SB 863 Fee Schedules

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Division of Workers’ Compensation
California Department of Industrial Relations

The most complete and up-to-date medical fee schedule regulations and tables are on the DWC OMFS webpage: http://www.dir.ca.gov/dwc/OMFS9904.htm (Labor Code 5307.1(g)(2))
# SB 863 Fee Schedules

<table>
<thead>
<tr>
<th>SB 863 Implementation</th>
<th>Status</th>
<th>Next Steps</th>
<th>Effective Date Per Labor Code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ambulatory Surgery Center (ASC)</strong> LC § 5307.1</td>
<td>Completed</td>
<td>Regulations effective: Jan. 1, 2013</td>
<td>Jan. 1, 2013</td>
</tr>
<tr>
<td><strong>Spinal Implant (Inpatient Fee Schedule)</strong> LC § 5307.1</td>
<td>Completed</td>
<td>Regulations effective: Jan. 1, 2013</td>
<td>Jan. 1, 2013</td>
</tr>
</tbody>
</table>

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<tbody>
<tr>
<td><strong>Copy Services Fee Schedule</strong> LC § 5307.9</td>
<td>Study presented: 10/17/13</td>
<td>Post draft regulations on forum</td>
<td>Dec. 31, 2013</td>
</tr>
<tr>
<td><strong>Interpreter Fee Schedule</strong> LC § 5811</td>
<td>Conducting study</td>
<td>Post study</td>
<td>Jan. 1, 2013</td>
</tr>
</tbody>
</table>
### SB 863 Fee Schedules

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<th>Status</th>
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<tbody>
<tr>
<td><strong>Home Health Care Fee Schedule</strong>&lt;br&gt;LC §§ 4600, 5307.8</td>
<td>Working group meeting: 10/2/12 Conducting study</td>
<td>Post study</td>
<td>July 1, 2013</td>
</tr>
<tr>
<td><strong>Vocational Expert Fee Schedule</strong>&lt;br&gt;LC § 5307.7</td>
<td>Working group meeting: 6/28/12</td>
<td>Post draft regulations on DWC forum</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Fee Schedule</strong>&lt;br&gt;LC § 5307.1</td>
<td>Drafting revisions</td>
<td>Begin formal rulemaking</td>
<td></td>
</tr>
</tbody>
</table>

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<tr>
<th>SB 863 Implementation</th>
<th>Status</th>
<th>Next Steps</th>
<th>Effective Date Per Labor Code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician Fee Schedule (RBRVS)</strong>&lt;br&gt;LC § 5307.1</td>
<td>Completed</td>
<td>Regulations effective: 1/1/14</td>
<td>Jan. 1, 2014</td>
</tr>
</tbody>
</table>
California Workers’ Compensation
Physician and Non-Physician
Practitioner Fee Schedule – 2014
8 CCR §§9789.12 – 9789.19

Background to the new fee schedule
• RBRVS transition has been under consideration since 1999
• SB 863 required the DWC to adopt an RBRVS-based physician fee schedule
  ▪ Annual update of procedure codes, relative weights, inflation factor and Medicare relative value scale adjustment factor
  ▪ Four-year transition between pre-2014 OMFS maximum and 120% of July 1, 2012 Medicare physician fees (before inflation and RVS adjustment)
  ▪ Required inclusion of payment ground rules that differ from Medicare as appropriate for WC
Out with the Old.....

1999 Book
Table A May 2005
Table A Addendum Feb. 2007

Major Differences Pre-2014 OMFS vs. New RBRVS-Based Fee Schedule

<table>
<thead>
<tr>
<th>Pre-2014 Fee Schedule</th>
<th>RBRVS Fee Schedule - 1/1/2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charge-based relative values</td>
<td>Resource-based relative values</td>
</tr>
<tr>
<td>Single relative value for each procedure</td>
<td>Work, Practice Expense, Malpractice relative values for each procedure</td>
</tr>
<tr>
<td>Same relative value/fee regardless of site of service</td>
<td>Practice Expense relative value usually different in “facility” vs. “non-facility”</td>
</tr>
<tr>
<td>Multiple Conversion Factors</td>
<td>Multiple Conversion Factors, transitioning to single CF in 2017</td>
</tr>
<tr>
<td>No geographic adjustments</td>
<td>Apply average statewide geographic adjustments to Work, PE, MP</td>
</tr>
<tr>
<td>Non-physician practitioners and physicians paid same rate</td>
<td>Nurse Practitioners and Physician Assistants paid at 85% unless “incident to” physician service (then paid at 100%)</td>
</tr>
<tr>
<td>CPT Consultation Codes for consultations</td>
<td>Use CPT visit codes for consultations</td>
</tr>
</tbody>
</table>
### Major Differences contd.

<table>
<thead>
<tr>
<th>Pre-2014 Fee Schedule</th>
<th>RBRVS Fee Schedule - 1/1/2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Separate payment for consultation service and consultation report</td>
<td>Consultation report bundled, not separately payable unless requested by an AME/QME or by the WCAB or Administrative Director</td>
</tr>
<tr>
<td>Prolonged E&amp;M Service without direct patient contact CPT 99358/99359 payable</td>
<td>Prolonged E&amp;M Service without direct patient contact CPT 99358/99359 NOT payable; Status Code B (bundled)</td>
</tr>
<tr>
<td>Interpreter used by patient – 110% of usual value of service</td>
<td>No extra payment for use of interpreter by patient</td>
</tr>
<tr>
<td>Anesthesia time units – 1 unit per 15 minutes for first 4 hours and 1 unit for each 10 minutes thereafter; 5 minutes or more is a unit</td>
<td>Actual anesthesia minutes reported divided by 15, then round the time unit to one decimal place</td>
</tr>
<tr>
<td>Anesthesia units increased for qualifying circumstances and specified patient status codes</td>
<td>No additional units</td>
</tr>
</tbody>
</table>

### Major Differences contd.

<table>
<thead>
<tr>
<th>Pre-2014 Fee Schedule</th>
<th>RBRVS Fee Schedule - 1/1/2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Therapy Cascade Formula reduces 2nd – 4th procedures</td>
<td>Multiple Procedure Payment Reduction Formula is different and applies only to Practice Expense RVUs (not to Work RVUs, MP RVUs)</td>
</tr>
<tr>
<td>Radiology multiple procedures paid at full value</td>
<td>Radiology MPPR applies to specified major radiology codes (CT, MRI, Ultrasound)</td>
</tr>
<tr>
<td>Supplies and materials “beyond those usually included with the service” may be separately billed</td>
<td>Supplies and materials generally bundled into the payment for the procedure; not separately payable</td>
</tr>
<tr>
<td>No coding edits specifically included</td>
<td>National Correct Coding Initiative Edits</td>
</tr>
<tr>
<td>No E&amp;M documentation guidelines specifically included</td>
<td>E&amp;M Documentation Guidelines – 1995 and 1997 adopted</td>
</tr>
</tbody>
</table>
Wide Variety of Providers Subject to Fee Schedule

- **Physicians** – Labor Code §3209.3
  - M.D.s, D.O.s
  - Psychologists
  - Chiropractors
  - Acupuncturists
  - Dentists
  - Optometrists
  - Podiatrists

- **Non-Physician Practitioners**
  - Nurse Practitioners
  - Physician Assistants
  - Physical Therapists, Speech Therapists, Occupational Therapists
  - Marriage and Family Therapists
  - Certified Registered Nurse Anesthetists

[http://www.dir.ca.gov/dwc/OMFS9904.htm](http://www.dir.ca.gov/dwc/OMFS9904.htm)
Free Access on DWC OMFS web page

Physician services

Labor Code section 5307.1 requires the DWC administrative director to adopt an official medical fee schedule for physician services. In California, for purposes of workers’ compensation “physician” is defined by Labor Code section 5309.3 subdivision (a) as follows:

“Physician” includes physicians and surgeons holding an M.D. or D.O. degree, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners licensed by California state law and within the scope of their practice as defined by California state law.

The physician fee schedule also covers services of non-physician practitioners, such as physical therapists, occupational therapists, nurse practitioners, physician assistants, clinical social workers, clinical nurse specialists, nurse anesthetists, and anesthesiologist assistants.

Rules related to paper medical treatment billing and electronic medical treatment billing are posted on the DWC website.

Effective date Fee schedule documents
January 1, 2014
- Order of the Acting Administrative Director - Effective Jan. 23, 2014 version 2 version 3
- Order of the Acting Administrative Director - Effective Jan. 1, 2014 version 2 version 3
- Explanation of changes version 2 version 3
- Regulation effective January 1, 2014 (sections 0788.12.1 through 0788.19)
- Version 2 version 3
- Clean copy of regulation effective January 1, 2014 (sections 9789.12.1 through 9789.15)
- Web site version 2 version 3
- National Correct Coding Initiative Policy Manual (2 zip archives of pdf files)

Procedure Coding – Mostly CPT

- AMA CPT® 2014
  https://commerce.ama-assn.org/store/
  It is incorporated by reference into fee schedule regulation. Purchase from AMA

- Other Codes Used
  - WC-specific codes (9789.12.14) WC001 – WC012
  - Physician-administered drugs use HCPCS J codes and NDC codes
  - Radiopharmaceuticals use HCPCS Q codes and A codes

- Specified Exceptions to CPT Code usage
  - Codes listed in §9789.19

- National Correct Coding Initiative (NCCI) applied
Medicare Physician Fee Schedule 2014 Relative Value ZIP File

- RVU File PPRRVU14_V1219
  - Relative Value Units
  - Status Codes – adapted for WC in §9789.12.8
  - Payment Policy Indicators
    - Professional Component/Technical Component Indicator
    - Surgery-related indicators (e.g. Global Days, Pre-Operative/Intra Op/Post Op percentages, Co-surgeon)
    - Multiple Procedure policy indicators
- PDF file labeled “RVUPUF14” in Zip has important information about the RVU file structure/usage

Fee Calculation Example

CPT® 99205 (new patient, comprehensive Hx & exam, high-complexity decision making)

Step 1: Determine if place of service is “facility” or “non-facility” (§9789.12.2(d)) - POS code 11 “Office” is “non-facility”

<table>
<thead>
<tr>
<th>POS Code and Name</th>
<th>Description</th>
<th>Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>01 Pharmacy</td>
<td>A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.</td>
<td>NF</td>
</tr>
<tr>
<td>03 School</td>
<td>A facility whose primary purpose is education.</td>
<td>NF</td>
</tr>
<tr>
<td>04 Homeless Shelter</td>
<td>A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).</td>
<td>NF</td>
</tr>
<tr>
<td>09 Prison/Correctional Facility</td>
<td>A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders.</td>
<td>NF</td>
</tr>
<tr>
<td>11 Office</td>
<td>Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.</td>
<td>NF</td>
</tr>
</tbody>
</table>
Fee Calculation Example contd.

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

(a) Non-facility site of service fee calculation

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

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

The base maximum fee for the procedure code is the maximum reasonable fee, except as otherwise provided by applicable provisions of this fee schedule, including but not limited to the application of ground rules and modifiers that affect reimbursement.

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Fee Calculation Example contd.

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

<table>
<thead>
<tr>
<th></th>
<th>Column</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work RVU</td>
<td>F</td>
<td>3.17</td>
</tr>
<tr>
<td>Non-facility PE</td>
<td>G</td>
<td>2.35</td>
</tr>
<tr>
<td>Malpractice</td>
<td>K</td>
<td>0.26</td>
</tr>
</tbody>
</table>
Fee Calculation Example contd.

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

<table>
<thead>
<tr>
<th>Statewide GAFs (Other than anesthesia)</th>
<th>Average Statewide Work GAF: 1.040</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Average Statewide Practice Expense GAF: 1.1606</td>
</tr>
<tr>
<td></td>
<td>Average Statewide Malpractice Expense GAF: 0.6636</td>
</tr>
</tbody>
</table>

Step 5: Identify the 2014 Conversion Factor to use (set forth in §9789.19). The “Evaluation and Management” code is not “anesthesia”, “surgery” or “radiology”; rather it falls within the “other services”

<table>
<thead>
<tr>
<th>CFs adjusted for MEI &amp; Relative Value Scale adjustment factor</th>
<th>Anesthesia Conversion Factor: $33.8190</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Surgery Conversion Factor: $55.2913</td>
</tr>
<tr>
<td></td>
<td>Radiology Conversion Factor: $53.1039</td>
</tr>
<tr>
<td></td>
<td><strong>Other Services Conversion Factor: $38.3542</strong></td>
</tr>
</tbody>
</table>

Fee Calculation Example contd.

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

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

\[
[(3.17 \times 1.040) + (2.35 \times 1.1606) + (0.26 \times 0.6636)] \times \$38.3542 = \$237.67
\]
Fee Calculation Example contd.

**Step 7:** Apply relevant ground rules, if any, to the Base Maximum Fee to determine the payable fee

Example:
The 99205 new patient visit was performed in the physician’s office which is located in a Health Professional Shortage Area
Apply ground rule in 8 CCR 9789.12.6 - HPSA 10% bonus to the Base Maximum Fee determined in Step 6

Base maximum fee = $237.67
Add HPSA 10% bonus $ 23.77
Total maximum fee $261.44

Consultations

- Pre-2014 OMFS used the CPT consultation codes; paid separately for a consultation report
- New RBRVS-based fee schedule follows the Medicare rules:
  - use CPT E&M visit codes instead of consultation codes
    - Office setting: use CPT visit codes for level of service
    - Inpatient setting: use CPT hospital care codes
  - Payment for consultant’s reporting of findings to referring physician is bundled into the visit code; no separate payment
  - Consultant’s report separately payable if consultation report requested by QME/AME or WCAB or AD
### Multiple Physical Therapy / Chiropractic / Acupuncture

**Pre-2014 OMFS Ground Rules**

- Physical Therapy “Cascade”
  - Highest value paid 100%
  - 2nd paid at 75%
  - 3rd paid at 50%
  - 4th paid at 25%

- Does not apply to additional time codes
- Limit on number of procedures /modalities on visit w/o preauthorization

**New Fee Schedule Ground Rules**

- Multiple Procedure Payment Reduction (MPPR)
  - Code with highest Practice Expense (PE) Relative Value paid at 100%
  - Subsequent codes paid at 50% of PE RVU, and 100% of Work RVU, and 100% of Malpractice RVU
  - Applies to “Always Therapy”, Chiro., Acupunc. codes billed on same day
  - Applies to more than 1 procedure & 1 unit
  - Limit on number of procedures /modalities on visit w/o preauthorization

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### Surgery Global Period

- RBRVS sets RVUs for “global surgical package”
  - Global Fee covers surgical procedure, immediate pre- and postsurgical services and follow-up E&M services
  - Zero, 10, 90 day global period specified in the Medicare National Physician Fee Schedule Relative Value File, Global Days column
- Global surgical package applied to procedures identified in the Global Days column regardless of setting
Surgery Global Period contd.

• Global Fee assumes one surgeon; if multiple physicians provide care during 10 or 90 day global period, fee is split
  ▪ Surgery billed with modifier 54 (surgical care only) or modifier 55 (postoperative management only)
  ▪ Columns of Relative Value File “Pre Op”, “Intra Op” and “Post Op” list percentages for pre-, intra-, and postoperative care of total RVUs

• Split global payment does not apply to procedures with 000 in “Glob Days” column

Services Paid in addition to global surgery fee

• Initial evaluation by the surgeon to determine need for major procedure
• Visits during the global period unrelated to the diagnosis for which the surgical procedure is performed
• Diagnostic tests and procedures
• Clearly distinct surgical procedures during the postoperative period
• Treatment for postoperative complications which require return trip to operating room
Schedule Differs from Medicare Rule: E&M Exception to Global Surgery

Labor Code §5307.1(a)(2)(B): fee schedule shall include ground rules that differ from Medicare as appropriate including payment of E&M services during a global period of surgery

- Primary Treating Physician’s Progress Reports (PR-2) are separately reimbursable during the global period (8 CCR §9789.16.4(b))
- Physician may separately bill one or more E&M codes for medically necessary services that exceed the number of visits that are listed for the global surgery code in the Medicare Physician Fee Schedule “Physician Time File” (8 CCR §9789.16.4(a))

How to use the Physician Time File

- Access the Medicare Physician Time File “CY 2014 PFS Physician Time.xls” (Link is in 8 CCR 9789.19)
- Example CPT® 25515 Open treatment of radial shaft fracture, includes internal fixation, when performed
  - Find 25515 in column A “Cpt_code”
  - Add number of visits for all E&M services shown on 25515 row in the Physician Time File
  - Add [column I 99212] 2.00 + [column J 99213] 2.00 + [column P 99238] 0.50 = 4.50. Round up to 5.0 Physician can bill for medically necessary E&M visits in excess of 5 that occur in global period
### Surgery Multiple Procedure Payment Reduction

<table>
<thead>
<tr>
<th>Pre-2014 OMFS</th>
<th>New RBRVS-based Fee Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Multiple procedures at one surgical session</td>
<td>• Multiple procedures at one surgical session</td>
</tr>
<tr>
<td>▪ Major (highest value) - 100%</td>
<td>▪ Major (highest value) - 100%</td>
</tr>
<tr>
<td>▪ 2nd - 50%</td>
<td>▪ 2nd thru 5th - 50%</td>
</tr>
<tr>
<td>▪ 3rd – 25%</td>
<td>▪ Procedures beyond 5th billed By Report (paid no less than 50%)</td>
</tr>
<tr>
<td>▪ 4 or more procedures – Global Fee billed By Report</td>
<td></td>
</tr>
</tbody>
</table>

- Medicare National Physician Fee Schedule Relative Value File designates procedures subject to the reduction by entry of “2” in the “Mult Proc” column

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### Radiology

- **Radiology Diagnostic Imaging Multiple Procedure Payment Reduction**
  - Applies to Diagnostic Imaging Codes on Medicare Physician Fee Schedule Final Rule Addendum F (noted as “4” in the “Mult Proc” column of the Relative Value File)
  - MPPR applies to both Professional Component only, Technical Component only, and to PC and TC of global services (procedures in same session/same day/same patient by one or more physicians in same group practice)
    - 100% for each PC and TC with highest payment
    - 75% for subsequent PC services
    - 50% for subsequent TC services
- **Radiology Consultations**: only one interpretation of x-ray payable; physician must prepare signed written report
Anesthesia

- Methodology for anesthesia services is different than RBRVS
  - Uses base units and time units rather than Work, PE, MP RVUs
  - Base units - Medicare zip file “2014 Anesthesia Base Units by CPT Code” (link is in 8 CCR §9789.19)
- Maximum anesthesia fee formula (8 CCR §9789.18.1):
  \[
  \text{[Base Unit + Time Unit]} \times \text{CF} \times \text{Statewide Anesthesia GAF} = \text{Base Maximum Fee}
  \]
- Apply any applicable ground rules to the base maximum fee
  - Personally performed rate 100%
  - Medically directed rate 50%
  - Medically supervised rate 3 base units per procedure
  - HPSA 10% bonus payment if service in a HPSA

Physician-Administered Drugs

- Physician-administered drugs, biologicals, vaccines, or blood products are separately payable
- “Administer” means the direct application of a drug or device to the body of a patient by injection, inhalation, ingestion, or other means.
- Maximum fee: “Basic Rate” for the HCPCS code on the Medi-Cal Rates file for the date of service minus $4.46
  - Medi-Cal Rates file uses Medicare’s Average Sales Price plus 6%, or the Medi-Cal pharmacy rate when the ASP +6% is not available
  - Injection administration determined under the RBRVS (generally bundled into procedure payment; paid separately only if injection is only service provided at the visit)
## Reports / WC-Specific Codes §§9789.12.14, 9789.19

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>WC001</td>
<td>Doctor’s First Report of Occupational Illness or Injury (Form 5021) (Section 9789.14(a)(1))</td>
<td>Not separately payable</td>
</tr>
<tr>
<td>WC002</td>
<td>Treating Physician’s Progress Report (PR-2 or narrative equivalent in accordance with § 9785) (Section 9789.14(b)(1))</td>
<td>$11.91</td>
</tr>
<tr>
<td>WC003</td>
<td>Primary Treating Physician’s Permanent and Stationary Report (Form PR-3) (Section 9789.14(b)(2))</td>
<td>$38.68 for first page, $23.80 each additional page. Maximum of six pages absent mutual agreement ($157.68)</td>
</tr>
<tr>
<td>WC004</td>
<td>Primary Treating Physician’s Permanent and Stationary Report (Form PR-4) (Section 9789.14(b)(3))</td>
<td>$38.68 for first page, $23.80 each additional page. Maximum of seven pages absent mutual agreement ($181.48)</td>
</tr>
<tr>
<td>WC005</td>
<td>Psychiatric Report requested by the WCAB or the Administrative Director, other than medical-legal report. Use modifier -32 (Section 9789.14(b)(4))</td>
<td>$38.68 for first page, $23.80 each additional page. Maximum of six pages absent mutual agreement ($157.68)</td>
</tr>
<tr>
<td>WC006</td>
<td>[Reserved]</td>
<td></td>
</tr>
<tr>
<td>WC007</td>
<td>Consultation Reports Requested by the Workers’ Compensation Appeals Board or the Administrative Director (Use modifier -32) Consultation Reports requested by the QME or AME in the context of a medical-legal evaluation (Section 9789.14(b)(5)). (Use modifier -30)</td>
<td>$38.68 for first page, $23.80 each additional page. Maximum of six pages absent mutual agreement ($157.68)</td>
</tr>
<tr>
<td>WC008</td>
<td>Chart Notes (Section 9789.14(c))</td>
<td>$10.26 for up to the first 15 pages, $0.25 for each additional page after the first 15 pages</td>
</tr>
<tr>
<td>WC009</td>
<td>Duplicate Reports (Section 9789.14(d))</td>
<td>$10.26 for up to the first 15 pages, $0.25 for each additional page after the first 15 pages</td>
</tr>
<tr>
<td>WC010</td>
<td>Duplication of X-Ray</td>
<td>$5.13 per x-ray</td>
</tr>
<tr>
<td>WC011</td>
<td>Duplication of Scan</td>
<td>$10.00 per scan</td>
</tr>
<tr>
<td>WC012</td>
<td>Missed Appointments. This code is designated for communication only. It does not imply that compensation is owed.</td>
<td>No Fee Prescribed. Non Reimbursable absent agreement</td>
</tr>
</tbody>
</table>

### Physician Fee Schedule Updates

- **Labor Code 5307.1(a)(2)(A)(ii)** requires annual updates to procedure codes, relative weights and adjustment factors in subdivision (g)
  - CPT® book
  - Medicare Physician Fee Schedule Relative Value File
  - Inflation Adjustment: Medicare Economic Index
  - Relative Value Scale Budget Neutrality Adjustment
- **Labor Code 5307.1(g)** requires OMFS to be adjusted to conform to relevant Medicare changes within 60 days
  - Exempt from Administrative Procedure Act
  - Adopted through issuance of Administrative Director Order to be posted on DWC website