

Title 8, California Code of Regulations
Chapter 4.5, Division of Workers' Compensation
Subchapter 1
Administrative Director – Administrative Rules

(Plain Text is Emergency Regulation Proposed for Permanent Adoption,
Deletions from the codified emergency regulatory text are indicated by strike-through,
thus: ~~deleted language~~.

Additions to the codified emergency regulatory text are indicated by underlining, thus:
underlined language.

Deletions from the amended regulatory text, as proposed on January 12, 2004, are
indicated by double strike-through underline, thus: ~~deleted language~~.

Additions to the amended regulatory text, as proposed on January 12, 2004, are indicated
by a double underline, thus: added language.)

Article 5.3

Official Medical Fee Schedule – Services Rendered after January 1, 2004

Section 9789.10. Physician Services - Definitions.

- (a) “Basic value” means the unit value for an anesthesia procedure that is set forth in the Official Medical Fee Schedule 2003.
- (b) “CMS” means the Centers for Medicare & Medicaid Services of the United States Department of Health and Human Services.
- (c) “Conversion factor” or “CF” means the factor set forth below for the applicable OMFS section:

Evaluation and Management	\$8.50
Medicine	\$6.15
Surgery	\$153.00
Radiology	\$12.50
Pathology	\$1.50
Anesthesia	\$34.50

- (d) “CPT[®]” means the procedure codes set forth in the American Medical Association’s Physicians’ Current Procedural Terminology (CPT) 1997, copyright 1996, American Medical Association, or the Physicians’ Current Procedural Terminology (CPT) 1994, copyright 1993, American Medical Association.
- (e) “Medicare rate” means the physician fee schedule rate derived from the Resource Based Relative Value Scale and related data, adopted for the Calendar Year 2004, published in the Federal Register on January 7, 2004, Volume 69, No. 4, pages 1117 through 1242 (CMS-1372-IFC), as amended by CMS Manual System, Pub. 100-04 Medicare Claims

~~Processing, Transmittal 105 (February 20, 2004), November 7, 2003, Volume 68, No. 216, pages 63262 through 63386 as "Addendum B," which is incorporated by reference.~~ The Medicare rate for each procedure is derived by the Administrative Director utilizing the non-facility rate (or facility rate if no non-facility rate exists), and a weighted average geographic adjustment factor of 1.063.

- (f) "Modifying units" means the anesthesia modifiers and qualifying circumstances as set forth in the Official Medical Fee Schedule 2003.
- (g) "Official Medical Fee Schedule" or "OMFS" means Article 5.3 of Subchapter 1 of Chapter 4.5 of Title 8, California Code of Regulations (Sections 9789.10 – 9789.110), adopted pursuant to Section 5307.1 of the Labor Code for all medical services, goods, and treatment provided pursuant to Labor Code Section 4600.
- (h) "Official Medical Fee Schedule 2003" or "OMFS 2003" means the Official Medical Fee Schedule incorporated into Section 9791.1 in effect on December 31, 2003, which consists of the OMFS book revised April 1, 1999 and as amended for dates of service on or after July 12, 2002.
- (i) "Percentage reduction calculation" means the factor set forth in Table A for each procedure code which will result in a reduction of the OMFS 2003 rate by 5%, or a lesser percent so that the reduction results in a rate that is no lower than the Medicare rate.
- (j) "Physician service" means professional medical service that can be provided by a physician, as defined in Section 3209.3 of the Labor Code, and is subject to reimbursement under the Official Medical Fee Schedule. For purposes of the OMFS, "physician service" includes service rendered by a physician or by a non-physician who is acting under the supervision, instruction, referral or prescription of a physician, including but not limited to a physician assistant, nurse practitioner, clinical nurse specialist, and physical therapist.
- (k) "RVU" means the relative value unit for a particular procedure that is set forth in the Official Medical Fee Schedule 2003.
- (l) "Time value" means the unit of time indicating the duration of an anesthesia procedure that is set forth in the Official Medical Fee Schedule 2003.

Authority: Sections 133, 4603.5, 5307.1, and 5307.3, Labor Code.

Reference: Sections 4600, 4603.2, and 5307.1, Labor Code.

Section 9789.11. Physician Services Rendered After January 1, 2004.

- (a) Except as specified below, or otherwise provided in this Article, the ground rule materials set forth in each individual section of the OMFS 2003 are applicable to physician services rendered after January 1, 2004.

- (1) The OMFS 2003's "General Information and Instructions" section is not applicable. The "General Information and Instructions, Effective for Dates of Service after January 1, 2004," are incorporated by reference and will be made available on the Division of Workers' Compensation Internet site (http://www.dir.ca.gov/DWC/dwc_home_page.htm) or upon request to the Administrative Director at:
Division of Workers' Compensation (Attention: OMFS – Physician Services)
P.O. Box 420603
San Francisco, CA 94142
- (b) For physician services rendered after January 1, 2004 the maximum allowable reimbursement amount set forth in the OMFS 2003 for each procedure code is reduced by five (5) percent, except that those procedures that are reimbursed under OMFS 2003 at a rate between 100% and 105% of the Medicare rate will be reduced between zero and 5% so that the OMFS reimbursement will not fall below the Medicare rate. The reduction rate for each procedure is set forth as the adjustment factor in Table A. Reimbursement for procedures that are reimbursed under OMFS 2003 at a rate below the Medicare rate will not be reduced.
- (c) Table A, "OMFS Physician Services Fees for Services Rendered after January 1, 2004," which sets forth each individual procedure code with its corresponding relative value, conversion factor, percentage reduction calculation (between 0 and 5.0%), and maximum reimbursable fee, is incorporated by reference. Table A may be obtained from the Division of Workers' Compensation Internet site (http://www.dir.ca.gov/DWC/dwc_home_page.htm) or upon request to the Administrative Director at:
Division of Workers' Compensation (Attention: OMFS – Physician Services)
P.O. Box 420603
San Francisco, CA 94142
- (d) (1) Except for anesthesia services, to determine the maximum allowable reimbursement for a physician service rendered after January 1, 2004 the following formula is utilized: $R\text{VU} \times \text{conversion factor} \times \text{percentage reduction calculation} = \text{maximum reasonable fee before application of ground rules}$. Applicable ground rules set forth in the OMFS 2003 and the "General Information and Instructions, Effective for Dates of Service after January 1, 2004," are then applied to calculate the maximum reasonable fee.
- (2) To determine the maximum allowable reimbursement for anesthesia services (CPT Codes 00100 through 01999) rendered after January 1, 2004, the following formula is utilized: $(\text{basic value} + \text{modifying units (if any)} + \text{time value}) \times (\text{conversion factor} \times .95) = \text{maximum reasonable fee}$.
- (e) The following procedures in the Pathology and Laboratory section (both professional and technical component) will be reimbursed under this section: CPT Codes 80500, 80502; 85060 through 85102; 86077 through 86079; 87164; and 88000 through 88399. All other pathology and laboratory services will be reimbursed pursuant to Section 9789.50.

including but not limited to ~~The following procedure codes in the Pathology and Laboratory section are reimbursed in accordance with subdivision Section 9789.50: CPT Codes 80002 through 80440; 81000 through 85048; 85130 through 86063; 86140 through 87163; 87166 through 87999; and 89050 through 89399. All other pathology and laboratory services will be reimbursed pursuant to Section 9789.50.~~

Authority: Sections 133, 4603.5, 5307.1, and 5307.3, Labor Code.

Reference: Sections 4600, 4603.2, and 5307.1, Labor Code.