CPT 99081 would continue to be paid separately under the RB-RVS. These WC-required reports are the Primary Treating Physician's Progress Reports [PR-2] and Final Discharge Report [final PR-2].

For purposes of the impact analysis, we priced the reports that would remain separately payable at the OMFS paid amounts for those reports. We were unable to model the nuances of the policies for WC-related reports in the proposed rule because we were unable to determine the type of consultation report billed under CPT 99080 (e.g., whether it was requested by the primary treating physician or by the Workers' Compensation Appeals Board). We assumed that reports billed within 30 days of a consultation visit would be bundled under the RB-RVS and that the remaining reports would be separately payable. The latter reports represented 19 percent of payments under CPT 99080. Because these are WC-related reports that are not Medicare covered services, the 120 percent limitation on aggregate fees is not affected by the separate payments for the reports.

Status codes C, N, or R: Status code C services are priced by the contractor on a case-by-case basis and are analogous to BR services under the OMFS. Status code N services are non-covered services. Status code R services have restricted coverage and to the extent they are covered, payment is often determined by the Medicare contractor. The work hardening codes (CPT 97545 and CPT 97546) are two high volume WC services that are assigned status code R in the MPFS. The typical Medicare contractor policy is that work hardening programs are not covered because they are not medically necessary (and therefore no prices are established) but most WC fee schedules have established prices for the codes. We considered several options for valuing these and other services with status codes C, N, or R.

1. Adopt MPFS RVUs applicable to comparable services
2. Adopt RVUs or dollar amounts based on rates paid by other payers
3. Continue current OMFS price or BR status

In evaluating the options for specific codes, we weighed the following considerations.

Ease of Administration. Assigning RVUs to codes that are currently valued using BR documentation will reduce the burden on claims administrators. Rather than perusing large amounts of paper work, claims administrators can simply pay providers based on appropriate units.

Standardized Payments. Payment codes assigned a value will be standardized based on relative resources required to perform the service rather than the judgment of claims administrators. This ensures objective and fair payment while at the same time reducing the potential for claims disputes.

Automatic Updates. Codes with assigned RVUs allow for easier and automatic updates by adjusting the CFs for inflation. Assigned dollar values could also be updated using the same inflation factors.

Equitable relative to OMFS allowance for other services. Assigning appropriate RVUs to these codes allows providers to be paid for services at a level comparable to other services, creating more equitable allowances for services furnished.

Other state WC programs that have adopted the RB-RVS have different approaches to pricing the codes that have not been assigned RVUs. Several states such as Oregon and Ohio have developed state-specific codes that are paid at a specified maximum allowable payment amount or, in the case of certain Ohio state-specific service codes, BR. For CPT codes that not valued by CMS, Maryland Workers' Compensation Commission releases maximum reimbursement amounts annually on their website that increase concurrent with the MEI and multiplier. For services without a negotiated or contracted amount, the Texas Department of Insurance DWC payment is the lower of its maximum reimbursement amount, the provider's usual and customary charge or a "fair and reasonable "amount.[21]

After consultation with DWC, we used the federal Office of Workers' Compensation Program (OWCP) fee schedule to assign RVUs to the status code C, R, and N services that do not have RVUs under the RB-RVS. The OWCP reviews state WC fee schedules and establishes prices based on the mid-range of state fee schedule amounts. There are several advantages to using this fee schedule. First, the values are updated annually and are available in a public use file on the OWCP website.[22] Second, the fee schedule uses RVUs and CFs for the codes rather than dollar amounts. We were able to maintain relativity across most codes without needing to translate dollar amounts into relative values.[23] Third, the fee schedule is used in California to pay for services to injured workers under the Federal Employees Compensation Act. 2013 CPT codes that do not have RVUs in either the Medicare or OWCP fee schedules will be priced BR by WC payers. For the impact analysis, we assumed that the RB-RVS BR allowed amounts are the same as OMFS paid amounts and updated the paid amounts for inflation by the estimated increase in the Medicare Economic Index.

Status Code I. Status code I services are not valid for Medicare purposes because Medicare uses another code for the reporting and payment of the services. Some status code I services, such as the consultation codes, have RVUs assigned to them but most do not. If Medicare uses another CPT code to price the service, we used the RVUs for the other code to price status code I procedures, e.g., the E&M visit codes instead of the consultation codes. However, if Medicare uses a HCPCS alpha-numeric code to price the service, we did not use the RVUs because DWC proposes to adopt the current CPT codes for purposes of the RB-RVS for professional services.

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[22] The fee schedule is available at http://www.dol.gov/owcp/regs/feeschedule/fee.htm.

[23] A few codes have different CFs from CF applicable to most services. To normalize the RVUs for these codes to the standard CF, we multiplied the RVUs for the code by its CF and divided by the standard CF.

(Alpha-numeric codes will be used to bill for physician-administered drug ingredients and vaccines, casting/splint supplies and low-osmolar contrast materials that are separately payable under the RB-RVS). Examples of these codes are CPT codes describing non-physician services furnished in the patient's home (CPT 99500-99602) that are also described by HCPCS alpha-numeric codes. For these codes, we used the RVUs published in Addendum B when available. Otherwise, we priced using the RVUs assigned by the federal OWCP and assumed BR pricing when RVUs are not assigned by the OWCP. [24]

Pricing OMFS Codes with No 2013 CPT Counterpart

In consultation with DWC staff, we assigned OMFS codes that we were unable to crosswalk to 2013 CPT codes into two categories for purposes pricing under the RB-RVS (Appendix C). The first category included codes that are likely to continue to be paid under the RB-RVS either as an unlisted code (e.g., 97680 Job site visit/assessment) or as a listed code, which could be either a continuation of the OMFS-specific code or an assigned 2013 CPT/modifier combination. These codes describe services that are mostly special services and reports such as CPT 99081 Required Reports. We priced these codes in the impact analysis at the OMFS paid amounts and updated them for inflation throughout the transition. We assumed that other OMFS codes with no 2013 CPT counterpart would not be payable under the RB-RVS. Generally, these are low volume codes that no longer exist or have been revised so that the 2013 describes a different service.

Transition CFs

Labor Code Section 5307.1(a)(2) specifies transition CFs that are to be effective until the AD issues regulations implementing a RB-RVS fee schedule. The default CFs are based on the budget neutral CFs estimated by The Lewin Group with the physical therapy cascade and adjusted to remove the estimated statewide GAF of 1.078 (Welch et. al., 2010). Separate CFs are specified for anesthesia, surgery, radiology, and all other services (Table 3.4). The CFs transition from multiple CFs in 2014 based on 75 percent of the budget neutral CFs and 25 percent of the Medicare 2012 CF x 1.2 to a single CF for all services other than anesthesia (which continues to have its own CF) based on the Medicare 2012 CF x 1.2 in 2017. The CFs in Table 3.4 are the factors specified in the Labor Code and have not been adjusted for inflation and geographic location.

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[24] The OMFS does not recognize the CPT codes for disability examinations (CPT 99455 and 99456). Instead, allowances are established through the E&M visit codes with a -17 modifier or the medical-legal procedure codes. Consistent with this policy, we did not assign OWCP RVUs to any services that were billed as CPT 99455 or 99456.

Table 3.4 Default Transition CFs Specified in Labor Code Section 5307.1(a)(2)

Type of Service	2014 75% OMFS CF + 25% Medicare 2012 CF x 1.2	2015 50% OMFS CF + 50% Medicare 2012 CF x 1.2	2016 25% OMFS CF + 75% Medicare 2012 CF x 1.2	2017 100% Medicare 2012 CF x 1.2
Surgery	$49.53	$46.63	$43.74	$40.85
Radiology	$56.23	$51.10	$45.97	$40.85
Anesthesia	$30.06	$28.61	$27.15	$25.69
All Other Services	$37.17	$38.40	$39.62	$40.85
Note: SB 863 specified CF that are to be used along with a 1.078 statewide geographic adjustment factor and updated for inflation if the AD does not implement a fee schedule by January 1, 2014				

We computed revised budget neutral CFs for all services that are paid under the OMFS and will be payable using RVUs under the RB-RVS fee schedule. We excluded services that are priced as BR under the RB-RVS from the calculations. We calculated separate budget neutral CFs for anesthesia, surgery, radiology and all other services:

$$\mathrm{CF} = \frac{\sum_i OMFS\ Maximum\ allowed\ amounts_{\ i}}{\sum_i (RVU \times GPCI)_i}$$

To be consistent with the proposed rule, we used the locality-adjusted GAF in the calculation in lieu of the statewide GAF specified as the default option. We found that the default CFs are no longer budget neutral to the OMFS maximum allowed amounts. This is not unexpected given the differences in the data and methodologies used in The Lewin Group report and our analyses and the changes that have been made in the MPFS in the intervening years. In consultation with DWC staff, we substituted our estimates of the budget neutral OMFS CFs for the default CFs and determined revised transition CFs for 2014-2017. By using the revised budget neutral CFs, the impact of the fee schedule changes are evenly distributed over the transition years. Further, we updated the CFs for inflation using the estimated cumulative increase in the MEI (Table 3.5).

Table 3.5 Estimated Increases in the Medicare Economic Index 2012-2017

Year	Annual Increase	Cumulative Increase
2012	NA	1.0000
2013[1]	1.007	1.0073
2014	1.011	1.0184
2015	1.016	1.0347
2016	1.023	1.0585
2017	1.023	1.0828

[1]For 2013, the 1.008 estimated increase in the MEI is multiplied by the 0.99932 budget neutrality factor that CMS applied to the 2013 CF to make changes in the RVUs budget neutral. This adjustment is required by Labor Code Section 5307.1(g).
Source: IHS Global Insight, 2012Q2, Historical Data through 2012Q1; Released by: CMS, OACT, National Health Statistics Group

Pricing Anesthesia Services

OMFS Pricing

Most anesthesia services are billed with base values and time values and, because the scale is different, there is a separate conversion factor. Under the OMFS, the time value is computed by allowing 1.0 unit for each 15 minutes of anesthesia time for the first four hours and 1.0 unit for each 10 minutes thereafter. Five minutes or more is considered a significant portion of the time unit. Additional units are added to the values for certain patient status codes and qualifying conditions. For example, CPT code 00670 is anesthesia for extensive spine and spinal cord procedures and is assigned 13 base units. A procedure taking 125 minutes for a patient with severe systemic disease (Patient status code = 3) would be priced as follows:

Base value = 13 units

Time value = 9 (120/15= 8 units. 125-120 = 5 minutes, which is minimum number of minutes to count as a unit).

Patient status code = 1 unit

Total units = 23

Maximum allowance = .95 x $34.50 x 23 units = $753.83

We were unable to model OMFS allowances using the WCIS data. The WCIS reporting instructions are unclear regarding how the anesthesia units should be reported. We found wide variation in the number of units reported for a given procedure code, and we could not determine reliably whether the values are reported in units or minutes and whether the units are time units

only or also include base units and/or the additional units allowed under the patient status codes. As a result, our impact analysis assumes that the total OMFS payments are the allowed amounts.

RB-RVS Pricing

Appendix A has a detailed comparison between the ground rules for the two anesthesia fee schedules. The most important difference is in the CFs. Other important differences are 1) patient status and qualifying codes count as additional units under the OMFS but are bundled under the RB-RVS and 2) the RB-RVS requires reporting time in minutes, which are divided by 15 and rounded to the nearest 0.1 unit by the payer. The unit interval remains the same regardless of procedure length. Across all procedures, the time values will be lower under the RB-RVS because the units are more precise. For example, a 35 minute procedure counts as 3 units under the OMFS (because five or more minutes is considered significant) and 2.3 units under the RB-RVS because the five minutes equates to 0.3 units). They will also be 1/3 lower for each hour that a procedure takes beyond four hours. The Lewin Group estimated that the differences in base units and time units increased a budget neutral CF 3.7 percent (Welch et al., 2008).

The unreliability of the reported units precluded a direct estimation of allowances under the RB-RVS. Instead, we estimated a percentage change in total allowances by accounting for the differences between the OMFS and RB-RVS ground rules. We used The Lewin Group estimate to increase the OMFS portion of the transition CFs 3.7 percent to account for differences in how anesthesia time will be reported and another 3.65 percent to account for the bundling of patient status and qualifying circumstances codes based on our analysis of the WCIS data.

4. Descriptive Results

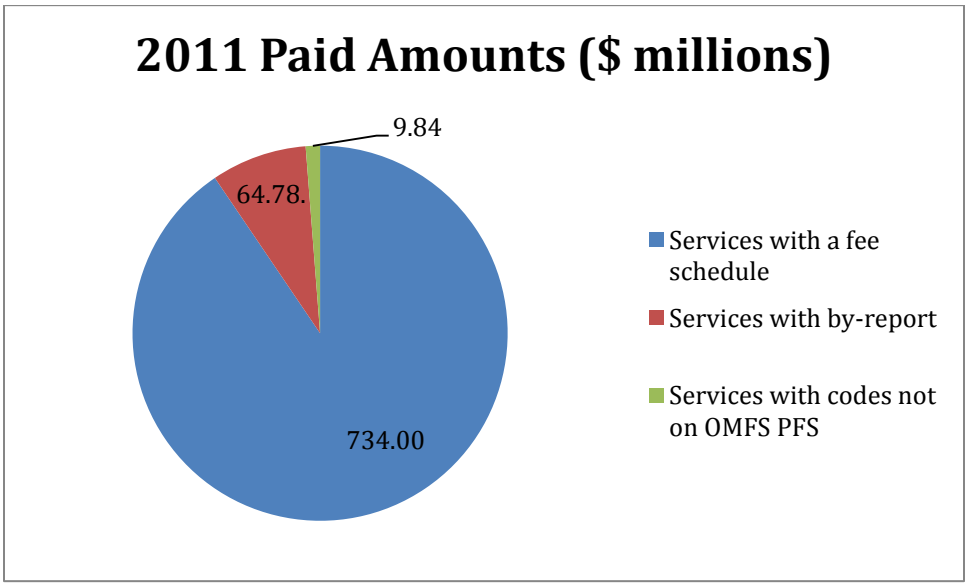
In this chapter, we provide summary descriptions of services and payments under the OMFS fee schedule and how they will be priced under the RB-RVS. The baseline impact analysis is presented in Chapter 5.

Services and Payments under the OMFS Fee Schedule

Distribution of Total Payments by Type of Payment

Our analysis file included 16 million services (exclusive of anesthesia services) provided by physician and other practitioners in 2011 that have paid amounts > $0. Total payments for these and anesthesia services were $809 million (Figure 4.1). Ninety-one percent of payments were for services with RVUs in the OMFS physician fee schedule, including $1.3 million billed by hospitals for professional services. Another eight percent were priced BR. The remaining one percent of payments was for missing or invalid OMFS codes. We retained invalid OMFS codes that were valid 2013 CPT codes in our analysis file since it is likely that some providers are billing and being paid using more recent codes than those used by the current OMFS. We excluded the remaining services that had missing codes or other invalid OMFS codes.

Figure 4.1 Distribution of Payments for Physician and Other Practitioner Services by Type of Payment



Distribution of Services and Payments by Type of Service

Figure 4.2 shows the distribution of total units of service across the type of service categories used in the OMFS exclusive of anesthesia services. We have excluded anesthesia because the units are not reported on a per service basis. Medicine accounts for 72 percent of the units of service. This category contains a wide range of services, including physical medicine, services provided by medical specialties exclusive of E&M and surgical procedures, and special services such as reports and supplies. Medicine also accounts for the highest proportion of OMFS payments (Figure 4.3).

Figure 4.2 Distribution of Services by OMFS Type of Service

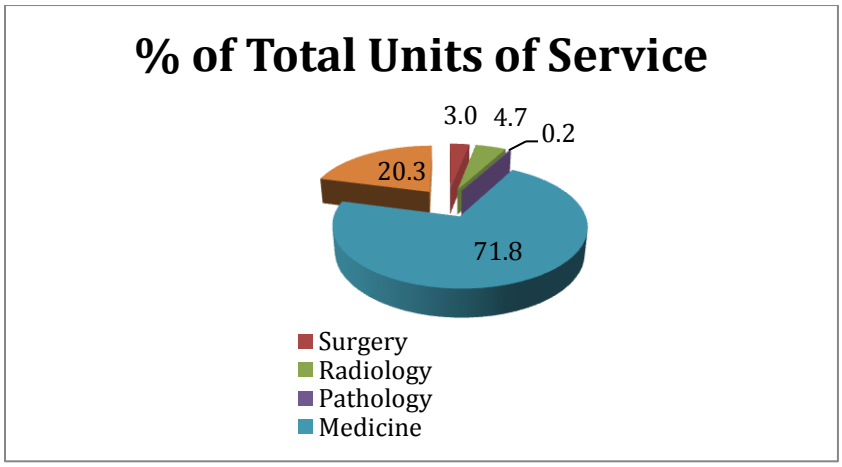
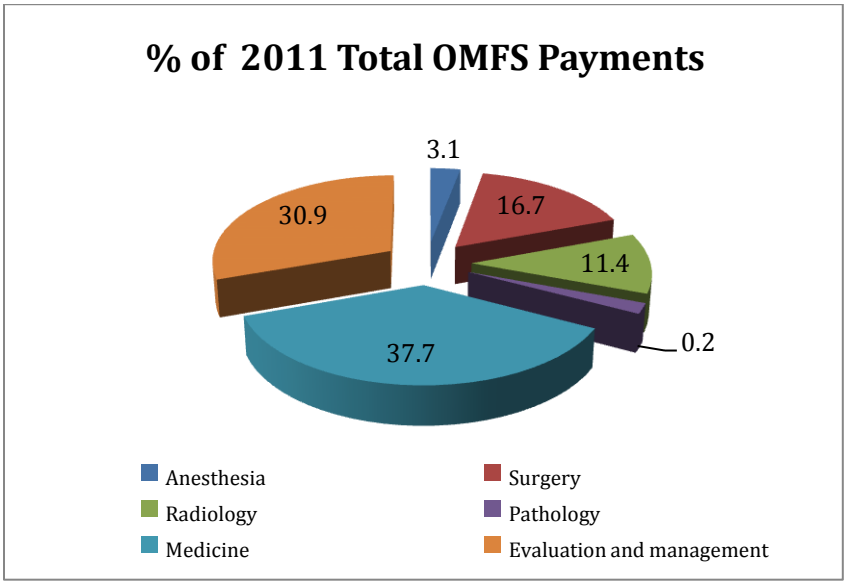


Figure 4.3 Distribution of Total OMFS Paid Amounts by Type of Service Category



During the RB-RVS transition period, separate CFs will be used for surgery (16.7% of OMFS payments), radiology (11.4 percent), and anesthesia (3.1 percent). The "all other service" CF will apply to medicine, E&M, and pathology, which together account for 68.8 percent of total OMFS payments.

Distribution of OMFS Payments by Provider Specialty

The OMFS payments shown in Table 4.1 are for all professional services provided by a physician or other practitioner. In addition to services that are specific to their specialty, most physicians provide other services. As a result, there is not a one-to-one correspondence between payments by type of service and payments by specialty. For example, the chiropractic manipulation codes account for 0.8 percent of total OMFS payments but professional services furnished by chiropractors account for 3.8 percent of payments. The two specialty groups that account for the highest percentage of OMFS payments are generalists in family medicine and internal medicine (24.0 percent) and surgeons (14.6 percent). Physical therapists account for 7.2 percent of payments.

Table 4.1 OMFS 2011 Paid Amounts by Provider Specialty

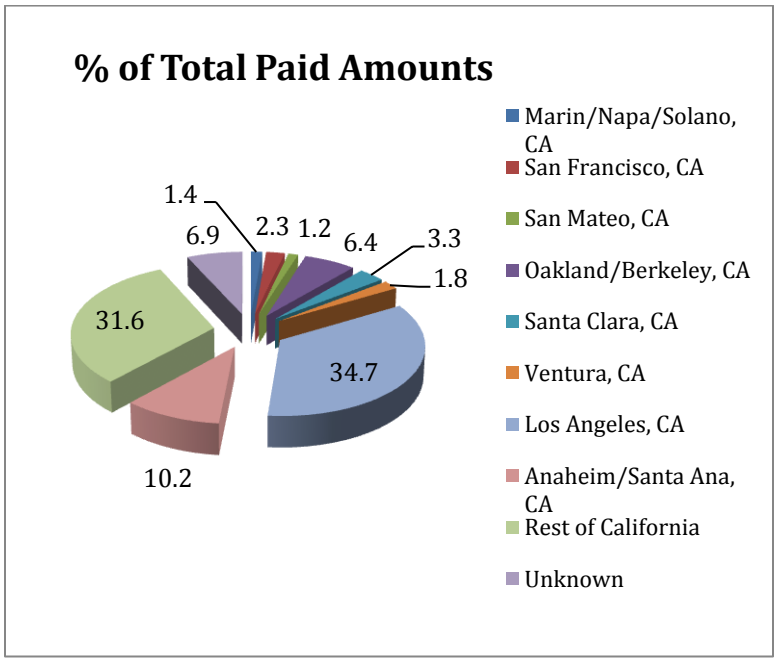
Provider specialty		Total payment ($ millions)	Total payment %
Practice groups	Multi-specialty groups	42.8	5.3
	Single-specialty groups	1.8	0.2
Individual providers	Family medicine or general practice	176.6	21.8
	Surgery	117.7	14.6
	Physical therapy	58.5	7.2
	Radiology	49.0	6.1
	Physical medicine & rehabilitation	43.3	5.3
	Occupational medicine	33.3	4.1
	Chiropractic providers	31.0	3.8
	Anesthesiology	25.9	3.2
	Behavioral health and social providers	20.2	2.5
	Internal medicine	17.9	2.2
	Acupuncture	10.8	1.3
	Neurology	10.4	1.3
	Occupational therapy[1]	7.7	1.0
	Emergency medicine	7.1	0.9
	Psychiatry	6.3	0.8
	Podiatry	4.1	0.5
	Pathology	1.2	0.1
Other[2]		143.1	17.7
Total		808.6	100.0

[1] Includes speech, language and hearing service providers
[2] Includes unspecified specialists or missing specialty codes (53%), various types of ambulatory clinics (6%), professional services billed by hospitals (6%), orthotists (5%), and pharmacy/DME suppliers (2%).

Distribution of OMFS Payments by Medicare Payment Locality

In Figure 4.4, payments are classified based on the Medicare payment locality in which the services were provided. Los Angeles County accounts for more than one-third of total OMFS payments. Nearly one-third of payments are also made for services provided in the "rest of California" locality, which is comprised of any urban area that is not designated as a separate payment locality and rural areas. We were unable to determine the payment locality for 6.9 percent of payment. We assigned the statewide GAF to these services in the impact analysis.

Figure 4.4 Distribution of 2011 OMFS Payments by Locality



Services under the RB-RVS

Distribution of Maximum Allowable Fees by Service Type

After crosswalking the OMFS services and payments to their 2013 CPT equivalents, we matched the new codes to their status codes under the MPFS. Table 4.2 shows the distribution of services and allowances by status code. The maximum allowed amounts include both services that are priced under the RB-RVS and services that are priced BR. The last column shows the percentage of maximum allowable fees that will be priced based on RB-RVS fee schedule

RVUs. Across all procedures, 96.4 percent of allowances will be based on RVUs determined either under the Medicare RB-RVS or the OWCP fee schedule (if the procedure is not priced under the Medicare RB-RVS). The remaining allowances will be determined BR or using current OMFS prices. Most status code C services are for unlisted procedures (for example CPT 99199 Unlisted special service, procedure or report), so that BR pricing is likely to decrease as coding improves. Reports account for most of the estimated payments in the status code B (CPT 99080 for certain consultation reports and PR-3 reports and WC-required CPT 90889 reports) and None (CPT 99081) categories that will continue to be paid using current OMFS allowances.

Table 4.2 Service Volume and Total Maximum Allowable Fees under RBRVS by Status Code

Status code	MPFS description	Units of service (millions)	% of total units of service	RB-RVS maximum allowable 2014 fees ($ millions)	% of total maximum allowable fees	% of total maximum allowable fees priced using RB-RVS
A	Active code with RVUs	12.27	76.0	878.4	87.7	100.0
B	Bundled	0.44	2.7	6.0	0.6	6.2
C	Priced by Medicare Contractor	0.11	0.7	14.0	1.4	4.5
I	Priced using a different code	1.31	8.1	47.4	4.7	97.5
J	Anesthesia[1]	-	-	24.5	2.4	100.0
N	Non-Covered	0.21	1.3	7.2	0.7	99.1
R	Restricted coverage; contractor priced	0.35	2.2	4.8	0.5	100.0
T	Injection codes payable only when another service is not provided	0.00	0.0	0.0	0.0	100.0
None	Not a 2013 CPT code	1.46	9.0	19.3	1.9	-
Total		16.15	100.0	1,001.5	100	96.4

[1]Anesthesia service volume not included because units are not reported on a per service basis. We have adjusted the anesthesia conversion factors for the differences between the OMFS and the Medicare ground rules.

Budget Neutral Conversion Factors by Type of Service

We used only services that were paid under the current OMFS and have RVUs under the RB-RVS to compute budget neutral conversion factors using the WCIS data. Table 4.3 shows the total OMFS allowed amounts, the total RVUs under the RB-RVS before geographic adjustment, the average GAF adjustment for each type of services, and the budget neutrality CF that result from dividing the OMFS maximum allowable amounts by the product of the applicable RVUs and GAFs.[25] The average GAF differs by type of service because the relative proportions of

[25] The allowed amounts are lower than the allowed amounts show in the Chapter 5 impact analyses because the impact analyses include services that will be priced BR and the CF calculation excludes these services.

work, PE and malpractice expense vary across different procedures. Further explanation of GAF differences by type of service is found in Chapter 6. For reference, we have included the CF that were calculated by The Lewin Group (Welch et al., 2010) that were used to establish the default transition CFs in Labor Code Section 5307.1(a)(2).

Table 4.3 Components of Budget Neutral CF Calculations

Type of Service	OMFS Maximum Allowed Amounts ($)	Total RB-RVS RVUs	Average locality-specific GAFs	Revised budget neutral CFs ($)	Lewin budget neutral CF/1.078 GAF ($)
Anesthesia	24,805,166	679,637	1.0212	34.490	31.52
Surgery	162,187,458	2,774,591	1.0515	55.594	52.43
Radiology	103,471,777	1,764,166	1.1181	52.458	61.36
All other services	648,846,468	17,733,465	1.0831	33.782	35.95
All services other than anesthesia	914,505,703	22,272,222	1.0819	37.952	40.85

[1]The OMFS allowable amounts for anesthesia are based on paid amounts. The total RB-RVUs are estimated by dividing OMFS allowed amounts by the OMFS conversion factor multiplied by the estimated percentage reduction in RVUs. Rounding may result in slight differences in the CF calculation.

Table 4.4 provides the budget neutral CFs for each year of the transition that we used to determine the impacts reported in Chapter 5. The amounts shown are appropriate blend of the revised budget neutral conversion factors and 120 percent of the Medicare CF updated for inflation.

Table 4.4 Revised Transition CF after Adjustment for Inflation and before Geographic Adjustment

Type of Service	RAND budget neutral CF before inflation	120% 2012 Medicare	2014 75/25 Blend adjusted for inflation	2015 50/50 Blend adjusted for inflation	2016 25/75 Blend adjusted for inflation	2017 120 % Medicare adjusted for inflation
Anesthesia	34.490	25.69	32.645	30.571	28.531	27.817
Surgery	55.594	40.85	52.478	48.993	45.56	44.233
Radiology	52.458	40.85	50.101	47.4	44.758	44.233
All other services	33.782	40.85	35.94	37.913	39.981	44.233

5. Impact analysis

This chapter summarizes the impact of RB-RBS implementation based on the policies that DWC proposes to establish. We modeled the impact using the transition conversion factors in Table 4.4 and locality-specific GAF. Other than specific policies for certain WC-related reports and services, we assumed that Medicare ground rules would apply. In Chapter 6, we discuss alternative policies that might be considered in lieu of the Medicare ground rules.

Table 5.1 summarizes the impact during the transition (2014-2017) by type of service. As discussed below, the impacts by type of service do not represent specialty impacts because most specialties furnish a mix of services. Over the 4-year period, total allowable fees are estimated to increase 19.6 percent. The increase represents that combined effect of inflation (which increases the rates 8 percent over the period) and the transition from current OMFS payment levels in the aggregate for all services other than anesthesia at 111 percent of Medicare to 120 percent of Medicare in 2017. For anesthesia, allowable fees decline 16.5 percent over the transition. There are also declines in surgery (-13.4 percent) and radiology (-9.6 percent). Within the "all other services" category, there are significant increases for medicine (23.3 percent) and E&M (49.0 percent). In contrast, there are significant reductions in pathology (-19.5 percent). Because pathology is grouped with other services that have relatively low OMFS payments, the transition policy does not work as intended for pathology services. The reduction is greatest in the first year (-38.1 percent) and lessens over the transition as the conversion factor increases (-19.1 percent). In Chapter 6 we discuss alternative transition CFs that might be considered to address this issue.

Procedures are assigned in Table 5.1 consistent with how they are classified in the CPT codebook. For example, reports and supplies are classified as "medicine" so that the changes in ground rules for bundling these services under the RB-RVS are included in the medicine rather than E&M service category. This explains why the percentage change in allowances for specialties that predominately furnish E&M services is lower than the increase seen in Table 5.1 for E&M services and why the percentage change for physical medicine specialties is higher than the increase seen in Table 5.1 for the medicine category (Table 5.2). Because surgeons furnish a substantial amount of E&M services as well as surgical services, the percentage change in allowances for the surgical specialties is -2.2 percent compared to the -13.4 percent change for surgery. The percentage change for radiologists (-17.9 percent) reflects the elimination of radiology consultation reports and bundling of supplies as well as the reduction in allowances for radiology. The reduction may be overstated to the extent certain contrast media that will continue to be separately under the RB-RVS were reported under CPT 99070.

Table 5.1 Impact of RBRVS Implementation on Maximum Allowable Fees, by Service Type and Transition Period

Type of service	OMFS		RBRVS 2014		RBRVS 2015		RBRVS 2016		RBRVS 2017	
	Total allowable fees ($ millions)	Percent of total	Total allowable fees ($ millions)	Percent change	Total allowable fees ($ millions)	Percent change	Total allowable fees ($ millions)	Percent change	Total allowable fees ($ millions)	Percent change
Anesthesia	24.81	2.5	24.47	-1.4	23.17	-6.6	21.97	-11.4	20.71	-16.5
Surgery	164.86	16.7	158.70	-3.7	150.72	-8.6	143.58	-12.9	142.69	-13.4
Radiology	104.34	10.5	100.33	-3.8	96.49	-7.5	93.26	-10.6	94.30	-9.6
Pathology	1.93	0.2	1.19	-38.1	1.28	-33.7	1.38	-28.6	1.55	-19.5
Medicine	425.08	42.9	409.88	-3.6	436.49	2.7	468.02	10.1	523.96	23.3
E&M	268.95	27.2	306.90	14.1	328.75	22.2	354.46	31.8	400.79	49.0
Total	989.96	100	1,001.48	1.2	1,036.89	4.7	1,082.68	9.4	1,184.00	19.6

Table 5.2 Impact of RBRVS Implementation on Maximum Allowable Fees, by Provider Specialty and Transition Period

Provider specialty	OMFS		RBRVS 2014		RBRVS 2015		RBRVS 2016		RBRVS 2017	
	Total allowable fees ($ millions)	Percent of total	Total allowable fees ($ millions)	Percent change	Total allowable fees ($ millions)	Percent change	Total allowable fees ($ millions)	Percent change	Total allowable fees ($ millions)	Percent change
Practice groups										
Multi-specialty	45.96	4.6	50.84	10.6	52.73	14.7	55.15	20.0	60.48	31.6
Single-specialty	2.94	0.3	2.88	-2.1	2.95	0.3	3.05	3.6	3.30	12.2
Individual providers										
Family medicine or general practice	211.16	21.3	213.12	0.9	221.00	4.7	231.11	9.4	253.29	20.0
Surgery	135.15	13.7	122.79	-9.1	123.19	-8.8	124.64	-7.8	132.16	-2.2
Physical therapist	63.16	6.4	86.61	37.1	92.42	46.3	99.30	57.2	111.93	77.2
Radiology	56.72	5.7	48.69	-14.2	47.07	-17.0	45.76	-19.3	46.57	-17.9
Physical medicine & rehabilitation	46.27	4.7	58.19	25.8	62.10	34.2	66.72	44.2	75.16	62.4
Psychiatry	37.96	3.8	35.55	-6.3	38.08	0.3	41.05	8.1	46.40	22.2
Occupational medicine	36.50	3.7	41.54	13.8	43.44	19.0	45.80	25.5	50.57	38.5
Chiropractic providers	34.69	3.5	35.19	1.4	37.56	8.3	40.36	16.3	45.46	31.0
Anesthesiology	27.49	2.8	26.02	-5.4	25.36	-7.8	24.86	-9.6	24.80	-9.8
Internal medicine	19.96	2.0	19.02	-4.7	19.65	-1.6	20.47	2.6	22.38	12.1
Neurology	13.53	1.4	9.76	-27.9	10.35	-23.6	11.05	-18.4	12.37	-8.6
Acupuncturist	11.84	1.2	10.88	-8.1	11.60	-2.0	12.45	5.2	13.97	18.0
Occupational therapist*	7.99	0.8	11.16	39.7	11.93	49.4	12.84	60.8	14.50	81.6
Emergency medicine	7.46	0.8	8.11	8.6	8.48	13.6	8.93	19.7	9.88	32.3
Podiatrist	4.58	0.5	5.42	18.4	5.51	20.2	5.64	23.2	6.07	32.5
Pathology	1.28	0.1	1.02	-20.1	1.09	-15.3	1.16	-9.5	1.30	1.3
Other	225.32	22.8	215.31	-11.5	222.83	-1.1	232.55	3.2	253.41	12.5
Total	989.96	100.0	1,001.48	1.2	1,036.89	4.7	1,082.68	9.4	1,184.00	100.0

6. Alternative Ground Rules

The impact analysis in Chapter 5 is consistent with the proposed rule. Where there are differences between the OMFS ground rules and the Medicare ground rules, the proposed policies follow the Medicare rules. Labor Code Section 5307.1(a)(2) provides that the OMFS shall to include payment ground rules that differ from Medicare payment ground rules "including, as appropriate, consultation codes and payment for E&M services provided during a global period of surgery." This chapter contains an analysis of potential alternative policies to the Medicare ground rules. The topics that we examine were drawn from public comments received during the 2010 pre-rulemaking activities, a stakeholders' meeting convened by DWC in November 2012, and postings to a public forum on the physician fee schedule in early 2013. The fee schedule topics include geographic adjustments, payment for non-physician practitioner services, bundling policies, consultations, and global fees. In addition, we discuss allowances for physician-administered drugs and for services provided by hospitals and ambulatory surgery centers that are currently paid under the OMFS for physician services.

The Labor Code limits aggregate allowances under the physician fee schedule to 120 percent of the amounts payable under the Medicare payment system for comparable services. In determining the maximum reasonable fees, any services that are not covered by Medicare are to be included at the rate established by the AD for the services. As a result, if a policy is implemented that deviates from the Medicare ground rules for a Medicare-covered service, an adjustment may be required to limit aggregate payments to 120 percent of Medicare payments. The general formula for determining the offsetting factor is as follows:

$$Adjustment\ factor = \frac{\sum estimated\ aggregate\ allowances\ using\ Medicare\ ground\ rules\ x\ 1.2}{\sum estimated\ aggregate\ allowances\ using\ Medicare\ ground\ rules\ x\ 1.2 + additional\ allowances\ for\ alternative\ policies}$$

Several issues would need to be addressed in making the offsetting adjustment:

- *What allowances should be affected by an offsetting adjustment?* For some alternative policies, it may be more appropriate to make an across-the-board offsetting adjustment to total aggregate allowances while it might be more appropriate for other policies to apply the offsetting adjustment to aggregate allowances for selected services. The preferred approach is not necessarily clear-cut. For example, if the higher RVUs were implemented for the consultation codes, the offset could be made through identifying specific policies that might be implemented to offset the higher allowances, adjusting allowances for some or all E&M visits so that total allowances for E&M services remain at 120 percent of aggregate Medicare payments (as CMS did when payments for consultations were eliminated) or by applying an across-the-board offsetting adjustment to the conversion factor for all services.

- *Should the adjustment be permanent or re-determined periodically?* If the higher allowances for consultation codes were implemented, the impact of the policy on aggregate allowances is likely to change over time as new Medicare policies are implemented and there are changes in the mix of services provided to WC patients. Would it be sufficient to determine a "one-time" offsetting adjustment when the policy is first implemented or would the impact need to be re-determined annually or on a periodic basis to assure that the aggregate limitation is not exceeded?
- *During the transition period, does the limitation on aggregate fees apply to the total amount payable under the blended rate or only to the portion of the rate based on Medicare payments?* If the adjustment were applied to total aggregate payments under the blended rate, the adjustment factor would change as the proportion of the rate based on Medicare changes.
- *In applying an offsetting adjustment, should services that are not covered by Medicare be included in the calculation?* For example, if an across-the-board adjustment were made to account for the higher allowances for the consultation codes, should the allowances for the services based on the federal OWCP fee schedule be included in the calculation of the offsetting adjustment?

Our discussion of alternative policies includes where relevant estimates of the impact that the alternative policy would have on aggregate allowances. It does not address how the offsetting adjustment required to implement the policy might be made for the particular alternative.

Geographic Adjustments

Currently, the OMFS uses a statewide fee schedule that makes no adjustment for differences in the cost of maintaining a practice across geographic areas. The Medicare program adjusts for geographic differences using nine payment localities in California. Separate geographic price cost index (GPCI) adjustments are made to the work, PE, and malpractice RVUs on a code-by-code basis. The work GPCI adjusts for geographic differences in the cost of living. The PE GPCI adjusts for differences across payment localities in the costs of maintaining an office such as employee compensation and office rent. Equipment costs are assumed to not vary across payment localities. The malpractice GPCI value adjusts for overall differences in the cost of malpractice insurance. (Specialty differences in malpractice insurance are accounted for in the RVUs). Collectively, these are called the geographic adjustment factor (GAF). The PE and malpractice GPCI values reflect the estimated prices in each locality relative to the national average. In contrast, the work GPCI by law accounts for only 25 percent of the difference in cost of living across payment localities.

On average, physician work accounts for 48.27 percent of the GAF, PE accounts for 47.44 percent, and malpractice accounts for 4.295 percent (CMS, 2012). However, the actual percentages vary by type of service. In particular, work accounts for a relatively higher percentage of the GAF for anesthesia services and a relatively lower percentage of the GAF for

radiology, for which a higher percentage of costs is attributable to PE. Because they have different CFs, we show in Table 6.1 by payment locality the cost shares and GPCI values separately for anesthesia and for other services. To determine the statewide geographic adjustment factor, we compared the aggregate allowances using the locality-specific GPCI to aggregate allowances with no geographic adjustment. We separately computed the statewide geographic adjustment factor for anesthesia and for all other services. The computed value for all services other than anesthesia (1.082) is slightly higher than the statewide geographic adjustment factor specified as the default in Labor Code Section 5307.1(a)(2).

Table 6.1 GPCI Values, Cost Shares and GAF by Type of CF

		Cost Shares (Percentage of GAF)				
		Work	PE	Malpractice		
Other than anesthesia		48.266	47.439	4.295		
Anesthesia		75.10	16.35	8.55		
Payment Locality	**% OMFS Allowances[1]**	**GPCI Values**			**GAF**	
		Work	**PE**	**Malpractice**	**All services other than anesthesia**	**Anesthesia**
Marin/Napa/Solano	1.8	1.051	1.248	0.456	1.119	1.032
San Francisco	3.5	1.072	1.36	0.516	1.185	1.071
San Mateo	1.2	1.072	1.354	0.516	1.182	1.070
Oakland/Berkeley	6.6	1.058	1.254	0.516	1.128	1.043
Santa Clara	3.5	1.077	1.337	0.516	1.176	1.071
Ventura	1.7	1.034	1.193	0.605	1.091	1.023
Los Angeles	34.3	1.036	1.154	0.642	1.075	1.021
Anaheim/Santa Ana	10.4	1.044	1.218	0.676	1.111	1.040
Rest of California[1]	30.6	1.024	1.085	0.547	1.032	0.993
Unknown	6.4					
Statewide	100.0				1.082	1.021

[1]Rest of California is comprised of the urban and rural counties that are not included in a locality for specific counties.

The purpose of the adjustments is to improve payment accuracy by accounting for the differences in input prices that providers face in each locality. The methodology that Medicare uses to make the adjustments has been subject to considerable criticism (Edmunds and Sloan, 2011). The payment localities are outdated and do not reflect changes in demographic and local economic conditions that have taken place since the localities were last configured. In California, 14 urban counties, including San Diego, Monterey, and Sacramento do not have separate payment localities and are included with rural counties in a “rest of California” payment locality. To improve payment accuracy, an Institute of Medicine Committee recommended that localities be reconfigured based on metropolitan statistical areas (Edmunds and Sloan, 2011). Implementing this recommendation in California would increase the allowances for urban areas

and reduce the allowances for rural areas within the "rest of California" locality. This approach would more accurately reflect geographic variation in the costs of maintaining an office. An alternative, which is the default option specified in Labor Codes Section 5307.1(a)(2) if the AD does not issue a regulation effective January 1, 2104 is to use a statewide average adjustment. Advocates for a statewide GAF argue that it rests on the precedent of the current statewide OMFS allowances, is less likely to raise access issues in the areas included in the "rest of California" locality than the alternatives and that it simplifies bill processing.

The Medicare program addresses access in underserved areas by providing an additional 10 percent payment for physician and other practitioner services provided in primary care health professional shortage areas (HPSAs). Areas are designated as HPSAs by the Health Resources and Services Administration based on census tracts, townships, and counties. HRSA also designates mental health shortage areas where services furnished by psychiatrists are eligible for a 10 percent bonus. [26] If an area has been designated as both a primary care and mental health shortage area, only one bonus is payable to a psychiatrist. If an area has been designated as a HPSA by December 31 of the prior year, providers furnishing services in the current year are eligible for a HPSA bonus throughout the current year (CMS, 2012). Our impact analysis assumes that if the geographic adjustment is made by payment locality that the HPSA bonus payments would also be made. Estimated bonus payments are $0.77 million or 0.08 percent of allowable amounts under the RB-RVS in 2014.

The default option in Section 5307.1(a)(2) specifies a statewide geographic adjustment factor of 1.078. This factor was derived by The Lewin Group in its analysis of options for implementing a RB-RVS using CWCI data for services provided during 2006 and 2010 payment rules (Welch et al., 2008; Welch et al., 2010). We recalculated the statewide adjustment factor separately for anesthesia services and all other services using the WCIS data for services furnished in 2011 and 2013 payment rules, including the HPSA bonus payments (Table 6.1). The statewide factors were 1.082 for all services other than anesthesia and 1.021 for anesthesia services. The lower GAF for anesthesia services is attributable to a relatively higher cost weight for the work component of anesthesia services. There is less variation in the work GPCI because it reflects only 25 percent of the variation in cost of living across localities. Table 6.2 compares total allowances under OMFS to total RB-RVS 2014 allowances using the locality-specific GPCI for each procedure and a statewide GAF for anesthesia and for all other services combined. As expected, the localities with higher GAF would receive lower allowances using the statewide GAF. For example, the allowances for San Francisco would increase 6.2 percent in 2014 using the locality-specific GAF compared to a negligible change using the statewide GAF. The GAF for Los Angeles is slightly lower than the statewide GAF (1.073 vs. 1.082) so that the RB-RVS

[26] More information on the HPSA designations is available on the HRSA website at http://bhpr.hrsa.gov/shortage/hpsas/designation criteria/index.html.

impact is similar using either GAF (-1.2 percent with the locality-specific compared to -1.0 percent with the statewide GAF). For the areas included in the "rest of California" locality, the locality-specific GAF would increase RB-RVS allowances 1.6 percent compared to a 5.8 percent increase using the statewide GAF. Because we modeled the HPSA bonuses only with the locality-specific GAF, there would be a reduction in total allowances in those areas under the statewide GAF. In the HPSA primary care bonus areas, payments would increase 29.8 percent under the RB-RVS with the locality-specific GAF and bonus payments compared to 22.4 percent using the statewide GAF without bonus payments.

Table 6.2 Comparison of Total Allowances under the OMFS and RB-RVS Using Nine Payment Localities and Statewide GAF, by Locality and HPSA Designation

	Total OMFS Allowances		RB-RVS Total Allowances (including BR)			
	Statewide GAF		9 Payment Localities and HPSA Bonus Payments		Statewide GAF	
Medicare locality	Total Allowances ($ millions)	% of Total Allowances	% Change from OMFS Total Allowances	% of RB-RVS Total Allowances	% Change from OMFS Total Allowances	% of RB-RVS Total Allowances
Marin/Napa/Solano	17.35	1.8	5.2	1.8	2.2	1.8
San Francisco	34.95	3.5	7.5	3.7	0.8	3.5
San Mateo	11.58	1.2	12.4	1.3	3.5	1.2
Oakland/Berkeley	65.79	6.6	5.7	6.9	1.6	6.6
Santa Clara	35.06	3.5	12.0	3.9	3.9	3.6
Ventura	16.41	1.7	2.8	1.7	1.1	1.6
Los Angeles	339.49	34.3	-0.1	33.5	-0.2	33.5
Anaheim/Santa Ana	103.19	10.4	-0.8	10.1	-3.7	9.8
Rest of California	302.44	30.6	2.7	30.7	6.5	31.9
Unknown	63.70	6.4	3.5	6.5	3.5	6.5
Total	989.96	100.0	2.3	100	2.1	100
HPSA designation						
Non-HPSA primary care designated areas	982.36	99.2	0.9	99.0	0.8	99.1
HPSA primary care designated areas	7.61	0.8	29.8	1.0	22.4	0.9
HPSA mental health designated areas (psychiatrist only)	0.10	0.0	-1.4	0.0	-8.0	0.0
Estimated bonus payments ($ millions)			.77			

Alternative Conversion Factors

The default option specified in Labor Code Section 5307.1(a)(2) is to transition from separate CFs for anesthesia, surgery, radiology and all other services to a single CF for all services other than anesthesia, which will continue to have its own CF. The impact analyses in Chapter 5 follow the structure of the default provision. The results indicate that the policy does not work as intended for pathology services, which are expected to have lower allowances under the RB-RVS than under the OMFS. Grouping pathology with services that will have higher allowances under the RB-RVS (namely, medicine and E&M) results in a 38.1 percent reduction in the first year allowances for pathology that lessens over the transition to a 19.5 percent reduction in 2017 as the "all other services" CF increases under the RB-RVS. Ideally, the transition would provide for a smaller reduction in the initial year that increases over the transition to the 19.5 percent reduction in 2017.

The OMFS transition budget neutral CFs are calculated by dividing total OMFS allowances by the total GAF-adjusted RVUs. Pathology services represent 0.2 percent of OMFS allowances so that a change in the transition conversion factor for these services has little impact on the conversion factors for other services. Alternatives for budget neutral conversion factors are shown in Table 6.3. The first alternative is the default option used in the Chapter 5 impact analyses, which combines pathology with medicine and E&M services. The second alternative combines pathology with radiology. It results in a 41.7 percent increase in aggregate allowances for pathology relative to the default option in 2014 (when 75 percent of the CF is based on the budget neutral CF).[27] The impact declines as the Medicare RB-RVS conversion factor is phased in. There is also a slight increase in the aggregate allowances for radiology (0.17 percent in 2014) and a slight reduction in aggregate allowances for medicine and E&M (- 0.10 percent in 2014).

The third alternative would group the three types of service that will have payment reductions under the RB-RVS into a single grouping for purposes of determining the OMFS conversion factors. This would result in two OMFS budget neutral CFs: one for services that will have an overall increase in aggregate allowances under the RB-RVS and one that will have an overall reduction. Because the OMFS conversion factor for surgery is higher than the CF for radiology, this alternative would reduce aggregate allowances for surgery 1.66 percent relative to the allowances under the default option. The allowances for radiology and pathology would increase 2.73 percent and 45.69 percent, respectively, relative to the default option. The impact on medicine and E&M is the same as the second alternative (-0.10 percent in 2014).

[27] The impact is estimated as (revised OMFS CF÷ default OMFS CF-1) x the applicable percentage of the CF based on the OMFS CF, e.g., 75 percent in 2014.

Table 6.3 Impact of Alternative Transition CFs on Aggregate Allowances by Type of Service Relative to the Default CF

	Surgery	Radiology	Pathology	Medicine	E&M
OMFS Maximum Fees	162,187,458	103,471,777	1,887,494	381,298,954	265,660,020
Total GAF-adjusted RVUs	2,917,373	1,972,457	31,497	10,891,351	8,283,825
1. Separate conversion factors for a) surgery, b) radiology, and c) pathology, medicine, and E&M					
Budget neutral CFs	55.594	52.458	33.782	33.782	33.782
2. Separate conversion factors for a) surgery, b) radiology + pathology, and c) medicine+ E&M					
Budget neutral CFs	55.594	52.576	52.576	33.739	33.739
% change in 2014 allowances	0.00	0.17	41.72	-0.10	-0.10
% change in 2015 allowances	0.00	0.11	27.82	-0.06	-0.06
% change in 2016 allowances	0.00	0.06	13.91	-0.03	-0.03
3. Separate conversion factors for a) surgery, radiology, pathology and b) medicine + E&M					
Budget neutral CFs	54.365	54.365	54.365	33.739	33.739
% change in 2014 allowances	-1.66	2.73	45.69	-0.10	-0.10
% change in 2015 allowances	-1.11	1.82	30.46	-0.06	-0.06
% change in 2016 allowances	-0.55	0.91	15.23	-0.03	-0.03

Non-physician Practitioners

Background

Allowances under the current OMFS are identical for services provided by physicians and by non-physician practitioners providing services within their scope of practice, including nurse practitioners, physician assistants, clinical social workers, and clinical nurse specialists.

Medicare and other health care payers pay non-physician practitioners at a specified fraction of physician payment levels. These lower rates may reflect the fact that they provide different products than do physicians. For example, nurse practitioners and physician assistants might see relatively healthier patients with less complex illness compared to physicians. However, there is little empirical evidence on whether nurse practitioners or physician assistants provide different products than physicians within specific billing codes (Everett, Schumacher, Wright, & Smith, 2009; Sox Jr, 1979). Similarly, there is little empirical evidence justifying specific payment reductions for their services relative to physicians. When the Medicare Payment Advisory Commission (MedPAC) looked at this issue, the Commission decided that there was too much uncertainty regarding product differences to recommend any changes to the Medicare payment differentials (MedPAC, 2002).

CMS pays 85% of the allowed amount for services provided by physician assistants and nurse practitioners under its RB-RVS.[28] However CMS pays 100% of the allowed amount for services provided "incident to" care furnished by a physician. The CMS "incident to" provision applies if the service provided by a physician assistant, nurse practitioner, or other health professional is:

- An integral, although incidental, part of the physician's professional service
- Commonly rendered without charge or included in the physician's bill
- Of a type that are commonly furnished in physician's offices or clinics
- Furnished by the physician or by auxiliary personnel under the physician's direct supervision (CMS, 2012).

Most state WC programs adopt the Medicare approach or a variation of the Medicare approach to set payment rates for non-physician practitioners. Table 6.4 summarizes non-physician practitioner payment rate policies in Medicare and six state WC programs. Two state programs (Tennessee and Texas) explicitly follow Medicare's policy. Other programs adopt Medicare's 85% allowance but do not specify whether services incident to care furnished by a physician are reimbursed at the physician rate. All states in Table 6.4 have the same payment rates for nurse practitioners and physician assistants. Clinical or independent social worker rates are usually fixed at 75% or 85% of the clinical psychologist or psychiatrist fees. The Oregon WC fee schedule is an exception to this rule; social worker evaluations are paid for at a fixed rate of $72.76. Other psychosocial services are similarly paid for at different fixed rates. Michigan, Florida, and Oregon designate separate payment rates for non-physician practitioners who assist in surgery (see notes to Table 6.4).

California WC Non-Physician Practitioner Billing and Payment Patterns

Less than one percent of services and payments are billed by the non-physician practitioners included in this analysis (see Figure 6.1). Physicians represent the largest share of services and payments and may bill for services provided by non-physician practitioners under a *de facto* "incident to" policy. As there is currently no distinction in payment rates for services provided by physicians and non-physician practitioners this arrangement does not affect the total cost of care. Non-physician practitioner services are also provided in multi-specialty groups (i.e., where clinicians of different specialties work in a single, integrated practice). These groups represent a relatively small share of total volume and payments.

[28] Medicare payments for services provided by federally qualified health centers are made on a per encounter basis. No distinction is made between encounters to physicians, nurse practitioners, and physician assistants. However, the rate per encounter is cost-based, so that a clinic that uses a high proportion of non-physician practitioners would presumably have lower costs than a clinic that is primarily staffed by physicians.

Table 6.4 WC Non-physician Practitioner Payment Policies

State	Nurse Practitioner	Physician Assistant	Clinical Social Worker
Medicare	85% of physician fee schedule, 100% if billed incident to in a physician office or clinic	85% of physician fee schedule, 100% if billed incident to in a physician office or clinic	75% of the clinical psychologist or psychiatrist fees
Florida	85% of a physician's allowable fee[1]	85% of a physician's allowable fee[1]	75% of the clinical psychologist or psychiatrist fees
Michigan	85% of a physician's allowable fee[2]	85% of a physician's allowable fee[2]	85% of the clinical psychologist or psychiatrist fees
Ohio	85% of a physician's allowable fee	85% of a physician's allowable fee	85% of the clinical psychologist or psychiatrist fees
Oregon	85% of a physician's allowable fee[3]	85% of a physician's allowable fee[3]	Fixed Fee: $72.76[4]
Tennessee[5]	Same as Medicare	Same as Medicare	Same as Medicare
Texas[5]	Same as Medicare	Same as Medicare	Same as Medicare

[1] PA or NP as Surgical Assistant: Payment will be 75% of 25% of the surgeon's allowable fee
[2] PA or NP as Surgical Assistant: Payment will be 13% of the surgeon's allowable fee, or the practitioner's usual and customary charge, whichever is less
[3] PA or NP as Surgical Assistant: Payment will be 15% of the surgeon's allowable fee
[4] Social worker evaluation - 30 minutes
[5] Uses locked in CF of 33.9764
[6] Uses Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) CF

Physician assistants, nurse practitioners, and clinical nurse specialists primarily bill routine office/outpatient visits and for completion of required reports (CPT 99081). E&M outpatient office visits account for about 60 percent of payments for services that are billed directly. Table 6.5 reports the top five specific codes (by payments) billed directly by these practitioner types.[29]

[29] Clinical social workers are excluded due to the low unit and payment amounts for specific procedure codes.

Figure 6.1 Services and Payments by Provider Type

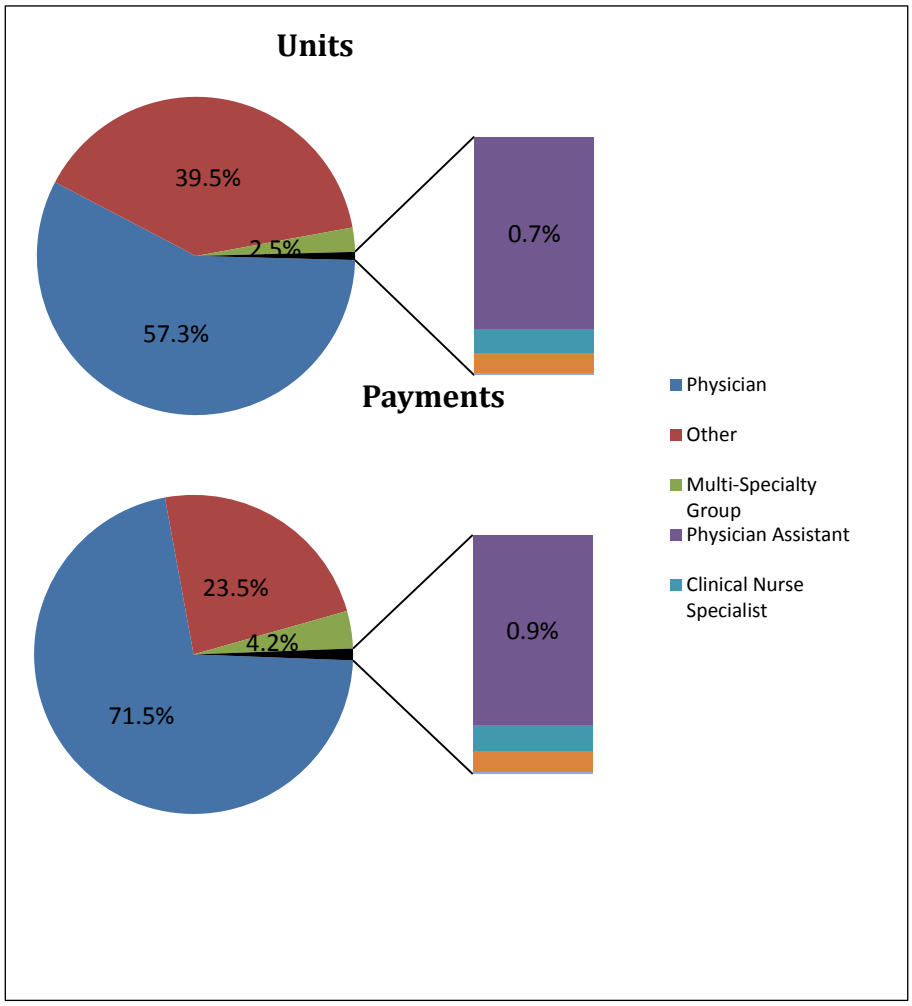


Table 6.5 Top Five Codes Billed Directly by Nurse Practitioners, Clinical Nurse Specialists, and Physician Assistants

OMFS Procedure Code	% payments directly billed by practitioner type	Payments ($, 000's)	Description
Nurse Practitioners			
99214	28.2	3,198.9	Established outpatient visit
99204	11.6	1,310.6	New outpatient visit
99213	8.5	964.6	Established outpatient visit
99215	6.6	742.6	Established outpatient visit
99081	4.3	484.4	Required reports
Clinical Nurse Specialist			
99214	30.4	798.3	Established outpatient visit
99215	13.3	348.3	Established outpatient visit
99204	8.0	209.8	New outpatient visit
99213	6.6	173.7	Established outpatient visit
99081	5.1	134.0	Required reports
Physician Assistant			
99214	22.3	234.9	Established outpatient visit
99213	18.9	199.7	Established outpatient visit
99203	5.8	61.1	New outpatient visit
99204	5.6	59.6	New outpatient visit
99081	5.0	52.9	Required reports

Policy Considerations

The OMFS policy for non-physician practitioners must balance the desire to ensure access to non-physician practitioners with efforts to provide appropriate care at the lowest possible cost. Below we outline key considerations that may affect choices related to payment of non-physician practitioners.

As noted above the two main considerations apart from consistency with Medicare rules and budget neutrality requirements are:

- Non-physician practitioners fill vital primary care functions in rural and underserved areas (AHRQ, 2012b; Grumbach, Hart, Mertz, Coffman, & Palazzo, 2003; Larson, Palazzo, Berkowitz, Pirani, & Hart, 2003). Reducing payment rates for non-physician practitioners may reduce access to these practitioners in these areas.[30]
- If the services furnished by non-physician practitioners differ from the services provided by physicians (i.e., within a given procedure code) then reducing payment rates may better align payment to services provided.

Other considerations include:

- Claims administrators will face an administrative burden under any policy alternative. Under the verbatim Medicare policy, documentation may be required to justify "incident to" payment. In general, following Medicare's rules will result in minimal administrative burden for practitioners already accustomed to this system. However, maintaining the status quo of 100% payment poses no increase in administrative burden.
- Non-physician practitioners will experience a significant increase in payment rates from the OMFS rates regardless of whether payment is 100% or 85% of the RB-RVS

[30] We did not identify empirical studies that directly test this hypothesis.

allowances.[31] See Table 6.6 for a comparison of the current OMFS allowance, 100% of the RB-RVS allowance, and 85% of the RB-RVS allowance for procedure code 99214.

- The numbers of practicing physician assistants and nurse practitioners are expected to increase dramatically over the next two decades (Auerbach, 2012; Hooker, Cawley, & Everett, 2011). This dramatic growth may result in the increasing substitution of physician services by non-physician practitioners
- Non-physician practitioners may more frequently bill directly in certain settings, e.g., in rural areas where the impacts of policy change on access warrant close scrutiny. The patient-centered medical home (AHRQ, 2012a) and accountable care organization (Healthcare.gov, 2012) delivery models emphasize care provided by teams of physicians and other practitioners. Medicare's "incident-to" requirements set payment conditions that require non-physician practitioners to affiliate with physicians to receive a higher payment rate. While the additional payment may be justified by the fact that the non-physician practitioner is working closely with the physician, it is unclear how well the "incident to" requirements are monitored or enforced.

Table 6.6 Comparison of Allowances for CPT 99214 under Current OMFS and RB-RVS during the Transition

Current OMFS Allowance	$89.57	NA
RB-RVS Allowance:	Allowance based on 100% of Medicare x 1.2 (current policy)	Allowance based on 85% of Medicare x 1.2 (proposed policy)
2014	121.72	103.46
2015	128.40	109.14
2016	135.40	115.09
2017	149.80	127.33

Note: Estimates based on 2013 RVUs for CPT 99214, transition conversion factors updated for inflation and adjusted by the average GAF.

Specific Policy Alternatives

1. Retain status quo policy where non-physician practitioners are paid the same fees as physicians

   Advantages:

   - Minimize potential access concerns to primary care services

[31] The access concern mentioned above is still relevant: All else equal, and assuming there is an effect of payment rate on access, access would be higher under the 100% RB-RVS payment level compared to the 85% RB-RVS payment level.

Disadvantages:

- Possible overpayment if services provided by physicians and non-physician practitioners differ in complexity, difficulty, or quality
- Requires an offsetting reduction for other services under the budget neutrality rules.

2. Adopt the Medicare policy including the incident-to provision

   Advantages:

   - Better match of payment to services provided if services by physicians and non-physician practitioners differ in complexity, difficulty, or quality
   - Consistent with general objective of adopting Medicare unless compelling reason not to

   Disadvantages:

   - Potential access concerns associated with relatively lower payment rate for non-physician practitioners
   - Possible administrative burden in monitoring "incident to" distinction.

3. Adopt the Medicare policy only with respect to the work component and pay the practice expense component at 100 percent

   Advantages:

   - Better match of payment to services provided if services by physicians and non-physician practitioners differ in complexity, difficulty, or quality but office expenses are comparable.
   - Raises less access concerns that across-the-board reductions

   Disadvantages:

   - Adds to administrative burden
   - Inconsistent with general objective of adopting Medicare unless compelling reason not to
   - Requires an offsetting reduction in payment for other services under budget neutrality rules.

The proposed rule incorporates Option 2 and is reflected in the baseline impact analyses. The impact of continuing current policies on aggregate allowances is shown in Table 6.7. Setting the allowances at 100 percent of the RB-RVS allowances for physicians would increase aggregate allowances an estimated $3.78 million in 2014 and $4.31 million in 2017. This represents a 0.40 percent increases in total aggregate allowances for all services under the RB-RVS that are paid using RVUs in 2014 and a 0.38 percent increase in 2017.

Table 6.7 Comparison of Total Allowances for Non-Practitioner Services under Proposed Policy and Current Policy ($ millions)

Total RB-RVS for All Services [1] ($ millions)		Total RB-RVS Amounts under Proposed Policy (85% of Medicare X 1.2) ($ millions)		Total RB-RVS Amounts Based on 100% of Medicare x 1.2 ($ millions)	
2014	2017	Using Medicare Rules in 2014	Total RB-RVS Amounts Using Medicare Rules in 2017	Total RB-RVS Amounts at 100 % in 2014	Total RB-RVS Amounts at 100 % in 2017
1,001.48	1,184.00	21.40	24.40	25.18	28.70

[1] 95.5 percent of the amounts shown are based on RVUs

Bundling Policies

Supplies

Background

In the OMFS, supplies and materials normally necessary to perform services are not separately payable. Supplies and materials provided over and above those usually included with office visits or other services may be charged for separately. This applies to providers furnishing services in their office or other settings in which a facility fee is not payable. Supplies that are not payable separately include applied hot or cold packs, trays, needles, sterile gloves, tissues, cotton balls, dressing for simple wounds, gauze, cotton balls, band-aids, tape, urine collection kits etc. Reimbursable supplies include cast and strapping materials, sterile trays for laceration repair, applied dressings beyond simple wound occlusion, taping supplies for sprains, and reusable patient electrodes.

CPT 99070 is used to bill for items that are separately payable. Items are priced at cost (i.e. purchase price including sales tax) plus 20% of cost up to a maximum of $15. Items that are dispensed to the patient (e.g., crutches, dressings, TENS electrodes, hot or cold packs) are payable under the fee schedule for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) and are not affected by the RB-RVS.

Under Medicare rules, supplies and materials are not separately payable; rather, the PE expense RVUs include the estimated costs for supplies used during an office-based procedure. (No supplies are payable for services provided in facility settings because the facility assumes the supply and equipment costs). The only exceptions to this rule for office-based procedures are injectable drugs, biologicals and casting materials billed using HCPCS alpha-numeric codes. In addition, certain drugs used during radiologic procedures and implants used in physician office

surgical procedures are separately payable using HCPCS alpha-numeric codes. [32] The non-specific CPT code 99070 is not payable in any setting.

We examined the WC fee schedule for several states that have adopted the RB-RVS. Texas and Washington bundle supplies following Medicare's policy (Table 6.8).

Table 6.8 Bundling of CPT Code 99070 for Select Comparison States Using RB-RVS

State WC Program	Pay for Code 99070
Florida	Yes
Michigan	Yes
Tennessee	Yes
Texas	No
Washington	No

Michigan, Tennessee, and Florida have similar policies for when CPT 99070 is separately payable. Minor medical and surgical supplies routinely used by the practitioner or health care organization in the office visit are not to be billed separately. Supplies, or other services, over and above those usually incidental to an office visit or other outpatient visit of a patient are be billed separately under CPT 99070.

Several comments were received on the DWC Forum that concerned payment for supplies. Many physical therapists urged that separate payment be made for supplies furnished during physical therapy visits. The commenters argued that WC patients use more supplies but provided no data to support their argument. A physical therapist who is unaffected by the fee schedule advised us that there is no apparent reason why WC patients would require more supplies during a visit. Any additional supplies dispensed to the patient would be separately payable under the DMEPOS fee schedule. One large provider indicated that billing and receiving payment for supplies under the current OMFS ground rules has been problematic and that bundling would reduce administrative burden.

At the stakeholder meeting on the RB-RVS, a provider requested that separate payment continue for surgical trays (but their comments on the Forum did not discuss supplies). Under the RB-RVS, separate rates apply to the PE component of the fee schedule. For services provided in a physician's office, the PE RVUs reflect the costs of equipment and supplies furnished during the service. A listing of the supplies that are included for different services is available on the

[32] When furnished to patients in settings in which a TC is payable, separate payments may be made for low osmolar contrast material used during intrathecal radiologic procedures, pharmacologic stressing agents used in connection with nuclear medicine and cardiovascular stress testing procedures, radionuclide used in connection nuclear medicine procedures furnished to beneficiaries in settings in which TCs are payable.

CMS website. [33] Surgical trays are included in the RVUs for wound repairs. A separate allowance for surgical trays would in essence be a duplicate payment.

Specific Policy Alternatives

We identified two options that might be considered. The first follows the Medicare rules without modification. The second would make a separate payment for atypically high supply costs.

1. Adopt Medicare policy of bundling payment policies for encounters. Code 99070 will not be payable.

Advantages:

- Decreases administrative burden and additional bill processing costs
- Discourages providers from providing potentially unnecessary supplies
- Consistent with Medicare policies

Disadvantages:

- Potential to create access issues for medically necessary high cost supplies

2. Allow payments for supplies above a threshold. Payment for supplies above this threshold will be on a by-report basis using code 99070. This threshold could be set to a certain fixed value, e.g. 95th percentile of supply costs.

   Advantages:

   - Bundles all but unusually high cost supplies
   - Discourages providers from providing potentially unnecessary supplies
   - Protects against potential access issues

   Disadvantages:

   - Higher administrative burden
   - Requires budget neutrality adjustment

We have summarized payments for supplies under CPT 99070 in Tables 6.9 and 6.10. Table 6.9 uses the 95th percentile as an example for a threshold above which payment of supplies will

[33] CY2013 PFS Direct PE Inputs available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1590-FC.html

no longer be bundled and will instead be on a "By Report" basis.[34] Using a monetary threshold value of $442 (95th percentile) drops the number of total bills for supplies by 96% and cuts payment for supplies by about 50%. This represents a large decrease in administrative costs and burden by reducing the number of bills processed on a "By Report" basis. Bills above the 95th percentile appear to be very high cost supplies with a mean of $986, which is nine times that of the mean of costs of all supplies taken together (data not shown). The mean payment for supply costs exceeding the 95th percentile threshold would be $913.72.

Table 6.9 OMFS Payments for Supplies Related to Diagnostic and Therapeutic Procedures

	Payments	Times billed	Mean[1]	Median[1]
Total paid for CPT 99070	$13,305,378	162,676	$81.79	$13.54
Total paid for CPT 99070 with $422 threshold (95th percentile)	$6,089,916	6,665	$913.72	$413.49
Total paid for CPT 99070 with $1873 threshold (99th percentile)	$2,005,777	1,211	$1,656.30	$850.95

[1]The mean and median are calculated for amounts that would be paid above the listed thresholds. For example, under the $422 threshold, a bill for $423 would be paid at most $1.

Table 6.10 shows the distribution of CPT 99070 payments across diagnostic and therapeutic services that were billed on the same day. Nearly $5.6 million of the payments were for supplies that were the only item billed on that day for that patient in the WCIS. We would have expected that supplies that are dispensed to patients would be billed using a HCPCS alphanumeric code rather than CPT 99070. Both WCIS incompleteness and inconsistencies in billing practices may explain why only supplies are being billed on a given day. It appears that several of the costly bills that would qualify for the additional payment might be associated with surgical procedures. Of the supplies that are billed on the same day as a diagnostic or therapeutic service, surgery accounts for 10.2 percent of the supply costs but 22.4 percent of supplies above the 99th percentile. We are unable to determine the types of supplies that are being billed in connection with surgery. Note that if a facility fee was also payable for the services, the items should not have been separately billable.

[34] Currently all supplies are billed "BR" so that the types of supplies cannot be determined. Also, a large proportion of CPT 99070 codes were billed without accompanying billings for other services and cannot be linked to services provided. This might arise as a result of inappropriate use of the CPT 99070 by providers for physician-dispensed items. Additionally, certain drugs also billed using CPT 99070 that cannot be parsed from the supply data billed under CPT 99070.

Table 6.10 Distribution of Total Payments for CPT 99070 across Types of Service with the Same Patient and Date of Service

Type of service by CPT code range	All 99070	Payment threshold at 95th percentile ($422)	Payment threshold at 99th percentile ($1873)
	Amount paid		
Total paid amount	$13,305,378	$6,089,916	$2,005,777
Amount paid, supply-only bills[1]	*$5,567,158*	*$3,142,151*	*$1,087,549*
	Percent of apportioned supply costs for bills with supplies and other services		
E&M	49.1	50.5	46.0
Anesthesiology	1.0	1.8	2.7
Surgery	10.2	14.6	22.4
Radiology	4.7	2.9	3.1
Pathology and Laboratory	0.0	0.0	0.0
Medicine	3.5	3.1	2.4
Physical Medicine	14.8	7.6	4.9
Manipulative Treatment	0.6	0.4	0.3
Special Services	9.9	10.3	8.0
Other	6.0	8.9	10.2

[1]This sum includes bills where the only paid service is CPT 99070.

Consistent with the proposed rule, we assumed that all supplies billed under CPT 99070 would be bundled under the RB-RVS. It is likely some of these supplies are items that would be payable under the RB-RVS so that the impact of bundling supplies may be overstated.

Reports

Under current OMFS rules, certain reports are separately reimbursable under three codes:

90889 Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultation purposes) for other individuals, agencies, or insurance carriers

99080 Special reports (Information in excess of mandated reports requested by claims AD, or WCAB, consulting physician reports (confirmatory or requested by a party to the claim, the AD or WCAB), Primary Treating Physician's Permanent and Stationary Report[PR-3]) . CPT 99080 is paid at a per page rate (capped at 6 pages unless additional length is authorized).

99081 Required reports (Primary Treating Physician's Progress Reports [PR-2], Final Discharge Report [final PR-2])

The first two codes are current CPT codes. CPT 99081 is not a 2013 CPT code. In addition to the reimbursable reports listed above, there are non-reimbursable treatment reports that are already included in the E&M allowance: Doctor's First Report of Occupational Illness or Injury [Form 5021], initial treatment report and plan (which should be in the Form 5021), and reports by a secondary physician to the primary treating physician. The rationale for paying separately for some required reports under CPT 99081 and not for others is not readily apparent. The first report of occupational injury or illness [Form 5021] is not separately reimbursable while the progress reports [PR-2] are.

Under the MPFS RVUs, reports are bundled into the payment for E&M services and are not separately paid. There are two related issues in creating a separate allowance for reports: would it be a duplicate payment and would a budget neutrality adjustment would be required because a separate payment deviates from Medicare's policies. Arguably, work-related reports are not the same as medical treatment reports that are an integral part of medical treatment. Separate payment for required reports recognizes the additional work-related documentation required for WC patients and responds to concerns that WC patients pose more administrative burden for E&M services. This rationale is strongest for the reports required for claims administration, e.g., those currently reimbursable under CPT 99081 and the Primary Treating Physician's Permanent and Stationary Report [PR-3] that is currently payable under CPT 99080 and WC-required reports under CPT 90889. It is less applicable to reports that are not WC-specific, such as consultation reports except to the extent they are WC-required consultation reports performed in the context of medical-legal evaluations (OMFS modifier=30) or other mandated consultations (OMFS modifier =32).

In addition to reports, the OMFS has allowances for copies of medical records and duplicate reports. These are not valid 2013 CPT codes. The codes are not heavily utilized under the WC program, but when they are used, we cannot tell from the WCIS data whether the reasons underlying the requested records.

The paid amounts for reports are shown in Table 6.11. Consistent with the proposed rule, we treat codes other than CPT 99080 and 990889 as if separate allowances will continue using OMFS prices under the RB-RVS. We were unable to model the nuances of the proposed rule to continue to pay for certain consultation reports and the Primary Treating Physician's Permanent and Stationary Report[PR-3]) under CPT 99080. To approximate the amount that would continue to be paid, we included 19 percent of the paid amounts for CPT 99080 in the RB-RVS allowances. This represents the percentage of payments for CPT 99080 reports that are not billed within 30 days of a consultation visit.

Table 6.11 OMFS Payments for Reports by CPT Code

OMFS CPT Code	Description	RB-RVS Status	Total 2011 OMFS Payments ($ millions)	Treatment under RB-RVS
76175	Duplication of x-ray	Not a CPT 2013 code	0	OMFS rate: $4.75 each
76176	Duplication of scan	Not a CPT 2013 code	0	OMFS rate: 9.50 each
90889	Special report of patient's psychiatric status	Bundled	0.40	Pay for WC-required reports at the OMFS rate: (6.5 1st page; 4.0 additional) x 6.15 x 0.95; bundle other reports
99080	Special reports or forms	Bundled	30.82	Pay for WC-required consultation reports and PR-3 at the OMFS rate: (6.5 1st page; 4.0 additional) x 6.15 x 0.95; bundle other consultation reports
99081	Required reports	Not a CPT 2013 code	15.82	OMFS rate: $11.69
99086	Reproduction of chart notes	Not a CPT 2013 code	0.27	OMFS rate: ($10 first 15 pages; 0.25 each additional page) x .95
99087	Reproduction of duplicate reports	Not a CPT 2013 code	0.04	OMFS rate: ($10 first 15 pages; 0.25 each additional page) x .95

Other Items and Services with Status Code B under the MPFS

Supplies and reports account for most of the allowances for services that are separately paid under the current OMFS that are assigned Status code B under the RB-RVS. Consistent with the proposed rule, we assumed that the remaining services would be bundled under the RB-RVS. For modeling purposes, we included the OMFS allowances for these services in our estimation of current OMFS allowances and we included no separate allowances for these services in our estimation of RB-RVS allowances.

Consultations

Background

Consultations are defined under the OMFS as "a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or appropriate source (e.g., a party to the claim, the

administrative director (AD) or Workers' Compensation Appeals Board (WCAB))." If the treating physician is asked for medical information other than that required to be reported as treatment reports, the service qualifies as a consultation. The current OMFS has separate allowances for consultations and for other E&M services. In addition, a report by the consulting physician is separately reimbursable.

The CPT 2013 consultation codes have been revised and clarified regarding usage. Key elements of the current definition are 1) the consultation must be at the request of a physician or other appropriate source to either recommend care or determine whether to accept responsibility for on-going care, 2) care may be initiated at the initial consultation, in which case E&M codes for established patients are used for follow-up care, 3) if transfer of care occurs before the initial evaluation, the consultation code should not be used, 4) if an additional request for advice is received regarding the same or new problem, the codes may be used again and 4) the referral should be documented in the medical record.

CMS eliminated payment for the consultation codes in 2010 because of inconsistent use of the consultation codes by physicians and Medicare contractors.[35] At issue were E&M documentation guidelines that distinguish a consultation from a transfer of care and the interchangeable use of the term "referral" by physicians to mean both a consultation and a transfer of care. The CPT Coding Guidelines were clarified that a transfer of care occurs when a physician relinquishes responsibility for management of some or all of a patient's problem to another physician or qualified health care professional effective January 2010 but CMS was skeptical that this would resolve the long-standing differences in interpretation regarding referrals and transfers of care. In addition, there was concern that the consultation codes may be overvalued relative to the E&M codes for initial hospital care and new patient office/outpatient visits. Physician work is clinically similar for these codes. According to CMS, many physicians contended that more work is actually involved with a new patient visit than with a consultation service because of the post-work involvement with a new patient. The payment for a consultation service had been set higher than for initial visits because a written report must be made to the requesting professional. However, CMS had reduced the reporting burden for the consultation reports so that it was no longer a defining aspect of the service.[36] The elimination of the consultation codes was made budget neutral by increasing the work RVUs for new and established office visits by approximately 6 percent and for initial hospital and facility visits by approximately 0.3 percent (which also affected the incremental work RVUs for the E&M codes

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[35] A 2006 report by the HHS Office of the Inspector General found that Medicare had inappropriately paid for a substantial volume of services billed as consultations. Seventy-five percent did not meet Medicare requirements (billed at the wrong type or level), 19 percent did not meet the definition of a consultation, and the remainder were insufficiently documented.

[36] The change was to allow any form of written communication, including submitting a copy of the evaluation report taken directly from the medical record submitted without a letter format.

that are built into the global surgical codes). Although the MPFS does not use the consultation codes, the annual update includes values for the consultation codes in Addendum B as a courtesy to the AMA.

Table 6.12 summarizes the differences in OMFS allowances under three fee schedule alternatives. Section A shows the current distribution of the consultation codes in the WCIS. Section B shows the results of crosswalking the current OMFS codes into their 2013 equivalents. The codes for follow-up inpatient consultations and confirmatory consultations have been eliminated. Services billed under these codes have been crosswalked to their equivalents in CPT 2013, namely, the follow-up inpatient consultation codes to the codes for subsequent hospital and nursing home care and the confirmatory consultations to the office and initial inpatient consultation codes. For the rate comparison, we have used the 2014 equivalent of fully-phased rates based on 1.2 times the Medicare rate since it is more reflective of final fee differences than the transition CF. Relative to the current OMFS, allowances would be 22 percent higher if the RB-RVS recognized the consultation codes at 1.20 of the published RVUs. Section C crosswalks the services into their CPT equivalents under Medicare rules (i.e., visit codes). Relative to the current OMFS, allowances would be 95 percent of the amounts payable under the current OMFS before consideration of differences in the payment rules for consultation reports. Aggregate payments in Section B are 27 percent higher than those in Section C, which follow the Medicare ground rules. Using the RVUs for consultation codes would increase aggregate allowances for E&M services 3.73 percent and total aggregate allowances 0.96 percent.

Allowances for consultation reports are not included in the Table 6.12 comparison. Under current OMFS ground rules, separate allowances apply to consultation reports. As noted earlier, the proposed rule provides for bundling consultation reports other than WC-required reports. For purposes of the impact analysis, we have assumed that 81 percent of current OMFS payments for reports billed under CPT99080 would be bundled. Payments for CPT 99080 totaled $30.82 million in our analysis file. Assuming that 81 percent, or $24.96 million is currently paid for consultation reports would be bundled under the OMFS, aggregate payments for both the consultation visits and reports total $62.7 million under the OMFS compared to $36.01 million under the RB-RVS. Total aggregate payments under the RB-RVS using the Medicare rules would be 57 percent of total OMFS allowances for consultations.

Section 5307.1(a)(2)(A)(iii) limits aggregate payments to 120 percent of the aggregate fees under the Medicare system and further stipulates that any service provided under WC that is not covered under Medicare will be included in the limit calculation at the rate of payment established by the AD. As indicated by the status code “I” on Addendum B of the Medicare fee schedule, consultations are covered by Medicare but paid under different CPT codes (i.e., the E&M visit codes). If the Medicare rules are not adopted, an offsetting adjustment would need to be made to limit aggregate fees to 120 percent of the amount payment under Medicare.

Table 6.12 Comparison of Allowances under Current OMFS and Alternatives under the RB-RVS

A. Current OMFS Code				B. CPT 2013 Consultation/Visit Codes				C. CPT Visit Codes Only			
Code	Volume	Allowed Fee	Total allowances ($ millions)	Code	Volume	Allowed Fee	Total allowances ($ millions)	Code	Volume	Allowed Fee	Total allowances ($ millions)
Office or Other Outpatient Consultations: New or Established Patient								Office or Other Outpatient Visit : New Patient			
99241	4,570	79.14	0.36	99241	4,795	62.27	0.30	99201	2,398	$58.63	0.14
99242	15,741	104.98	1.65	99242	15,954	117.26	1.87	99202	7,977	$99.54	0.79
99243	36,655	131.62	4.82	99243	37,839	159.99	6.05	99203	18,919	$144.08	2.73
99244	66,512	184.86	12.30	99244	67,683	236.34	16.00	99204	33,841	$219.98	7.44
99245	70,496	238.79	16.83	99245	71,058	289.07	20.54	99205	35,529	$272.25	9.67
Initial Inpatient Consultations : New or Established Patient								Office or Other Outpatient Visit: Established Patient			
99251	140	85.60	0.01	99251	167	63.18	0.01	99211	2,398	$27.27	0.07
99252	243	113.05	0.03	99252	316	97.26	0.03	99212	7,977	$58.63	0.47
99253	868	142.12	0.12	99253	1,128	148.17	0.17	99213	18,919	$96.81	1.83
99254	1,701	190.57	0.32	99254	2,024	213.62	0.43	99214	33,841	$142.26	4.81
99255	1,935	243.87	0.47	99255	2,101	265.89	0.56	99215	35,529	$190.89	6.78
Follow-up Inpatient Consultations				Subsequent hospital care				Initial Hospital Care: New or established patient			
99261	16	50.07	0.00	99231	104	50.91	0.01	99221	228	$132.26	0.03
99262	259	79.14	0.02	99232	259	93.63	0.02	99222	1,609	$179.53	0.29
99263	198	114.67	0.02	99233	99	134.99	0.01	99223	2,179	$264.07	0.58
Confirmatory Consultations				Subsequent nursing home care				Initial Nursing Home Care: New or established patient			
99271	14	73.48	0.00	99307	2	58.18	0.00	99304	98	$122.26	0.01
99272	44	97.71	0.00	99308	5	90.45	0.00	99305	689	$173.62	0.12
99273	1,012	127.59	0.13	99309	3	118.63	0.00	99306	934	$219.53	0.21
99274	1,432	173.61	0.25	99310	0	176.80	0.00	Subsequent Hospital and Nursing Home Visits			
99275	1,702	227.72	0.39					99321-99233	462		0.04
								99307-99310	11		0.00
Total	203,538		37.74		203,538		46.00		203,538		36.01

Other states using RB-RVS have adopted different policies regarding the consultation codes (Table 6.13).

Table 6.13 Summary of Selected State Policies on Consultation Codes

State	Policy
Florida	Allows an initial consultation but requires any subsequent visits be billed using E&M visit codes.
Maryland	Recognizes consultation codes.
Tennessee	Follows Medicare rules.
Washington	Recognizes consultation codes. Follows E&M documentation guidelines.
Ohio	Recognizes consultation codes.
Texas	Follows Medicare.
Federal OWCP	Follows Medicare.

Specific Policy Alternatives

We have identified three basic options that might be considered: follow Medicare rules, follow Medicare rules but continue to pay separately for consultation reports, and pay for consultations but eliminate separate payment for consultation reports since they are part of the defined service and reason for higher relative values.

1. Follow Medicare ground rules

   Advantages
   - Consistent with Medicare rules and RVUs
   - Reduces opportunity for coding inconsistencies

   Disadvantages
   - Could reduce the quality of consultation reports
   - Could discourage specialties from providing consultations for WC patients

2. Use E&M visit codes only but allow consultation reports
   Advantages
   - Addresses concern that consultation reports might be undervalued in visit codes
   - Pays for actual consultation reports

   Disadvantages
   - Contrary to Medicare rules
   - Requires a budget neutrality adjustment (estimated $40 per report)
   - Adds to administrative burden

3. Allow consultation codes and bundle reports
   Advantages

- Avoids creating potential difficulties in access to specialists for consultations

Disadvantages

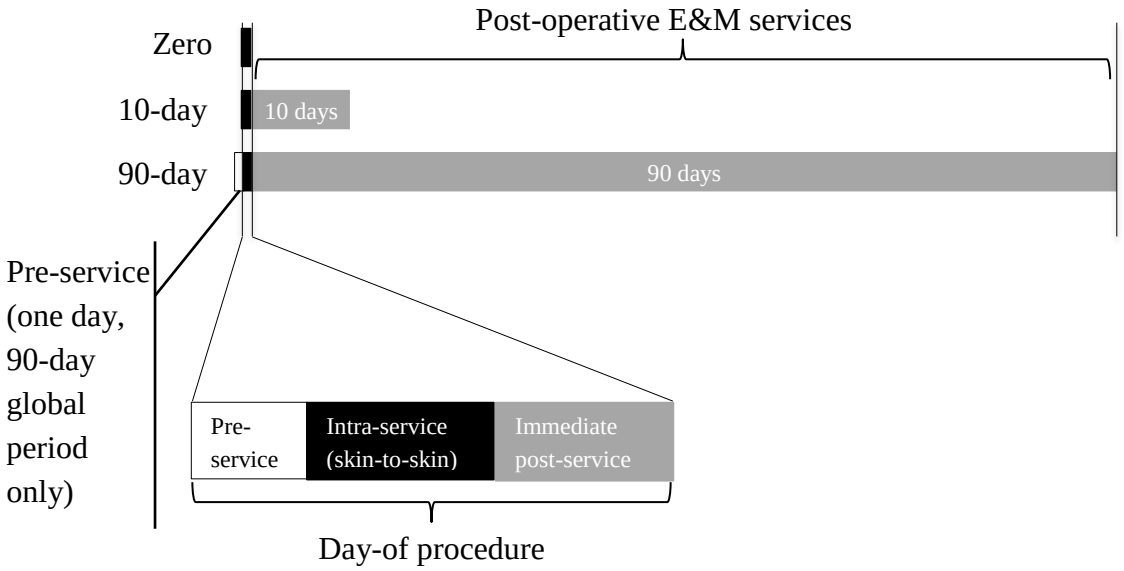
- Budget neutrality adjustment complicates fee schedule updating
- Increases administrative burden of monitoring correct coding
- Does not create incentives to provide quality consultation reports

Global fees

Background

Under the MPFS, CMS pays practitioners a single global surgical fee for 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 length of the global period determines which post-operative E&M visits are included in the global fee. Endoscopies and some minor procedures have a zero day period, i.e., only services provided on the day of the procedure are included in the global fee. Other minor procedures have a 10-day global period including the day of the procedure and the following 10 days (11 total days). Major procedures have a 90-day global period including one day before the procedure, the day of the procedure, and the following 90 days (92 total days). Figure 6.2 illustrates the various component of zero, 10, and 90-day global periods.

Figure 6.2 Global Period Definitions



Services in the global surgery payment usually include pre-operative visits after the decision to operate is made, intra-operative services considered usual and necessary, all follow-up care days, pain management, supplies and miscellaneous services such as dressing changes and removal of casts, tubes, wires etc. Initial consultations, diagnostic tests, treatment for underlying conditions and clearly distinct procedures are not included in this package. The same package of services are bundled across all medical settings regardless of the setting in which the surgery is performed and the follow-up services are provided.

The total time and work values associated with surgical codes with global periods combine estimates of time and work on the day of the procedure and time and work from an estimated number of post-operative E&M services provided in the global period. Practitioner surveys were the initial basis for time and work values and are still used extensively to inform revisions. For the day-of procedure component, practitioners are asked to provide time estimates specific to pre-service, intra-service, and immediate post-service components for the procedure itself.[37] For post-operative E&M services in the global period, practitioners are asked to estimate the typical number of specific E&M services[38] they perform for a typical patient. Each E&M service is associated with its own time and work estimates. The total global fee amount is based on the sum of these component-specific time and work values. For example, the total work RVUs for CPT 29881 (arthoscopy of the knee with medial or lateral meniscectomy) is calculated from the components listed in Table 6.14. The global fee for the work component of the fee schedule is calculated from 7.03 total RVUs which accounts for services provided on the day of the procedure and the day prior to the procedure as well as the typical post-operative E&M services related to the procedure.

California WC also uses global periods to pay for certain surgical procedures. The CMS and CA global period definitions are nearly identical. Language describing other important details, e.g., the services included and excluded from the global payment, the use of modifiers, and other exceptions, are very similar in the California OMFS and CMS billing manuals.

The initial global periods assigned to CPT codes in the OMFS were adopted from the 1997 MPFS.[39,40] Since then CMS has updated global period lengths for some services. Table 6.14 reports the current OMFS and MPFS global periods for the twenty surgical services with the highest WC payments. The surgical procedure associated with the greatest spending, CPT 29826 Shoulder arthroscopy/surgery, has a 90-day global period in the OMFS. It is an add-on code

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[37] In the case of a 90-day global period, practitioners also estimate time spent on the day before the procedure.

[38] These services include hospital visits (CPT 99231-99233, 99291, and 99292), discharge day visits (99238, 99239), office visits (99211-99215), and prolonged services (99354-99237).

[39] See Federal Register: Vol. 61, No. 227. MPFS zero-day global periods or special alphanumeric codes (e.g., "ZZZ") were converted to "blank" OMFS global periods.

[40] 1999 OMFS Book. The Surgery Ground Rules, No. 20

("ZZZ") in the MPFS that is billed in addition to the primary procedures- all of which have a 90-day global period.[41] Another code, CPT 63650 (Implant neuroelectrodes), has a 90-day global period in the OMFS and a 10-day global period in the MPFS.

Table 6.14 Service Components Included in Work Component of the Global Fee for CPT 29881 Arthroscopy of the Knee with Medial or Lateral Meniscectomy (90 day global period)

		Time		Intensity	Work
Day-of components		**Minutes**		**RVUs per minute**	**Total RVUs**
Pre-service: Evaluation			33	0.0224	0.74
Pre-service: Positioning			10	0.0224	0.22
Pre-service: Scrubbing, etc.			15	0.0081	0.12
Intra-service			40	0.0637	2.55
Immediate post-service			15	0.0224	0.34
Post-operative E&M	**Number**	**Mins ea.**	**Total**	**RVUs per service**	**Total RVUs**
Outpatient visit: 99212[42]	1	16	16	0.48	0.48
Outpatient visit: 99213[43]	2	23	46	0.97	1.94
Discharge mgmt.: 99238[44]	0.5	38	19	1.28	0.64
Total		**Minutes**		**RVUs per minute**	**RVUs**
			194	0.0362	7.03

WC's current global periods closely align with those of CMS under the MPFS in terms of duration. The key difference is that CMS global periods have been revised over time while OMFS global periods have not. Table 6.16 compares CMS and OMFS global periods for all surgical codes. Ninety-five percent of codes with an OMFS 90-day global period also have a 90-day CMS MPFS global period. Nearly 90 percent of codes with an OMFS 10-day global period also have a 10-day CMS MPFS global period.

Post-surgical E&M visits account for a considerable proportion of the total time and work associated with surgical procedures in the MPFS. For the twenty surgical codes listed in Table 6.15, post-surgical E&M visits accounted for 40.7% on average (median 38.3%) of total service time. Nevertheless, there is concern regarding whether the global billing rules provide sufficient recognition of work-related components of follow-up care.

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[41] Under the MPFS, the global period for the primary procedure will determine the global period for 29826. This code is used in conjunction with 29806-29825, 29827, and 29828, all of which have a 90-day global period.

[42] Outpatient office visit, established patient, with at least two of the following components: (1) a problem focused history; (2) a problem focused examination; or (3) straightforward medical decision making.

[43] Outpatient office visit, established patient, with at least two of the following components: (1) an expanded problem focused history; (2) an expanded problem focused examination; or (3) medical decision making of low complexity.

[44] Hospital discharge day management, 30 minutes or less.

Table 6.15 Comparison of Global Periods under the OMFS and MPFS for High Volume Procedures

OMFS CPT	2013 CMS CPT	Brief Description	WC 2011 Payments ($millions)	OMFS Global[45]	CMS (2013) Global[46]
29826	Same	Shoulder arthroscopy/surgery	8.64	90	ZZZ
29881	Same	Knee arthroscopy/surgery	4.65	90	90
22845	Same	Insert spine fixation device	3.80	0	ZZZ
63047	Same	Remove spine lamina 1 lmbr	3.79	90	90
29823	Same	Shoulder arthroscopy/surgery	3.54	90	90
29880	Same	Knee arthroscopy/surgery	3.40	90	90
22851	Same	Apply spine prosth device	3.15	0	ZZZ
27447	Same	Total knee arthroplasty	3.04	90	90
22842	Same	Insert spine fixation device	2.71	0	ZZZ
64721	Same	Carpal tunnel surgery	2.62	90	90
63650	Same	Implant neuroelectrodes	2.13	90	10
62278	62311	Inject spine lumbar/sacral	2.01	0	0
63030	Same	Low back disk surgery	1.93	90	90
20610	Same	Drain/inject joint/bursa	1.92	0	0
29888	Same	Knee arthroscopy/surgery	1.83	90	90
22612	Same	Lumbar spine fusion	1.82	90	90
22554	Same	Neck spine fusion	1.57	90	90
22558	Same	Lumbar spine fusion	1.52	90	90
63048	Same	Remove spinal lamina add-on	1.41	0	ZZZ
20550	Same	Inj tendon sheath/ligament	1.37	0	0

Table 6.16 Summary Comparison of OMFS and MPFS Global Periods for Surgical Procedures

	CMS MPFS						
OMFS	Blank	XXX[47]	YYY[48]	ZZZ[49]	0	10	90
Blank[50]	19%	49%	2%	5%	14%	3%	9%
10	9%	0%	0%	0%	4%	87%	0%
90	4%	0%	0%	0%	0%	1%	95%

[45] From OMFS Table A.

[46] From the CMS National Physician Fee Schedule Relative Value File Calendar Year 2013.

[47] The CMS "XXX" designation indicates the global fee concept does not apply to the specific code.

[48] The CMS "YYY" designation indicates Medicare contractors rather than CMS determine whether the global fee concept applies to the specific code. Contractors may assign these codes a zero, 10-day, or 90-day global period.

[49] The CMS "ZZZ" designation indicates the code is always included in the global period of another service and therefore does not have its own global period.

[50] Codes without a OMFS 10 or 90-day global may have a zero-day global period or a special global period code like the CMS XXX, YYY, or ZZZ codes.

Policy Considerations

Global period policy aims to incentivize the appropriate and efficient provision of post-surgical E&M visits. The global period also simplifies billing and adds predictability in terms of payment for providers and payers. The rationale for a global period is tied to the rationale for bundled, capitated, or prospective payment generally: Given a fixed payment rate, practitioners will provide only appropriate services. However global period payment is subject to the same potential adverse effects of bundled and capitated payment, including incentives to provide fewer services at the potential expense of quality of care and health. The tension between promoting quality and controlling utilization and spending is a hallmark of the more general debate between fee-for-service and capitation payment arrangements. In most cases, hybrid payment systems develop over time to offset the most serious adverse effects of each individual payment approach.

The global payment issue also raises questions related to data collection, data analysis, and the use of data as a quality and value-improvement tool. It is extremely difficult to assess whether, when, and how post-surgical E&M services are provided to Medicare beneficiaries or to WC patients given the current global billing policies. As a result, neither CMS nor WC data can inform whether changes to the global billing policy are warranted to evaluate the appropriateness of post-operative care, target interventions to improve the quality of post-surgical care or prevent double-billing by multiple practitioners,

In weighing whether the WC program should continue to use the global periods, important considerations include the following:

- *Global periods are consistent with both OMFS current policy and Medicare policy.* They have not been an issue under the OMFS, although this may be because the current allowances are substantially higher than the Medicare allowances. One implication is that the continuation of the global periods should not be an issue if the reduced payment rates are phased-in.
- *Because both Medicare and WC use global periods, data are not available to determine whether WC patients require more follow-up visits.*[51] Because WC patients have a shorter length of stay than Medicare patients, it is likely they have fewer inpatient visits associated with inpatient surgeries. It is also likely that more surgeries are performed on an outpatient basis than inpatient. Data are not available to determine the impact that this might have on the number and intensity of post-operative office visits and whether fewer hospital visits offset any additional office visits. However, because WC patients are younger and healthier, they are likely to require fewer follow-up visits for *medical* reasons.
- *Work-related issues may require additional visits or more visit time.* Several commenters during pre-rulemaking activities noted that visits solely to address work-related reporting

[51] It should be noted that the estimated services provided during the global periods are based on the "typical" patient receiving the services and not necessarily Medicare patients.

requirements may be needed during the global period. Separate allowances for these visits and for WC-required reports is one approach to address this issue. In addition, it could be argued that the 1.2 multiplier provides a cushion for longer visits. Regardless of whether the visits are covered in the global fee or separately billed, there is no assurance that work-related services are actually provided during the visit unless data are collected about the nature of the post-operative services.

- *If global billing is eliminated, an adjustment is needed to avoid duplicate payment.* Because the RB-RVS pricing covers post-operative visits, the RVUs would need to be adjusted so that WC payers do not pay twice for the care: once in the allowance for the surgical procedure and again in the separate billings for E&M services.
- *Available data to make an adjustment are problematic.* Empirical data are not available to decompose the global RVUs into separate and appropriate RVUs for the surgery from the post-operative E&M services.[52] Medicare publishes separate values that are to be used when surgeon transfers the responsibility for post-operative care to another practitioner.[53] These situations are identified by modifier. Modifier -54 is reported by the surgeon, and the RVUs cover services provided in the pre-operative, intra-operative period and post-operative hospital visits. Modifier-55 is reported for the post-operative care and covers office visits. The intraoperative/postoperative percentages are used only infrequently (primarily for cataract surgery) and have not undergone much scrutiny. While the modifiers and percentages could be used to establish separate allowances, it is unlikely to be budget neutral. If, for example, a higher proportion of WC post-operative visits occur as office visits, the CMS RVU allocation would overpay for the intraoperative time and increase total expenditures before accounting for any increases in the total number of E&M services for WC patients that might occur if the global period is eliminated.
- *Global periods are the norm in payment policies.* Our analysis of other state fee schedules indicates other WC programs are using the Medicare global periods (some with separate payments for reports). To date, we have not been able to identify any group health payers that do not use global fee structures.

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[52] While time data are collected as part of the valuation process, they are not a direct input into the total RVU estimation. Instead, total work RVUs for a global surgery are estimated as a single value without regard to the time and intensity values for the individual service components. This disconnect can produce anomalous results if an allowance for the surgical procedure only is estimated by subtracting the RVUs for the E&M visits from the total RVUs for the global surgery. In particular, if the pre- or post-services are overvalued, the estimated value for the surgical procedure only will be undervalued. See Peter Braun, Methodological Concerns with the RB-RVS Payment System and Recommendations for Additional Study, December, 2011 available at http://www.medpac.gov/documents/Aug11_Methodology_RB-RVS_contractor.pdf.

[53] The CMS methodology for splitting the fees is based on findings when the RB-RVS study was initially implemented that the intra-operative portion of surgical procedures accounts for roughly 50-65% of the total work of most hospital-based procedures (Braun and McCall, 2011).

Specific Policy Alternatives

Below, we outline several policy options and their potential advantages/disadvantages from the perspective of how they might influence the efficient delivery of high-quality care and impact administrative burden.

1. Allow separate billing of post-surgical E&M visits.
   Advantages:
   - Avoids potentially penalizing practitioners who provide services to complex worker's compensation patients with complex post-surgical care needs
   - Provides data on utilization of post-surgical E&M visits that could be used to refine the policy in the future

   Disadvantages:
   - Requires adjustments that are not empirically based in the MPFS to avoid duplicate payments
   - Budget neutrality cannot be assured
   - Individual fee-for-service payments will incentivize practitioners to provide potentially unnecessary post-surgical E&M visits
   - Increases administrative burden of additional bill processing

2. Adopt CMS MPFS rule and integrate ALL post-surgical visits into global period.
   Advantages:
   - Consistent with the RVUs established for the services under both the OMFS and the MPFS
   - Provides incentives for provision of only medically necessary post-operative visits
   - Avoids budget neutrality issues
   - Avoids additional bill processing costs

   Disadvantages:
   - May incentivize practitioners to avoid WC patients with complex post-surgical E&M care needs or to "cherry pick" WC patients with few post-surgical E&M care needs or informally hand off care to other providers
   - Payment based on estimated "average" care is less accurate than payments based on actual care provided
   - May disadvantage surgeons who performed work-related activities during the global period

3. Integrate typical post-operative services (as defined in the CMS MPFS) into the global period and allow separate payment for visits beyond typical post-operative services. These services could include a) WC-required visits that are not related to post-operative medical care and b) visits in excess of the estimated number included in the RVU estimation (or above an "outlier" threshold).
   Advantages:
   - Allows automatic payment for typical post-surgical E&M visits without administrative burden or separate payment

- Practitioners retain flexibility to provide and bill for additional services above typical levels when either WC-required or medically necessary
- WC will collect and aggregate data on atypical post-surgical E&M visits

Disadvantages:

- Requires documentation when atypical services are billed separately
- Practitioners may still avoid complex WC patients if they do not believe the 1.2 multiplier is sufficient to compensate for additional WC administrative burden
- Pays surgeons for "average" post-operative care even when less care is provided.

Physician-administered Drugs

Background

California WC pays for outpatient pharmaceuticals dispensed to patients as well as pharmaceuticals administered directly to patients by physicians. Physician-administered drugs (PAD) are injected or infused in the office setting and include low-cost generic drugs, high-cost specialty drugs of biologic origin, and immunizations. Our discussion focuses primarily on different payment options for PAD materials. It also covers payment for injection services related to PAD. We do not address physician-dispensed repackaged or compounded drugs.

WC currently applies the OMFS pharmaceutical formula to set allowable fees for therapeutic or diagnostic PAD.[54] Fees for brand-name and generic pharmaceuticals are set at average wholesale price (AWP) plus ten or forty percent, respectively.[55] Providers are expected to report the National Drug Code (NDC) when they bill for PAD. But providers often bill using HCPCS "J-codes" that group comparable PAD into a single code. Because NDCs have AWP prices, the allowances for the therapeutic and diagnostic PAD are regularly updated when providers bill NDCs. We do not know how WC J-code allowed fees are priced and the allowances may be outdated. There is no additional dispensing fee for PAD, but practitioners can bill a separate injection service code (90700-90799) when injecting drugs as well as similar infusion procedure-related CPT codes.

WC uses a different system to determine allowable fees for most immunizations. The OMFS has RVUs for certain immunizations (including the injection fee) while others are BR. The BR allowance is the acquisition cost of the immunization plus a $14.30 injection fee.[56] The CPT

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[54] The specific OMFS language is as follows: "Pharmaceutical injection materials administered during therapeutic, diagnostic, or antibiotic injections are separately reimbursable using the Pharmaceutical Formula. A dispensing fee is not allowable with these injections."

[55] AWP is a metric published by third-party data aggregates using industry-reported transaction prices.

[56] This policy applies to CPT codes 90725-90749 and 90710-90711. Practitioners must submit an invoice for the vaccine product. The $15 injection fee was discounted 5 percent under SB 228 (2003) and remains discounted.

codes used to describe the immunizations and the RVUs are outdated. For most other non-physician-administered drugs, including physician-dispensed drugs, OMFS adopts MediCal's allowable fees which are generally equal to 83 percent of AWP.

There are significant differences between the current OMFS approach to PAD payment and Medicare's approach. CMS uses HCPCS J-codes rather than NDCs for drugs and biologicals. CPT codes describe immunizations and vaccines (most of which are not covered by Medicare). In 2003, CMS transitioned from an AWP-based payment system to an average sales price (ASP)-based system due to uncertainty surrounding the accuracy and applicability of AWP estimates. Under the old policy, practitioners were paid AWP minus five percent for PAD. Practitioners are currently paid ASP, a more robust and reliable estimate of acquisition cost, plus six percent for PAD. Several classes of PAD – including blood and blood products other than clotting factors, infusion drugs administered via durable medical equipment, and immunizations[57]- are exempt from the new ASP-based policy and continue to be paid at 95 percent of AWP.

Currently, the reimbursement rate for PAD under Medi-Cal is equal to the Medicare Part B reimbursement rate for drugs, biologics, and vaccines when available and published by CMS, currently defined as ASP plus 6 percent.[58] If a CMS rate is not available, the pharmacy rate of reimbursement applies. The pharmacy rate is defined as the lower of 1) AWP minus 17 percent, 2) the federal upper limit, or 3) the maximum allowable ingredient costs. Providers are instructed to report the NDC paired with the appropriate HCPCS J-code except for vaccines for which the NDC is not required. [59] The prices listed under Medi-Cal rates for PAD include a one-time injection administration fee of $4.46 for injections and immunizations.[60]

Other state WC programs follow three general approaches (Table 6.17). Like California, some states (e.g., Michigan, Oregon, Tennessee, and Washington) set PAD allowable fees at AWP times a multiple (from .835 to 1). California uniquely adds a significant margin (10 or 40% for brand and generic drugs, respectively) on top of AWP. Texas pays a multiple (125%) of Texas Medicaid rates which follow the Medicare ASP+6% approach. Ohio leaves PAD payment decisions to managed care contractors.

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[57] Only influenza, pneumococcal, and hepatitis B vaccines are covered by Medicare. Payment rates for these vaccines are established annually based on the AWP methodology.

[58] The Medical Services provider manual outlining PAD billing and reimbursement is at http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp.

[59] The NDC is required because physician-administered drugs other than vaccines are subject to the drug rebate program. The NDC is also needed to price drugs that do not have a Medicare price. Crosswalks are available to link NDCs to J-codes.

[60] The injection fee is applied only once for the first billed unit of the drug and is subtracted from the published rate for additional units.

Table 6.17 Payment Approaches Related to Physician-administered Drugs.

	Physician-administered drug material fees	Administration fees	Immunization provisions
California OMFS	AWP plus 10 or 40% for brand and generic drugs, respectively, no dispensing fee	Injection codes billable alongside E&M services.	RVUs (including injection fee) for most immunizations. Acquisition cost plus $15 injection fee payable for BR immunization codes.
Medicare	ASP plus 6% for most drugs. AWP minus 5% for certain categories (e.g., blood products)	Bundled with E&M services if provided at the same time.	Few immunizations covered. Paid AWP minus 5%.
Medi-Cal	ASP plus 6% when there is a Medicare allowed amount. Other drugs reimbursed at the pharmacy rate.	One-time drug injection administration fee of $4.46 for the first unit included in the pricing.	Same as other PAD.
Florida[61]	J-codes reimbursed at contract price. Exceptions for 90749 and J3490 (paid no more than 20% of the actual cost of material)	Injection codes are not on the fee schedule.	Unclear which vaccines are covered. No separate administration fee mentioned.
Michigan[62,63]	Generally AWP	Injection codes not billable alongside E&M services	Both vaccine and injection fee paid separately. AWP plus administration fee (90471 and 90472)
Ohio[64]	At MCO discretion – generally not covered	Surgical injection codes paid at medical CF of $51. Otherwise not paid.	At MCO discretion – generally not covered.
Oregon[65]	83.5% AWP	No mention	No mention
Tennessee[66]	Generally AWP	Administration can be billed only once per visit.	No mention
Texas[67]	Uses 125% of Medicaid rates for J-codes.[68] Most Medicaid rates are ASP+6% with exceptions for drugs administered via DME or new drug (89.5% of AWP).[69]	Appears to follow Medicare so no separate payment.	Appears to follow Medicare so no separate administration fee.
Washington	Must use J-codes. Percentage of AWP. Providers must bill acquisition costs: Payment is less than published fee schedule amount or acquisition cost.	Not clear.	Immunization materials payable when authorized. 90471 and 90472 payable in addition to immunization material codes. 90472 is an add-on code for additional vaccines administered at the same time.

[61] http://www.myfloridacfo.com/wc/pdf/2008HCPRM.pdf

[62] http://www.michigan.gov/documents/wca_hcs_05_rules_114254_7.pdf

[63] http://www.michigan.gov/documents/wca/12_manual_414073_7.pdf

[64] http://www.ohiobwc.com/downloads/blankpdf/OAC4123-6-08Appendix.pdf

[65] http://www.cbs.state.or.us/ins/consumer/pip_info/wc-fee-schedule.pdf

[66] http://www.tn.gov/labor-wfd/wc_medfeebook.pdf

[67] http://www.tdi.texas.gov/wc/pharmacy/index.html

[68] https://www.tdi.state.tx.us/wc/rules/adopted/documents/aordermfg0108.pdf

[69] http://www.tmhp.com/HTMLmanuals/TMPPM/2012/Vol1_02_Texas_Medicaid_Reimbursement.04.06.html

Policy Considerations

The three key policy issues are: (1) selecting a price benchmark; (2) setting an adjustment above or below the benchmark; (3) determining when additional services, for example injection services, are billable in addition to the material itself.

Physicians purchase PAD from manufacturers and wholesalers, and when they administer a drug they keep the difference between the amount paid by insurers and what they paid to acquire the drug. In one approach, payers use a price benchmark to approximate the prices at which physicians buy drugs. Payers use benchmarks to avoid significantly under or over-estimating physician's costs. Physicians might increase utilization if payment is much higher than acquisition cost or not provide PAD at all if payment is much lower than acquisition cost.

One particular benchmark – average wholesale price (AWP) – was widely used by payers including Medicare and state Medicaid programs in the early 2000's and continues to be used as a benchmark by some payers. Estimates of AWP were published by aggregators of industry-reported data. But because pharmaceutical transactions often involve proprietary rebates, volume discounts, and other adjustments, these industry-reported amounts typically do not necessarily reflect final prices paid by purchasers. Furthermore, publishers of AWP were involved in legal action related to manipulation of AWP and two publishers announced they would discontinue publication of AWP (although one publisher subsequently reversed this decision).[70]

Average sales price (ASP) is an alternative to AWP.[71] ASP is defined in Medicare statute[72] and is calculated using actual transaction data. The definition of ASP includes the most comprehensive list of rebates and other discounts that might reduce actual transaction costs. A report issued by the US Department of Health and Human Services Office of Inspector General found ASP was 49% lower than AWP at the median in a sample of drugs.

As describe above, Medicare currently pays ASP plus 6% for most drugs and AWP minus 5% for special categories of PAD. There may be some PAD that are not currently priced by Medicare. MediCal pays the same as Medicare when a Medicare rate is available and uses its pharmacy rate of reimbursement when Medicare does not have a listed rate. The pharmacy rate is currently defined as the lower of (1) the average wholesale price (AWP) minus 17 percent; (2) the federal upper limit (FUL); or (3) the maximum allowable ingredient cost (MAIC).

Current WC payment is calculated using the higher of the two common benchmarks (AWP as opposed to ASP) and adds rather than subtracts a margin on top of the benchmark. As a

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[70] http://www.amcp.org/data/jmcp/492-501.pdf

[71] Other less frequently used benchmarks include wholesale acquisition cost (WAC) and average manufacturer price (AMP). Neither WAC or AMP is used by Medicare or MediCal.

[72] Section 1847A(c) of the Social Security Act, as added by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173.

result, switching to the Medicare, Medi-Cal, or another payment approach will result in lower payment rates for most PAD materials. There is consensus that changes in payment rates can drive changes in utilization by physicians, although the net effect of a payment changes on utilization is not entirely clear. Policymakers should be interested in the impacts changes in utilization may have on spending and outcomes but these changes too are ambiguous. Lower utilization of wasteful or inappropriate prescriptions may decrease spending and improve quality. Lower utilization of clinically appropriate drugs may decrease spending but adversely affect patient health. These impacts are context-dependent and there is insufficient evidence to speculate how changes in quantity might play out in the WC context.

Immunizations and other special categories

The Medicare ASP+6% policy excludes immunizations and other specific categories of PAD. There are two practical reasons for doing so. First, under the assumption that physicians are more likely to use services for which they receive a large margin, policymakers may pay for services with special health or public health relevance at a higher rate than other PAD. Second, ASP may be less meaningful or reliable for specialized categories of PAD like immunizations.

Administration fees

Over 54,000 injection codes (90780-90799) were billed by WC providers in 2011. More than 90 percent of these codes were billed at the same time as an E&M code. In other words, in most cases providers are billing separately for three components: (1) the injectable material; (2) administration; and (3) an E&M visit. The effect of separate administration fees may be significant when the payment for the injectable material is small, for example with generic drugs and some routine immunizations. Medicare's policy is to bundle payment for the immunization service itself into another clinical service such as an E&M visit. Medi-Cal takes an alternative approach and includes an administration fee in the ingredient payment amount.

Specific Policy Alternatives

Implementation of the RB-RVS presents an opportunity to revise the policies for PAD ingredients. The current OMFS codes and allowances for immunization injections are outdated and need to be updated. The BR pricing for some codes is administratively burdensome. The OMFS pharmaceutical formula provides excessive AWP allowances. We assume that the bundling policies for injections will be implemented as a RB-RVS ground rule. We focus on fee schedule options for the ingredient cost allowances that are consistent across all ingredients and can be automatically updated.

1. Status quo: Continue AWP plus percentage pricing

   Advantages:

- Limits concerns surrounding access to PAD because payment rates are almost certainly above acquisition costs.
- AWP available for all PAD.
- Provides a mechanism for automatic updating.

Disadvantages:

- Rates significantly higher than those of MediCal and other payers.
- Relies on a fundamentally flawed proxy for ingredient costs when more accurate and objective estimates are available.
- Other payers migrating away from AWP-based payment.[73]
- May provide excessive margins resulting in overutilization.
- More administrative burden than linking to a fee schedule.

2. Adopt Medicare Fee Schedule

Advantages:

- Ingredient payment rates better reflect actual acquisition costs.

Disadvantages:

- Some providers may not offer PAD because ASP plus 6% may not be greater than acquisition costs for some independent physicians or small group practices.
- ASP not used by Medicare for some classes of PAD, e.g., immunizations. Would need to develop policies for those services.

3. Adopt MediCal Fee Schedule

Advantages:

- Relies on the Medicare approach and prices in most cases.
- Uses AWP-based payment to fill in gaps in Medicare pricing.
- Builds on the OMFS using MediCal for outpatient prescription drugs.

Disadvantages:

- Other payers migrating away from AWP-based payment.[74]
- Pricing includes administration fee for injections that would be bundled under Medicare RB-RVS rules.

Payment for administration: Under the Medicare approach, administration services are not reimbursed separately if they occur at the same time as an E&M service. Under the MediCal approach a separate administration fee is integrated into the ingredient allowed amount for the

[73] https://oig.hhs.gov/oei/reports/oei-03-11-00060.pdf

[74] https://oig.hhs.gov/oei/reports/oei-03-11-00060.pdf

first unit of the drug. This amount could be subtracted in determining the maximum allowable fee. At a minimum, it should be subtracted from the published price for additional units.

We analyzed the WCIS 2011 data to compare the PAD pricing alternatives. An explanation of our methodology and data limitations is in Appendix D. Table 6.18 compares maximum allowed fees under the CMS PAD fee schedule and the Medi-Cal fee schedule. Allowed fees are for the most part similar across the two fee schedules, which reflects Medi-Cal's recent transition to ASP+6% pricing.

Table 6.18 Comparison of CMS and Medi-Cal Maximum Allowed Fees for PAD Ingredients[1] in Aggregate and for the Top 25 HCPCS Codes Ranked by 2011 OMFS Paid Amount

		CMS maximum allowed fees ($000's)	Medi-Cal maximum allowed fees ($000's)[2]	Ratio of CMS to Medi-Cal maximum allowed fees
ALL J-CODES		**47,419.9**	**49,940.6**	**0.96**
J7324	Orthovisc inj per dose	1,123.3	1,665.5	0.67
J0878	Daptomycin injection	315.1	298.5	1.06
J7321	Hyalgan/supartz inj per dose	1,414.1	2,281.6	0.62
J9035	Bevacizumab injection	310.4	304.9	1.02
J1650	Inj enoxaparin sodium	43.1	52.7	0.82
J0696	Ceftriaxone sodium injection	15.2	15.1	1.01
J7323	Euflexxa inj per dose	398.2	382.8	1.04
J1885	Ketorolac	39.6	31.1	1.27
J0475	Baclofen 10 mg injection	41,172.4	42,134.3	0.98
J0585	Botulinum toxin type a, per 1 unit	283.3	283.3	1.00
J2357	Omalizumab injection 5mg	76.5	76.4	1.00
J3010	Fentanyl citrate injeciton	92.2	155.7	0.59
J1745	Infliximab injection	174.8	171.6	1.02
J3370	Vancomycin hcl injeciton	54.9	54.6	1.01
J0735	Clonidine hydrochloride, 1 mg	197.4	188.7	1.05
J1170	Injection, hydromorphone, <5	104.9	108.5	0.97
J1815	Insulin injection	8.2	76.6	0.11
J7325	Synvisc or synvisc-one, 1 mg	106.1	147.1	0.72
J2278	Ziconotide injection	75.5	75.4	1.00
J0135	Adalimumab injection	79.5	74.8	1.06
J2001	Lidocaine injection	1.7	1.9	0.90
J0702	Betamethasone acet&sod phosphate	104.7	104.9	1.00
J1030	Methylprednisolone 40 mg inj	62.6	87.3	0.72
J1100	Dexamethasone sodium phosphate	3.7	3.9	0.94
J3301	Injection triamcinolone acetonide	48.3	44.9	1.08
	All other J-codes	1,114.3	1,118.7	0.99

[1]Uses January 1, 2013 CMS and Medi-Cal payment rates applied to unadjusted OMFS-reported volume. Only for PAD with both CMS and Medi-Cal listed maximum allowable fees.
[2] Subtracts an administration fee of $4.46 for drugs with a "030" modifier in the Medi-Cal fee schedule. The Medi-Cal fee schedule may not fully reflect the recent transition to Medicare-based allowed fees for PAD.

We also estimated maximum allowed fees under the current OMFS approach (pay administration codes separately), the CMS approach (pay administration codes only when they occur outside the context of an E&M visit), and the Medi-Cal approach (pay a flat injection administration fee for most drugs). Table 6.19 compares the maximum allowed fees using these three approaches. Either the Medicare or Medi-Cal approaches result in significantly lower maximum allowed fees compared to the current OMFS approach because administration is bundled when an E&M service is provided. If the Medi-Cal fee schedule were adopted and the flat fee were included as a drug ingredient cost in addition to the Medicare separate payments for drug administration when no other service is provided, the total allowable fees would be $1.9 million.

Table 6.19 Comparison of OMFS, CMS, and Medi-Cal Administration Fee Approaches

Approach	Description	Maximum allowed fees, administration only ($ millions)
OMFS	Pay administration separately	12.4
CMS	Pay administration only when separate from E&M	1.3
Medi-Cal	Pay flat $4.46 administration fee	0.6

Hospital Outpatient Services

Background

The OMFS for physician services currently applies to all covered medical services provided, referred or prescribed by physicians, regardless of the type of facility in which the services are provided. With the exception of facility fees for the use of emergency rooms or ambulatory surgical suites, the OMFS for physician services applies to services furnished to hospital outpatients, including clinic services and diagnostic tests (other than tests that are payable under the OMFS for diagnostic laboratory services). As a result, regardless of whether a diagnostic test is provided in a physician's office, a freestanding diagnostic testing facility or to a hospital outpatient, the same allowances apply. OMFS allowances for most diagnostic procedures have a professional component (PC) that covers the physician's professional services related to supervising and interpreting the test results and a technical component (TC) that covers the staff and equipment costs associated with providing the actual test. When the complete service is performed, the payment equals the sum of the payments for these two components.

Under Medicare, the outpatient prospective payment system fee schedule (OPPS) applies to services furnished by hospitals to outpatients.[75] The OPPS rate covers the facility fees for providing the services. A separate payment is made under the RB-RVS for the physician's services. The RB-RVS PE component is typically lower for comparable services provided in hospitals and other facility settings than for services provided in physician offices and other non-facility settings. The lower PE rate accounts for the separate payment to the hospital for the clinical staff, supplies and equipment costs that would be incurred by the physician if the service were furnished in an office setting. For most diagnostic tests, the allowances are split into TC and PC components similar to the OMFS allowances. Only the PC component is payable if the service is furnished in a facility setting.

Labor Code Section 5307.1(a)(2) is silent on how the services furnished by hospitals that are currently payable under the OMFS for physician services should be paid when the RB-RVS is implemented. The provision specifies that the AD shall adopt the RB-RVS based fee schedule "for physician services and non-physician practitioner services, as defined by the administrative director." Section 5307.2(a)(2)(C) provides that the default option shall apply to the maximum reasonable fees "for physician services and non-physician practitioner services, including, but not limited to, physician assistant, nurse practitioner, and physical therapist services…." Section 5307.1(a)(1), which was not amended by SB 863 requires the AD to adopt fee schedules for other than physician services, including health care facility fees. The Labor Code does not define health care facility fees, but when the AD implemented Medicare-based fee schedules for non-physician services, health care facility fees for outpatient services were defined by CPT code as inclusive only of surgical codes and ED visit codes. One rationale for doing so was that the OMFS allowances for medical services did not differentiate by setting. Since the costs of providing clinic services were already reflected in the OMFS allowance, making a separate payment for facility costs under the OPPS would have resulted in a duplicate payment. With the PE payment differential under the RB-RVS, this rationale is no longer applicable.

There are other reasons, however, that the AD might want to continue to pay for hospital outpatient services under the physician fee schedule. The underlying policy question is whether WC should pay a premium for services that could appropriately be provided in a less costly setting. MedPAC, for example, has recommended that Medicare pay for clinic visits at the same rate as office visits (MedPAC, 2012) and is considering whether to extend the recommendation to other services. The principles that MedPAC has laid out to make this evaluation are:[76]

- Patients should have access to settings that provide an appropriate level of care

[75] The OPPS does not apply to outpatient rehabilitation services. The RB-RVS fee schedule applies to services provided by hospitals and by therapists in community-based practices.

[76] MedPAC March 7, 2013 staff presentation available at http://www.medpac.gov/transcripts/addressing%20payment%20differences%20across%20settings_March%2013_public.pdf.

- A prudent purchaser should not pay more for a service in one setting than another
- Payment rates should be based on the resources needed to treat patients in the lowest-cost clinically appropriate setting

Payment rates for HOPD services are typically higher for three reasons: 1) hospitals incur costs for standby capacity for emergencies and have higher infrastructure and regulatory costs, 2) patient severity might be greater in HOPDs than in office settings and 3) the OPPS has broader bundling policies than the RB-RVS fee schedule.[77]

In recommending that the clinic visits be paid at the same rate as office visits, MedPAC concluded that these higher costs should not affect the costs of E&M visits outside of the emergency department. Moreover, MedPAC was concerned with the growing trend toward hospital purchases of physician practices. When a hospital purchases a physician practice, Medicare's fee schedule changes from the RB-RVS to the OPPS with no change in the nature of the services. Others have also highlighted the inappropriateness of OPPS and MPFS differentials for comparable services.[78]

For WC, the issue largely involves the technical component of imaging and other diagnostic tests. For most of these procedures, separate payments apply to the facility and staffing costs involved in performing the procedure (the technical component) and to the professional services involved in supervising the procedure and interpreting the results (the professional component).[79] The professional services would be payable under the OMFS physician fee schedule regardless of where the services are furnished. The issue is whether the TC should be paid under the OMFS based on the OPPS rate or the RB-RVS rate. Table 6.20 compares the payment rates for procedures with the highest aggregate technical allowances under the current OMFS to what would be payable using the OPPS rate and the RB-RVS rate for the TC only *after* cross-walking any outdated CPT codes to their 2013 equivalents. In general, the OPPS has broader bundling policies than the RB-RVS, which means the RB-RVS allowance may be slightly understated relative to the OPPS payments.

Across all procedures, the rate is higher when the procedure is paid under the OPPS relative to the payment under the RB-RVS. Generally, the differential is greater for less resource-intensive services, e.g., radiologic examinations, than for more resource intensive services such

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[77] For example, stress agents, low low osmolar contrast material, and radionuclides are separately payable under the RB-RVS but not the OPPS.

[78] See for example the Report of the National Commission on Physician Payment Reform, "*Our nation cannot control runaway medical spending without fundamentally changing how physicians are paid*," March 2013 available at http://physicianpaymentcommission.org/wp-content/uploads/2012/02/physician_payment_report.pdf.

[79] For a few services, there are separate procedure codes for the technical and professional components. For example, 93000 applies to the full electrocardiogram (routine ECG), 93005 to only the tracing, and 93010 to the interpretation and report only.

as MRIs and CT scans. Overall, aggregate allowances would be 75 percent higher if based on the OPPS rates than the RB-RVS rates. Further, the OPPS rates represent a 40 percent increase over current OMFS rates while the RB-RVS would result in a 20 percent reduction.

In addition to diagnostic services, there are several other high volume services that were provided to WC outpatients by hospitals (see Table 6.21). For these services, the basic choice is between two payment approaches:

1. Pay an OPPS facility fee and, when appropriate, a professional fee that reflects PEs for services furnished in a facility setting. This is Medicare's policy and is also the policy adopted by other WC fee schedules that used Medicare-based fee schedules for both outpatient and physician services.
2. Pay a single professional fee that reflects PEs for services furnished in a non-facility setting. This is consistent with current OMFS policies.

Specific Policy Alternatives

1. Pay for HOPD services under the OPPS at 120 percent of Medicare rate

Advantages

- Most straightforward reading of the Labor Code
- Consistent with Medicare rules and other payers

Disadvantages

- Increases expenditures unnecessarily when services could be provided in a less costly medically appropriate setting
- Move is contrary to prudent buyer policy directions

2. Pay for HOPD services consistent with current OMFS rules

Advantages

- Encourages provision of care in the least costly setting
- Levels the playing field across hospitals and community-based providers for comparable services
- Consistent with the policy direction advocated under Medicare payment reform

Disadvantages

- Fails to recognize that hospitals have higher infrastructure costs
- Results in about a 20 percent reduction in payments for services furnished to hospital outpatients

3. Pay for services furnished in conjunction with ED visits using OPPS rates and remaining services under the RB-RVS

Advantages

- Strikes a balance between prudent buyer objectives and recognizing when higher costs may be justified

Table 6.20 Comparison of Allowances for Highest Expenditure Diagnostic Procedures

Code	Description	HOPD volume[1]	OMFS TC Allowance[2]	OPPS TC[3]	RB-RVS TC[4]	Ratio OPPS to RB-RVS	Estimated OMFS Allowances	Estimated OPPS Allowances	Estimated RB-RVS Allowances
72148	MRI Spinal Canal and Lumbar; w/o Contrast	1,379	512.00	501.11	388.16	1.3	706,000	690,984	535,239
73721	MRI Any Joint of Lower Extremity	1,020	532.00	501.11	269.71	1.9	542,488	510,989	275,028
73221	MRI Any Joint of Lower Extremity; w/o Contrast	1,131	521.91	501.11	269.71	1.9	590,083	566,566	304,941
72141	MRI Spinal Canal; w/o Contrast	703	516.8	501.11	387.74	1.3	363,415	352,382	272,657
93005	Electrocardiogram Tracing	11,506	35.06	39.48	12.78	3.1	403,386	454,240	147,070
72100	Radiologic Exam, Spine, Lumbosacral; AP and Lat	6,387	31.35	68.03	31.96	2.1	200,228	434,497	204,100
73030	Radiologic Exam, Shoulder; Complete, Min 2 Views	4,912	34.73	68.03	27.70	2.5	170,583	334,143	136,032
70450	CT Scan, Head/Brain; w/o Contrast	642	223.61	256.97	158.50	1.6	143,500	164,909	101,718
73130	Radiologic Exam, Hand; Min 3 views	5,064	24.94	68.03	31.53	2.2	126,296	344,504	159,669
73610	Radiologic Exam, Ankle; Complete, Min 3 views	4,307	27.79	68.03	32.81	2.1	119,687	292,995	141,301
73110	Radiologic Exam, Wrist; Min 3 views	3,986	29.33	68.03	38.35	1.8	116,896	271,137	152,836
72110	Radiologic Exam spine lumbosacral; Complete w/ Oblique Views	2,481	43.46	104.87	43.46	2.4	107,811	260,151	107,813
73630	Radiologic Exam, Foot; Min 3 Views	3,885	28.56	68.03	30.68	2.2	110,951	264,286	119,180
72131	CT Scan, Lumbar	315	275.2	256.97	206.22	1.2	86,672	80,931	64,949

Code	Description	HOPD volume[1]	OMFS TC Allowance[2]	OPPS TC[3]	RB-RVS TC[4]	Ratio OPPS to RB-RVS	Estimated OMFS Allowances	Estimated OPPS Allowances	Estimated RB-RVS Allowances
	Spine; w/o Contrast								
73222	MRI Any Joint of Lower Extremity; w/ Contrast	168	521.91	672.94	455.91	1.5	87,810	113,220	76,705
73564	Radiologic Exam, Knee; Complete, 4+ Views	2,637	33.49	104.87	42.18	2.5	88,308	276,526	111,228
93971	Duplex Scan, Extremity Veins	989	85.98	147.03	119.30	1.2	85,022	145,391	117,974
72050	Radiologic Exam, Spine, 4-5 views	1,845	42.75	104.87	42.61	2.5	78,867	193,469	78,606
73562	Radiologic Exam, Knee; Min 3 Views	2,764	28.5	67.61	36.64	1.8	78,774	186,874	101,282
78452	Myocardial Perfusion Imaging, Tomographic (SPECT), Multiple Studies	130	360	1,006.21	533.03	1.9	46,688	130,495	69,129
Total estimated allowances, 20 codes							4,253,467	6,068,691	3,277,458
Total estimated allowances, all diagnostic codes							6,902,472	11,941,012	5,914,403

[1]Sum of HOPD volume for all procedures exclusive of PC modifiers
[2]Crosswalk-weighted OMFS allowed amount (off most recent table A from 2005 with 2007 E&M update)
[3]CY2013 OPPS standard payment rates adjusted for difference in OMFS CF (70.761 vs. 71.313), estimated statewide wage index (1.35) and updated to 2014 by estimated increase in the hospital market basket (1.027 percent).
[4]CY2013 relative values for TC multiplied by 2012 Medicare CF ($38.53), the statewide GAF of 1.082, and updated to 2014 by estimated increase in the CMI (2.58 percent)

Disadvantages

- Could result in unnecessary provision of ED services to obtain higher allowances
- Complicates administration but arguably not more so than current rules

4. Pay for services using OPPS rates but with a lower multiplier

Advantages

- Avoids large and arguably unjustifiable increase in payments. Aggregate payments would be about 17 percent higher than under the current OMFS with a 1.0 multiplier (versus 40 percent)
- Avoids potential gaming between ED and clinic visits
- Recognizes that the higher costs for WC patients are most likely to be associated with the E&M services rather than diagnostic services
- Consistent with following Medicare's lead in determining appropriate payment rates

Disadvantages

- May result in lower payment than 120 percent of RB-RVS (this occurs only once among the top 20 diagnostic services)

Table 6.21 Non-diagnostic High Volume Hospital Outpatient Services

Procedure Code	99213	96372[1]	96374[1]	96365	90471
Description	Intermediate office visit	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug)	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); IV push, single or initial substance/drug	IV infusion therapy, prophylaxis, or diagnosis; initial, up to 1 hour	Immunization administration, 1 vaccine
HOPD volume	2,267	4,886	3,172	1,078	2,778
Current OMFS allowance	56.93	15.38	31.37	95.33	15.00[2]
1. Pay under Medicare rules					
OPPS facility fee	109.08	57.93	57.93	216.50	57.93
RB-RVS facility setting fee	66.36	0	0	0	0
Total allowance	175.44	57.93	57.93	216.50	57.93
Aggregate allowances	247,136	282,558	183,692	180,600	160,917
2. Pay under OMFS rules					
RB-RVS non-facility setting fee	62.20	32.38	72.01	94.59	32.38
Aggregate allowances	140,945	157,952	228,337	78,907	89,953
Difference in aggregate allowances	106,191	124,606	-44,645	101,693	70,964

[1]Bundled
[2]By Report Allowance

Ambulatory Surgery Center Services

Under the OMFS, surgical procedures furnished in an ambulatory surgery center (ASC) are paid based using the Medicare OPPS relative values. For services rendered in ASCs on or after January 1, 2013, the WC multiplier is 0.80 of the Medicare conversion factor (or 0.82 with payment for high cost outlier cases). The lower multiplier reflects the lower costs of performing ambulatory surgery in an ASC relative to a hospital. By linking the OMFS to the Medicare OPPS rates, payment is made without regard to whether the surgery is on Medicare's list of covered ASC procedures.

Under Medicare ground rules, an ASC is recognized for the limited purpose of providing ambulatory surgical services. Medicare's payment under its ASC fee schedule is limited to procedures that Medicare has determined can safely be performed in an ASC and are not commonly performed in an office setting. For surgical procedures that are commonly performed in an office setting (and therefore are not on the ASC list of covered procedures), Medicare pays the ASC for the lower of the amount that would be payable under the ASC fee schedule or the PE component of the MPFS. In addition, the physician receives the MPFS payment for performing the service in a facility setting. The facility portion of these services is currently paid under the OMFS based on 0.80 x the Medicare OPPS conversion factor.

For non-surgical services furnished in an ASC (other than diagnostic services that are an integral part of the surgical procedure), Medicare rules for physician and supplier services apply. We assume that these services will be paid under the RB-RVS instead of the OPPS fee schedule. We found that about $200,000 was paid for these services under the OMFS in 2011. It may be that the place of service code is physician office when services are provided for which an ASC facility fee is not payable.

Coding and Documentation Policies

National Correct Coding Initiative (NCCI) edits

Background

The NCCI edits are a set of coding guidelines developed by CMS to minimize the incidence of improper coding and inappropriate payments (Department of Health and Human Services, 2004). There are two types of NCCI edits:

1. Edits that define pairs of HCPCS/CPT codes that should not be reported together and,
2. Medically Unlikely Edits (MUE) that define for each HCPCS/CPT code, the number of units of service beyond which the reported number is unlikely to be correct.

NCCI edits are operationalized in a set of tables provided and updated quarterly by CMS. There are nearly one million NCCI edits (see Table 6.22). Selected edits are shown in

Table 6.22. If a provider reports both codes in Column 1 and 2 of Table 6.23, only the code in Column 1 is eligible for payment. Payment for the second code is denied.

Table 6.22 Distribution of NCCI Edits by CPT Code Ranges

Code Range	Column 1 Count	Column 2 Count
Anesthesia	75,896	4,331
Evaluation & Management	8,265	36,588
Medicine	35,216	225,086
Pathology	4,616	4,978
Radiology	11,626	16,189
Surgery	811,912	640,227
Other	16,993	37,125
Total	964,524	964,524

Note: Counts include only active edits

The NCCI edits are based on a few general principles:

- *No "unbundling" of services*. Multiple codes should not be used to report a provided service when there is a comprehensive CPT code that describes the services performed.
- *'Integral' services.* Some services are considered to be integral to the provision of other services and should not be reported separately.
- *Mutually exclusive services.* Certain procedures are considered to be mutually exclusive and therefore cannot be reported together.
- *Sequential procedures.* Some surgical procedures may be performed using different approaches. If an initial surgical approach fails and a second surgical approach (described by a different CPT code) is utilized at the same patient encounter, the two procedures are considered sequential and only the code corresponding to the second surgical approach may be reported.

Exceptions to these edits are allowed in certain cases and appropriate modifiers are provided for this purpose. As an example, E&M services provided during the global surgery period are generally not reportable separately but if the E&M service is significant and separately identifiable from other services reported on the same date of service, the provider is allowed to use modifier 25 to bypass this edit. In the edit tables (see Table 6.22), codes that allow use of a modifier are indicated by a "1".

Table 6.23 Selected NCCI Edits

Column 1 Code	Column 2 Code	Modifier Status
00160	99479	0
00222	93316	1
00300	99303	0
00454	31622	1
00908	99318	0
01112	92520	1
17272	96372	1

24066	64408	0
25119	64435	0
25270	51702	1
25505	64517	0
26530	64446	0
27047	64420	0
27356	96372	1
33403	32557	1
35518	94681	1
41018	12007	1
42844	94002	1
47125	64447	1
47135	12006	1
61312	64508	1
64493	93040	1
91112	94770	1
95829	95939	9
95851	97530	9

Medically Unlikely Edits (MUE)

The NCCI includes a set of edits known as MUE that define the maximum allowable number of units of service reportable by a provider for the same beneficiary on the same date of service.[80] Each line of a claim is adjudicated separately against the MUE value for the code reported on that line (Tomkins, 2011). If the unit of service for the line item exceeds the MUE value, the entire line is denied. The MUE value is chosen to allow the vast majority of appropriately coded claims to successfully pass through and is based on several considerations including:

- Anatomic considerations (the MUE value for an appendectomy is one since there is only one appendix)
- Coding instructions in the CPT manual (a CPT code for the initial 30 minutes of a service has an MUE value of one because of the use of the term "initial")
- Clinical judgment of physicians and coders
- Claims history

Policy Considerations

The main benefit of adopting the NCCI edits is its potential to reduce inappropriate payments. A 2004 study commissioned by the AMA, found that 30 percent of physicians' claims submitted to a major commercial insurer were paid incorrectly.[81] This study found that

[80] Not all MUE values are published online. Some are considered to be confidential by CMS and are not publicly available.

[81] Inaccurate claims included underpayments and overpayments.

application of NCCI-type edits resulted in savings of $0.03 for every dollar in physician charges (National Healthcare Exchange Services, 2005).[82]

The impact of adopting the NCCI edits will depend to a large extent on how much overlap there is with edits that are currently used by WC. On one extreme, if NCCI edits are fully subsumed by edits already in use, then implementation of NCCI edits will add little value. On the other extreme, if current edits and NCCI edits do not overlap at all, then adoption of the NCCI edits will have the maximum possible benefit.

The 2010 pre-rulemaking version of the RB-RVS proposed rule required that payers adopt the CCI edits. The requirement was generally supported because the CCI edits provide a uniform method for assuring that adjustments for correct coding are uniformly handled with consistent rules known to both payers and providers. Having all parties use the same ground rules should reduce a source of friction with the WC program.

In its comments on the DWC Forum, the California Orthopedic Association suggested that instead of the CCI edits, the American Association of Orthopedic Surgeon's Global Service Data bundling edits be adopted[83]. The AAOS argues that these edits are superior because they are compiled by orthopedic surgeons who are coding experts and are more comprehensive. One difference between the AAOS edits and the NCCI edits is that the NCCI edits were developed primarily for high volume codes and do not include all possible combinations of correct coding edits or types of unbundling that exist. The lack of a NCCI edit does not excuse incorrect coding. In our view, there are several drawbacks to adopting the AAOS edits: 1) using one set of internally consistent edits for all services is preferable to using two different sets of edits. The latter might have inconsistencies that would need to be reconciled; 2) the NCCI edits are consistent with the Medicare payment rules underlying the RB-RVS; and 3) the AAOS guidelines would need to be purchased whereas an electronic version of the NCCI is available for free download.

Other policy considerations include:

Cost of Implementation. There are likely to be non-trivial costs associated with modifying claims processing architecture to enable utilization of NCCI edits. There are nearly 1 million edits (Table 6.21) and updated tables have to be downloaded and applied quarterly. It is expected however that the availability of commercial software and vendors should minimize these costs. There are also costs associated with training claims processing staff to be fully conversant with these guidelines that need to be taken into account.

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[82] Edits were based on CPT code guidelines, NCCI guidelines; and CMS payment rules.

[83] American Association of Orthopedic Surgeon's Global Service Data Bundling Edits http://www.aaos.org/about/papers/position/1181.asp

Cost of Adoption for Physician Practices. One concern with adoption of NCCI edits is the administrative burden on providers, but given that these edits are used by Medicare and many commercial payers, costs of adoption (including learning costs) for providers are likely to be low. Providers are likely to already be familiar with NCCI edits based on billing experiences with other payers. We also note that the Affordable Care Act (ACA) mandates adoption of NCCI edits by State Medicaid agencies increasing the likelihood that providers will have some experience with NCCI edits. There may be other costs to providers, particularly costs associated with appeal of denied claims (including the cost of researching the denial, identifying the appropriate action, and completing the refiling or reopening of claims). Costs of audit and appeal can however be minimized by taking advantage of electronic data interchange (EDI) standards and by following basic review and auditing procedures. Note also that because of the complexity of claims edit systems, payer errors i.e. denials for services validly provided may go undetected and result in losses to providers.

Operational costs. Prior experience suggests that providers are likely to see an increase in the number of denied claims as a result of adoption of the edits (Tomkins, 2011). Ultimately however it remains to be seen whether administrative costs related to claims review will increase, decrease, or stay the same. While an increase in the number of claims reviewed may result in higher administrative costs, standardization may lead to processing efficiencies that reduce costs.

Policy Considerations

Modifications to the NCCI edits may be required because of the peculiarities of the WC system. The extent of modification will depend on how closely the new WC ground rules mirror Medicare ground rules. For example, the proposed rule for the OMFS allows for separate reporting and payment of WC-related reports. The NCCI edits do not allow for the separate payment for reports. Modification of the NCCI edits will be needed to take this into account.

E&M guidelines

Background

To provide a standardized framework for proper documentation of E&M services, CMS released a set of guidelines in 1995 and an updated version in 1997.[84] The guidelines consist of a set of general principles in addition to providing specific guidance regarding documentation of the different components of E&M services (see Table 6.24).

[84] There are some differences between the two and CMS recommends that either one or the other be used, not both. In general, the 1997 guidelines provide more detailed instructions.

Table 6.24 General Principles of Documentation for Medical Records

1. The medical record should be complete and legible
2. The documentation of each patient encounter should include:
   - Reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results
   - Assessment, clinical impression, or diagnosis
   - Plan for care
   - Date and legible identity of the observer
3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred
4. Past and present diagnoses should be accessible to the treating and/or consulting physician
5. Appropriate health risk factors should be identified
6. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented
7. The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record

Three E&M components – history, examination and medical decision making – are recognized as key in selecting the level of E/M services. We discuss the documentation guidelines for each component briefly below.

Documentation of History

The medical history consists of four key elements: Chief complaint (CC); History of present illness (HPI); Review of systems (ROS); and Past, family and/or social history (PFSH). The extent of information collected by the provider for the latter three elements is used in classifying a history as **Problem Focused**, **Expanded Problem Focused**, **Detailed**, or **Comprehensive**.

CMS includes specific guidelines for how each of these elements (and their sub-components) is defined and how they should be documented (see Table 6.25).[85] For example, a *problem*

[85] To highlight a difference between the 1995 and 1997 guidelines, the former state that for a HPI to be considered **extended**, it should describe four or more elements (e.g. location, quality, severity, duration, etc.) or associated comorbidities, while in the latter, an **extended** HPI consists of four or more elements or the status of at least three chronic or inactive conditions.

pertinent ROS inquires about the system directly related to the problem(s) identified in the HPI and requires that the patient's positive responses and pertinent negatives for the system related to the problem be documented. For an *extended* ROS, the patient's positive responses and pertinent negatives for *two to nine systems* should be documented.

Table 6.25 Clinical History Matrix

Type of History	HPI	ROS	PSFH
Problem Focused	Brief	n/a	n/a
Expanded Problem Focused	Brief Problem	Problem Pertinent	n/a
Detailed	Extended	Extended	Pertinent
Comprehensive	Extended	Complete	Complete

Documentation of Examination

A clinical examination can also be **Problem Focused**, **Expanded Problem Focused**, **Detailed**, or **Comprehensive**. Like with the medical history, guidelines are provided for how these are defined and how they should be documented.

For purposes of documentation, approximately ten body areas and twelve organ systems[86] are recognized. The 1997 guidelines also outline specific documentation elements within each body area or organ system and distinguish between documentation requirements for single organ and multi-system examinations. According to the documentation guidelines for clinical examinations, a notation of "abnormal" without elaboration after an examination of the affected or symptomatic body area(s) or organ system(s) is insufficient, but a brief statement or notation indicating "negative" or "normal" is sufficient documentation for normal findings related to unaffected area(s) or asymptomatic organ system(s).

Documentation of Medical Decision Making

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option. Three elements of decision making are recognized:

- Number of diagnoses or management options
- Amount and/or complexity of data to be reviewed
- Risk of complications and/or morbidity or mortality

These elements are combined to create four levels of decision making complexity (see Table 6.26).

[86] The body areas recognized are the: Head, including the face; Neck; Chest, including breasts and axillae; Abdomen; Genitalia, groin, buttocks; Back, including spine; and each extremity. The organ systems recognized are the: Constitutional (e.g., vital signs, general appearance); Eyes; Ears, nose, mouth, and throat; Cardiovascular; Respiratory; Gastrointestinal; Genitourinary; Musculoskeletal; Skin; Neurologic; Psychiatric; and Hematologic/lymphatic/immunologic.

Table 6.26 Medical Decision Making Matrix

Type of decision making	Number of diagnoses or management options	Amount and/or complexity of data to be reviewed	Risk of complications and/or morbidity or mortality
Straightforward	Minimal	Minimal or None	Minimal
Low complexity	Limited	Limited	Low
Moderate complexity	Multiple	Multiple	Multiple
High complexity	Extensive	Extensive	Extensive

To qualify for a given type of decision making, two of the three elements in Table 6.26 must be either met or exceeded. The guidelines include specific documentation requirements for each cell in Table 6.26.

Policy Considerations

The documentation guidelines were developed in the context of the RB-RVS and in collaboration with the AMA. They have been in effect for over a decade and are generally accepted as a template to guide physicians and their staffs on documenting E&M visits and for reviewers to assess coding accuracy. The guidelines have been adopted by other payers, including the Washington State WC program. The Texas WC program has adopted a more generic requirement for medical records "satisfying the AMA's requirements for use of those CPT codes."

The CMS documentation guidelines provide a common operational definition of the CPT codes. There is a need for such guidelines in California, where WCRI data indicate WC providers tend to bill a higher intensity visit level than providers in other states. Having a common standard has the potential to reduce friction between providers and payers. However, there are also concerns within the physician community that they will be unfairly penalized for inadvertent coding or documentation errors or omissions. Some see these guidelines as rigid rules that must be followed to the letter in every instance if penalties are to be averted. If payers use these guidelines in this manner, frictional costs will increase.

Incorporating Pay-for-performance Elements into the OMFS

Background

Pay-for-performance or P4P, is a general term used to describe programs that reward health care organizations, physician practices or individual health care providers for meeting specified targets on selected metrics.[87] This issue paper focuses exclusively on P4P for physician services. While most P4P programs use financial rewards, it is important to recognize that incentives may

[87] P4P is in use in other sectors including education for example, but in many ways the term P4P has come to be symbolized with health care.

also be non-financial (e.g. public reporting). P4P programs generally reward performance in one or more of the following domains: quality, cost/efficiency, or administrative processes (e.g. reporting requirements).

The Promise of P4P

Economic theory and decades of empirical research show that individuals respond to incentives. The premise (and the promise) of P4P is that tying payment to performance will induce providers to change their behavior. A landmark report on the quality of health care in the US released by the Institute of Medicine in 2001 (IOM, 2001) is often credited with catalyzing discussions about quality of care in the US, and one of the issues highlighted in this report was the potential role of P4P in reforming health care. Since the release of the IOM report, pay-for-performance has become increasingly popular. In 2007, according to the Integrated Healthcare Association, there were over 148 sponsors of P4P programs covering more than 60 million insured lives. The Centers for Medicare and Medicaid Services (CMS) is also increasingly involved in various P4P pilots and demonstration projects (James, 2012).

Reviewing the Evidence

Early P4P efforts mostly focused on quality improvements, and evaluations of these programs have found mixed evidence regarding their effectiveness (Rosenthal and Frank, 2006; Peterson et al. 2006). Early P4P experiments however tended to be of fairly short duration (six months to a year), and involved relatively small financial incentives (Damberg, 2009). In many cases, payers also accounted for only a small fraction of the targeted provider's panel (Rosenthal and Frank, 2006). Evidence emerging from newer experiments continues to find inconsistent results. A few studies have found modest improvements in quality (Young et al., 2007), but the extent to which these are causal remains unclear. A recent Cochrane review concludes that there is insufficient evidence to support or not support the use of financial incentives to improve quality (Scott et al., 2011). A Cochrane review of reviews however concludes that "financial incentives may be effective in changing healthcare professional practice" while noting that the existing evidence has serious methodological limitations (Flodgren et al. 2011).

Despite the less than overwhelming evidence about the effectiveness of P4P, and some recent criticism of P4P in general (Woolhandler et al., 2012), enthusiasm remains strong.[88] A recent study of stakeholders involved in the California Integrated Healthcare Association (IHA) program, the largest P4P program in the United States, found that more than two-thirds of the physician organizations reported that the positives of the program outweighed the negatives, and

[88] There is also some concern about possible undesired consequences such as "cherry-picking" (providers avoiding sicker patients), and worsening of health care disparities (Shen, 2003; Friedberg et al., 2010).

more than half reported a positive return on investment (Damberg et al., 2009).[89] Within the public payer system, there also continues to be strong support for P4P as clearly highlighted by recent provisions of the Affordable Care Act expanding the use of P4P (James, 2012). Current research is focused on program optimization, for example finding better measures and identifying the right size and mix of incentives.

P4P in the Context of Workers Compensation

P4P is not widely used in WC programs even though the same problems of inconsistent quality and inefficient provision of care that have led to the increasing use of P4P within the health care system in general, also exist in WC programs.[90] There are indications that these problems may even be worse in WC (Wickizer et al., 2004). Given the relative lack of P4P initiatives, there are few published evaluations of WC P4P programs. Wickizer et al. (2004) report results from an evaluation of a P4P program implemented in Washington State. In this program known as the Occupational Health Services (OHE) project, physicians were offered financial incentives for meeting targets on various performance indicators.[91] Financial incentives included payment for previously unreimbursed activities as well as higher fees for already reimbursed activities.

A simple before-after comparison using data from one of the two pilot sites (representing approximately 2700 cases treated by high-volume providers[92]) showed improvements on some measures but not on others. For example, the authors found that the rate of completing activity prescription reports increased dramatically from 11 percent in the first quarter of 2003 to 79 percent in the second quarter, but found no change in the percentage of accident reports submitted within two business days. Attributing observed changes to the P4P initiative is however difficult because of the lack of a comparison group and changes in the composition of providers joining the program over time.

A larger and more comprehensive evaluation published in 2011 analyzed 105,606 claims – 33,910 in the pre-intervention period (July 2001 to June 2003) and 71,696 in the post-intervention period (July 2004 to June 2007), and found that workers exposed to the P4P program were less likely to be off work and on disability after 1 year (Wickizer et al. 2011). The authors also found a 20 percent decrease in the number of disability days and an average

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[89] The program targets 225 capitated integrated medical groups and independent practice associations contracting with the seven largest HMOs in California (Damberg et al., 2005). The physician organizations represent approximately 35,000 physicians.

[90] The rationale for P4P in the specific context of the California WC program has been discussed in an earlier RAND report (Wynn and Sorbero, 2008).

[91] The threshold was set at 80 percent over a given period.

[92] Providers who treated more than 250 workers compensation patients within the first year

decrease of $510 per claim post-implementation. The methodological limitations of the earlier study however still apply here.

Implementing P4P in California's WC Program

What Outcomes Should be Rewarded?

The two domains generally considered in P4P programs are quality and efficiency. While earlier P4P programs focused on quality, newer programs include measures of both quality and efficiency. This reflects the priorities of better care, better health, and lower cost that are outlined in the National Quality Strategy (2011).

The research on quality measurement is quite advanced and numerous measures of quality for various medical conditions have been developed by organizations such as the National Quality Forum (NQF), the National Committee for Quality Assurance (NCQA), and the Agency for Healthcare Research and Quality (AHRQ). In general, quality indicators can be grouped into:

- *Structural indicators* e.g. adoption of Health IT
- *Process indicators* e.g. whether a heart attack patient received aspirin in the ER
- *Outcome indicators* e.g. mortality rates or patient experience

Earlier P4P programs focused on structure and process because of the difficulties associated with paying providers based on outcomes, such as the longer time frame required for measurement, and the challenge of assigning accountability for outcomes when multiple providers are responsible for care. Ultimately however, outcomes are what we care about, and newer programs such as the Massachusetts Blue Cross Blue Shield Alternative Quality Contract and the California IHA program track intermediate outcomes, such as blood pressure control and rates of hospital acquired infections, that influence longer-term outcomes. In the context of WC, rates of worker disability are an example of an outcome that could be used for performance measurement. Adjusting for underlying differences in patient risk between providers will however be critical in order to avoid unintended consequences such as avoidance of high-risk patients (Shen, 2003). Any measure is likely to be imperfect given the importance of psychosocial and workplace factors that are difficult to measure and are often beyond the physician's control.

The research on efficiency measurement is not as well developed and there are only a small number of efficiency measures available, and many have not been fully tested for their validity or reliability (Damberg, 2013). A commonly used indicator of efficiency is average costs. In the context of WC, this could be average medical costs or total costs (medical + disability). For example the average cost per claim (Wickizer et al. 2011). The time taken for an injured worker to return to sustained work is another measure that has been proposed (Wynn and Sorbero, 2008).

Administrative measures such as timely submission of the first report of occupational injury or illness can also be included as a component of a P4P program. The WC system has unique

reporting requirements that place an additional burden on providers, and because in many cases providers are not separately reimbursed for these administrative tasks, necessary forms are not submitted on time or are incomplete when submitted. Providers can also be rewarded for timely communication with employers.

In Table 6.27 we outline a few potential performance indicators drawn from various sources. The choice of the final subset of indicators should be dictated by program objectives and practical considerations of feasibility and data collection costs.

Table 6.27 Example Performance Indicators

Administrative measures	Quality measures	Efficiency measures
• Timeliness of submitting report of accident e.g. report submitted within X days • Provider writing a modified duty prescription for the patient • Provider performing work activity assessments • Communication between provider and employer about workers' return to work or work modification	Structure • Complete a continuing-education course on caring for injured workers and disability management • Use of electronic health records • Use of computerized, physician order-entry systems • Board certification • Maintain active medication list Process • Timeliness of access to care • Referrals consistent with guidelines • Activity prescription at each evaluation • Condition-specific indicators (these will depend on the condition of focus) Outcomes • Number of disability days • Rates of disability • Patient-retention rate • Intermediate health outcomes (depending on condition of focus)	• Average medical cost per claim • Average total cost per claim • Time to return to work • Total compensation days • Measures of utilization e.g. use of PT visits or rates of back surgery • Outpatient surgeries done in ASCs

Collecting Performance Data

A central issue is collecting the data required to measure provider performance. The WC system in California has more than 100 participating insurers.[93] Payers maintain their own databases and the information available differs from one payer to the next. While individual payers can operate their own P4P programs and define their own metrics, a standardized cross-

[93] Self-insured employers cover about 20 percent of the WC population in California.

payer incentive program has clear advantages. For example it allows data on WC patients to be pooled across multiple payers at the provider level. As we have earlier noted, WC patients are generally a small fraction of a provider's patient pool, splitting this by payer only exacerbates this problem. The CWCI and WCIS databases are existing databases that collect data from multiple payers and could therefore serve as a base upon which to build. Currently, CWCI reporting is voluntary and therefore incomplete, while the WCIS database contains detailed medical information but limited administrative data.

While some data is already available, data on other measures will need to be collected. A related issue is that many existing quality measures require medical-record review, and medical records are costly to abstract. A solution that has been advocated is to pay providers to collect and report the information required for performance measurement. This is known as Paying for Reporting or P4R. Medicare has a P4R program known as the Physician Quality Reporting Initiative or PQRI where physicians earn a bonus payment for reporting on specific quality measures for their patients. The Affordable Care of Act of 2010 extends the PQRI until 2014 after which physicians who do not submit measures will have their Medicare payments reduced. Audit processes and protocols for review and correction of data will also need to be developed and built in. In the WC context, this could mean paying for prompt filing of the doctor's first report of injury and other reports.

There are many other important considerations such as how rewards should be structured, mechanisms for financing, how results should be reported to providers/employers, etcetera that are not considered in this brief issue paper but interested readers are directed to a RAND report that explores these issues in greater depth (Wynn and Sorbero, 2008).

Roadmap for the Future

There still remains considerable uncertainty about how best to design and implement P4P programs (Schneider et al., 2011), but previous experience suggests that two important components are: (1) a robust set of performance indicators and (2) an integrated health information system that is conducive to performance measurement, and supports physicians in their quality improvement efforts (Stecher et al., 2010). Below we lay out a few bullet points to serve as guidelines in development of a P4P system.

- **Agree on program priorities** – getting structured input and feedback from all the relevant stakeholders including providers, payers, and employers is important for identifying program priorities for example which conditions to focus on, what performance measures to include, etc.
- **Start with low-hanging fruit** – a reasonable starting point once priorities and indicators are agreed upon is to pay providers for reporting the required data. As the program is expanded, performance on these indicators can then be gradually included in the reward structure.

- **Start small** – piloting the program among providers who voluntarily agree to participate is critical for working out potential kinks. The experience of the Washington State program suggests that providers are interested in quality improvement and are willing to participate in pilot initiatives (Wickizer et al., 2004). Pilots can target high-volume providers to reduce the problem of small numbers.
- **Build in a rigorous evaluation** – we are not aware of any randomized experiments of P4P in WC or even any good quasi-experiments. This would be an opportunity to build in a proper evaluation. Demonstrating effectiveness of the program will be important in building consensus among all the relevant stakeholders. A process evaluation will also help to identify key facilitators and barriers to program effectiveness.
- **Expand incrementally** – the P4P program can begin with paying for performance on a base set of indicators and then slowly including more quality measures as they are developed.

7. Summary

SB 863 requires that DWC implement a RB-RVS fee schedule to establish maximum allowances for physician and other practitioner services. The RB-RVS addresses major shortcomings in the current system:

- The OMFS uses outdated procedure codes to describe medical services. This poses an administrative burden on providers, who must maintain a separate coding system for WC patients and increases fee disputes between providers and payers over services that are not described in the OMFS. The RB-RVS replaces 983 outdated codes. The percentage of payments that will be using fee schedule rates rather than BR increases from 90 percent to 96 percent. This percentage will increase with improved coding and less frequent use of unlisted procedure codes.
- The relative values in the current fee schedule are based on historical charges, which tended to undervalue E&M services relative to procedures. The resource-based relative value scale (RB-RVS) reflects the resources (costs) required to furnish services and provides neutral incentives for providing services.
- The current fee schedule does not provide for regular updates for changes in coding, practice patterns and inflation. Linking the OMFS to the MPFS provides a mechanism for annual updates.

We used 2011 Workers' Compensation Information System (WCIS) medical data to model the impact of implementing the RB-RVS over a four-year transition period. Following the framework for the transition specified in Labor Code Section 5307.1(a)(2), we computed separate CFs for anesthesia, surgery, radiology, and all other services based on current OMFS allowances and assessed the impact by comparing estimated total aggregate allowances under the OMFS to estimated allowances under the RB-RVS during 2014-2017.

Over the 4-year period, total allowable fees are estimated to increase 19.6 percent. The increase represents that combined effect of estimated inflation (which increases the rates 8 percent over the period) and the transition from current OMFS payment levels in the aggregate for all services other than anesthesia at 111 percent of Medicare to 120 percent of Medicare in 2017. For anesthesia, allowable fees decline 16.5 percent over the transition. There are also declines in surgery (-13.4 percent) and radiology (-9.6 percent). Within the "all other services" category, there are significant increases for medicine (23.3 percent) and evaluation and management (49.0 percent) and significant reductions in pathology (-19.5 percent).

Because most specialties furnish a range of services, the impacts by specialty are generally less than the impacts by type of service. For example, surgeons furnish a substantial amount of E&M services as well as surgical services, so that the percentage change in allowances for the surgical specialties is -2.2 percent compared to the -13.4 percent change for surgery.

Consistent with the policies that DWC proposes to implement, our impact analysis assumes that except for a few WC-required services and reports, the fee schedule would follow Medicare ground rules. For certain issues, we examined alternative policies that might be considered and separately analyzed their impact.

Appendix A

Physician Fee Schedule Payment Ground Rules: A Comparison of the OMFS and Medicare [1]

Ground Rule and/or Issue	Workers' Compensation	Medicare Policy Calendar Year 2013
OVERALL FEE SCHEDULE DESIGN		
CF	Separate CFs for: Evaluation & Management Medicine Surgery Radiology Pathology Anesthesia	Single CF for all services other than anesthesia
Geographic practice cost index (GPCI)	Statewide fee schedule with no geographic adjustments	Geographic adjustments for eight localities
Site of service differential	Payment is the same for all sites of service	Facility (hospital) and non-facility (office) differentials for the PE component of most services
Non-physician practitioners	No reduction for services provided by a non-physician practitioner is acting within the scope of their practice	Nurse practitioner and physician assistant services paid at 85% of the Medicare allowed amount unless billed under incident-to rules(use modifiers to identify) Clinical social workers paid at 75% "Incident-to" reimbursed at 100%
Hospital outpatient services (other than emergency and surgery services)	Paid under the OMFS for physician services.	Paid under the Medicare prospective payment system for hospital outpatient services.
CODING RULES		
Healthcare Common Procedure Coding System (HCPCS)	OMFS uses CPT 1997 revision (1994 for Physical Medicine) NDC for pharmaceuticals	Medicare uses HCPCS coding system Level I: 2013 CPT codes Level II: A system of letter and number codes assigned to

Ground Rule and/or Issue	Workers' Compensation	Medicare Policy Calendar Year 2013
	California only codes By report HCPCS Level II not recognized for physician services (however, HCPCS Level II used for DMEPOS fee schedule, dental service billing)	services (mostly non-professional) services, medications, supplies and equipment HCPCS codes updated quarterly and on an annual basis CMS maintains a crosswalk between NDC codes and HCPCS drug codes
Modifiers	Uses 1997 CPT modifiers with some variation in description and modifiers unique to California Workers' Compensation * See OMFS for complete description of California WC modifiers	Medicare adopts current year AMA CPT modifiers and descriptions effective January 1 of each year
Bundled procedures	No specific rule with use of bundling edits varying by payer	Correct Coding Initiative has bundling edits for coding and bill processing system applies standard bundling rules for payment purposes
Unlisted service procedure	Services may be determined by the value assigned to a comparable procedure (by report) Must use unlisted procedure code	Similar policy
E&M AND RELATED SERVICES		
Consultations	Separate payment rates apply to consultations and consultation reports	Medicare pays for consultations using the E&M visit codes (99201-99215) Medicare does make a separate payment for documentation of any kind, including consultation reports
New and established patient definition	A new patient is either new to the physician or is an established patient with a new industrial injury or condition If a physician is on call or covering for another physician, the patient's encounter would be the same as if the patient was treated by his/her own physician	A new patient has not received any professional services within the past three (3) years from the physician or another physician of the same specialty who belongs to the same group practice An establish patient has received professional services within the past three (3) years from the physician or another physician of the same specialty who belongs to the same group practice If a physician is on call for or covering for another physician, the patient's encounter will be classified the same as if the physician had been available
Interpreter used by patient	Payment is 110% of the normal value of the service. Use modifier -93 to report for billing purposes	Patient use of interpreters does not affect physician's payment
Venipuncture (routine)	Allows for the payment of routine venipuncture or needle stick for collection of specimen	36415 Collection of venous blood by venipuncture is paid under the clinical laboratory fee schedule 36416 Collection of capillary blood specimen (e.g, finger, heel, ear stick) is bundled into the office visit payment

Ground Rule and/or Issue	Workers' Compensation	Medicare Policy Calendar Year 2013
Specimen handling	Allows for the reimbursement of transfer or conveyance of specimens from the physician's office to a laboratory	Medicare does not pay separately for the transfer or conveyance of specimens from the physician's office to a laboratory
ANESTHESIA		
Base Units	1993 ASA RVU guide	Mostly ASA RVU guide for current CPT but some of the new codes have lower base units than ASA guide
Time Units	1 unit per 15 minutes for first 4 hours and 1 unit for each 10 minutes thereafter; 5 minutes or more is considered a unit. No time unit recognized for 01995.	Billed in minutes; converted to 15-minute units by contractor and rounded to one decimal place. No time unit recognized for 01995 or 01996.
Time definition	Anesthesia time begins when the anesthesiologist physician starts to prepare the patient for induction of anesthesia in the OR (or its equivalent) and ends when anesthesiologist is no longer in constant attendance	Similar to OMFS except the anesthesia provider can add blocks of time around an interruption in anesthesia time, as long as the anesthesia provider is furnishing continuous anesthesia care within the time periods around the interruption
Monitored anesthesia care	BR	Paid same as other procedures- modifier QS reported for informational purposes only
Qualifying circumstances6.	Additional RVUs payable for codes 99100-99140	Not paid
Patient status modifiers	Additional units paid for P3 (1), P4 (2). And P5 (3).	Not paid
Services performed by physician (modifier = 47)	Covered separately when performed by surgeon Use code 01995 (in CPT 1997 but not CPT 2013); regional anesthesia is paid for base units only.	Not separately paid when performed by physician performing procedure and conscious sedation is provided for a code listed in Appendix G of CPT®; anesthesiologist uses 01991 for anesthesia furnished for nerve blocks or injections
Anesthesia supervision (medical direction) (m48)	Combined payment for an anesthesiologist supervising a nurse anesthetist cannot exceed what would have been payable if only the anesthesiologist furnished the service	CRNA may work and bill independently; anesthesiologist's assistant cannot Specific rules/modifiers apply for supervision of concurrent procedures and for medical direction of nurse anesthetists
SURGERY		
Assistant surgeon	Paid at 20% of the allowed surgical fee	Paid at 16% of the allowed surgical fee
Non-physician surgical assistant	Paid at 10% of the allowed surgical fee	Physician assistants paid at 13.6 % (85% of 16%) of the allowed surgical fee
Co- surgeons	Procedure paid at 125% of the OMFS	Procedure paid at 125% of Medicare allowable surgical fee
Multiple or bilateral procedure reduction	100% for first procedure 50% for the second procedure 25% for the third procedure The procedures are ranked from highest value to lowest. If there are four or more procedures, a global fee should be	100% for first procedure 50% for the second thru fifth procedures. The procedures are ranked from highest value to lowest.

Ground Rule and/or Issue	Workers' Compensation	Medicare Policy Calendar Year 2013
	charged by the physician and be supported by a report	Any procedures beyond the fifth require supporting documentation and *may* be paid upon carrier review
Arthroscopy	Special billing provision for multiple arthroscopic procedures performed on the same joint during the same surgery. Payment is at 100% for the first procedure and 10% for the second and additional procedures. CPT codes covered by this provision are as follows: Shoulder:29815, 29819, 29820, 29822, 29825 Elbow: 29830, 29834, 29835, 29837 Wrist: 29840, 29844 Knee: 29870, 29872, 29874, 29875, 29877, 29884 Ankle: 29894, 29895, 29897 All other arthroscopic procedures not listed above fall under the multiple or bilateral formula.	Payment 100% of Medicare allowable for 1st procedure in the same joint. All other procedures considered bundled, unless modifier -59 is used to indicate different site, joint or compartment.
Endoscopy - multiple	Multiple surgery payment rules apply	Special rules for payment of multiple endoscopies with the same base code. Medicare will pay the full value of the higher valued endoscopy, plus the difference between the next highest endoscopy and the base endoscopy
Global surgical rule	Global surgery delineates the number of days allowed for pre and postoperative management 0-10-90 days 0-days: Minor surgical or endoscopic procedure with "0" days postoperative care 10-days: Minor surgical procedure with 10 days postoperative care 90-days: Major surgical procedure with 90 days postoperative and one day preoperative care	Similar policy
Starred (*) procedure rule	OMFS only rule Allows separate payment for associated pre and post-operative services Note: AMA discontinued Starred Procedure designations	Payment for minor surgery codes generally includes the E/M services provided in order to perform the procedure on the day of surgery or service. Codes are assigned "0" or "10" day global periods beginning the day following the procedure. Modifier -25 is allowed to by-pass rule if an unrelated E&M service is provided on same day.
RADIOLOGY		
Multiple procedure discounting	No payment reductions are applied when multiple services are furnished on the same day	Multiple procedure payment reduction (MPPR) applies to advanced imaging (CT scans, MRI and ultrasound) furnished in

Ground Rule and/or Issue	Workers' Compensation	Medicare Policy Calendar Year 2013
		the same session by a single physician or multiple physicians in the same practice regardless of imaging modality. Payment is reduced 25% for both the technical and professional components of the service.
PHYSICAL MEDICINE		
Multiple procedure discounting	There are limits on how much can be billed on a single date of service and there is a multiple procedure formula for determining the billing amount. Modalities: No more than two are paid on one date of service. Procedures: Codes have an assigned time, and if not specified, the time is considered to be 30 minutes. Where not otherwise specified, time over the first 30 minutes is billed in15 minute increments and may be billed more than once in a single visit. There is a 60- minute limitation without prior authorization; this limits the number of procedures to two in a single visit. Additional time codes do not count in the two-procedure limit. Combined Billing: There is combined maximum of four procedures and/or modalities in a single visit. If one procedure is billed, then a maximum of four codes (including additional time codes) can be billed for one visit. For example, a physician can bill for two modalities and two procedures or two modalities, one procedure and two additional time codes. When combining the modalities and procedures for billing, the physician must use the multiple billing formulas. Payment formula 100% for the first procedure/modality, 75% for the second, 50% for the third, and 25% for the fourth. The procedures and/or modalities should be ranked using the highest value.	MPPR applies to the HCPCS codes contained on the list of "always therapy" services that are paid under the MPFS. The list of procedures is published as Addendum H of the MPFS. The MPPR applies to the PE payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. It does not apply to add-on or bundled codes. Full payment is made for the unit or procedure with the highest PE payment. Effective April 1, 2013 the remaining procedures/units will be reimbursed at 50% payment in all settings (as required by the Taxpayer Relief Act of 2012).
Patient assessments	Physicians use E&M evaluation codes (95831-95852) Therapists use codes 98770-98778 for their assessments, evaluations, and consultations Values for physical medicine codes and acupuncture codes include routine follow-up assessment for E&M purposes. 2.4 RVUs are deducted when treatment and E&M/Physical Therapist Assessment codes are billed for the same visit, by the same	CPT 2013 has codes for physical therapy and occupational therapy evaluation and re-evaluation that apply to all qualified practitioners. The RVUs for physical therapy do not include RVUs for patient assessments.

Ground Rule and/or Issue	Workers' Compensation	Medicare Policy Calendar Year 2013
	medical provider. If the physical therapist has a separate facility or is not employed by the physician, then full value is paid for both treatment and E&M/Physical Therapist Assessment codes.	
Acupuncture	Acupuncture codes may be combined with physical medicine modalities and procedures or may be billed alone using this formula. Additional time codes are not included for these services.	Not a Medicare-covered service but RVUs are published as part of the annual fee schedule update
Chiropractic services	Chiropractic services are subject to the multiple procedure discounting.	Chiropractic services are extremely limited in Medicare and are not included in the "always therapy" codes and therefore not subject to the multiple procedure reduction.
Work hardening and conditioning	Covered service.	Not a Medicare-covered service and no RVUs are published as part of the annual fee schedule update
DRUGS, IMMUNIZATIONS, OTHER PHARMACEUTICALS AND SUPPLIES		
Supplies, materials, durable medical equipment (DME)	Supplies and materials provided over and above those usually included with the service or procedure may be charged for separately Paid at cost (purchase price plus sales tax) plus 20% of cost up to a maximum of cost plus $15.00. Dispensed items separately reimbursed include cast and strapping materials, iontophoresis. electrodes, supplies for strains, reusable electrodes, canes, braces, slings, ace wraps, TENS electrodes, crutches, splints, back supports, hot or cold packs Examples of supplies that are usually not separately reimbursable include applied hot or cold packs, eye patches injections or debridement trays, steristrips, needles, syringes, eye/ear trays, drapes, sterile gloves, eyewash or drops, creams (massage), florescein, ultrasound pads & gel, tissues, urine collection kits, gauze, cotton balls, sterile water, dressings (simple wound), head sheet, aspiration trays, tape for dressing Dangerous device dispensed by a physician: reimbursement not to exceed either 1) the fee schedule amount, 2) 120% of documented paid cost but not less than 100% of documented paid cost plus the dispensing fee allowed for prescription drug dispensing and not more than 100% of documented paid cost plus $250	With the exception of administration of injectable drugs and biologicals and casting materials, supplies used in a doctor office are not separately reimbursed under Medicare and are included in either the E&M service or surgical procedure Re-casting (as well as casting) supplies are separately paid Medical supplies and equipment for home use are payable under the DMEPOS- same as OMFS

Ground Rule and/or Issue	Workers' Compensation	Medicare Policy Calendar Year 2013
Physician-dispensed drugs	Medi-Cal fee schedule rate for NDC applies. For repackaged drugs whose NDC is not in the Medi-Cal database, the Medi-Cal rate for the underlying NDC applies Reimbursement for compounded medications dispensed in a physician's office cannot exceed 300% of documented paid costs, but in no case exceed $20 above documented paid costs.	Medicare does not reimburse for the dispensing of pharmaceuticals other than drugs and biologicals administered in the physician's office e.g. injectable and infusible drugs and therapeutics.
Injectable Drugs	Injectable materials administered during therapeutic, diagnostic, or antibiotic injections are separately reimbursable at 110% of the average wholesale price (AWP) for brand or 140% of the average wholesale price (AWP) for generic No dispensing fee is allowed	Most drugs and biologicals reimbursed under the Medicare program are listed in the MPFS. Those that are do not require copy of invoice submitted with bill. Medicare uses Healthcare Common Procedure Coding System (HCPCS) Level II J-codes to describe drugs, vaccines, and supplies Drugs and biologicals paid at averages sales price (ASP) methodology
Immunizations	Immunizations provided under Medicine codes 90725-90749 and 90710-90711 are reimbursable Cost of the vaccine plus a $14.25 injection fee By report and invoice required	Generally vaccines are not covered with the exception of influenza, pneumococcal and hepatitis B vaccines Vaccine rates are updated annually as part of the fee schedule update.
REPORTS		
OMFS reimbursable reports	The following reports are separately reimbursable. If an office visit is involved, separate payment is made in addition to the office visit. Primary Treating Physicians' Progress Reports - (PR2) – at least every 45-days or change in patient status Primary Treating Physician's Final Discharge Report Primary Treating Physician's Permanent and Stationary ("P&S") Report Consultation reports are separately reimbursable.	Medicare does not separately pay for reports Physicians may charge Medicare beneficiaries for the completion of forms i.e., life insurance applications, disability forms, DMV etc. at physician's usual and customary charge. Physicians may charge Medicare beneficiaries for the completion of forms i.e., life insurance applications, disability forms, DMV, copies of medical records etc (but not CMS 1500 and/or UB claim forms)
Duplicate reports	When requested by a claims administrator duplicate reports are separately reimbursable at $10.00 for up to the 1st – 15 pages and at $0.25 for each additional page Use CPT code 99087 to identify charge duplicate reports	Medicare does not pay separately for reports
Medical records	Chart note requests are separately reimbursable at 95 percent of	Medicare does not pay for furnishing medical records

Ground Rule and/or Issue	Workers' Compensation	Medicare Policy Calendar Year 2013
	a fee set at $10.00 for up to the first 15 pages and $0.25 per page in excess of 15. Chart note requests shall be made only by the claims administrator and shall be in writing. Use code 99086 to identify	

Appendix B OMFS to 2013 CPT Crosswalk

* Indicates codes originally crosswalked by The Lewin Group but updated by RAND

OMFS Code	2013 CPT	Crosswalk
00320	00320	Lewin
00320	00326	Lewin
00420	00300	Lewin
00528	00528	Lewin
00528	00529	Lewin
00544	00542	Lewin
00850	01961	Lewin
00855	01963	Lewin
00857	01968	Lewin
00857	01969	Lewin
00884	01930	Lewin
00900	00300	Lewin
00900	00400	Lewin
00946	01960	Lewin
00955	01967	Lewin
01000	00400	Lewin
01110	00300	Lewin
01214	01214	Lewin
01214	01215	Lewin
01240	00400	Lewin
01300	00400	Lewin
01460	00400	Lewin
01600	00400	Lewin
01632	01630	RAND
01632	01638	RAND
01700	00400	Lewin
01784	01770	Lewin
01784	01780	Lewin
01800	00400	Lewin
01900	00952	Lewin
01902	00214	Lewin
01904	01935	Lewin
01904	01936	Lewin
01905	01935	RAND

OMFS Code	2013 CPT	Crosswalk
01905	01936	RAND
01906	01935	Lewin
01906	01936	Lewin
01908	01935	Lewin
01908	01936	Lewin
01910	01935	Lewin
01910	01936	Lewin
01912	01935	Lewin
01912	01936	Lewin
01914	01935	Lewin
01914	01936	Lewin
01918	01916	Lewin
01921	01924	Lewin
01921	01925	Lewin
01921	01926	Lewin
01995	01200	Lewin*
01995	01202	Lewin*
01995	01210	Lewin*
01995	01212	Lewin*
01995	01214	Lewin*
01995	01215	Lewin*
01995	01220	Lewin*
01995	01230	Lewin*
01995	01232	Lewin*
01995	01234	Lewin*
01995	01250	Lewin*
01995	01260	Lewin*
01995	01270	Lewin*
01995	01272	Lewin*
01995	01274	Lewin*
01995	01320	Lewin*
01995	01340	Lewin*
01995	01360	Lewin*
01995	01380	Lewin*

OMFS Code	2013 CPT	Crosswalk
01995	01382	Lewin*
01995	01390	Lewin*
01995	01392	Lewin*
01995	01400	Lewin*
01995	01402	Lewin*
01995	01404	Lewin*
01995	01420	Lewin*
01995	01430	Lewin*
01995	01432	Lewin*
01995	01440	Lewin*
01995	01442	Lewin*
01995	01444	Lewin*
01995	01462	Lewin*
01995	01464	Lewin*
01995	01470	Lewin*
01995	01472	Lewin*
01995	01474	Lewin*
01995	01480	Lewin*
01995	01482	Lewin*
01995	01484	Lewin*
01995	01486	Lewin*
01995	01490	Lewin*
01995	01500	Lewin*
01995	01502	Lewin*
01995	01520	Lewin*
01995	01522	Lewin*
01995	01610	Lewin*
01995	01620	Lewin*
01995	01622	Lewin*
01995	01630	Lewin*
01995	01634	Lewin*
01995	01636	Lewin*
01995	01638	Lewin*
01995	01650	Lewin*
01995	01652	Lewin*
01995	01654	Lewin*
01995	01656	Lewin*
01995	01670	Lewin*
01995	01680	Lewin*
01995	01682	Lewin*

OMFS Code	2013 CPT	Crosswalk
01995	01710	Lewin*
01995	01712	Lewin*
01995	01714	Lewin*
01995	01716	Lewin*
01995	01730	Lewin*
01995	01732	Lewin*
01995	01740	Lewin*
01995	01742	Lewin*
01995	01744	Lewin*
01995	01756	Lewin*
01995	01758	Lewin*
01995	01760	Lewin*
01995	01770	Lewin*
01995	01772	Lewin*
01995	01780	Lewin*
01995	01782	Lewin*
01995	01810	Lewin*
01995	01820	Lewin*
01995	01829	Lewin*
01995	01830	Lewin*
01995	01832	Lewin*
01995	01840	Lewin*
01995	01842	Lewin*
01995	01844	Lewin*
01995	01850	Lewin*
01995	01852	Lewin*
01995	01860	Lewin*
11040	97597	RAND
11040	97598	RAND
11041	97597	RAND
11041	97598	RAND
11042	11042	RAND
11042	11045	RAND
11043	11043	RAND
11043	11046	RAND
11044	11044	RAND
11044	11047	RAND
11050	11055	Lewin
11050	17000	Lewin
11051	11056	Lewin

OMFS Code	2013 CPT	Crosswalk
11051	17003	Lewin
11052	11057	Lewin
11052	17003	Lewin
11052	17004	Lewin
11731	11732	Lewin
11975	11981	RAND
11977	11976	RAND
11977	11981	RAND
13300	13102	Lewin
13300	13122	Lewin
13300	13133	Lewin
13300	13153	Lewin
14300	14301	RAND
14300	14302	RAND
15000	15002	Lewin
15000	15003	Lewin
15000	15004	Lewin
15000	15005	Lewin
15001	15003	RAND
15001	15005	RAND
15170	15271	RAND
15170	15272	RAND
15171	15273	RAND
15171	15274	RAND
15175	15275	RAND
15175	15276	RAND
15176	15277	RAND
15176	15278	RAND
15300	15271	RAND
15300	15272	RAND
15301	15273	RAND
15301	15274	RAND
15320	15275	RAND
15320	15276	RAND
15321	15277	RAND
15321	15278	RAND
15330	15271	RAND
15330	15272	RAND
15331	15273	RAND
15331	15274	RAND

OMFS Code	2013 CPT	Crosswalk
15335	15275	RAND
15335	15276	RAND
15336	15277	RAND
15336	15278	RAND
15340	15271	RAND
15340	15275	RAND
15341	15272	RAND
15341	15276	RAND
15350	15271	Lewin*
15350	15272	Lewin*
15350	15273	Lewin*
15350	15274	Lewin*
15350	15275	Lewin*
15350	15276	Lewin*
15350	15277	Lewin*
15350	15278	Lewin*
15360	15271	RAND
15360	15272	RAND
15361	15273	RAND
15361	15274	RAND
15365	15275	RAND
15365	15276	RAND
15366	15277	RAND
15366	15278	RAND
15400	15271	Lewin*
15400	15272	Lewin*
15400	15273	Lewin*
15400	15274	Lewin*
15400	15275	Lewin*
15400	15276	Lewin*
15400	15277	Lewin*
15400	15278	Lewin*
15401	15273	RAND
15401	15274	RAND
15420	15275	RAND
15420	15276	RAND
15421	15277	RAND
15421	15278	RAND
15430	15271	RAND
15430	15272	RAND

OMFS Code	2013 CPT	Crosswalk
15430	15275	RAND
15430	15276	RAND
15431	15273	RAND
15431	15274	RAND
15431	15277	RAND
15431	15278	RAND
15580	15574	Lewin
15625	15620	Lewin
15810	NONE	Lewin
15811	NONE	Lewin
15831	15830	Lewin
15831	15847	Lewin
15831	17999	Lewin
16010	16020	Lewin
16015	16025	Lewin
16015	16030	Lewin
16035	16035	Lewin
16035	16036	Lewin
16040	15002	Lewin
16040	15004	Lewin
16041	15002	Lewin
16041	15004	Lewin
16042	15002	Lewin
16042	15004	Lewin
17001	17003	Lewin
17001	17004	Lewin
17002	17003	Lewin
17002	17004	Lewin
17010	NONE	Lewin
17100	17000	Lewin
17100	17003	Lewin
17100	17004	Lewin
17101	17000	Lewin
17101	17003	Lewin
17101	17004	Lewin
17102	17000	Lewin
17102	17003	Lewin
17102	17004	Lewin
17104	17000	Lewin
17104	17003	Lewin

OMFS Code	2013 CPT	Crosswalk
17104	17004	Lewin
17105	17000	Lewin
17105	17003	Lewin
17105	17004	Lewin
17110	17110	Lewin
17110	17111	Lewin
17200	11200	Lewin
17200	11201	Lewin
17201	11200	Lewin
17201	11201	Lewin
17304	17311	Lewin
17305	17312	Lewin
17305	17314	Lewin
17306	17312	Lewin
17306	17314	Lewin
17307	17312	Lewin
17307	17314	Lewin
17310	17315	Lewin
19100	19100	Lewin
19100	19101	Lewin
19100	19102	Lewin
19100	19103	Lewin
19101	19100	Lewin
19101	19101	Lewin
19101	19102	Lewin
19101	19103	Lewin
19140	19300	Lewin
19160	19301	Lewin
19162	19302	Lewin
19180	19303	Lewin
19182	19304	Lewin
19200	19305	Lewin
19220	19306	Lewin
19240	19307	Lewin
20000	10060	RAND
20000	10061	RAND
20986	0054T	RAND
20986	0055T	RAND
20987	0054T	RAND
20987	0055T	RAND

OMFS Code	2013 CPT	Crosswalk
21015	21015	RAND
21015	21016	RAND
21040	21040	Lewin
21040	21046	Lewin
21040	21047	Lewin
21041	21040	Lewin
21041	21046	Lewin
21041	21047	Lewin
21300	NONE	Lewin
21493	NONE	Lewin
21494	NONE	Lewin
21555	21552	RAND
21555	21555	RAND
21556	21554	RAND
21556	21556	RAND
21557	21557	RAND
21557	21558	RAND
21740	21740	Lewin
21740	21742	Lewin
21740	21743	Lewin
21930	21930	RAND
21930	21931	RAND
21930	21932	RAND
21930	21933	RAND
21935	21935	RAND
21935	21936	RAND
22900	22900	RAND
22900	22901	RAND
22900	22902	RAND
22900	22903	RAND
22900	22904	RAND
22900	22905	RAND
23075	23071	RAND
23075	23075	RAND
23076	23073	RAND
23076	23076	RAND
23077	23077	RAND
23077	23078	RAND
23221	23220	RAND
23222	23220	RAND

OMFS Code	2013 CPT	Crosswalk
24075	24071	RAND
24075	24075	RAND
24076	24073	RAND
24076	24076	RAND
24077	24077	RAND
24077	24079	RAND
24151	24150	RAND
24153	24152	RAND
24350	24357	Lewin
24350	24358	Lewin
24350	24359	Lewin
24351	24357	Lewin
24351	24358	Lewin
24351	24359	Lewin
24352	24357	Lewin
24352	24358	Lewin
24352	24359	Lewin
24354	24357	Lewin
24354	24358	Lewin
24354	24359	Lewin
24356	24357	Lewin
24356	24358	Lewin
24356	24359	Lewin
25075	25071	RAND
25075	25075	RAND
25076	25073	RAND
25076	25076	RAND
25077	25077	RAND
25077	25078	RAND
25274	25274	Lewin
25274	25275	Lewin
25611	25606	Lewin
25620	25607	Lewin
25620	25608	Lewin
25620	25609	Lewin
26115	26111	RAND
26115	26115	RAND
26116	26113	RAND
26116	26116	RAND
26117	26117	RAND

OMFS Code	2013 CPT	Crosswalk
26117	26118	RAND
26255	26250	RAND
26261	26260	RAND
26504	26390	Lewin
26585	26587	Lewin
27047	27043	RAND
27047	27047	RAND
27048	27045	RAND
27048	27048	RAND
27049	27049	RAND
27049	27059	RAND
27079	27078	RAND
27315	27325	Lewin
27320	27326	Lewin
27327	27327	RAND
27327	27337	RAND
27328	27328	RAND
27328	27339	RAND
27329	27329	RAND
27329	27364	RAND
27615	27615	RAND
27615	27616	RAND
27618	27618	RAND
27618	27632	RAND
27619	27619	RAND
27619	27634	RAND
28030	28055	Lewin
28043	28039	RAND
28043	28043	RAND
28045	28041	RAND
28045	28045	RAND
28046	28046	RAND
28046	28047	RAND
29220	29799	RAND
29590	NONE	RAND
29815	29805	Lewin
29909	29999	Lewin
31585	NONE	Lewin
31586	NONE	Lewin
31622	31622	Lewin

OMFS Code	2013 CPT	Crosswalk
31622	31623	Lewin
31622	31624	Lewin
31628	31628	Lewin
31628	31632	Lewin
31629	31629	Lewin
31629	31633	Lewin
31656	31899	RAND
31700	NONE	Lewin
31708	NONE	Lewin
31710	NONE	Lewin
31715	31899	RAND
32000	32554	Lewin*
32000	32555	Lewin*
32002	32554	Lewin*
32002	32555	Lewin*
32005	32560	Lewin
32019	32550	RAND
32020	32551	Lewin
32095	32096	RAND
32095	32097	RAND
32095	32098	RAND
32402	32098	RAND
32420	32405	RAND
32421	32554	RAND
32421	32555	RAND
32422	32554	RAND
32422	32555	RAND
32500	32505	RAND
32500	32506	RAND
32500	32507	RAND
32520	NONE	Lewin
32522	NONE	Lewin
32525	NONE	Lewin
32602	32607	RAND
32602	32608	RAND
32602	32609	RAND
32603	32601	RAND
32605	32601	RAND
32850	32850	Lewin
32850	32855	Lewin

OMFS Code	2013 CPT	Crosswalk
32850	32856	Lewin
33200	NONE	Lewin
33201	NONE	Lewin
33242	33218	Lewin
33242	33220	Lewin
33245	NONE	Lewin
33246	NONE	Lewin
33247	33216	Lewin
33253	33254	Lewin
33253	33255	Lewin
33253	33256	Lewin
33861	33864	RAND
33918	33925	Lewin
33918	33926	Lewin
33919	33925	Lewin
33919	33926	Lewin
33930	33930	Lewin
33930	33933	Lewin
33940	33940	Lewin
33940	33944	Lewin
35161	37799	Lewin
35162	37799	Lewin
35301	35301	Lewin
35301	35302	Lewin
35301	35303	Lewin
35301	35304	Lewin
35301	35305	Lewin
35301	35306	Lewin
35381	35302	Lewin
35381	35303	Lewin
35381	35304	Lewin
35381	35305	Lewin
35381	35306	Lewin
35454	37220	RAND
35454	37221	RAND
35454	37222	RAND
35454	37223	RAND
35456	37224	RAND
35456	37225	RAND
35456	37226	RAND

OMFS Code	2013 CPT	Crosswalk
35456	37227	RAND
35459	37228	RAND
35459	37229	RAND
35459	37230	RAND
35459	37231	RAND
35459	37232	RAND
35459	37233	RAND
35459	37234	RAND
35459	37235	RAND
35470	37228	RAND
35470	37229	RAND
35470	37230	RAND
35470	37231	RAND
35470	37232	RAND
35470	37233	RAND
35470	37234	RAND
35470	37235	RAND
35473	37220	RAND
35473	37221	RAND
35473	37222	RAND
35473	37223	RAND
35474	37224	RAND
35474	37225	RAND
35474	37226	RAND
35474	37227	RAND
35480	0234T	RAND
35480	0235T	RAND
35481	0236T	RAND
35482	0238T	RAND
35483	37225	RAND
35483	37227	RAND
35484	0237T	RAND
35485	37229	RAND
35485	37231	RAND
35485	37233	RAND
35485	37235	RAND
35490	0234T	RAND
35490	0235T	RAND
35491	0236T	RAND
35492	0238T	RAND

OMFS Code	2013 CPT	Crosswalk
35493	37225	RAND
35493	37227	RAND
35494	0237T	RAND
35495	37229	RAND
35495	37231	RAND
35495	37233	RAND
35495	37235	RAND
35507	35506	Lewin
35541	35537	Lewin
35541	35538	Lewin
35546	35539	Lewin
35546	35540	Lewin
35548	35537	RAND
35548	35539	RAND
35548	35565	RAND
35549	35537	RAND
35549	35538	RAND
35549	35539	RAND
35549	35540	RAND
35549	35565	RAND
35551	35539	RAND
35551	35540	RAND
35551	35556	RAND
35551	35583	RAND
35582	NONE	Lewin
35601	35601	Lewin
35601	35637	Lewin
35601	35638	Lewin
35641	35637	Lewin
35641	35638	Lewin
35646	35646	Lewin
35646	35647	Lewin
35681	35681	Lewin
35681	35682	Lewin
35681	35683	Lewin
36145	36147	RAND
36145	36148	RAND
36488	36555	Lewin
36488	36556	Lewin
36488	36568	Lewin

OMFS Code	2013 CPT	Crosswalk
36488	36569	Lewin
36488	36580	Lewin
36488	36584	Lewin
36489	36555	Lewin
36489	36556	Lewin
36489	36568	Lewin
36489	36569	Lewin
36489	36580	Lewin
36489	36584	Lewin
36490	36555	Lewin
36490	36556	Lewin
36490	36568	Lewin
36490	36569	Lewin
36490	36580	Lewin
36490	36584	Lewin
36491	36555	Lewin
36491	36556	Lewin
36491	36568	Lewin
36491	36569	Lewin
36491	36580	Lewin
36491	36584	Lewin
36493	36597	Lewin
36520	36511	Lewin
36520	36512	Lewin
36530	36563	Lewin
36531	36575	Lewin
36531	36576	Lewin
36531	36578	Lewin
36531	36581	Lewin
36531	36582	Lewin
36531	36584	Lewin
36531	36585	Lewin
36532	36590	Lewin
36533	36557	Lewin
36533	36558	Lewin
36533	36560	Lewin
36533	36561	Lewin
36533	36565	Lewin
36533	36566	Lewin
36533	36570	Lewin

OMFS Code	2013 CPT	Crosswalk
36533	36571	Lewin
36534	36575	Lewin
36534	36576	Lewin
36534	36578	Lewin
36534	36581	Lewin
36534	36582	Lewin
36534	36583	Lewin
36534	36585	Lewin
36535	36589	Lewin
36540	36591	RAND
36550	36593	RAND
36821	36819	Lewin
36821	36820	Lewin
36821	36821	Lewin
36832	36832	Lewin
36832	36833	Lewin
37201	37211	RAND
37201	37212	RAND
37201	37213	RAND
37201	37214	RAND
37203	37197	RAND
37209	37211	RAND
37209	37212	RAND
37209	37213	RAND
37209	37214	RAND
37620	37191	RAND
37620	37619	RAND
37720	37718	Lewin
37720	37722	Lewin
37730	37718	Lewin
37730	37722	Lewin
38231	38205	Lewin
38231	38206	Lewin
39502	43332	RAND
39502	43333	RAND
39520	43334	RAND
39520	43335	RAND
39530	43336	RAND
39530	43337	RAND
39531	43336	RAND

OMFS Code	2013 CPT	Crosswalk
39531	43337	RAND
42325	NONE	Lewin
42326	NONE	Lewin
43234	43235	RAND
43259	43237	Lewin
43259	43259	Lewin
43324	43327	RAND
43324	43328	RAND
43326	43327	RAND
43326	43328	RAND
43600	43605	RAND
43638	NONE	Lewin
43639	NONE	Lewin
43750	43246	Lewin
43846	43845	Lewin
43846	43846	Lewin
44152	44799	Lewin
44153	44799	Lewin
44625	44625	Lewin
44625	44626	Lewin
44900	44900	Lewin
44900	44901	Lewin
45170	45171	RAND
45170	45172	RAND
46210	46999	RAND
46211	46999	RAND
46934	46930	RAND
46935	46930	RAND
46936	46930	RAND
46937	45190	RAND
46938	45190	RAND
47010	47010	Lewin
47010	47011	Lewin
47134	47140	Lewin
47716	NONE	Lewin*
47719	NONE	RAND
48005	48105	Lewin
48180	48548	Lewin
48510	48510	Lewin
48510	48511	Lewin

OMFS Code	2013 CPT	Crosswalk
48550	48550	Lewin
48550	48551	Lewin
48550	48552	Lewin
49040	49040	Lewin
49040	49041	Lewin
49060	49060	Lewin
49060	49061	Lewin
49080	49082	RAND
49080	49083	RAND
49080	49084	RAND
49081	49082	RAND
49081	49083	RAND
49081	49084	RAND
49085	49402	Lewin
49200	49203	Lewin
49200	49204	Lewin
49200	49205	Lewin
49200	58957	Lewin
49200	58958	Lewin
49201	49203	Lewin
49201	49204	Lewin
49201	49205	Lewin
49201	58957	Lewin
49201	58958	Lewin
49420	49418	RAND
49420	49421	RAND
49421	49418	RAND
49421	49421	RAND
50020	50020	Lewin
50020	50021	Lewin
50300	50300	Lewin
50300	50323	Lewin
50320	50320	Lewin
50320	50325	Lewin
50559	NONE	Lewin
50578	NONE	Lewin
50959	NONE	Lewin
50978	NONE	Lewin
51000	51100	Lewin
51005	51101	Lewin

OMFS Code	2013 CPT	Crosswalk
51010	51102	Lewin
51726	51726	RAND
51726	51727	RAND
51726	51728	RAND
51726	51729	RAND
52335	52351	Lewin
52336	52352	Lewin
52337	52353	Lewin
52338	52354	Lewin
52339	52355	Lewin
52340	52400	Lewin
52510	NONE	Lewin
52606	52214	RAND
52612	52601	RAND
52614	52601	RAND
52620	52630	RAND
53443	53431	Lewin
53447	53447	Lewin
53447	53448	Lewin
53670	51701	Lewin
53670	51702	Lewin
53675	51703	Lewin
53853	55899	RAND
54152	54150	Lewin
54402	54415	Lewin
54402	54416	Lewin
54407	54406	Lewin
54407	54408	Lewin
54407	54410	Lewin
54409	54408	Lewin
54510	54512	Lewin
54820	54865	Lewin
55859	55875	Lewin
56300	49320	Lewin
56301	58670	Lewin
56302	58671	Lewin
56303	58662	Lewin
56304	58660	Lewin
56305	49321	Lewin
56306	49322	Lewin

OMFS Code	2013 CPT	Crosswalk
56307	58661	Lewin
56308	58550	Lewin
56308	58552	Lewin
56309	58545	Lewin
56309	58546	Lewin
56311	38570	Lewin
56312	38571	Lewin
56313	38572	Lewin
56315	44970	Lewin
56316	49650	Lewin
56317	49651	Lewin
56320	55550	Lewin
56322	43651	Lewin
56323	43652	Lewin
56324	47570	Lewin
56340	47562	Lewin
56341	47563	Lewin
56342	47564	Lewin
56343	58673	Lewin
56344	58672	Lewin
56350	58555	Lewin
56351	58558	Lewin
56352	58559	Lewin
56353	58560	Lewin
56354	58561	Lewin
56355	58562	Lewin
56356	58563	Lewin
56362	47560	Lewin
56363	47561	Lewin
56399	NONE	Lewin
56720	56442	Lewin
57108	57106	Lewin
57110	57110	Lewin
57110	57111	Lewin
57110	57112	Lewin
57282	57282	Lewin
57282	57283	Lewin
57284	57284	Lewin
57284	57285	Lewin
57452	57452	Lewin

OMFS Code	2013 CPT	Crosswalk
57452	57454	Lewin
57452	57455	Lewin
57452	57456	Lewin
57452	57460	Lewin
57452	57461	Lewin
57454	57452	Lewin
57454	57454	Lewin
57454	57455	Lewin
57454	57456	Lewin
57454	57460	Lewin
57454	57461	Lewin
57460	57452	Lewin
57460	57454	Lewin
57460	57455	Lewin
57460	57456	Lewin
57460	57460	Lewin
57460	57461	Lewin
57820	57558	Lewin
58140	58140	Lewin
58140	58146	Lewin
59000	59000	Lewin
59000	59001	Lewin
60001	60300	Lewin
61106	NONE	Lewin
61130	NONE	Lewin
61538	61537	Lewin
61538	61538	Lewin
61538	61539	Lewin
61538	61540	Lewin
61539	61537	Lewin
61539	61538	Lewin
61539	61539	Lewin
61539	61540	Lewin
61712	69990	Lewin
61793	61796	RAND
61793	61797	RAND
61793	61798	RAND
61793	61799	RAND
61793	61800	RAND
61793	63620	RAND

OMFS Code	2013 CPT	Crosswalk
61793	63621	RAND
61795	61781	RAND
61795	61782	RAND
61795	61783	RAND
61855	61867	Lewin
61855	61868	Lewin
61865	61867	Lewin
61865	61868	Lewin
61885	61885	Lewin
61885	61886	Lewin
62274	62310	Lewin
62274	62311	Lewin
62275	62310	Lewin
62276	62318	Lewin
62276	62319	Lewin
62277	62318	Lewin
62277	62319	Lewin
62278	62311	Lewin
62279	62319	Lewin
62288	62310	Lewin
62288	62311	Lewin
62289	62311	Lewin
62298	62310	Lewin
63040	63040	Lewin
63040	63043	Lewin
63040	63044	Lewin
63660	63661	RAND
63660	63662	RAND
63660	63663	RAND
63660	63664	RAND
63690	95970	Lewin
63690	95971	Lewin
63691	95970	Lewin
63691	95971	Lewin
64415	64415	Lewin
64415	64416	Lewin
64440	64479	Lewin
64440	64483	Lewin
64441	64480	Lewin
64441	64484	Lewin

OMFS Code	2013 CPT	Crosswalk
64442	64493	Lewin*
64443	64494	Lewin*
64443	64495	Lewin*
64445	64445	Lewin
64445	64446	Lewin
64470	64490	RAND
64472	64491	RAND
64472	64492	RAND
64475	64493	RAND
64476	64494	RAND
64476	64495	RAND
64555	64555	Lewin
64555	64561	Lewin
64560	NONE	RAND
64573	NONE	RAND
64575	64575	Lewin
64575	64581	Lewin
64577	NONE	RAND
64622	64635	Lewin*
64623	64636	Lewin*
64626	64633	RAND
64627	64634	RAND
64680	64680	Lewin
64680	64681	Lewin
64830	69990	Lewin
65805	65800	RAND
66710	66710	Lewin
66710	66711	Lewin
67038	67041	Lewin
67038	67042	Lewin
67038	67043	Lewin
67228	67228	Lewin
67228	67229	Lewin
67350	67346	Lewin
69410	NONE	Lewin
69802	NONE	RAND
70540	70540	Lewin
70540	70542	Lewin
70540	70543	Lewin
70541	70544	Lewin

OMFS Code	2013 CPT	Crosswalk
70541	70545	Lewin
70541	70546	Lewin
70541	70547	Lewin
70541	70548	Lewin
70541	70549	Lewin
71036	77002	Lewin
71038	31628	Lewin
71038	31632	Lewin
71040	76499	RAND
71060	76499	RAND
71090	NONE	RAND
71550	71550	Lewin
71550	71551	Lewin
71550	71552	Lewin
72196	72195	Lewin
72196	72196	Lewin
72196	72197	Lewin
73220	73218	Lewin
73220	73219	Lewin
73220	73220	Lewin
73221	73221	Lewin
73221	73222	Lewin
73221	73223	Lewin
73542	27096	RAND
73720	73718	Lewin
73720	73719	Lewin
73720	73720	Lewin
73721	73721	Lewin
73721	73722	Lewin
73721	73723	Lewin
74181	74181	Lewin
74181	74182	Lewin
74181	74183	Lewin
74350	49440	Lewin
74405	74400	Lewin
74405	74410	Lewin
74405	74415	Lewin
75552	75557	Lewin*
75552	75559	Lewin*
75553	75561	Lewin*

OMFS Code	2013 CPT	Crosswalk
75553	75563	Lewin*
75554	75557	Lewin*
75554	75559	Lewin*
75554	75561	Lewin*
75554	75563	Lewin*
75555	75557	Lewin*
75555	75559	Lewin*
75555	75561	Lewin*
75555	75563	Lewin*
75556	75565	Lewin*
75558	75565	RAND
75560	75565	RAND
75562	75565	RAND
75564	75565	RAND
75650	36221	RAND
75650	36222	RAND
75650	36223	RAND
75650	36224	RAND
75650	36225	RAND
75650	36226	RAND
75660	36227	RAND
75662	36227	RAND
75665	36223	RAND
75665	36224	RAND
75671	36223	RAND
75671	36224	RAND
75676	36222	RAND
75676	36223	RAND
75676	36224	RAND
75680	36222	RAND
75680	36223	RAND
75680	36224	RAND
75685	36225	RAND
75685	36226	RAND
75722	36251	RAND
75722	36253	RAND
75724	36252	RAND
75724	36254	RAND
75790	36147	RAND
75790	75791	RAND

OMFS Code	2013 CPT	Crosswalk
75900	37211	RAND
75900	37212	RAND
75900	37213	RAND
75900	37214	RAND
75940	37191	RAND
75961	37197	RAND
75992	0238T	RAND
75992	37225	RAND
75992	37227	RAND
75992	37229	RAND
75992	37231	RAND
75993	0238T	RAND
75993	37233	RAND
75993	37235	RAND
75994	0234T	RAND
75995	0235T	RAND
75996	0235T	RAND
75998	77001	RAND
76003	77002	Lewin
76005	77003	RAND
76006	77071	RAND
76012	72291	RAND
76013	72292	RAND
76020	77072	Lewin
76040	77073	Lewin
76061	77074	Lewin
76062	77075	Lewin
76065	77076	Lewin
76066	77077	Lewin
76070	77078	Lewin*
76071	NONE	RAND
76075	77080	Lewin
76076	77081	RAND
76077	77082	RAND
76078	NONE	RAND
76082	77051	RAND
76083	77052	RAND
76086	77053	Lewin
76088	77054	Lewin
76090	77055	Lewin

OMFS Code	2013 CPT	Crosswalk
76091	77056	Lewin
76092	77057	Lewin
76093	77058	Lewin
76094	77059	Lewin
76095	77031	Lewin
76096	77032	Lewin
76150	NONE	RAND
76350	NONE	RAND
76355	77011	Lewin
76360	77012	Lewin
76362	77013	RAND
76365	77012	Lewin
76370	77014	Lewin
76375	76376	Lewin*
76375	76377	Lewin*
76393	77021	RAND
76394	77022	RAND
76400	77084	Lewin
76511	76510	Lewin
76511	76511	Lewin
76511	76512	Lewin
76512	76510	Lewin
76512	76511	Lewin
76512	76512	Lewin
76778	76775	Lewin
76778	76776	Lewin
76805	76801	Lewin
76805	76802	Lewin
76805	76805	Lewin
76805	76810	Lewin
76810	76801	Lewin
76810	76802	Lewin
76810	76805	Lewin
76810	76810	Lewin
76818	76818	Lewin
76818	76819	Lewin
76880	76881	RAND
76880	76882	RAND
76934	76942	Lewin*
76938	76942	Lewin

OMFS Code	2013 CPT	Crosswalk
76960	76950	Lewin
76986	76998	Lewin
77079	NONE	RAND
77083	NONE	RAND
77419	77427	Lewin
77420	77427	Lewin
77425	77427	Lewin
77430	77427	Lewin
77781	77785	RAND
77781	77786	RAND
77782	77785	RAND
77782	77786	RAND
77782	77787	RAND
77783	77785	RAND
77783	77786	RAND
77783	77787	RAND
77784	77785	RAND
77784	77786	RAND
77784	77787	RAND
78000	78012	RAND
78001	78012	RAND
78003	78012	RAND
78006	78013	RAND
78006	78014	RAND
78007	78013	RAND
78007	78014	RAND
78010	78013	RAND
78010	78014	RAND
78011	78013	RAND
78011	78014	RAND
78017	78018	Lewin
78160	NONE	Lewin
78162	NONE	Lewin
78170	NONE	Lewin
78172	NONE	Lewin
78220	NONE	RAND
78223	78226	RAND
78223	78227	RAND
78455	NONE	Lewin
78460	78451	RAND

OMFS Code	2013 CPT	Crosswalk
78460	78453	RAND
78461	78452	RAND
78461	78454	RAND
78464	78451	RAND
78465	78452	RAND
78478	78453	RAND
78478	78454	RAND
78480	78453	RAND
78480	78454	RAND
78584	78582	RAND
78585	78582	RAND
78586	78579	RAND
78587	78579	RAND
78588	78582	RAND
78591	78579	RAND
78593	78579	RAND
78594	78579	RAND
78596	78597	RAND
78596	78598	RAND
78615	78610	Lewin
78704	78707	Lewin
78704	78708	Lewin
78704	78709	Lewin
78707	78707	Lewin
78707	78708	Lewin
78707	78709	Lewin
78715	78707	Lewin
78715	78708	Lewin
78715	78709	Lewin
78726	78799	Lewin
78727	78700	Lewin
78727	78701	Lewin
78727	78707	Lewin
78727	78708	Lewin
78727	78709	Lewin
78760	78761	Lewin
78800	78800	Lewin
78800	78802	Lewin
78800	78804	Lewin
78802	78800	Lewin

OMFS Code	2013 CPT	Crosswalk
78802	78802	Lewin
78802	78804	Lewin
78810	78811	Lewin
78810	78812	Lewin
78810	78813	Lewin
78890	NONE	RAND
78891	NONE	RAND
78990	NONE	Lewin
79000	79005	Lewin
79001	79005	Lewin
79020	79005	Lewin
79030	79005	Lewin
79035	79005	Lewin
79100	79101	Lewin
79400	79101	Lewin
79420	79445	Lewin
79900	NONE	Lewin
82307	82306	RAND
82926	82930	RAND
82928	82930	RAND
83890	81200	RAND
83890	81201	RAND
83890	81202	RAND
83890	81203	RAND
83890	81205	RAND
83890	81206	RAND
83890	81207	RAND
83890	81208	RAND
83890	81209	RAND
83890	81210	RAND
83890	81211	RAND
83890	81212	RAND
83890	81213	RAND
83890	81214	RAND
83890	81215	RAND
83890	81216	RAND
83890	81217	RAND
83890	81220	RAND
83890	81221	RAND
83890	81222	RAND

OMFS Code	2013 CPT	Crosswalk
83890	81223	RAND
83890	81224	RAND
83890	81225	RAND
83890	81226	RAND
83890	81227	RAND
83890	81228	RAND
83890	81229	RAND
83890	81235	RAND
83890	81240	RAND
83890	81241	RAND
83890	81242	RAND
83890	81243	RAND
83890	81244	RAND
83890	81245	RAND
83890	81250	RAND
83890	81251	RAND
83890	81252	RAND
83890	81253	RAND
83890	81254	RAND
83890	81255	RAND
83890	81256	RAND
83890	81257	RAND
83890	81260	RAND
83890	81261	RAND
83890	81262	RAND
83890	81263	RAND
83890	81264	RAND
83890	81265	RAND
83890	81266	RAND
83890	81267	RAND
83890	81268	RAND
83890	81270	RAND
83890	81275	RAND
83890	81280	RAND
83890	81281	RAND
83890	81282	RAND
83890	81290	RAND
83890	81291	RAND
83890	81292	RAND
83890	81293	RAND

OMFS Code	2013 CPT	Crosswalk
83890	81294	RAND
83890	81295	RAND
83890	81296	RAND
83890	81297	RAND
83890	81298	RAND
83890	81299	RAND
83890	81300	RAND
83890	81301	RAND
83890	81302	RAND
83890	81303	RAND
83890	81304	RAND
83890	81310	RAND
83890	81315	RAND
83890	81316	RAND
83890	81317	RAND
83890	81318	RAND
83890	81319	RAND
83890	81321	RAND
83890	81322	RAND
83890	81323	RAND
83890	81324	RAND
83890	81325	RAND
83890	81326	RAND
83890	81330	RAND
83890	81331	RAND
83890	81332	RAND
83890	81340	RAND
83890	81341	RAND
83890	81342	RAND
83890	81350	RAND
83890	81355	RAND
83890	81370	RAND
83890	81371	RAND
83890	81372	RAND
83890	81373	RAND
83890	81374	RAND
83890	81375	RAND
83890	81376	RAND
83890	81377	RAND
83890	81378	RAND

OMFS Code	2013 CPT	Crosswalk
83890	81379	RAND
83890	81380	RAND
83890	81381	RAND
83890	81382	RAND
83890	81383	RAND
83890	81400	RAND
83890	81401	RAND
83890	81402	RAND
83890	81403	RAND
83890	81404	RAND
83890	81405	RAND
83890	81406	RAND
83890	81407	RAND
83890	81408	RAND
83890	81479	RAND
83891	81200	RAND
83891	81201	RAND
83891	81202	RAND
83891	81203	RAND
83891	81205	RAND
83891	81206	RAND
83891	81207	RAND
83891	81208	RAND
83891	81209	RAND
83891	81210	RAND
83891	81211	RAND
83891	81212	RAND
83891	81213	RAND
83891	81214	RAND
83891	81215	RAND
83891	81216	RAND
83891	81217	RAND
83891	81220	RAND
83891	81221	RAND
83891	81222	RAND
83891	81223	RAND
83891	81224	RAND
83891	81225	RAND
83891	81226	RAND
83891	81227	RAND

OMFS Code	2013 CPT	Crosswalk
83891	81228	RAND
83891	81229	RAND
83891	81235	RAND
83891	81240	RAND
83891	81241	RAND
83891	81242	RAND
83891	81243	RAND
83891	81244	RAND
83891	81245	RAND
83891	81250	RAND
83891	81251	RAND
83891	81252	RAND
83891	81253	RAND
83891	81254	RAND
83891	81255	RAND
83891	81256	RAND
83891	81257	RAND
83891	81260	RAND
83891	81261	RAND
83891	81262	RAND
83891	81263	RAND
83891	81264	RAND
83891	81265	RAND
83891	81266	RAND
83891	81267	RAND
83891	81268	RAND
83891	81270	RAND
83891	81275	RAND
83891	81280	RAND
83891	81281	RAND
83891	81282	RAND
83891	81290	RAND
83891	81291	RAND
83891	81292	RAND
83891	81293	RAND
83891	81294	RAND
83891	81295	RAND
83891	81296	RAND
83891	81297	RAND
83891	81298	RAND

OMFS Code	2013 CPT	Crosswalk
83891	81299	RAND
83891	81300	RAND
83891	81301	RAND
83891	81302	RAND
83891	81303	RAND
83891	81304	RAND
83891	81310	RAND
83891	81315	RAND
83891	81316	RAND
83891	81317	RAND
83891	81318	RAND
83891	81319	RAND
83891	81321	RAND
83891	81322	RAND
83891	81323	RAND
83891	81324	RAND
83891	81325	RAND
83891	81326	RAND
83891	81330	RAND
83891	81331	RAND
83891	81332	RAND
83891	81340	RAND
83891	81341	RAND
83891	81342	RAND
83891	81350	RAND
83891	81355	RAND
83891	81370	RAND
83891	81371	RAND
83891	81372	RAND
83891	81373	RAND
83891	81374	RAND
83891	81375	RAND
83891	81376	RAND
83891	81377	RAND
83891	81378	RAND
83891	81379	RAND
83891	81380	RAND
83891	81381	RAND
83891	81382	RAND
83891	81383	RAND

OMFS Code	2013 CPT	Crosswalk
83891	81400	RAND
83891	81401	RAND
83891	81402	RAND
83891	81403	RAND
83891	81404	RAND
83891	81405	RAND
83891	81406	RAND
83891	81407	RAND
83891	81408	RAND
83891	81479	RAND
83892	81200	RAND
83892	81201	RAND
83892	81202	RAND
83892	81203	RAND
83892	81205	RAND
83892	81206	RAND
83892	81207	RAND
83892	81208	RAND
83892	81209	RAND
83892	81210	RAND
83892	81211	RAND
83892	81212	RAND
83892	81213	RAND
83892	81214	RAND
83892	81215	RAND
83892	81216	RAND
83892	81217	RAND
83892	81220	RAND
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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OMFS Code	2013 CPT	Crosswalk
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85095	38220	Lewin
85102	38221	Lewin
86586	86356	RAND
86586	86486	RAND
86781	86780	RAND

OMFS Code	2013 CPT	Crosswalk
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88150	88152	Lewin
88150	88153	Lewin
88150	88154	Lewin
88151	88141	Lewin
88170	10021	Lewin
88171	10022	Lewin
88180	88182	Lewin
88180	88189	Lewin
88318	88313	RAND
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OMFS Code	2013 CPT	Crosswalk
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88384	81267	RAND
88384	81268	RAND
88384	81270	RAND
88384	81275	RAND
88384	81280	RAND
88384	81281	RAND
88384	81282	RAND
88384	81290	RAND
88384	81291	RAND
88384	81292	RAND
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88384	81296	RAND
88384	81297	RAND
88384	81298	RAND
88384	81299	RAND
88384	81300	RAND
88384	81301	RAND
88384	81302	RAND

OMFS Code	2013 CPT	Crosswalk
88384	81303	RAND
88384	81304	RAND
88384	81310	RAND
88384	81315	RAND
88384	81316	RAND
88384	81317	RAND
88384	81318	RAND
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88384	81342	RAND
88384	81350	RAND
88384	81355	RAND
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88384	81371	RAND
88384	81372	RAND
88384	81373	RAND
88384	81374	RAND
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88384	81381	RAND
88384	81382	RAND
88384	81383	RAND
88384	81400	RAND
88384	81401	RAND
88384	81402	RAND
88384	81403	RAND

OMFS Code	2013 CPT	Crosswalk
88384	81404	RAND
88384	81405	RAND
88384	81406	RAND
88384	81407	RAND
88384	81408	RAND
88384	81479	RAND
88385	81200	RAND
88385	81201	RAND
88385	81202	RAND
88385	81203	RAND
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88385	81235	RAND
88385	81240	RAND
88385	81241	RAND
88385	81242	RAND
88385	81243	RAND
88385	81244	RAND
88385	81245	RAND

OMFS Code	2013 CPT	Crosswalk
88385	81250	RAND
88385	81251	RAND
88385	81252	RAND
88385	81253	RAND
88385	81254	RAND
88385	81255	RAND
88385	81256	RAND
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88385	81301	RAND
88385	81302	RAND
88385	81303	RAND
88385	81304	RAND
88385	81310	RAND
88385	81315	RAND
88385	81316	RAND

OMFS Code	2013 CPT	Crosswalk
88385	81317	RAND
88385	81318	RAND
88385	81319	RAND
88385	81321	RAND
88385	81322	RAND
88385	81323	RAND
88385	81324	RAND
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88385	81342	RAND
88385	81350	RAND
88385	81355	RAND
88385	81370	RAND
88385	81371	RAND
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88385	81374	RAND
88385	81375	RAND
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88385	81378	RAND
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88385	81381	RAND
88385	81382	RAND
88385	81383	RAND
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88385	81401	RAND
88385	81402	RAND
88385	81403	RAND
88385	81404	RAND
88385	81405	RAND
88385	81406	RAND
88385	81407	RAND
88385	81408	RAND

OMFS Code	2013 CPT	Crosswalk
88385	81479	RAND
88386	81200	RAND
88386	81201	RAND
88386	81202	RAND
88386	81203	RAND
88386	81205	RAND
88386	81206	RAND
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88386	81244	RAND
88386	81245	RAND
88386	81250	RAND
88386	81251	RAND
88386	81252	RAND
88386	81253	RAND
88386	81254	RAND

OMFS Code	2013 CPT	Crosswalk
88386	81255	RAND
88386	81256	RAND
88386	81257	RAND
88386	81260	RAND
88386	81261	RAND
88386	81262	RAND
88386	81263	RAND
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88386	81268	RAND
88386	81270	RAND
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88386	81282	RAND
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88386	81315	RAND
88386	81316	RAND
88386	81317	RAND
88386	81318	RAND
88386	81319	RAND
88386	81321	RAND
88386	81322	RAND

OMFS Code	2013 CPT	Crosswalk
88386	81323	RAND
88386	81324	RAND
88386	81325	RAND
88386	81326	RAND
88386	81330	RAND
88386	81331	RAND
88386	81332	RAND
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88386	81355	RAND
88386	81370	RAND
88386	81371	RAND
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88386	81407	RAND
88386	81408	RAND
88386	81479	RAND
88400	88720	RAND
89100	43756	RAND
89105	43757	RAND
89130	43754	RAND

OMFS Code	2013 CPT	Crosswalk
89130	43755	RAND
89131	43754	RAND
89131	43755	RAND
89132	43754	RAND
89132	43755	RAND
89133	43754	RAND
89133	43755	RAND
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89141	43754	RAND
89141	43755	RAND
89225	NONE	RAND
89235	NONE	RAND
90379	90378	RAND
90465	90460	RAND
90465	90471	RAND
90465	90473	RAND
90466	90461	RAND
90466	90472	RAND
90466	90474	RAND
90467	90460	RAND
90467	90471	RAND
90467	90473	RAND
90468	90461	RAND
90468	90472	RAND
90468	90474	RAND
90470	NONE	RAND
90663	90664	RAND

OMFS Code	2013 CPT	Crosswalk
90665	NONE	RAND
90701	NONE	RAND
90709	NONE	Lewin
90711	NONE	Lewin
90714	90690	Lewin
90714	90691	Lewin
90714	90692	Lewin
90714	90693	Lewin
90718	90714	RAND
90724	90655	Lewin
90724	90657	Lewin
90724	90658	Lewin
90724	90660	Lewin
90726	90675	Lewin
90726	90676	Lewin
90728	90585	Lewin
90728	90586	Lewin
90730	90632	Lewin
90730	90633	Lewin
90730	90634	Lewin
90737	90645	Lewin
90737	90646	Lewin
90737	90647	Lewin
90737	90648	Lewin
90741	90281	Lewin*
90741	90283	Lewin*
90741	90284	Lewin*
90742	90287	Lewin*
90742	90288	Lewin*
90742	90291	Lewin*
90742	90296	Lewin*
90742	90371	Lewin*
90742	90375	Lewin*
90742	90376	Lewin*
90742	90378	Lewin*
90742	90384	Lewin*
90742	90385	Lewin*
90742	90386	Lewin*
90742	90389	Lewin*
90742	90393	Lewin*

OMFS Code	2013 CPT	Crosswalk
90742	90396	Lewin*
90742	90399	Lewin*
90745	90743	Lewin*
90745	90744	Lewin*
90746	90739	RAND
90746	90746	RAND
90760	96360	RAND
90761	96361	RAND
90765	96365	RAND
90766	96366	RAND
90767	96367	RAND
90768	96368	RAND
90769	96369	RAND
90770	96370	RAND
90771	96371	RAND
90772	96372	RAND
90773	96373	RAND
90774	96374	RAND
90775	96375	RAND
90776	96376	RAND
90779	96379	RAND
90780	96360	Lewin*
90780	96361	Lewin*
90780	96365	Lewin*
90780	96366	Lewin*
90780	96367	Lewin*
90780	96368	Lewin*
90781	96360	Lewin*
90781	96361	Lewin*
90781	96365	Lewin*
90781	96366	Lewin*
90781	96367	Lewin*
90781	96368	Lewin*
90782	96372	Lewin*
90783	96373	Lewin*
90784	96374	Lewin*
90788	96372	Lewin*
90799	96379	Lewin*
90801	90791	RAND
90801	90792	RAND

OMFS Code	2013 CPT	Crosswalk
90802	90791	RAND
90802	90792	RAND
90804	90832	RAND
90805	90833	RAND
90806	90834	RAND
90807	90836	RAND
90808	90837	RAND
90809	90838	RAND
90810	90832	RAND
90811	90833	RAND
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90823	90832	RAND
90824	90833	RAND
90826	90834	RAND
90827	90836	RAND
90828	90837	RAND
90829	90838	RAND
90835	90865	Lewin
90841	90832	Lewin*
90841	90834	Lewin*
90841	90837	Lewin*
90842	90837	Lewin*
90842	90838	Lewin*
90843	90832	Lewin*
90843	90833	Lewin*
90844	90834	Lewin*
90844	90836	Lewin*
90855	90832	Lewin*
90855	90833	Lewin*
90855	90834	Lewin*
90855	90836	Lewin*

OMFS Code	2013 CPT	Crosswalk
90855	90837	Lewin*
90855	90838	Lewin*
90857	90853	RAND
90862	90863	RAND
90871	90870	Lewin
90918	90951	RAND
90918	90952	RAND
90918	90953	RAND
90918	90963	RAND
90918	90967	RAND
90919	90954	RAND
90919	90955	RAND
90919	90956	RAND
90919	90964	RAND
90919	90968	RAND
90920	90957	RAND
90920	90958	RAND
90920	90959	RAND
90920	90965	RAND
90920	90969	RAND
90921	90960	RAND
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90921	90962	RAND
90921	90966	RAND
90921	90970	RAND
90922	90951	RAND
90922	90952	RAND
90922	90953	RAND
90922	90963	RAND
90922	90967	RAND
90923	90954	RAND
90923	90955	RAND
90923	90956	RAND
90923	90964	RAND
90923	90968	RAND
90924	90957	RAND
90924	90958	RAND
90924	90959	RAND
90924	90965	RAND
90924	90969	RAND

OMFS Code	2013 CPT	Crosswalk
90925	90960	RAND
90925	90961	RAND
90925	90962	RAND
90925	90966	RAND
90925	90970	RAND
91000	43200	RAND
91011	91013	RAND
91012	91013	RAND
91032	91034	Lewin
91032	91035	Lewin
91033	91034	Lewin
91033	91035	Lewin
91052	43754	RAND
91052	43755	RAND
91055	43754	RAND
91055	43755	RAND
91060	NONE	Lewin
91100	NONE	RAND
91105	43753	RAND
91123	NONE	RAND
92070	92071	RAND
92070	92072	RAND
92120	NONE	RAND
92130	NONE	RAND
92135	92133	RAND
92135	92134	RAND
92330	NONE	Lewin
92335	NONE	Lewin
92390	NONE	Lewin
92391	NONE	Lewin
92392	NONE	Lewin
92393	NONE	Lewin
92395	NONE	Lewin
92396	NONE	Lewin
92510	NONE	Lewin
92525	92610	Lewin
92525	92611	Lewin
92569	92570	RAND
92573	92700	Lewin
92589	NONE	Lewin

OMFS Code	2013 CPT	Crosswalk
92598	NONE	Lewin
92599	92700	Lewin
92980	92928	RAND
92980	92933	RAND
92980	92937	RAND
92980	92941	RAND
92980	92943	RAND
92981	92929	RAND
92981	92934	RAND
92981	92938	RAND
92981	92944	RAND
92982	92920	RAND
92982	92937	RAND
92982	92941	RAND
92982	92943	RAND
92984	92921	RAND
92984	92938	RAND
92984	92944	RAND
92995	92924	RAND
92995	92933	RAND
92995	92937	RAND
92995	92941	RAND
92995	92943	RAND
92996	92925	RAND
92996	92934	RAND
92996	92938	RAND
92996	92944	RAND
93012	93268	RAND
93012	93270	RAND
93012	93271	RAND
93014	93272	RAND
93230	93224	RAND
93231	93225	RAND
93232	93226	RAND
93233	93227	RAND
93235	93224	RAND
93236	93225	RAND
93236	93226	RAND
93237	93227	RAND
93501	93451	RAND

OMFS Code	2013 CPT	Crosswalk
93508	93454	RAND
93508	93455	RAND
93508	93456	RAND
93508	93457	RAND
93508	93458	RAND
93508	93459	RAND
93508	93460	RAND
93508	93461	RAND
93510	93452	RAND
93511	93452	RAND
93514	93452	RAND
93524	93453	RAND
93526	93453	RAND
93527	93453	RAND
93528	93453	RAND
93529	93453	RAND
93536	33967	Lewin
93539	93563	RAND
93540	93564	RAND
93541	93568	RAND
93542	93566	RAND
93543	93565	RAND
93544	93567	RAND
93545	NONE	RAND
93555	NONE	RAND
93556	NONE	RAND
93607	93622	Lewin
93651	93653	RAND
93651	93654	RAND
93651	93655	RAND
93651	93656	RAND
93651	93657	RAND
93652	93653	RAND
93652	93654	RAND
93652	93655	RAND
93652	93656	RAND
93652	93657	RAND
93720	94726	RAND
93721	94726	RAND
93722	94726	RAND

OMFS Code	2013 CPT	Crosswalk
93727	93285	RAND
93727	93291	RAND
93727	93298	RAND
93731	93280	RAND
93731	93288	RAND
93731	93294	RAND
93732	93280	RAND
93732	93288	RAND
93732	93294	RAND
93733	93293	RAND
93734	93279	RAND
93734	93288	RAND
93734	93294	RAND
93735	93279	RAND
93735	93288	RAND
93735	93294	RAND
93736	93293	RAND
93737	93282	Lewin*
93737	93283	Lewin*
93737	93289	Lewin*
93737	93292	Lewin*
93737	93295	Lewin*
93738	93282	Lewin*
93738	93283	Lewin*
93738	93289	Lewin*
93738	93292	Lewin*
93738	93295	Lewin*
93741	93282	RAND
93741	93289	RAND
93741	93292	RAND
93741	93295	RAND
93742	93282	RAND
93742	93289	RAND
93742	93292	RAND
93742	93295	RAND
93743	93283	RAND
93743	93289	RAND
93743	93295	RAND
93744	93283	RAND
93744	93289	RAND

OMFS Code	2013 CPT	Crosswalk
93744	93295	RAND
93760	NONE	RAND
93762	NONE	RAND
93875	93880	RAND
94240	94726	RAND
94240	94727	RAND
94260	94726	RAND
94260	94727	RAND
94350	94726	RAND
94350	94727	RAND
94360	94726	RAND
94360	94728	RAND
94370	94726	RAND
94370	94727	RAND
94620	94620	Lewin
94620	94621	Lewin
94650	NONE	Lewin
94651	NONE	Lewin
94652	NONE	Lewin
94656	94002	Lewin
94656	94004	Lewin
94657	94003	Lewin
94657	94004	Lewin
94665	NONE	Lewin
94720	94729	RAND
94725	94729	RAND
95010	95017	RAND
95010	95018	RAND
95015	95017	RAND
95015	95018	RAND
95075	95076	RAND
95075	95079	RAND
95078	NONE	Lewin
95858	NONE	Lewin
95900	95907	RAND
95900	95908	RAND
95900	95909	RAND
95900	95910	RAND
95900	95911	RAND
95900	95912	RAND

OMFS Code	2013 CPT	Crosswalk
95900	95913	RAND
95903	95907	RAND
95903	95908	RAND
95903	95909	RAND
95903	95910	RAND
95903	95911	RAND
95903	95912	RAND
95903	95913	RAND
95904	95907	RAND
95904	95908	RAND
95904	95909	RAND
95904	95910	RAND
95904	95911	RAND
95904	95912	RAND
95904	95913	RAND
95920	95940	RAND
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95934	95907	RAND
95934	95908	RAND
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95934	95910	RAND
95934	95911	RAND
95934	95912	RAND
95934	95913	RAND
95936	95907	RAND
95936	95908	RAND
95936	95909	RAND
95936	95910	RAND
95936	95911	RAND
95936	95912	RAND
95936	95913	RAND
96100	96101	Lewin
96100	96102	Lewin
96100	96103	Lewin
96115	96116	Lewin
96117	96118	Lewin
96117	96119	Lewin
96117	96120	Lewin
96400	96401	Lewin
96400	96402	Lewin

OMFS Code	2013 CPT	Crosswalk
96408	96409	Lewin
96410	96413	Lewin
96412	96415	Lewin
96414	96416	Lewin
96445	96446	RAND
96520	96521	Lewin
96530	96522	Lewin
96545	NONE	Lewin
97020	97024	Lewin
97110	97110	Lewin
97110	97112	Lewin
97110	97113	Lewin
97110	97124	Lewin
97110	97139	Lewin
97112	97110	Lewin
97112	97112	Lewin
97112	97113	Lewin
97112	97124	Lewin
97112	97139	Lewin
97114	97530	Lewin
97118	97032	Lewin
97120	97033	Lewin
97122	97140	Lewin
97124	97110	Lewin
97124	97112	Lewin
97124	97113	Lewin
97124	97124	Lewin
97124	97139	Lewin
97126	97034	Lewin
97128	97035	Lewin
97139	97110	Lewin
97139	97112	Lewin
97139	97113	Lewin
97139	97124	Lewin
97139	97139	Lewin
97145	97110	Lewin
97145	97112	Lewin
97145	97113	Lewin
97145	97116	Lewin
97145	97124	Lewin

OMFS Code	2013 CPT	Crosswalk
97145	97139	Lewin
97145	97140	Lewin
97220	97036	Lewin
97221	97036	Lewin
97240	97036	Lewin
97240	97113	Lewin
97241	97036	Lewin
97241	97113	Lewin
97250	97140	Lewin
97260	97140	Lewin
97261	97140	Lewin
97500	97760	Lewin
97501	97760	Lewin
97520	97761	Lewin
97521	97761	Lewin
97531	97530	Lewin
97540	97535	Lewin
97540	97537	Lewin
97541	97535	Lewin
97541	97537	Lewin
97610	97140	Lewin
97616	97140	Lewin
97630	97150	Lewin
97631	97150	Lewin
97660	97750	Lewin
97670	97750	Lewin
97690	97750	Lewin
97691	97750	Lewin
97700	97762	Lewin
97701	97762	Lewin
97720	97750	Lewin
97721	97750	Lewin
97752	97750	Lewin
98770	97001	Lewin
98771	97001	Lewin
98772	97001	Lewin
98773	97001	Lewin
98774	97001	Lewin
98775	97002	Lewin
98776	97002	Lewin

OMFS Code	2013 CPT	Crosswalk
98777	97002	Lewin
98778	97002	Lewin
99025	99201	Lewin*
99025	99202	Lewin*
99025	99203	Lewin*
99025	99204	Lewin*
99025	99205	Lewin*
99050	99050	Lewin
99050	99051	Lewin
99050	99053	Lewin
99052	99050	Lewin*
99052	99051	Lewin*
99052	99053	Lewin*
99054	99050	Lewin*
99054	99051	Lewin*
99058	99058	Lewin*
99058	99060	Lewin*
99071	99071	Lewin
99075	99075	Lewin
99078	99078	Lewin
99080	99080	Lewin
99185	99116	RAND
99186	99116	RAND
99190	99190	Lewin
99195	99195	Lewin
99261	99231	Lewin
99261	99232	Lewin
99261	99233	Lewin
99261	99307	Lewin
99261	99308	Lewin
99261	99309	Lewin
99261	99310	Lewin
99262	99231	Lewin
99262	99232	Lewin
99262	99233	Lewin
99262	99307	Lewin
99262	99308	Lewin
99262	99309	Lewin
99262	99310	Lewin
99263	99231	Lewin

OMFS Code	2013 CPT	Crosswalk
99263	99232	Lewin
99263	99233	Lewin
99263	99307	Lewin
99263	99308	Lewin
99263	99309	Lewin
99263	99310	Lewin
99271	99241	Lewin
99271	99242	Lewin
99271	99243	Lewin
99271	99244	Lewin
99271	99245	Lewin
99271	99251	Lewin
99271	99252	Lewin
99271	99253	Lewin
99271	99254	Lewin
99271	99255	Lewin
99272	99241	Lewin
99272	99242	Lewin
99272	99243	Lewin
99272	99244	Lewin
99272	99245	Lewin
99272	99251	Lewin
99272	99252	Lewin
99272	99253	Lewin
99272	99254	Lewin
99272	99255	Lewin
99273	99241	Lewin
99273	99242	Lewin
99273	99243	Lewin
99273	99244	Lewin
99273	99245	Lewin
99273	99251	Lewin
99273	99252	Lewin
99273	99253	Lewin
99273	99254	Lewin
99273	99255	Lewin
99274	99241	Lewin
99274	99242	Lewin
99274	99243	Lewin
99274	99244	Lewin

OMFS Code	2013 CPT	Crosswalk
99274	99245	Lewin
99274	99251	Lewin
99274	99252	Lewin
99274	99253	Lewin
99274	99254	Lewin
99274	99255	Lewin
99275	99241	Lewin
99275	99242	Lewin
99275	99243	Lewin
99275	99244	Lewin
99275	99245	Lewin
99275	99251	Lewin
99275	99252	Lewin
99275	99253	Lewin
99275	99254	Lewin
99275	99255	Lewin
99289	99466	RAND
99290	99467	RAND
99293	99471	RAND
99294	99472	RAND
99295	99468	RAND
99296	99469	RAND
99297	99469	Lewin*
99298	99478	RAND
99299	99479	RAND
99300	99480	RAND
99301	99304	Lewin
99301	99305	Lewin
99301	99306	Lewin
99301	99307	Lewin
99301	99308	Lewin
99301	99309	Lewin
99301	99310	Lewin
99301	99318	Lewin
99302	99304	Lewin
99302	99305	Lewin
99302	99306	Lewin
99302	99307	Lewin
99302	99308	Lewin
99302	99309	Lewin

OMFS Code	2013 CPT	Crosswalk
99302	99310	Lewin
99302	99318	Lewin
99303	99304	Lewin
99303	99305	Lewin
99303	99306	Lewin
99303	99307	Lewin
99303	99308	Lewin
99303	99309	Lewin
99303	99310	Lewin
99303	99318	Lewin
99311	99304	Lewin
99311	99305	Lewin
99311	99306	Lewin
99311	99307	Lewin
99311	99308	Lewin
99311	99309	Lewin
99311	99310	Lewin
99311	99318	Lewin
99312	99304	Lewin
99312	99305	Lewin
99312	99306	Lewin
99312	99307	Lewin
99312	99308	Lewin
99312	99309	Lewin
99312	99310	Lewin
99312	99318	Lewin
99313	99304	Lewin
99313	99305	Lewin
99313	99306	Lewin
99313	99307	Lewin
99313	99308	Lewin
99313	99309	Lewin
99313	99310	Lewin
99313	99318	Lewin
99321	99324	Lewin
99321	99325	Lewin
99321	99326	Lewin
99321	99327	Lewin
99321	99328	Lewin
99321	99334	Lewin

OMFS Code	2013 CPT	Crosswalk
99321	99335	Lewin
99321	99336	Lewin
99322	99324	Lewin
99322	99325	Lewin
99322	99326	Lewin
99322	99327	Lewin
99322	99328	Lewin
99322	99334	Lewin
99322	99335	Lewin
99322	99336	Lewin
99323	99324	Lewin
99323	99325	Lewin
99323	99326	Lewin
99323	99327	Lewin
99323	99328	Lewin
99323	99334	Lewin
99323	99335	Lewin
99323	99336	Lewin
99331	99324	Lewin
99331	99325	Lewin
99331	99326	Lewin
99331	99327	Lewin
99331	99328	Lewin
99331	99334	Lewin
99331	99335	Lewin
99331	99336	Lewin
99332	99324	Lewin
99332	99325	Lewin
99332	99326	Lewin
99332	99327	Lewin
99332	99328	Lewin
99332	99334	Lewin
99332	99335	Lewin
99332	99336	Lewin
99333	99324	Lewin
99333	99325	Lewin
99333	99326	Lewin
99333	99327	Lewin
99333	99328	Lewin
99333	99334	Lewin

OMFS Code	2013 CPT	Crosswalk
99333	99335	Lewin
99333	99336	Lewin
99341	99341	Lewin
99341	99342	Lewin
99341	99343	Lewin
99341	99344	Lewin
99341	99345	Lewin
99342	99341	Lewin
99342	99342	Lewin
99342	99343	Lewin
99342	99344	Lewin
99342	99345	Lewin
99343	99341	Lewin
99343	99342	Lewin
99343	99343	Lewin
99343	99344	Lewin
99343	99345	Lewin
99351	99347	Lewin
99352	99348	Lewin
99353	99349	Lewin
99358	99358	Lewin
99358	99359	Lewin
99361	99367	Lewin

OMFS Code	2013 CPT	Crosswalk
99362	99366	Lewin
99362	99367	Lewin
99362	99368	Lewin
99371	99441	Lewin
99371	99442	Lewin
99371	99443	Lewin
99372	99441	Lewin
99372	99442	Lewin
99372	99443	Lewin
99373	99441	Lewin
99373	99442	Lewin
99373	99443	Lewin
99375	99374	Lewin
99375	99375	Lewin
99376	99375	Lewin
99376	99378	Lewin
99376	99380	Lewin
99431	99460	RAND
99432	99461	RAND
99433	99462	RAND
99435	99463	RAND
99436	99464	RAND
99440	99465	RAND

Appendix C OMFS Codes with No 2013 CPT Equivalent Codes

This appendix contains two categories of OMFS codes that we did not crosswalk into 2013 CPT codes. Table C.1 shows codes that DWC proposes to continue to recognize using either a WC-specific code or an unlisted code. The paid amounts for these codes were carried over as paid amounts under the RB-RVS in the impact analyses. Table C.2 shows codes that DWC proposes to delete. The paid amounts for these codes were are in the OMFS allowances but are not included in the RB-RVS allowances. The services described by several of these codes would typically be bundled under Medicare ground rules or have been replaced by other codes that are likely to be used to describe the services in the future.

Table C.1 OMFS Codes with No 2013 CPT Counterpart That Were Priced under the RB-RVS at OMFS Allowances

OMFS code	OMFS Description	Total Payments	OMFS Allowance	Treatment under RB-RVS
76175	Duplication of x-ray	1,858	$4.75 each	Continue at OMFS allowance
76176	Duplication of scan	775	$9.50 per scan	Continue at OMFS allowance
97680	Job site visit/assessment	28,662	BR	Pay BR under 97999
99048	Telephone calls by provider	25,741	BR	Pay using CPT 99442 and 99443 values
99049	Missed appointment	230,884	BR with optional payment	Continue BR with optional payment
99060	Environmental intervention	18,156	BR	Pay BR under 99199
99086	Reproduction of chart notes	272,092	0.95 x ($10 first 15 pages + 0.25 each additional page)	Continue at OMFS prices
99087	Reproduction of duplicate reports	38,165	$10 first 15 pages; 0.25 each additional	Continue at OMFS prices

Table C.2 OMFS Special Services with No 2013 CPT Counterpart That Were Priced with No Payment under the RB-RVS

OMFS code	OMFS Description	Units billed	Total Payments ($)	Disposition
99017	Preparation Of Specimen For Transfer	---	----	Delete
99019	Single Venous/Cap Punct-Ref To Other Lab	8	80	Delete
99020	Mult. Venous Or Capillary Puncture	---	---	Delete
99025	Init Visit When (*) Surg Proc = Maj Serv @ Visit	3,600	82,967	Delete.
99026	Mileage Within 7 Miles	83	376	Delete- code has been recycled
99027	Mileage Charge, Over 7 Miles	9	377	Delete-code has been recycled
99028	Apportioned Mileage	--	--	Delete
99030	Mileage > 7 Miles	219	740	Delete
99031	Travel Add-On For Large Urban Area	65	4,690	Delete
99052	Svc Request 6Pm To7Am In Addition To Basic Svc'B	2,355	53,932	Delete. Replaced by 99050 and 99053.
99054	Serv Requested Sun & Holidays	2,490	48,207	Delete. Replaced by 99050.
99065	Outside Office Hrs payment for Technologist	363	2,518	Delete. Replaced by 99050.
99085	External Medical Photography	747	4,198	Delete

Appendix D Analysis of Alternative PAD Pricing Policies

We identified several data constancy issues when analyzing 2011 WC drug data. First, despite OMFS instructions to report NDC when billing for any drug, providers use both NDC codes and HCPCS "J" codes to bill for PAD ingredients. Providers are currently paid for PAD regardless of whether they are billed as an NDC or as a HCPCS J-code. Second, quantities were inconsistently reported across three separate variables, including units, days of drug dispensed, and quantity of drug dispensed. For PAD billed by NDC, the days of drug dispensed and quantity of drug dispensed variables often did not correspond to one another. For PAD billed by HCPCS code, providers often billed in number of drug units, e.g., milliliters, when the HCPCS code indicates the PAD should be billed per each injection (or vice versa). Finally, service dates were missing for many drug claims in the WC data.

We identified physician-administered drugs (PAD) in 2011 WC data to the extent possible given these limitations. First, we isolated all bill lines with either a HCPCS J-code (210,000 lines) or an NDC (3.6 million lines). Many lines billed by NDC are for outpatient drugs rather than PAD. We used the CMS NDC to HCPCS crosswalk (maintained by Noridian) to identify drugs billed by NDC that were likely to be PAD. Of the 3.6 million lines, only 150,000 lines matched to the CMS crosswalk. We eliminated 24,000 records with a procedure code other than a J-code. The final drug analysis file included roughly 340,000 lines.

We aggregated WC 2011 paid amounts, volume, the product of volume and CMS price, and the product of volume and Medi-Cal price by HCPCS code. We imputed volume using the number of units variable first and filling is as feasible with the other two drug volume variables. All lines paid zero were excluded from the analysis.

Table 6.17 in the report compares maximum allowed fees from the CMS PAD fee schedule and from the Medi-Cal fee schedule. Allowed fees are for the most part similar across the two fee schedules which reflects Medi-Cal's recent transition to ASP+6% pricing.

We also estimated ingredient plus administration maximum allowed fees under the current OMFS approach (pay administration codes separately), the CMS approach (pay administration codes only when they occur outside the context of an E&M visit), and the Medi-Cal approach (pay a flat administration fee for most drugs). We simulated the payment of an administration code 90780 for all lines to approximate the current OMFS approach. For the CMS approach, we assumed that injection fees would be bundled in payment for E&M visit when the injection is included on the same bill as an E&M visit. In a separate analysis we found that more than 90 percent of PAD were billed with an E&M code. We therefore simulated the payment of 90780 for 10% of lines to approximate the CMS approach. Finally, we added a $4.46 administration fee to all lines with a Medi-Cal "030" modifier to simulate the Medi-Cal approach. Table 6.18 compares the total ingredient plus administration maximum allowed fees using these three

approaches. Either the CMS or Medi-Cal approaches result in significantly lower maximum allowed fees compared to the current OMFS approach because administration is bundled in E&M services.

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