State of California
Office of Administrative Law

In re:
Division of Workers' Compensation

Regulatory Action:

Title 08, California Code of Regulations

Adopt section: 9789.19.1
Amend sections: 9789.12.1, 9789.12.2, 9789.12.6, 9789.12.8, 9789.12.12, 9789.12.13, 9789.13.2, 9789.16.1, 9789.16.7, 9789.18.1, 9789.18.2, 9789.18.3, 9789.18.11, 9789.19

NOTICE OF FILING AND PRINTING ONLY

Government Code Section 11343.8

OAL Matter Number: 2018-0926-04FP

OAL Matter Type: File and Print Only (FP)

This regulatory action by the Division of Workers' Compensation within the Department of Industrial Relations adopts the workers' compensation physician fee schedule for services rendered on or after January 1, 2019, and is submitted as exempt from the Administrative Procedure Act as fixing a rate, price, or tariff, pursuant to Government Code section 11340.9, subdivision (g).

OAL filed this regulation(s) or order(s) of repeal with the Secretary of State, and will publish the regulation(s) or order(s) of repeal in the California Code of Regulations.

Date: November 6, 2018

Steven J. Escobar
Attorney

Original: George Parisotto, Administrative Director
Copy: Jarvia Shu

For: Debra M. Cornez
Director

STATE OF CALIFORNIA—OFFICE OF ADMINISTRATIVE LAW

NOTICE PUBLICATION/REGULATIONS SUBMISSION

FILE PRINT

(See instructions on reverse)

STD. 400 (REV. 01-2013)

For use by Secretary of State only

ENDORSED - FILED
In the office of the Secretary of State
of the State of California
NOV 06 2018
1:47 P.M.

OAL FILE NUMBERS	NOTICE FILE NUMBER	REGULATORY ACTION NUMBER	EMERGENCY NUMBER
	Z-	2018-0926-04FP	

For use by Office of Administrative Law (OAL) only

2018 SEP 26 P 12:31

OFFICE OF ADMINISTRATIVE LAW

NOTICE | REGULATIONS

AGENCY WITH RULEMAKING AUTHORITY
Division of Workers' Compensation, within Dept. of Industrial Relations

AGENCY FILE NUMBER (If any)
None

A. PUBLICATION OF NOTICE (Complete for publication in Notice Register)

1. SUBJECT OF NOTICE	TITLE(S)	FIRST SECTION AFFECTED	2. REQUESTED PUBLICATION DATE

3. NOTICE TYPE	4. AGENCY CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)
☐ Notice re Proposed Regulatory Action ☐ Other			

OAL USE ONLY	ACTION ON PROPOSED NOTICE	NOTICE REGISTER NUMBER	PUBLICATION DATE
	☐ Approved as Submitted ☐ Approved as Modified ☐ Disapproved/ Withdrawn		

B. SUBMISSION OF REGULATIONS (Complete when submitting regulations)

1a. SUBJECT OF REGULATION(S)
Workers' Compensation-Official Medical Fee Schedule-Physician

1b. ALL PREVIOUS RELATED OAL REGULATORY ACTION NUMBER(S)

2. SPECIFY CALIFORNIA CODE OF REGULATIONS TITLE(S) AND SECTION(S) **(Including title 26, if toxics related)**

SECTION(S) AFFECTED (List all section number(s) individually. Attach additional sheet if needed.)

ADOPT
9789.19.1

AMEND
9789.12.1, 9789.12.2, 9789.12.6, 9789.12.8, 9789.12.12, 9789.12.13, 9789.13.2, 9789.16.1, cont'd

TITLE(S)
8

REPEAL

3. TYPE OF FILING

- ☐ Regular Rulemaking (Gov. Code §11346)
- ☐ Resubmittal of disapproved or withdrawn nonemergency filing (Gov. Code §§11349.3, 11349.4)
- ☐ Emergency (Gov. Code, §11346.1(b))
- ☐ Certificate of Compliance: The agency officer named below certifies that this agency complied with the provisions of Gov. Code §§11346.2-11347.3 either before the emergency regulation was adopted or within the time period required by statute.
- ☐ Resubmittal of disapproved or withdrawn emergency filing (Gov. Code, §11346.1)
- ☐ Emergency Readopt (Gov. Code, §11346.1(h))
- ☒ File & Print
- ☒ Other (Specify) Exempt-Gov't Code Sec. 11340.9(g)
- ☐ Changes Without Regulatory Effect (Cal. Code Regs., title 1, §100)
- ☐ Print Only

4. ALL BEGINNING AND ENDING DATES OF AVAILABILITY OF MODIFIED REGULATIONS AND/OR MATERIAL ADDED TO THE RULEMAKING FILE (Cal. Code Regs. title 1, §44 and Gov. Code §11347.1)

5. EFFECTIVE DATE OF CHANGES (Gov. Code, §§ 11343.4, 11346.1(d); Cal. Code Regs., title 1, §100)

- ☐ Effective January 1, April 1, July 1, or October 1 (Gov. Code §11343.4(a))
- ☐ Effective on filing with Secretary of State
- ☐ §100 Changes Without Regulatory Effect
- ☒ Effective other (Specify) January 1, 2019

6. CHECK IF THESE REGULATIONS REQUIRE NOTICE TO, OR REVIEW, CONSULTATION, APPROVAL OR CONCURRENCE BY, ANOTHER AGENCY OR ENTITY

- ☐ Department of Finance (Form STD. 399) (SAM §6660)
- ☐ Fair Political Practices Commission
- ☐ State Fire Marshal
- ☐ Other (Specify)

7. CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)	E-MAIL ADDRESS (Optional)
Jarvia Shu	(510) 286-0646	(510) 286-0687	jshu@dir.ca.gov

8. **I certify that the attached copy of the regulation(s) is a true and correct copy of the regulation(s) identified on this form, that the information specified on this form is true and correct, and that I am the head of the agency taking this action, or a designee of the head of the agency, and am authorized to make this certification.**

SIGNATURE OF AGENCY HEAD OR DESIGNEE

DATE
September 20, 2018

TYPED NAME AND TITLE OF SIGNATORY
George Parisotto, Administrative Director

For use by Office of Administrative Law (OAL) only

AUTHORIZED FOR FILING AND PRINTING

NOV 06 2018

Office of Administrative Law

NOTICE PUBLICATION/REGULATIONS SUBMISSION
STD. 400

Agency with Rulemaking Authority: Division of Workers' Compensation, within Dept. of Industrial Relations
Subject of Regulations: Workers' Compensation-Official Medical Fee Schedule-Physician
Section B(2): Submission of Regulations, Sections Affected – Amend, continuation:

9789.16.7, 9789.18.1, 9789.18.2, 9789.18.3, 9789.18.11, 9789.19

§ 9789.12.1 Physician Fee Schedule: Official Medical Fee Schedule for Physician and Non-Physician Practitioner Services – For Services Rendered On or After January 1, 2014

(a) Maximum reasonable fees for physician and non-physician practitioner medical treatment provided pursuant to Labor Code section 4600, which is rendered on or after January 1, 2014, shall be no more than the amount determined by the Official Medical Fee Schedule for Physician and Non-Physician Practitioners, consisting of the regulations set forth in Sections 9789.12.1 through ~~9789.19~~ 9789.19.1 ("Physician Fee Schedule.") Maximum fees for services rendered prior to January 1, 2014 shall be determined in accordance with the fee schedule in effect at the time the service was rendered. The Physician Fee Schedule shall not govern fees for services covered by a contract setting such fees as permitted by Labor Code section 5307.11.

(b) Maximum fees for services of a physician or non-physician practitioner are governed by the Physician Fee Schedule, regardless of specialty, for services performed within his or her scope of practice or license as defined by California law, except:
(1) Evaluation and management codes are to be used only by physicians (as defined by Labor Code §3209.3), as well as physician assistants and nurse practitioners who are acting within the scope of their practice and are under the direction of a supervising physician.
(2) Osteopathic Manipulation Codes (98925-98929) are to be used only by licensed Doctors of Osteopathy and Medical Doctors.

(c) Physicians and non-physician practitioners shall utilize other applicable parts of the OMFS to determine maximum fees for services or goods not covered by the Physician Fee Schedule, such as pharmaceuticals (section 9789.40), pathology and clinical laboratory (section 9789.50) and durable medical equipment, prosthetics, orthotics, supplies (section 9789.60), except: 1) where such services or goods are bundled into the Physician Fee Schedule payment, and/or 2) as otherwise specified in the Physician Fee Schedule.

Authority: Sections 133, 4603.5, 5307.1 and 5307.3, Labor Code.
Reference: Sections 4600, 5307.1 and 5307.11, Labor Code.

§ 9789.12.2 Calculation of the Maximum Reasonable Fee - Services Other than Anesthesia

Except for fees determined pursuant to §9789.18.1 et seq., (Anesthesia), the base maximum reasonable fee for physician and non-physician professional medical practitioner services shall be the non-facility or facility fee calculated as follows:

(a) Non-facility site of service fee calculation:

For dates of service on or after January 1, 2014, but before January 1, 2019:

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

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

For dates of service on or after January 1, 2019:

[(Work RVU * Work GPCI) +
(Non-Facility PE RVU * PE GPCI) +
(MP RVU * MP GPCI)] * Conversion Factor (CF) = Base Maximum Fee

Key: RVU = Relative Value Unit
GPCI = Geographic Practice Cost Index (by locality corresponding to the county where service was provided)
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 ~~effect~~affect reimbursement.

(b) Facility site of service fee calculation:

For dates of service on or after January 1, 2014, but before January 1, 2019:

[(Work RVU * Statewide Work GAF) +
(Facility PE RVU * Statewide PE GAF) +
(MP RVU * Statewide MP GAF)] * Conversion Factor = Base Maximum Fee

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

For dates of service on or after January 1, 2019:

[(Work RVU * Work GPCI) +
(Facility PE RVU * PE GPCI) +

(MP RVU * MP GPCI)] * Conversion Factor (CF) = Base Maximum Fee

Key: RVU = Relative Value Unit
GPCI = Geographic Practice Cost Index (by locality corresponding to the county where service was provided)
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 ~~effect~~affect reimbursement.

(c) "Facility RVUs" shall be used where the place of service is listed as facility ("F") in subdivision (d). "Non-Facility Total RVUs" shall be used where the place of service is listed as nonfacility ("NF") in subdivision (d).

(d)(1) The place of service code (POS) is used to identify where the procedure is furnished. All services shall be assigned the POS code for the setting in which the patient received the face-to-face service. In cases where the face-to-face requirement is obviated such as those when a physician/practitioner provides the PC/interpretation of a diagnostic test, from a distant site, the POS code assigned by the physician/practitioner shall be the setting in which the patient received the Technical Component (TC) of the service.

(2) This face-to-face rule does not apply where the patient is receiving care as a registered inpatient or an outpatient of a hospital. The correct POS code assignment will be for the setting in which the patient is receiving inpatient care or outpatient care from a hospital, including the inpatient hospital (POS code 21) or the outpatient hospital (POS 19 or POS 22).

POS Code and Name Description	Payment Rate Facility = F Nonfacility = NF
01 Pharmacy A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.	NF
02 Telehealth The location where health services and health related services are provided or received, through a telecommunication system. (Effective for services on or after March 1, 2017)	F
03 School A facility whose primary purpose is education.	NF
04 Homeless Shelter A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).	NF
09 Prison/Correctional Facility A prison, jail, reformatory, work farm, detention center, or any other similar	NF

facility maintained by either Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders.	
11 Office 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.	NF
12 Home or Private Residence of Patient Location, other than a hospital or other facility, where the patient receives care in a private residence.	NF
13 Assisted Living Facility Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.	NF
14 Group Home A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).	NF
15 Mobile Unit A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.	NF
16 Temporary Lodging A short-term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code.	NF
17 Walk-in Retail Health Clinic A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services.	NF
18 Place of Employment/Worksite A location, not described by any other POS code, owned or operated by a public or private entity where the patient is employed, and where a health professional provides on-going or episodic occupational medical, therapeutic or rehabilitative services to the individual.	NF
19 Off Campus-Outpatient Hospital A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Effective for Services on or after January 1, 2016)	F
20 Urgent Care Facility Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory	NF

patients seeking immediate medical attention.	
21 Inpatient Hospital A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.	F
22 Outpatient Hospital A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Effective for Services prior to January 1, 2016)	F
22 On Campus-Outpatient Hospital A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Effective for Services on or after January 1, 2016)	F
23 Emergency Room-Hospital A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.	F
24 Ambulatory Surgical Center A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.	F
31 Skilled Nursing Facility A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.	F
32 Nursing Facility A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.	NF
33 Custodial Care Facility A facility which provides room, board and other personal assistance services, generally on a longterm basis, and which does not include a medical component.	NF
34 Hospice – for inpatient care A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.	F
41 Ambulance—Land A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.	F
42 Ambulance—Air or Water An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.	F
49 Independent Clinic A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.	NF

51 Inpatient Psychiatric Facility A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.	F
52 Psychiatric Facility-Partial Hospitalization A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.	F
53 Community Mental Health Center A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.	F
54 Intermediate Care Facility/Mentally Retarded A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or skilled nursing facility (SNF).	NF
55 Residential Substance Abuse Treatment Facility A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.	NF
56 Psychiatric Residential Treatment Center A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.	F
57 Non-residential Substance Abuse Treatment Facility A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.	NF
60 Mass Immunization Center A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.	NF
61 Comprehensive Inpatient Rehabilitation Facility A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.	F

62 Comprehensive Outpatient Rehabilitation Facility A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.	NF
65 End-Stage Renal Disease Treatment Facility A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.	NF
71 State or Local Public Health Clinic A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician.	NF
72 Rural Health Clinic A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.	NF
81 Independent Laboratory A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.	NF
99 Other Place of Service Other place of service not identified above.	NF

(e)(1) For dates of service on or after January 1, 2014, but before January 1, 2019,Ssee section 9789.19, by date of service, for the average statewide GAFs.

(2) For dates of service on or after January 1, 2019, see section 9789.19, by date of service, for reference to the Geographic Practice Code Index (GPCI) values by payment locality.

(A) Determination of Payment Locality: The payment locality is based upon the county in which the service was provided, determined by the ZIP code of the location where the service is actually performed and not necessarily the physical locality of the provider's office, except as otherwise specified in subdivisions (e)(2)(B) and (e)(2)(C).
(i) For purposes of determining the appropriate payment locality, the name and address, including the ZIP code, for each service code must be included on the bill, in accordance with the medical treatment billing regulations at 9792.5.0 et seq.
(ii) See section 9789.19, by date of service, for reference to: counties included in locality file; the zip code to payment locality file; and the zip codes requiring +4 extension file. For zip codes that span more than one county, the 9-digit zip code is required to map to the payment locality.

(B) Determination of Payment Locality for Radiology Services, Pathology Services, and Other Diagnostic Procedures:
(i) Global Service Code – If the global diagnostic code (no modifier TC and no modifier -26) is billed, the provider must report the name and address, including the ZIP code, of where the test was furnished on the bill for the global diagnostic service code. For example, when the global diagnostic service code is billed for chest x-ray as described by

CPT code 71045 (no modifier TC and no modifier -26), the locality is determined by the ZIP code applicable to the testing facility.
In order to bill for a global diagnostic service code, the same physician or supplier entity must furnish both the TC and the PC of the diagnostic service and the TC and PC must be furnished within the same payment locality.
(ii) Separate Billing of Professional Interpretation:
If the physician or supplier entity does not furnish both the TC and PC of the diagnostic service, or if the physician or supplier entity furnishes both the TC and PC but the professional interpretation was furnished in a different payment locality from where the TC was furnished, the professional interpretation of a diagnostic test must be separately billed with modifier -26 by the interpreting physician. The interpreting physician must report the name and address, including ZIP code, of the location where professional interpretation was furnished on the bill. If the professional interpretation was furnished at an unusual and infrequent location, for example, a hotel, the locality of the professional interpretation is determined based on where the interpreting physician most commonly practices.

(C) Global Surgical Package - Determination of Payment Locality When Services are Provided in Different Payment Localities:
If portions of the global period are provided in different payment localities, the physician must report the name and address, including ZIP code, of the location where the service was rendered. The procedure code for the surgery is billed with modifier -54; and the postoperative care is billed with the procedure code for the surgery with modifier -55. For example, if the surgery is performed in one GPCI locality and the postoperative care is provided in another GPCI locality, the surgery is billed with modifier "- 54" and the payment locality would be where the surgery was performed. The postoperative care is billed with modifier "-55" and the payment locality would be where the postoperative care was performed. This is true whether the services were performed by the same physician/group or different physicians/groups. See sections 9789.16.2, et seq. for additional billing requirements for global surgeries.

(f) The maximum fee for physician and non-physician practitioner services shall be the lesser of the actual charge or the calculated rate established by this fee schedule.

Authority: Sections 133, 4603.5, 5307.1 and 5307.3, Labor Code.
Reference: Sections 4600, 5307.1 and 5307.11, Labor Code.

§ 9789.12.6 Geographic Health Professional Shortage Area Bonus Payment: Primary Care; Mental Health

(a) Physicians who provide professional services in a Geographic Health Professional Shortage Area (HPSA) are eligible for a 10-percent bonus payment. Eligibility for receiving the 10 percent bonus payment is based on whether the specific location at which the service is furnished is within an area that is designated as a Geographic HPSA

by the Health Resources and Services Administration (HRSA), within the United States Department of Health & Human Services.

Physicians, including psychiatrists, furnishing services in a primary medical care Geographic HPSA are eligible to receive bonus payments. In addition, psychiatrists furnishing services in mental health Geographic HPSAs are eligible to receive bonus payments.

It is not enough for the physician merely to have his/her office or primary service location in a Geographic HPSA, nor must the injured worker reside in a Geographic HPSA. Eligibility for the bonus is determined by where the service is actually provided (place of service). For example, a physician providing a service in his/her office, the patient's home, or in a hospital qualifies for the incentive payment as long as the specific location of the service is within an area designated as a Geographic HPSA. On the other hand, a physician may have an office in a Geographic HPSA but go outside the office (and the designated Geographic HPSA area) to provide the service. In this case, the physician would not be eligible for the incentive payment.

(b) Only services provided in areas that are designated as of December 31 of the prior year are eligible for the Geographic HPSA bonus payment. Physicians providing services in areas that were designated as of December 31 of the prior year but not on the automated file shall use the AQ modifier. Only services provided in areas that were designated as of December 31 of the prior year but not on the automated file may use the modifier. Services provided in areas that are designated during the year will not be eligible for the Geographic HPSA bonus payment until the following year, provided they are still designated on December 31. Services provided in areas that are de-designated during the year will continue to be eligible for the Geographic HPSA bonus through the end of the calendar year.

(c) The claims administrator shall automatically pay bonuses for services rendered in ZIP Code areas that fully fall within a designated primary care or mental health full county Geographic HPSA; are considered to fully fall in the county based on a determination of dominance made by the United States Postal Service (USPS); or are fully within a partial county Geographic HPSA area.

(d) Should a ZIP Code fall within both a primary care and mental health Geographic HPSA, only one bonus will be paid on the service. Bonuses for mental health Geographic HPSAs will only be paid when performed by the provider specialty of 26 – psychiatry.

(e) For services rendered in ZIP Code areas that do not fall within a designated full county Geographic HPSA; are not considered to fall within the county based on a determination of dominance made by the USPS; or are partially within a partial county Geographic HPSA, physicians must submit an AQ modifier to receive payment.

To determine whether a modifier is needed, physicians must review the information provided on the CMS web site or the HRSA web site for Geographic HPSA designations

to determine if the location where they render services is within a Geographic HPSA bonus area. Physicians may also base the determinations on letters of designations received from HRSA. They must be prepared to provide these letters as documentation upon the request of the claims administrator.

For services rendered in ZIP Code areas that cannot automatically receive the bonus, it will be necessary to know the census tract of the area to determine if a bonus should be paid and a modifier submitted. Census tract data can be retrieved by visiting the U.S. Census Bureau Web site at http://www.census.gov/ or the Federal Financial Institutions Examination Council (FFIEC) Web site at http://www.ffiec.gov/geocode/. Instructions on how to use these Web sites can be found on the CMS Web site at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses/index.html?redirect=/hpsapsaphysicianbonuses/.

(f) The claims administrator shall pay the 10% bonus together with the payment for the service performed in the Geographic HPSA designated area. The Geographic HPSA bonus pertains only to physician's professional services. Should a service be billed that has both a professional and technical component, only the professional component will receive the bonus payment.

(g) See section 9789.19, by date of service, for:
(1) The links for the Primary Care HPSA zip code file and the Mental Health HPSA zip code file listing zip codes that will automatically receive the Geographic HPSA bonus;
(2) The HRSA web link to determine if a particular address is in a Primary Care Geographic HPSA and/or a Mental Health Geographic HPSA;
(3) The HRSA web link to find Primary Care Geographic HPSA and Mental Health Geographic HPSA by State & County.

Authority: Sections 133, 4603.5, 5307.1 and 5307.3, Labor Code.
Reference: Sections 4600, 5307.1 and 5307.11, Labor Code.

§ 9789.12.8 Status Codes

The Medicare Status Codes have been adapted for workers' compensation and have the following meanings:

A =	Active Code. These codes are paid separately under the physician fee schedule. There will be RVUs for codes with this status.

B =	Bundled Code. Payment for covered services are always bundled into payment for other services not specified. If RVUs are shown, they are not used for payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident. (An example is a telephone call from a hospital nurse regarding care of a patient).
C =	If payable, these codes will be paid using the RVUs listed in the Centers for Medicare and Medicaid Services (CMS') National Physician Fee Schedule Relative Value File, or if no RVUs are assigned, then by "By Report,"~~,~~ generally following review of documentation such as an operative report.
E =	If payable: (a) HCPCS codes beginning with "J" or "P", maximum fee is determined according section 9789.13.2. (b) Other codes are paid under the applicable fee schedule contained in Section 9789.30-9789.70, or if none of those schedules is applicable the code is payable "By Report."
I =	Except as otherwise provided, not valid code for workers' compensation physician billing. See section 9789.12.3.
J =	Anesthesia Services. The intent of this value is to facilitate the identification of anesthesia services. There are no RVUs and no payment amounts for these codes in the National Physician Fee Schedule Relative Value File. Instead, the Anesthesia Base Units file is to be used to determine the base units for these codes.
M =	Measurement codes. Used for reporting purposes only.
N =	If payable, these CPT codes are paid using the listed RVUs; but if no RVUs are listed, then By Report. See section 9789.12.3.
P =	Bundled/Excluded Codes. There are no RVUs and no payment amounts for these services. No separate payment should be made for them under the fee schedule. --If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident. (An example is an elastic bandage furnished by a physician incident to physician service.) --If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (i.e., colostomy supplies) and should be paid under the other portions of the fee schedule.
Q =	Therapy functional information code (used for required Medicare reporting purposes only; not used for workers' compensation).
R =	If payable, these codes will be paid pursuant to section 9789.12.3.

T =	Injections. There are RVUS and payment amounts for these services, but they are only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the physician services for which payment is made.
X =	No RVUS or payment amounts are shown for these codes. If payable, these codes are paid under the applicable fee schedule contained in Sections 9789.30 - 9789.70, or if none of those schedules is applicable the code is payable "By Report." (Examples of services payable under another fee schedule are ambulance services and clinical diagnostic laboratory services.)

Authority: Sections 133, 4603.5, 5307.1 and 5307.3, Labor Code.
Reference: Sections 4600, 5307.1 and 5307.11, Labor Code.

§ 9789.12.12 Consultation Services Coding - Use of Visit Codes

(a) Maximum fees for physicians and qualified non-physician practitioners performing consultation services shall be determined utilizing the appropriate RVU for a patient evaluation and management visit and the RVU(s) for prolonged service codes if warranted under CPT guidelines. Physicians and qualified non-physician practitioners shall code consultation visits as patient evaluation and management visits utilizing the CPT Evaluation and Management codes that represent where the visit occurs and that identify the complexity of the visit performed. CPT consultation codes shall not be utilized.

(1) In the inpatient hospital setting and the nursing facility setting consulting physicians (and qualified non-physician practitioners where permitted) who perform an initial evaluation may bill the initial hospital care codes (99221 – 99223) or nursing facility care codes (99304 – 99306).

Follow-up consultation visits in the inpatient hospital setting shall be billed as subsequent hospital care visits (99231 – 99233) and subsequent nursing facility care visits (99307 - 99310.)

(2) In the office or other outpatient setting where a consultation / evaluation is performed, physicians and qualified non-physician practitioners shall use the CPT visit codes (99201 – 99215) depending on the complexity of the visit and whether the patient is a new or established patient to that physician, as defined in section 9789.12.11.

(b) Consultation reports are bundled into the underlying evaluation and management visit code or hospital care code, and are not separately payable, except as specified in subdivision (c).

(c) The following consultation reports are separately reimbursable:
(1) Consultation reports requested by the Workers' Compensation Appeals Board or the Administrative Director. Use WC007, modifier -32.
(2) Consultation reports requested by the Qualified Medical Evaluator ("QME") or Agreed Medical Evaluator ("AME") in the context of a medical-legal evaluation. Use WC007, modifier -30.

Authority: Sections 133, 4603.5, 5307.1 and 5307.3, Labor Code.
Reference: Sections 4600, 5307.1 and 5307.11, Labor Code.

§ 9789.12.13 Correct Coding Initiative

(a) The National Correct Coding Initiative Edits ("NCCI") adopted by the CMS shall apply to payments for medical services under the Physician Fee Schedule. Except where payment ground rules differ from the Medicare ground rules, claims administrators shall apply the NCCI physician coding edits ~~and medically unlikely edits~~ (Practitioner PTP Edits and Medically Unlikely Edits, excluding codes with an MUE value of zero) to bills to determine appropriate payment. Claims Administrators shall utilize the National Correct Coding Initiative Coding Policy Manual for Medicare Services. If a billing is reduced or denied reimbursement because of application of the NCCI, the claims administrator must notify the physician or qualified non-physician practitioner of the basis for the denial, including the fact that the determination was made in accordance with the NCCI.

(b) The National Correct Coding Initiative Coding Policy Manual may be obtained from the CMS website: http://www.cms.hhs.gov/NationalCorrectCodInitEd/. See section 9789.19 for the adopted version of the NCCI Coding Policy Manual, by date of service.

(c) Medically Unlikely Edits are published by CMS on its website at: http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html in the document "Practitioner Services MUE Table." See section 9789.19 for the adopted version of the Practitioner Services MUE Table, by date of service. For services on or after July 1, 2018, see section 9789.19 for the excerpt of the adopted Practitioner Services MUE Table (which excludes codes with zero value), by date of service.

(d) Physician NCCI Edits are published by CMS on its website at: http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html in the documents ~~"Physician CCI Edits".~~ "Practitioner PTP Edits." See section 9789.19 for the adopted version of the ~~Physician CCI~~ Practitioner PTP Edits, by date of service.

Authority: Sections 133, 4603.5, 5307.1 and 5307.3, Labor Code.
Reference: Sections 4600, 5307.1 and 5307.11, Labor Code.

§ 9789.13.2 Physician-Administered Drugs, Biologicals, Vaccines, Blood Products

(a) Physician-administered drugs, biologicals, vaccines, or blood products are separately payable.

(1) Vaccines shall be reported using the NDC and CPT-codes for the vaccine. Other physician-administered drugs, biological and blood products shall be reported using the NDC and J-codes assigned to the product.

(2) The maximum reimbursement shall be determined using the "Basic Rate" for the HCPCS code contained on the Medi-Cal Rates file for the date of service. The Medi-Cal fee schedule reimburses drug products, vaccines and immunizations at the Medicare rate of reimbursement when established and published by the Centers for Medicare & Medicaid Services (CMS) or the Medi-Cal pharmacy rate of reimbursement when the Medicare rate is not available. The Medicare rate is currently defined as average sales price (ASP) plus 6 percent. 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).

(3) The "Basic Rate" price listed on the Medi-Cal rates page of the Medi-Cal website for each physician-administered drug includes an injection administration fee of $4.46. This injection administration fee should be subtracted from the published rate because payment for the injection administration fee will be determined under the RBRVS. See section 9789.19 for a link to the Department of Health Care Services' Medi-Cal rates file.

(4) For a physician-administered drug, biological, vaccine or blood product not contained in the Medi-Cal Rates file referenced in subdivision (a)(2), the maximum reimbursement is the amount prescribed in the Medi-Cal Pharmacy Fee Schedule as adopted by the Division of Workers' Compensation in section 9789.40 and posted on the Division website as the Pharmaceutical Fee Schedule. See section 9789.19 for a link to the Division of Workers' Compensation Pharmaceutical Fee Schedule.

(b) The ~~RBRVS~~ physician fee schedule shall be used to determine the maximum reimbursement for the drug administration fee.

(1) Injection services (codes 96365 through 96379) are not paid for separately, if the physician is paid for any other physician fee schedule service furnished at the same time. Pay separately for those injection services only if no other physician fee schedule service is being paid.

(2) Pay separately for cancer chemotherapy injections (CPT codes 96401-96549) in addition to the visit furnished on the same day.

(c) Physician-administered radiopharmaceuticals. When furnished to patients in settings in which a technical component is payable, separate payments may be made for low osmolar contrast material used during intrathecal radiologic procedures (HCPCS Q-codes Q9965-9967), pharmacologic stressing agents used in connection with nuclear medicine and cardiovascular stress testing procedures HCPCS A-codes A4641, A4642, A9500-A9507, A9600), radionuclide used in connection nuclear medicine procedures furnished to beneficiaries in settings in which TCs are payable.

Low-osmolar contrast media is reported using HCPCS Q-codes.

(d) All claims for a physician-administered drug, biological, vaccine, or blood product must include the specific name of the drug and dosage.

(e) "Administer" means the direct application of a drug or device to the body of a patient by injection, inhalation, ingestion, or other means.

Authority: Sections 133, 4603.5, 5307.1 and 5307.3, Labor Code.
Reference: Sections 4600, 5307.1 and 5307.11, Labor Code.

§9789.16.1 Surgery – Global Fee

(a) Global Surgical Package.
A global surgical package refers to a payment policy of bundling payment for the various services associated with a surgical procedure into a single payment covering the operation and these other services.

(1) Definition of a Global Surgical Package. The National Physician Fee Schedule Relative Value File, Global Days column (labeled "Glob Days"), provides the postoperative periods that apply to each surgical procedure. The payment rules for surgical procedures apply to codes with entries of 000, 010, 090. For workers' compensation, the global period will not apply to codes with "YYY".
(A) Codes with "000" in the Global Days column are minor procedures or endoscopies with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; evaluation and management services on the day of the procedure are generally not payable.
(B) Codes with "010" in the Global Days column are minor procedures or endoscopies with preoperative relative values on the day of the procedure and postoperative relative values during a 10 day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during the 10-day postoperative period generally not payable.
(C) Codes with "090" in the Global Days column ~~U~~ are major surgeries with a 1-day preoperative period and 90-day postoperative period included in the fee schedule amount.
(D) Codes with "ZZZ" are surgical codes related to another service and are always included in the global period of the other service. They are add-on codes that are always billed with another service. There is no postoperative work included in the fee schedule

payment for the "ZZZ" codes. Payment is made for both the primary and the add-on codes, and the global period assigned is applied to the primary code.

(2) Components of a Global Surgical Package. A global surgical package is applied to all procedures with the appropriate entry in the Global Days column of the National Physician Fee Schedule Relative Value File. The services included in the global surgical package may be furnished in any setting, e.g., in hospitals, ASCs, physicians' offices. Visits to a patient in an intensive care or critical care unit are also included if made by the surgeon. However, critical care services (99291 and 99292) are payable separately in some situations.

The global fee includes payment for the following services related to the surgery when furnished by the physician who performs the surgery:
(A) Preoperative Visits - Preoperative visits after the decision is made to operate beginning with the day before the day of surgery for major procedures and the day of surgery for minor procedures;
(B) Intra-operative Services - Intra-operative services that are normally a usual and necessary part of a surgical procedure;
(C) Complications Following Surgery - All additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications which do not require additional trips to the operating room (OR). For the purposes of this section, an operating room is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term includes a cardiac catheterization suite, a laser suite, and an endoscopy suite. It does not include a patient's room, a minor treatment room, a recovery room, or an intensive care unit (unless the patient's condition was so critical there would be insufficient time for transportation to an OR);
(D) Postoperative Visits - Follow-up visits during the postoperative period of the surgery that are related to recovery from the surgery;
(E) Postsurgical Pain Management - By the surgeon;
(F) Supplies - Except for those identified as exclusions; and
(G) Miscellaneous Services - Items such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes.

(3) Services Not Included in the Global Surgical Package. The services listed below may be paid for separately:
(A) The initial evaluation of the problem by the surgeon to determine the need for a major surgical procedure. (The initial evaluation is always included in the allowance for a minor surgical procedure and is not separately payable);
(B) Services of other physicians except where the surgeon and the other physician(s) agree on the transfer of care; this agreement may be in the form of a letter or an annotation in the discharge summary, hospital record, or ASC record;

(C) Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complications of the surgery;
(D) Treatment for the underlying condition or an added course of treatment which is not part of normal recovery from surgery;
(E) Diagnostic tests and procedures, including diagnostic radiological procedures;
(F) Clearly distinct surgical procedures during the postoperative period which are not re-operations or treatment for complications. (A new postoperative period begins with the subsequent procedure.) This includes procedures done in two or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure. Examples of this are procedures to diagnose and treat epilepsy (codes 61533, 61534-61536, 61539, 61541, and 61543) which may be performed in succession within 90 days of each other;
(G) Treatment for postoperative complications which requires a return trip to the operating room (OR);
(H) If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately;
(I) Splints and casting supplies are payable separately;
(J) Immunosuppressive therapy for organ transplants; and
(K) Critical care services (codes 99291 and 99292) unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the physician.
(L) Services that fall within section 9789.16.4 (Primary Treating Physician's Progress Reports, and specified Evaluation and Management visits.)

(4) Minor Surgeries and Endoscopies. Visits by the same physician on the same day as a minor surgery or endoscopy are included in the payment for the procedure, unless a significant, separately identifiable service is also performed. A postoperative period of 10 days applies to some minor surgeries. The postoperative period for these procedures is indicated in the Global Days column of the National Physician Fee Schedule Relative Value File. If the Global Days column entry is "010", no separate payment is allowed for postoperative visits or services within 10 days of the surgery that are related to recovery from the procedure. If a diagnostic biopsy with a 10-day global period precedes a major surgery on the same day or in the 10-day period, the major surgery is payable separately. Services by other physicians are not included in the global fee for a minor procedure except as otherwise excluded. If the Global Days column entry is "000", postoperative visits beyond the day of the procedure are not included in the payment amount for the surgery. Separate payment is made in this instance.

(5) Physicians Furnishing Less Than the Full Global Package. There are occasions when more than one physician provides services included in the global surgical package. It may be the case that the physician who performs the surgical procedure does not furnish the follow-up care. Payment for the postoperative, postdischarge care is split between two or more physicians where the physicians agree on the transfer of care. When more than one physician furnishes services that are included in the global surgical package, the sum of

the amount approved for all physicians may not exceed what would have been paid if a single physician provides all services, except where permitted. When either modifier "-54" or "-55" is used, a percentage of the fee schedule is applied as appropriate. The percentages for pre-, intra-, and postoperative care of the total RVUs for major surgical procedures and for minor surgeries with a postoperative period of 10 days may be found in the columns Preoperative Percentage ("Pre Op"), Intraoperative Percentage ("Intra Op"), and Postoperative Percentage ("Post Op"), respectively, of the National Physician Fee Schedule Relative Value File. The intra-operative percentage includes postoperative hospital visits. Split global care does apply to procedures with "000" in the Global Days column ~~U~~ of the National Physician Fee Schedule Relative Value File.

(6) Determining the Duration of a Global Period. To determine the global period for major surgeries, count 1 day immediately before the day of surgery, the day of surgery, and the 90 days immediately following the day of surgery. To determine the global period for minor procedures, count the day of surgery and the appropriate number of days (either 0 or 10 days) immediately following the date of surgery.

Authority: Sections 133, 4603.5, 5307.1 and 5307.3, Labor Code.
Reference: Sections 4600, 5307.1 and 5307.11, Labor Code.

§9789.16.7 Surgery – Co-surgeons and Team Surgeons.

(a) General

Under some circumstances, the individual skills of two or more surgeons are required to perform surgery on the same patient during the same operative session. This may be required because of the complex nature of the procedure(s) and/or the patient's condition. In these cases, the additional physicians are not acting as assistants-at-surgery.

(b) Billing Instructions / Determination of Maximum Payment

The following billing procedures apply when billing for a surgical procedure or procedures that required the use of two surgeons or a team of surgeons:

(1) If two surgeons (each in a different specialty) are required to perform a specific procedure, each surgeon bills for the procedure with a modifier "-62." Co-surgery also refers to surgical procedures involving two surgeons performing the parts of the procedure simultaneously, i.e., heart transplant or bilateral knee replacements. Documentation of the medical necessity for two surgeons is required for certain services identified in the Co-Surgeons ("Co Surg") column of the National Physician Fee Schedule Relative Value File. If the surgery is billed with a "-62" modifier and the Co-Surgeons column contains an indicator of "1," any documentation submitted with the claim should be reviewed to identify support for the need for co-surgeons. If the documentation supports the need for co-surgeons, base payment for each physician on the lower of the billed amount or 62.5 percent of the fee schedule amount. If the surgery is

billed with a "-62" modifier and the Co-Surgeons column contains an indicator of "2," payment rules for two surgeons apply. The claims administrator shall base payment for each physician on the lower of the billed amount or 62.5 percent of the fee schedule amount. If the surgery is billed with a "-62" modifier and the Co-Surgeons column contains an indicator of "0," payment for co-surgeons is not allowed.

(2) If a team of surgeons (more than 2 surgeons of different specialties) is required to perform a specific procedure, each surgeon bills for the procedure with a modifier "-66." The Team Surgery ("Team Surg") column of the National Physician Fee Schedule Relative Value File identifies certain services submitted with a "-66" modifier which must be sufficiently documented to establish that a team was medically necessary.

If the surgery is billed with a "-66" modifier and the Team Surgery column contains an indicator of "1," the claim should be reviewed to identify support for the need for a team of surgeons. If the claims administrator determines that team surgeons were medically necessary, each physician is paid on a "by report" basis.

If the surgery is billed with a "-66" modifier and the Team Surgery column contains an indicator of "2," the claims administrator shall pay "by report".

All claims for team surgeons must contain sufficient information to allow pricing "by report."

(3) If surgeons of different specialties are each performing a different procedure (with specific CPT codes), neither co-surgery nor multiple surgery rules apply (even if the procedures are performed through the same incision). If one of the surgeons performs multiple procedures, the multiple procedure rules apply to that surgeon's services.

(4) For co-surgeons (modifier 62), the fee schedule amount applicable to the payment for each co-surgeon is 62.5 percent of the global surgery fee schedule amount. Team surgery (modifier 66) is paid for on a "By Report" basis.

NOTE: A fee may have been established for some surgical procedures that are billed with the "-66" modifier. In these cases, all physicians on the team must agree on the percentage of the payment amount each is to receive. If the claims administrator receives a bill with a "-66" modifier after the claims administrator has paid one surgeon the full payment amount (on a bill without the modifier), deny the subsequent claim.

(5) Apply the rules relating to global surgical packages to each of the physicians participating in a co- or team surgery.

Authority: Sections 133, 4603.5, 5307.1 and 5307.3, Labor Code.
Reference: Sections 4600, 5307.1 and 5307.11, Labor Code.

§ 9789.18.1 Payment for Anesthesia Services - General Payment Rule

(a) For dates of service on or after January 1, 2014, but before January 1, 2019:

The fee schedule amount for physician anesthesia services is, with the exceptions noted, based on allowable base and time units multiplied by an anesthesia conversion factor and statewide anesthesia GAF.

The maximum reasonable fee for physician and non-physician practitioner anesthesia services shall be calculated as follows:

[Base Unit + Time Unit] * CF * Statewide Anesthesia GAF = Base Maximum Fee

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.

(1) Base Unit: The base unit for each anesthesia procedure is listed in a file entitled "Anesthesia Base Units by CPT Code," which is adopted and incorporated by reference ~~released annually by Medicare~~. See Section 9789.19 for reference to the "Anesthesia Base Units by CPT Code" file, by date of service.

(2) Time Units: The way in which time units are to be calculated is set forth in Section 9789.18.~~8~~7.

~~The Anesthesia Base Units by CPT Code file and conversion factor are updated by Administrator Director Order.~~

(3) Anesthesia Conversion Factor and Statewide Anesthesia GAF: See Section 9789.19 for the ~~file,~~ anesthesia conversion factor, and statewide anesthesia GAF, by date of service.

~~The maximum reasonable fee for physician and non-physician practitioner anesthesia services shall be calculated as follows:~~

~~[Base Unit + Time Unit] * CF * Statewide Anesthesia GAF = Base Maximum Fee~~

~~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 effect reimbursement.~~

(b) For dates of service on or after January 1, 2019:

The fee schedule amount for physician anesthesia services is, with the exceptions noted, based on allowable base and time units multiplied by an anesthesia conversion factor adjusted by the anesthesia shares and Geographic Practice Cost Index (GPCIs) specific to a locality where the service was provided.

The maximum reasonable fee for physician and non-physician practitioner anesthesia services shall be calculated as follows:

[Base Unit + Time Unit] * Adjusted CF by locality = Base Maximum Fee

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.

(1) Base Unit: The base unit for each anesthesia procedure is listed in a file entitled "Anesthesia Base Units by CPT Code", which is adopted and incorporated by reference. See Section 9789.19 for reference to the "Anesthesia Base Units by CPT Code" file, by date of service.

(2) Time Units: The way in which time units are to be calculated is set forth in Section 9789.18.8.

(3) Adjusted Anesthesia Conversion Factor is set forth in 9789.19.1, Table A applicable to the date of service.

The adjusted conversion factor for the locality corresponding to the county where the service is provided, is determined as follows:

[(Work GPCI by locality*Anesthesia Work Share) + (Practice Expense GPCI by locality*Anesthesia Practice Expense Share) + (Malpractice GPCI by locality*Anesthesia Malpractice Share)] * Anesthesia Conversion Factor].

The appropriate payment locality will be determined according to subdivision (e)(2) of section 9789.12.2.

Authority: Sections 133, 4603.5, 5307.1 and 5307.3, Labor Code.
Reference: Sections 4600, 5307.1 and 5307.11, Labor Code.

§ 9789.18.2 Anesthesia - Personally Performed Rate

The anesthesia fee calculation will recognize the base unit for the anesthesia code and ~~one~~ time units ~~per 15 minutes of anesthesia time~~ as calculated in accordance with section 9789.18.8 in any of the following circumstances:

(a) The physician personally performed the entire anesthesia service alone;

(b) The physician is involved with one anesthesia case with a resident and the physician is a teaching physician. A teaching physician is a physician (other than another resident) who involves residents in the care of his or her patients. The teaching physician must document in the medical records that he/she was present during all critical (or key) portions of the procedure. The teaching physician's physical presence during only the preoperative or postoperative visits with the patient is not sufficient;

(c)The physician is involved in the training of physician residents in a single anesthesia case, two concurrent anesthesia cases involving residents or a single anesthesia case involving a resident that is concurrent to another case paid under the medical direction rules. The teaching anesthesiologist, or different anesthesiologists in the same anesthesia group, must be present during all critical or key portions of the anesthesia service or procedure involved. The teaching anesthesiologist (or another anesthesiologist with whom the teaching physician has entered into an arrangement) must be immediately available to

furnish anesthesia services during the entire procedure. The documentation in the patient's medical records must indicate the teaching physician's presence during all critical or key portions of the anesthesia procedure and the immediate availability of another teaching anesthesiologist as necessary;

(d) The physician is continuously involved in a single case involving a student nurse anesthetist;

(e) The physician is continuously involved in one anesthesia case involving a CRNA (or AA). If the physician is involved with a single case with a CRNA (or AA) the physician service and the CRNA (or AA) service may be paid in accordance with the medical direction payment policy; or

(f) The physician and the CRNA (or AA) are involved in one anesthesia case and the services of each are found to be medically necessary. Documentation must be submitted by both the CRNA and the physician to support payment of the full fee for each of the two providers. The physician reports the "AA" modifier and the CRNA reports the "QZ" modifier for a nonmedically directed case.

Authority: Sections 133, 4603.5, 5307.1 and 5307.3, Labor Code.
Reference: Sections 4600, 5307.1 and 5307.11, Labor Code.

§ 9789.18.3 Anesthesia - Medically Directed Rate

(a) Payment for the physician's medical direction service is determined on the basis of 50 percent of the allowance for the service performed by the physician alone. Medical direction occurs if the physician medically directs qualified individuals (all of whom could be CRNAs, AAs, interns, residents, or combinations of these individuals) in two, three, or four concurrent cases and the physician performs all the following activities:

(1) Performs a pre-anesthetic examination and evaluation;

(2) Prescribes the anesthesia plan;

(3) Personally participates in the most demanding procedures in the anesthesia plan, including, if applicable, induction and emergence;

(4) Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist;

(5) Monitors the course of anesthesia administration at frequent intervals;

(6) Remains physically present and available for immediate diagnosis and treatment of emergencies; and

(7) Provides indicated-post-anesthesia care.

(b) The physician must participate only in the most demanding procedures of the anesthesia plan, including, if applicable, induction and emergence. The physician must document in the medical record that he or she performed the pre-anesthetic examination

and evaluation. Physicians must also document that they provided indicated post-anesthesia care, were present during some portion of the anesthesia monitoring, and were present during the most demanding procedures, including induction and emergence, where indicated.

(c) The physician can medically direct two, three, or four concurrent procedures involving qualified individuals, all of whom could be CRNAs, AAs, interns, residents or combinations of these individuals. The medical direction rules apply to cases involving student nurse anesthetists if the physician directs two concurrent cases, each of which involves a student nurse anesthetist, or the physician directs one case involving a student nurse anesthetist and another involving a CRNA, AA, intern or resident.

(d) The medical direction rules do not apply to a single resident case that is concurrent to another anesthesia case paid under the medical direction rules or to two concurrent anesthesia cases involving residents.

(e) If anesthesiologists are in a group practice, one physician member may provide the pre-anesthesia examination and evaluation while another fulfills the other criteria. Similarly, one physician member of the group may provide post-anesthesia care while another member of the group furnishes the other component parts of the anesthesia service. However, the medical record must indicate that the services were furnished by physicians and identify the physicians who furnished them.

(f) A physician who is concurrently directing the administration of anesthesia to not more than four surgical patients cannot ordinarily be involved in furnishing additional services to other patients. However, addressing an emergency of short duration in the immediate area, administering an epidural or caudal anesthetic to ease labor pain, or periodic, rather than continuous, monitoring of an obstetrical patient does not substantially diminish the scope of control exercised by the physician in directing the administration of anesthesia to surgical patients. It does not constitute a separate service for the purpose of determining whether the medical direction criteria are met. Further, while directing concurrent anesthesia procedures, a physician may receive patients entering the operating suite for the next surgery, check or discharge patients in the recovery room, or handle scheduling matters without affecting fee schedule payment. However, if the physician leaves the immediate area of the operating suite for other than short durations or devotes extensive time to an emergency case or is otherwise not available to respond to the immediate needs of the surgical patients, the physician's services to the surgical patients are supervisory in nature. See section 9789.18.4 for a definition of concurrent anesthesia procedures.

Authority: Sections 133, 4603.5, 5307.1 and 5307.3, Labor Code.
Reference: Sections 4600, 5307.1 and 5307.11, Labor Code.

§9789.18.11 Anesthesia Claims Modifiers

Physicians shall report the appropriate anesthesia modifier to denote whether the service was personally performed, medically directed, or medically supervised in addition to any applicable CPT modifier.

Specific anesthesia modifiers include:

AA - Anesthesia Services performed personally by the anesthesiologist;

AD - Medical Supervision by a physician; more than 4 concurrent anesthesia procedures;

G8 - Monitored anesthesia care (MAC) for deep complex complicated, or markedly invasive surgical procedures;

G9 - Monitored anesthesia care for patient who has a history of severe cardio- pulmonary condition;

QK - Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals;

QS - Monitored anesthesia care service - The QS modifier is for informational purposes. Providers must report actual anesthesia time and payment modifier on the claim;

QX - CRNA service; with medical direction by a physician;

QY - Medical direction of one ~~certified registered nurse~~ qualified non-physician anesthetist by an anesthesiologist;

QZ - CRNA service: without medical direction by a physician; and

GC - these services have been performed by a resident under the direction of a teaching physician. The GC modifier is reported by the teaching physician to indicate he/she rendered the service in compliance with the teaching physician requirements in section 9789.18.2. One of the payment modifiers must be used in conjunction with the GC modifier.

Authority: Sections 133, 4603.5, 5307.1 and 5307.3, Labor Code.
Reference: Sections 4600, 5307.1 and 5307.11, Labor Code.

§ 9789.19 Update Table

(a) Services Rendered On or After 1/1/2014. Documents listed in the following table are incorporated by reference and will be made available upon request to the Administrative Director.

Document	Services Rendered On or After 1/1/2014
Adjustment Factors (These factors have been incorporated into the conversion factors listed below)	For all services other than anesthesia: 2014 Total RVS adjustment factor: 1.0477 2014 RVU budget neutrality factor: 1.00046 2014 RVU rescaling adjustment factor: 1.04718 2014 Annual increase in the MEI: 1.008 2014 Cumulative adjustment factor: 1.0638 For anesthesia services: 2014 Total RVS adjustment factor: 1.0291 2014 RVU budget neutrality factor: 1.00046

	2014 RVU rescaling adjustment factor: 1.04718 2014 anesthesia practice expense adjustment factor: 0.9823 2014 Annual increase in the MEI: 1.008 2014 Cumulative adjustment factor: 1.0449
Anesthesia Base Units by CPT Code	2014anesBASEfin
California-Specific Codes	WC001 – Not reimbursable WC002 - $11.91 WC003 - $38.68 for first page $23.80 each additional page. Maximum of six pages absent mutual agreement ($157.68) WC004 - $38.68 for first page $23.80 each additional page. Maximum of seven pages absent mutual agreement ($181.48) WC005 - $38.68 for first page, $23.80 each additional page. Maximum of six pages absent mutual agreement ($157.68) WC007 - $38.68 for first page $23.80 each additional page. Maximum of six pages absent mutual agreement ($157.68) WC008 - $10.26 for up to the first 15 pages. $0.25 for each additional page after the first 15 pages. WC009 - $10.26 for up to the first 15 pages. $0.25 for each additional page after the first 15 pages. WC010 - $5.13 per x-ray WC011 - $10.26 per scan WC012 - No Fee Prescribed/Non Reimbursable absent agreement
CCI Edits: Medically Unlikely Edits	For services rendered on or after 1/1/2014, use: "Practitioner Services MUE Table – Updated 10/1/2013." For services rendered on or after 1/23/2014, use: "Practitioner Services MUE Table – Updated 1/1/2014." For services rendered on or after 4/1/2014, use: "Practitioner Services MUE Table – Updated 4/1/2014." For services rendered on or after 7/1/2014, use: "Practitioner Services MUE Table – Updated 7/1/2014." For services rendered on or after 10/1/2014, use: "Practitioner Services MUE Table – Updated 10/1/2014."

	Copies of the MUE Tables are posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm CMS posts only the most recent version of the Practitioner Services MUE Table on the web at: http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html .
CCI Edits: National Correct Coding Initiative Policy Manual for Medicare Services	NCCI Policy Manual for Medicare Services - Effective January 1, 2014 [ZIP, 749KB] Copy of the 1/1/2014 Manual is posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm
CCI Edits: Physician CCI Edits	For services rendered on or after January 1, 2014: Physician CCI Edits v19.3 (819,852 records). The last row contains edit column 1 = 39599 and column 2 = 49570 Physician CCI Edits v19.3 (710,236 records). The first row contains edit column 1 = 40490 and column 2 = C8950 For services rendered on or after April 15, 2014: Physician CCI Edits v20.1 effective April 1, 2014 (851,137 records). The last row contains edit column 1 = 39599 and column 2 = 49570 Physician CCI Edits v20.1 effective April 1, 2014 (744,393 records). The first row contains edit column 1 = 40490 and column 2 = C8950 For services rendered on or after July 1, 2014: Physician CCI Edits v20.2 effective July 1, 2014 (863,712 records). The last row contains edit column 1 = 39599 and column 2 = 49570 Physician CCI Edits v20.2 effective July 1, 2014 (752,547 records). The first row contains edit column 1 = 40490 and column 2 = C8950 For services rendered on or after October 1, 2014: Physician CCI Edits v20.3 effective October 1, 2014 (864,930 records). The last row contains edit column 1 = 39599 and column 2 = 49570 Physician CCI Edits v20.3 effective October 1, 2014 (756,576 records). The first row contains edit column 1 = 40490 and column 2 = C8950
CMS' Medicare National Physician Fee Schedule Relative Value File [Zip]	For services rendered on or after January 1, 2014: RVU14A [Zip] • RVUPUF14 (Excluding Attachment A)

	• PPRRVU14_V1219 • OPPSCAP_V1219 Excluding: 14LOCCO ANES 2014_V0103 CY 2014 GPCI _12172013 For services rendered on or after April 15, 2014: RVU14B [Zip] • RVUPUF14 (Excluding Attachment A) • PPRRVU14_V0324 • OPPSCAP_V0324 Excluding: 14LOCCO ANES_2014_V0103 CY 2014 GPCI_12172013 For services rendered on or after July 1, 2014: RVU14C [Zip 3MB] • RVUPUF14 (Excluding Attachment A) • PPRRVU14_V0515 • OPPSCAP_V0515 Excluding: 14LOCCO ANES 2014_V0103 CY 2014 GPCI_12172013 For services rendered on or after October 1, 2014: RVU14D [Zip 3MB] • RVUPUF14 (Excluding Attachment A) • PPRRVU14_V0815_v4 • OPPSCAP_V0815 Excluding: 14LOCCO ANES 2014_V0103 CY 2014 GPCI_12172013
CMS Pub 100-04 Medicare Claims Processing: Casting and Splint Supplies	For services rendered on or after 1/1/2014, use: Transmittal 2837 (Change Request 8523) For services rendered on or after 4/1/2014, use: the OMFS Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS) Fee Schedule applicable to the date of service

Conversion Factors adjusted for MEI and Relative Value Scale adjustment factor, if any	Anesthesia Conversion Factor: $33.8190 Surgery Conversion Factor: $55.2913 Radiology Conversion Factor: $53.1039 Other Services Conversion Factor: $38.3542
Current Procedural Terminology (CPT®)	CPT 2014 https://commerce.ama-assn.org/store/
Current Procedural Terminology CPT codes that shall not be used	Do not use CPT codes: 27215 (Use G0412 and Surgery CF) 27216 (Use G0413 and Surgery CF) 27217 (Use G0414 and Surgery CF) 27218 (Use G0415 and Surgery CF) 76140 (see §9789.17.2) 80100 through 80104 (see clinical lab fee schedule, §9789.50) 90889 (See §9789.14. Use codeWC005 code) 97014 (Use G0283 and Other Services CF) 99075 (see Medical-Legal fee schedule, §9795) 99080 (see §9789.14) 99241 through 99245 (see §9789.12.12) 99251 through 99255 (see §9789.12.12) 99455 and 99456.
Diagnostic Cardiovascular Procedure CPT codes subject to the MPPR	For services rendered on or after January 1, 2014: RVU14A, PPRRVU14_V1219, Number "6" in Column labeled "Mult Proc" (Modifier 51) also Addendum I, Diagnostic Cardiovascular Services Subject to The Multiple Procedure Payment Reduction (MPPR) CY 2014 CMS 1600 FC: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1600-FC.html?DLPage=1&DLSort=3&DLSortDir=descending For services rendered on or after April 15, 2014: RVU14B, PPRRVU14_V0324, Number "6" in Column labeled "Mult Proc" (Modifier 51) also Addendum I, Diagnostic Cardiovascular Services Subject to The Multiple Procedure Payment Reduction (MPPR) CY 2014 CMS 1600 FC For services rendered on or after July 1, 2014: RVU14C, PPRRVU14_V0515, Number "6" in Column labeled "Mult Proc" (Modifier 51) also Addendum I,

	Diagnostic Cardiovascular Services Subject to The Multiple Procedure Payment Reduction (MPPR) CY 2014 CMS 1600 FC For services rendered on or after October 1, 2014: RVU14D, PPRRVU14_V0815_v4, Number "6" in Column labeled "Mult Proc" (Modifier 51) also Addendum I, Diagnostic Cardiovascular Services Subject to The Multiple Procedure Payment Reduction (MPPR) CY 2014 CMS 1600 FC
Diagnostic Imaging Family Indicator Description	For services rendered on or after January 1, 2014: National Physician Fee Schedule Relative Value File Calendar Year 2014 http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU14A.html?DLPage=1&DLSort=0&DLSortDir=descending RVUPUF14 (PDF document) For services rendered on or after April 15, 2014: RVU14B, PPRRVU14_V0324, RVUPUF14 (PDF document) For services rendered on or after July 1, 2014: RVU14C, PPRRVU14_V0515, RVUPUF14 (PDF document) For services rendered on or after October 1, 2014: RVU14D, PPRRVU14_V0815_v4, RVUPUF14 (PDF document)
Diagnostic Imaging Family Indicator for Procedure	For services rendered on or after January 1, 2014: RVU14A, PPRRVU14_V1219, column AB, labeled, "Diagnostic Imaging Family Indicator". Also Addendum F, Diagnostic Imaging Service Subject to the Multiple Procedure Payment Reduction (MPPR) CY2014 CMS 1600 FC For services rendered on or after April 15, 2014: RVU14B, PPRRVU14_V0324, column AB, labeled, "Diagnostic Imaging Family Indicator". Also Addendum F, Diagnostic Imaging Service Subject to the Multiple Procedure Payment Reduction (MPPR) CY2014 CMS 1600 FC

	For services rendered on or after July 1, 2014: RVU14C, PPRRVU14_V0515, column AB, labeled, "Diagnostic Imaging Family Indicator". Also Addendum F, Diagnostic Imaging Service Subject to the Multiple Procedure Payment Reduction (MPPR) CY2014 CMS 1600 FC For services rendered on or after October 1, 2014: RVU14D, PPRRVU14_V0815_v4, column AB, labeled, "Diagnostic Imaging Family Indicator". Also Addendum F, Diagnostic Imaging Service Subject to the Multiple Procedure Payment Reduction (MPPR) CY2014 CMS 1600 FC
DWC Pharmaceutical Fee Schedule	http://www.dir.ca.gov/dwc/OMFS9904.htm#8
Geographic Health Professional Shortage Area zip code data files	2014 Primary Care HPSA [ZIP, 97KB] 2014 Mental Health HPSA [ZIP, 222KB]
Health Resources and Services Administration: Geographic HPSA shortage area query (By State & County) (By Address)	http://hpsafind.hrsa.gov/ http://datawarehouse.hrsa.gov/geoHPSAAdvisor/GeographicHPSAAdvisor.aspx
Incident To Codes	For services rendered on or after January 1, 2014: RVU14A, PPRRVU14_V1219, with PC/TC indicator number "5" For services rendered on or after April 15, 2014: RVU14B, PPRRVU14_V0324, with PC/TC indicator number "5" For services rendered on or after July 1, 2014: RVU14C, PPRRVU14_V0515, with PC/TC indicator number "5" For services rendered on or after October 1, 2014: RVU14D, PPRRVU14_V0815_v4, with PC/TC indicator number "5"

Medi-Cal Rates – DHCS	For services rendered on or after 1/1/2014, use: Medi-Cal Rates file - Updated 12/15/~~2014~~2013 For services rendered on or after 1/23/2014, use: Medi-Cal Rates file - Updated 1/15/2014 For services rendered on or after 2/15/2014, use: Medi-Cal Rates file - Updated 2/15/2014 For services rendered on or after 3/15/2014, use: Medi-Cal Rates file - Updated 3/15/2014 For services rendered on or after 6/15/2014, use: Medi-Cal Rates file - Updated 6/15/2014 For services rendered on or after 7/15/2014, use: Medi-Cal Rates file - Updated 7/15/2014 For services rendered on or after 8/15/2014, use: Medi-Cal Rates file - Updated 8/15/2014 For services rendered on or after 9/15/2014, use: Medi-Cal Rates file - Updated 9/15/2014 For services rendered on or after 10/15/2014, use: Medi-Cal Rates file - Updated 10/15/2014 For services rendered on or after 11/15/2014, use: Medi-Cal Rates file - Updated 11/15/2014 For services rendered on or after 12/15/2014, use: Medi-Cal Rates file - Updated 12/15/2014 For services rendered on or after 1/15/2015, use: Medi-Cal Rates file - Updated 1/15/2015 For services rendered on or after 2/15/2015, use: Medi-Cal Rates file - Updated 2/15/2015 Copies of the Medi-Cal Rates files (without CPT descriptors) are posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm

Ophthalmology Procedure CPT codes subject to the MPPR	For services rendered on or after January 1, 2014: RVU14A, PPRRVU14_V1219, Number "7" in Column labeled "Multiple Procedure" (Modifier 51). Also Addendum J, Diagnostic Ophthalmology Services Subject to the Multiple Procedure Payment Reduction (MPPR) CY 2014 CMS 1600 FC For services rendered on or after April 15, 2014: RVU14B, PPRRVU14_V0324, Number "7" in Column labeled "Multiple Procedure" (Modifier 51). Also Addendum J, Diagnostic Ophthalmology Services Subject to the Multiple Procedure Payment Reduction (MPPR) CY 2014 CMS 1600 FC For services rendered on or after July 1, 2014: RVU14C, PPRRVU14_V0515, Number "7" in Column labeled "Multiple Procedure" (Modifier 51). Also Addendum J, Diagnostic Ophthalmology Services Subject to the Multiple Procedure Payment Reduction (MPPR) CY 2014 CMS 1600 FC For services rendered on or after October 1, 2014: RVU14D, PPRRVU14_V0815_v4, Number "7" in Column labeled "Multiple Procedure" (Modifier 51). Also Addendum J, Diagnostic Ophthalmology Services Subject to the Multiple Procedure Payment Reduction (MPPR) CY 2014 CMS 1600 FC
Physical Therapy Multiple Procedure Payment Reduction: "Always Therapy" Codes; and Acupuncture and Chiropractic Codes	For services rendered on or after January 1, 2014: RVU14A, PPRRVU14_V1219, Number "5" in Column labeled "Mult Proc". Also Addendum H, Separately Payable Always Therapy Services Subject to the Multiple Procedure Payment Reduction (MPPR) CY 2014 CMS 1600 FC In addition, CPT codes: 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943 For services rendered on or after April 15, 2014: RVU14B, PPRRVU14_V0324 , Number "5" in Column labeled "Mult Proc". Also Addendum H, Separately Payable Always Therapy Services Subject to the Multiple Procedure Payment Reduction (MPPR) CY 2014 CMS 1600 FC In addition, CPT codes: 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943

	For services rendered on or after July 1, 2014: RVU14C, PPRRVU14_V0515 , Number "5" in Column labeled "Mult Proc". Also Addendum H, Separately Payable Always Therapy Services Subject to the Multiple Procedure Payment Reduction (MPPR) CY 2014 CMS 1600 FC In addition, CPT codes: 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943 For services rendered on or after October 1, 2014: RVU14D, PPRRVU14_V0815_v4 , Number "5" in Column labeled "Mult Proc". Also Addendum H, Separately Payable Always Therapy Services Subject to the Multiple Procedure Payment Reduction (MPPR) CY 2014 CMS 1600 FC In addition, CPT codes: 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943
Physician Time	CY 2014 PFS Physician Time [ZIP, 504KB]
Radiology Diagnostic Imaging Multiple Procedures	For services rendered on or after January 1, 2014: RVU14A, PPRRVU14_V1219, number "4" in column S, labeled, "Mult Proc" For services rendered on or after April 15, 2014: RVU14B, PPRRVU14_V0324 , number "4" in column S, labeled, "Mult Proc" For services rendered on or after July 1, 2014: RVU14C, PPRRVU14_V0515 , number "4" in column S, labeled, "Mult Proc" For services rendered on or after October 1, 2014: RVU14D, PPRRVU14_V0815_v4 , number "4" in column S, labeled, "Mult Proc"
Statewide GAFs (Other than anesthesia)	Average Statewide Work GAF: 1.040 Average Statewide Practice Expense GAF: 1.1606 Average Statewide Malpractice Expense GAF: 0.6636
Statewide GAF (Anesthesia)	Average Statewide Anesthesia GAF: 1.0313
The 1995 Documentation	https://www.cms.gov/Outreach-and-Education/Medicare-

Guidelines for Evaluation & Management Services	Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf
The 1997 Documentation Guidelines for Evaluation and Management Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf.

(b) Services Rendered On or After 3/1/2015. Documents listed in the following table are incorporated by reference and will be made available upon request to the Administrative Director.

Document/Data	**Services Rendered On or After March 1, 2015 & Mid-year Updates**
Adjustment Factors (These factors have been incorporated into the conversion factors listed below)	For all services other than anesthesia: 2015 Cumulative Relative Value Scale adjustment factor: 1.0703 [2015 annual adjustment factor x 2014 cumulative adjustment factor = 2015 cumulative adjustment factor (1.006 x 1.0638 = 1.0703)] 2015 RVS adjustment factor†: 0.9981 2015 Annual increase in the MEI: 1.008 2015 Annual adjustment factor: 1.006 (0.9981 x 1.008) For anesthesia services: 2015 Anesthesia cumulative adjustment factor: 1.0461 [2015 anesthesia annual adjustment factor x 2014 anesthesia cumulative adjustment factor = 2015 cumulative adjustment factor (1.001 x 1.0449 = 1.0461)] 2015 Total RVS adjustment factor†: 0.9932 2015 RVU budget neutrality factor: 0.9981 2015 Anesthesia practice expense adjustment factor: 0.99506 2015 Annual increase in the MEI: 1.008 2015 Anesthesia annual adjustment factor: 1.001 [BN RVU x Anesthesia PE Adjustment x MEI = (0.9981 x 0.99506 x 1.008) = 1.001] †RVS adjustment factor for 2015 is 1) the RVU budget neutrality adjustment factor for "all services other than anesthesia"; and 2) the product of RVU budget neutrality adjustment factor and the anesthesia practice expense

Document/Data	Services Rendered On or After March 1, 2015 & Mid-year Updates
	adjustment factor for anesthesia services.
Anesthesia Base Units by CPT Code	2014anesBASEfin
California-Specific Codes	WC001 – Not reimbursable WC002 - $12.01 WC003 - $38.99 for first page $23.99 each additional page. Maximum of six pages absent mutual agreement ($158.94) WC004 - $38.99 for first page $23.99 each additional page. Maximum of seven pages absent mutual agreement ($182.93) WC005 - $38.99 for first page, $23.99 each additional page. Maximum of six pages absent mutual agreement ($158.94) WC007 - $38.99 for first page $23.99 each additional page. Maximum of six pages absent mutual agreement ($158.94) WC008 - $10.34 for up to the first 15 pages. $0.25 for each additional page after the first 15 pages. WC009 - $10.34 for up to the first 15 pages. $0.25 for each additional page after the first 15 pages. WC010 - $5.17 per x-ray WC011 - $10.34 per scan WC012 - No Fee Prescribed/Non Reimbursable absent agreement
CCI Edits: Medically Unlikely Edits	For services rendered on or after March 1, 2015, use: "Practitioner Services MUE Table – Effective 1/1/2015." For services rendered on or after April 1, 2015, use: "Practitioner Services MUE Table – Effective 4/1/2015." For services rendered on or after July 1, 2015, use: "Practitioner Services MUE Table – Effective 7/1/2015." For services rendered on or after October 1, 2015, use: "Practitioner Services MUE Table – Effective 10/1/2015." Copies of the MUE Tables are posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm CMS posts only the most recent version of the Practitioner

Document/Data	Services Rendered On or After March 1, 2015 & Mid-year Updates
	Services MUE Table on the web at: http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html.
CCI Edits: National Correct Coding Initiative Policy Manual for Medicare Services	For services rendered on or after March 1, 2015: "NCCI Policy Manual for Medicare Services - Effective January 1, 2015 [ZIP, 1MB] " Copy of the 2015 Manual is posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm#7
CCI Edits: Physician CCI Edits (Practitioner PTP Edits)	For services rendered on or after March 1, 2015: Physician CCI Edits v21.0 effective January 1, 2015 (898,800 records). The last row contains edit column 1 = 39599 and column 2 = 49570 Physician CCI Edits v21.0 effective January 1, 2015 (787,357 records). The first row contains edit column 1 = 40490 and column 2 = C8950 For services rendered on or after April 1, 2015: Practitioner PTP Edits v21.1 effective April 1, 2015 (899,747 records). The last row contains edits column 1 = 39599 and column 2 = 49570 Practitioner PTP Edits v21.1 effective April 1, 2015 (787,520 records). The first row contains edits column 1 = 40490 and column 2 = C8950 For services rendered on or after July 1, 2015: Practitioner PTP Edits v21.2 effective July 1, 2015 (872,404 records). The last row contains edits column 1 = 39599 and column 2 = 49570 Practitioner PTP Edits v21.2 effective July 1, 2015 (821,537 records). The first row contains edits column 1 = 40490 and column 2 = 00170 For services rendered on or after October 1, 2015: Practitioner PTP Edits v21.3 effective October 1, 2015 (880,855 records). The last row contains edits column 1 = 39599 and column 2 = 49570 Practitioner PTP Edits v21.3 effective October 1, 2015 (832,093 records). The first row contains edits column 1 = 40490 and column 2 = 00170 Access the Physician CCI Edits on the CMS website: http://www.cms.gov/Medicare/Coding/NationalCorrectCodIni

Document/Data	Services Rendered On or After March 1, 2015 & Mid-year Updates
	tEd/NCCI-Coding-Edits.html Note: the Physician CCI Edits excel file maintained by CMS contains effective date and deletion date (if any) for each column 1/column 2 pair. Therefore, the most recent file is the only file posted on the CMS website, and covers all time periods.
CMS' Medicare National Physician Fee Schedule Relative Value File [Zip]	For services rendered on or after March 1, 2015: RVU15A (Updated 01/08/15) [ZIP, 2MB] • RVUPUF15 (Excluding Attachment A) • PPRRVU15_V1223c • OPPSCAP_V1223 Excluding: 15LOCCO ANES 2015_V122314 CY2015_GPCIs For services rendered on or after May 1, 2015: RVU15B [ZIP, 3MB] • RVUPUF15 (Excluding Attachment A) • PPRRVU15_V0213_Current • OPPSCAP_V0217 Excluding: 15LOCCO Anes_2015_122314 Anes_Conv_122314_fmt CY2015_GPCIs For services rendered on or after July 1, 2015: RVU15C [ZIP, 5MB] (Except the 0.5% update is not adopted) • RVUPUF15 (Excluding Attachment A) • PPRRVU15_UP05_V0622 • OPPSCAP_UP05_V0619 Excluding: 15LOCCO Anes_2015_122314 ANES_2015_UP05_V0701 CY2015_GPCIs PPRRVU15_UP0.V0515 OPPSCAP_UP0_V0515 For services rendered on or after October 1, 2015:

Document/Data	Services Rendered On or After March 1, 2015 & Mid-year Updates
	RVU15D [ZIP, 5MB] (Except the 0.5% update is not adopted) • RVUPUF15 (Excluding Attachment A) • PPRRVU15_OCT05_V1001 • OPPSCAP_UP05_V0815 Excluding: 15LOCCO Anes_2015_122314 ANES_2015_UP05_V0701 CY2015_GPCIs OPPSCAP_UP0_V0815 PPRRVU15_OCT_V1001
Conversion Factors adjusted for MEI and Relative Value Scale adjustment factor	Anesthesia Conversion Factor: $31.5290 Surgery Conversion Factor: $51.6570 Radiology Conversion Factor: $50.1900 Other Services Conversion Factor: $40.2970
Current Procedural Terminology (CPT®)	CPT 2015 https://commerce.ama-assn.org/store/
Current Procedural Terminology CPT codes that shall not be used	Do not use CPT codes: 27215 (Use G0412 and Surgery CF) 27216 (Use G0413 and Surgery CF) 27217 (Use G0414 and Surgery CF) 27218 (Use G0415 and Surgery CF) 76140 (see §9789.17.2) 90889 (See §9789.14. Use codeWC005 code) 97014 (Use G0283 and Other Services CF) 99075 (see Medical-Legal fee schedule, §9795) 99080 (see §9789.14) 99241 through 99245 (see §9789.12.12) 99251 through 99255 (see §9789.12.12) 99455 and 99456.
Diagnostic Cardiovascular Procedure CPT codes subject to the MPPR	For services rendered on or after March 1, 2015: RVU15A, PPRRVU15_V1223c, Number "6" in Column labeled "Mult Proc" (Modifier 51), also listed in CY 2015 PFS Final Rule Multiple Procedure Payment Reduction Files [Zip, 44KB], in the document CY_2015_PFS_1612-F_ Diagnostic Cardiovascular Services Subject To the Multiple Procedure Payment Reduction (MPPR) For services rendered on or after May 1, 2015:

Document/Data	Services Rendered On or After March 1, 2015 & Mid-year Updates
	RVU15B, PPRRVU15_V0213_Current, Number "6" in Column labeled "Mult Proc" (Modifier 51), also listed in CY 2015 PFS Final Rule Multiple Procedure Payment Reduction Files [Zip, 44KB], in the document CY_2015_PFS_1612-F_ Diagnostic Cardiovascular Services Subject To the Multiple Procedure Payment Reduction (MPPR) For services rendered on or after July 1, 2015: RVU15C, PPRRVU15_UP05_V0622, Number "6" in Column labeled "Mult Proc" (Modifier 51), also listed in CY 2015 PFS Final Rule Multiple Procedure Payment Reduction Files [Zip, 44KB], in the document CY_2015_PFS_1612-F_ Diagnostic Cardiovascular Services Subject To the Multiple Procedure Payment Reduction (MPPR) For services rendered on or after October 1, 2015: RVU15D, PPRRVU15_OCT05_V1001, Number "6" in Column labeled "Mult Proc" (Modifier 51), also listed in CY 2015 PFS Final Rule Multiple Procedure Payment Reduction Files [Zip, 44KB], in the document CY_2015_PFS_1612-F_ Diagnostic Cardiovascular Services Subject To the Multiple Procedure Payment Reduction (MPPR)
Diagnostic Imaging Family Indicator Description	For services rendered on or after March 1, 2015: Diagnostic Imaging Family Indicator: 88 = Subject to the reduction 99 = Concept does not apply RVU15A, RVUPUF15 (PDF document) For services rendered on or after May 1, 2015: Diagnostic Imaging Family Indicator: 88 = Subject to the reduction 99 = Concept does not apply RVU15B, RVUPUF15 (PDF document) For services rendered on or after July 1, 2015: Diagnostic Imaging Family Indicator: 88 = Subject to the reduction 99 = Concept does not apply RVU15C, RVUPUF15 (PDF document)

Document/Data	Services Rendered On or After March 1, 2015 & Mid-year Updates
	For services rendered on or after October 1, 2015: Diagnostic Imaging Family Indicator: 88 = Subject to the reduction 99 = Concept does not apply RVU15D, RVUPUF15 (PDF document)
Diagnostic Imaging Family Procedures Subject to the MPPR	For services rendered on or after March 1, 2015: RVU15A, PPRRVU15_V1223c, number "88" in column AB, labeled, "Diagnostic Imaging Family Indicator", also listed in CY 2015 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 44KB], in the document CY_2015_PFS_1612-F_Diagnostic Imaging Services Subject To the Multiple Procedure Payment Reduction (MPPR) For services rendered on or after May 1, 2015: RVU15B, PPRRVU15_V0213_Current, number "88" in column AB, labeled, "Diagnostic Imaging Family Indicator", also listed in CY 2015 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 44KB], in the document CY_2015_PFS_1612-F_Diagnostic Imaging Services Subject To the Multiple Procedure Payment Reduction (MPPR) For services rendered on or after July 1, 2015: RVU15C, PPRRVU15_UP05_V0622, number "88" in column AB, labeled, "Diagnostic Imaging Family Indicator", also listed in CY 2015 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 44KB], in the document CY_2015_PFS_1612-F_Diagnostic Imaging Services Subject To the Multiple Procedure Payment Reduction (MPPR) For services rendered on or after October 1, 2015: RVU15D, PPRRVU15_OCT05_V1001, number "88" in column AB, labeled, "Diagnostic Imaging Family Indicator", also listed in CY 2015 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 44KB], in the document CY_2015_PFS_1612-F_Diagnostic Imaging Services Subject To the Multiple Procedure Payment Reduction (MPPR)
Diagnostic Imaging	For services rendered on or after March 1, 2015:

Document/Data	Services Rendered On or After March 1, 2015 & Mid-year Updates
Multiple Procedures Subject to the MPPR	RVU15A, PPRRVU15_V1223c, number "4" in column S, labeled, "Mult Proc", also listed in CY 2015 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 44KB], in the document CY_2015_PFS_1612-F_Diagnostic Imaging Services Subject To the Multiple Procedure Payment Reduction (MPPR) For services rendered on or after May 1, 2015: RVU15B, PPRRVU15_V0213_Current, number "4" in column S, labeled, "Mult Proc", also listed in CY 2015 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 44KB], in the document CY_2015_PFS_1612-F_Diagnostic Imaging Services Subject To the Multiple Procedure Payment Reduction (MPPR) For services rendered on or after July 1, 2015: RVU15C, PPRRVU15_UP05_V0622, number "4" in column S, labeled, "Mult Proc", also listed in CY 2015 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 44KB], in the document CY_2015_PFS_1612-F_Diagnostic Imaging Services Subject To the Multiple Procedure Payment Reduction (MPPR) For services rendered on or after October 1, 2015: RVU15D, PPRRVU15_OCT05_V1001, number "4" in column S, labeled, "Mult Proc", also listed in CY 2015 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 44KB], in the document CY_2015_PFS_1612-F_Diagnostic Imaging Services Subject To the Multiple Procedure Payment Reduction (MPPR)
DWC Pharmaceutical Fee Schedule	http://www.dir.ca.gov/dwc/OMFS9904.htm#8
Geographic Health Professional Shortage Area zip code data files	2015 Primary Care HPSA [ZIP, 88KB] 2015 Mental Health HPSA [ZIP, 185KB]
Health Resources and Services Administration: Geographic HPSA shortage area query	http://hpsafind.hrsa.gov/

Document/Data	Services Rendered On or After March 1, 2015 & Mid-year Updates
(By State & County) (By Address)	http://datawarehouse.hrsa.gov/geoHPSAAdvisor/GeographicHPSAAdvisor.aspx
Incident To Codes	For services rendered on or after March 1, 2015: RVU15A, PPRRVU15_V1223c, with PC/TC indicator number "5" For services rendered on or after May 1, 2015: RVU15B, PPRRVU15_V0213_Current, with PC/TC indicator number "5" For services rendered on or after July 1, 2015: RVU15C, PPRRVU15_UP05_V0622, with PC/TC indicator number "5" For services rendered on or after October 1, 2015: RVU15D, PPRRVU15_OCT05_V1001, with PC/TC indicator number "5"
Medi-Cal Rates – DHCS	Pursuant to section 9789.13.2, the Medi-Cal Rates file's "Basic Rate" is used in calculating maximum fee for physician-administered drugs, biologicals, vaccines or blood products, by date of service. For services rendered on or after March 1, 2015, use: Medi-Cal Rates file - Updated 2/15/2015 For services rendered on or after March 15, 2015, use: Medi-Cal Rates file - Updated 3/15/2015 For services rendered on or after April 15, 2015, use: Medi-Cal Rates file - Updated 4/15/2015 For services rendered on or after May 15, 2015, use: Medi-Cal Rates file - Updated 5/15/2015 For services rendered on or after June 15, 2015, use: Medi-Cal Rates file - Updated 6/15/2015 For services rendered on or after July 15, 2015, use: Medi-Cal Rates file - Updated 7/15/2015 For services rendered on or after August 15, 2015, use:

Document/Data	Services Rendered On or After March 1, 2015 & Mid-year Updates
	Medi-Cal Rates file - Updated 8/15/2015 For services rendered on or after September 15, 2015, use: Medi-Cal Rates file - Updated 9/15/2015 For services rendered on or after October 15, 2015, use: Medi-Cal Rates file - Updated 10/15/2015 For services rendered on or after November 15, 2015, use: Medi-Cal Rates file - Updated 11/15/2015 For services rendered on or after December 15, 2015, use: Medi-Cal Rates file - Updated 12/15/2015 Copies of the Medi-Cal Rates files (without CPT descriptors) are posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm
Ophthalmology Procedure CPT codes subject to the MPPR	For services rendered on or after March 1, 2015: RVU15A, PPRRVU15_V1223c, Number "7" in Column labeled "Mult Proc" (Modifier 51). Also listed in CY 2015 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 44KB], in the document CY_2015_PFS_1612-F Diagnostic Ophthalmology Services Subject to the Multiple Procedure Payment Reduction (MPPR) For services rendered on or after May 1, 2015: RVU15B, PPRRVU15_V0213_Current, Number "7" in Column labeled "Mult Proc" (Modifier 51). Also listed in CY 2015 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 44KB], in the document CY_2015_PFS_1612-F Diagnostic Ophthalmology Services Subject to the Multiple Procedure Payment Reduction (MPPR) For services rendered on or after July 1, 2015: RVU15C, PPRRVU15_UP05_V0622, Number "7" in Column labeled "Mult Proc" (Modifier 51). Also listed in CY 2015 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 44KB], in the document CY_2015_PFS_1612-F Diagnostic Ophthalmology Services Subject to the Multiple Procedure Payment Reduction (MPPR)

Document/Data	Services Rendered On or After March 1, 2015 & Mid-year Updates
	For services rendered on or after October 1, 2015: RVU15D, PPRRVU15_OCT05_V1001, Number "7" in Column labeled "Mult Proc" (Modifier 51). Also listed in CY 2015 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 44KB], in the document CY_2015_PFS_1612-F Diagnostic Ophthalmology Services Subject to the Multiple Procedure Payment Reduction (MPPR)
Physical Therapy Multiple Procedure Payment Reduction: "Always Therapy" Codes; and Acupuncture and Chiropractic Codes	For services rendered on or after March 1, 2015: RVU15A, PPRRVU15_V1223c, Number "5" in Column labeled "Mult Proc". Also listed in the CY 2015 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 44KB] in the document CY_2015_PFS_1612-F Separately Payable Always Therapy Services Subject to the Multiple Procedure Payment Reduction (MPPR) In addition, CPT codes: 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943 For services rendered on or after May 1, 2015: RVU15B, PPRRVU15_V0213_Current, Number "5" in Column labeled "Mult Proc". Also listed in the CY 2015 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 44KB] in the document CY_2015_PFS_1612-F Separately Payable Always Therapy Services Subject to the Multiple Procedure Payment Reduction (MPPR) In addition, CPT codes: 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943 For services rendered on or after July 1, 2015: RVU15C, PPRRVU15_UP05_V0622, Number "5" in Column labeled "Mult Proc". Also listed in the CY 2015 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 44KB] in the document CY_2015_PFS_1612-F Separately Payable Always Therapy Services Subject to the Multiple Procedure Payment Reduction (MPPR) In addition, CPT codes: 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943 For services rendered on or after October 1, 2015:

Document/Data	Services Rendered On or After March 1, 2015 & Mid-year Updates
	RVU15D, PPRRVU15_OCT05_V1001, Number "5" in Column labeled "Mult Proc". Also listed in the CY 2015 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 44KB] in the document CY_2015_PFS_1612-F Separately Payable Always Therapy Services Subject to the Multiple Procedure Payment Reduction (MPPR) In addition, CPT codes: 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943
Physician Time	CY 2015 PFS Final Rule Physician Time Updated 01/20/15 [ZIP 478KB]
Statewide GAFs (Other than anesthesia)	Average Statewide Work GAF: 1.0420 Average Statewide Practice Expense GAF: 1.1621 Average Statewide Malpractice Expense GAF: 0.7388
Statewide GAF (Anesthesia)	Average Statewide Anesthesia GAF: 1.0391
Splints and Casting Supplies	For services rendered on or after March 1, 2015, use: The OMFS Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS) Fee Schedule applicable to the date of service.
The 1995 Documentation Guidelines for Evaluation & Management Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf
The 1997 Documentation Guidelines for Evaluation and Management Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf.

(c) Services Rendered On or After 1/1/2016. Documents listed in the following table are incorporated by reference and will be made available upon request to the Administrative Director.

Document/Data	Services Rendered On or After January 1, 2016 & Mid-year Updates
Adjustment Factors (These factors have been	For services rendered on or after January 1, 2016:

Document/Data	Services Rendered On or After January 1, 2016 & Mid-year Updates
incorporated into the conversion factors listed below)	For all services other than anesthesia: 2016 Cumulative adjustment factor: 1.0818 2016 RVU budget neutrality adjustment factor: 0.9998 2016 Annual increase in the MEI: 1.011 2015 Cumulative "other than anesthesia" adjustment 1.0703 For anesthesia services: 2016 Cumulative anesthesia adjustment factor: 1.0527 2016 RVU budget neutrality adjustment factor: 0.9998 2016 Anesthesia Practice Expense and Malpractice adjustment factor: 0.99555 2016 Annual increase in the MEI: 1.011 2015 Cumulative anesthesia adjustment: 1.0461 For services rendered on or after April 1, 2016: For all services other than anesthesia: 2016 Cumulative adjustment factor: 1.0812 2016 RVU budget neutrality adjustment factor: 0.99924 2016 Annual increase in the MEI: 1.011 2015 Cumulative "other than anesthesia" adjustment 1.0703 For anesthesia services: 2016 Cumulative anesthesia adjustment factor: 1.0317 2016 RVU budget neutrality adjustment factor: 0.99924 2016 Anesthesia Practice Expense and Malpractice adjustment factor: 0.97628 2016 Annual increase in the MEI: 1.011 2015 Cumulative anesthesia adjustment: 1.0461
Anesthesia Base Units by CPT Code	2014anesBASEfin
California-Specific Codes	WC001 – Not reimbursable WC002 - $12.14 WC003 - $39.42 for first page $24.25 each additional page. Maximum of six pages absent mutual agreement ($160.69) WC004 - $39.42 for first page $24.25 each additional page. Maximum of seven pages absent mutual agreement ($184.94) WC005 - $39.42 for first page, $24.25 each additional page. Maximum of six pages absent mutual agreement ($160.69) WC007 - $39.42 for first page

Document/Data	Services Rendered On or After January 1, 2016 & Mid-year Updates
	$24.25 each additional page. Maximum of six pages absent mutual agreement ($160.69) WC008 - $10.45 for up to the first 15 pages. $0.25 for each additional page after the first 15 pages. WC009 - $10.45 for up to the first 15 pages. $0.25 for each additional page after the first 15 pages. WC010 - $5.23 per x-ray WC011 - $10.45 per scan WC012 - No Fee Prescribed/Non Reimbursable absent agreement
CCI Edits: Medically Unlikely Edits	For services rendered on or after January 1, 2016, use: "Practitioner Services MUE Table – Effective 1/1/2016." For services rendered on or after April 1, 2016, use: "Practitioner Services MUE Table – Effective 4/1/2016." For services rendered on or after July 1, 2016, use: "Practitioner Services MUE Table – Effective 7/1/2016." For services rendered on or after October 1, 2016, use: "Practitioner Services MUE Table – Effective 10/1/2016." Copies of the MUE Tables are posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm CMS posts only the most recent version of the Practitioner Services MUE Table on the web at: http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html
CCI Edits: National Correct Coding Initiative Policy Manual for Medicare Services	For services rendered on or after January 1, 2016: "NCCI Policy Manual for Medicare Services - Effective January 1, 2016 [ZIP, 761MB] " Copy of the 2016 Manual is posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm#7
CCI Edits: Physician CCI Edits (Practitioner PTP Edits)	For services rendered on or after January 1, 2016: Practitioner PTP Edits v22.0 effective January 1, 2016 (903,287 records). The last row contains edits column 1 = 39599 and column 2 = 49570

Document/Data	Services Rendered On or After January 1, 2016 & Mid-year Updates
	Practitioner PTP Edits v22.0 effective January 1, 2016 (866,823 records). The first row contains edits column 1 = 40490 and column 2 = 00170 For services rendered on or after April 1, 2016: Practitioner PTP Edits v22.1 effective April 1, 2016 (914,985 records). The last row contains edits column 1 = 39599 and column 2 = 49570 Practitioner PTP Edits v22.1 effective April 1, 2016 (877,109 records). The first row contains edits column 1 = 40490 and column 2 = 00170 For services rendered on or after July 1, 2016: Practitioner PTP Edits v22.2 effective July 1, 2016 (915,436 records). The last row contains edits column 1 = 39599 and column 2 = 49570 Practitioner PTP Edits v22.2 effective July 1, 2016 (877,847 records). The first row contains edits column 1 = 40490 and column 2 = 00170 For services rendered on or after October 1, 2016: Practitioner PTP Edits v22.3 effective October 1, 2016 (668,511 records) 0001M/36591 – 29999/G0354 Practitioner PTP Edits v22.3 effective October 1, 2016 (498,018 records) 30000/0213T - 49999/49570 Practitioner PTP Edits v22.3 effective October 1, 2016 (489,682 records) 50010/0213T - 79999/90784 Practitioner PTP Edits v22.3 effective October 1, 2016 (179,162 records) 80003/80002 – R0075/R0070 Access the Physician CCI Edits on the CMS website: http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html Note: the Physician CCI Edits excel file maintained by CMS contains effective date and deletion date (if any) for each column 1/column 2 pair. Therefore, the most recent file is the

Document/Data	Services Rendered On or After January 1, 2016 & Mid-year Updates
	only file posted on the CMS website, and covers all time periods.
CMS' Medicare National Physician Fee Schedule Relative Value File [Zip]	For services rendered on or after January 1, 2016: RVU16A (Released January 2016) [ZIP, 3MB] • RVUPUF16 (Excluding Attachment A) • PPRRVU16_V0122 • OPPSCAP_V0105 Excluding: 16LOCCO ANES_V0105 CY2016_GPCIs For services rendered on or after April 1, 2016: RVU16B (April 2016 release) [ZIP, 3MB] • RVUPUF16 (Excluding Attachment A) • PPRRVU16_April_V0202 • OPPSCAP_V0215 Excluding: 16LOCCO ANES_V0105 CY2016_GPCIs For services rendered on or after July 1, 2016: RVU16C (July 2016 release) [ZIP, 3MB] • RVUPUF16 (Excluding Attachment A) • PPRRVU16_V0517 • OPPSCAP_V0515 Excluding: 16LOCCO ANES_V0105 CY2016_GPCIs For services rendered on or after October 1, 2016: RVU16D [ZIP, 3MB] • RVUPUF16 (Excluding Attachment A) • PPRRVU16_V0804 • OPPSCAP_V0815 Excluding: 16LOCCO ANES_V0105 CY2016_GPCIs

Document/Data	Services Rendered On or After January 1, 2016 & Mid-year Updates
Conversion Factors adjusted for MEI and Relative Value Scale adjustment factor	For services rendered on or after January 1, 2016: Anesthesia Conversion Factor: $29.3852 Surgery Conversion Factor: $48.2013 Radiology Conversion Factor: $47.4598 Other Services Conversion Factor: $42.4599 For services rendered on or after April 1, 2016: Anesthesia Conversion Factor: $28.8003 Surgery Conversion Factor: $48.1743 Radiology Conversion Factor: $47.4332 Other Services Conversion Factor: $42.4361
Current Procedural Terminology (CPT®)	CPT 2016 https://commerce.ama-assn.org/store/
Current Procedural Terminology CPT codes that shall not be used	Do not use CPT codes: 27215 (Use G0412 and Surgery CF) 27216 (Use G0413 and Surgery CF) 27217 (Use G0414 and Surgery CF) 27218 (Use G0415 and Surgery CF) 76140 (see §9789.17.2) 90889 (See §9789.14. Use codeWC005 code) 97014 (Use G0283 and Other Services CF) 99075 (see Medical-Legal fee schedule, §9795) 99080 (see §9789.14) 99241 through 99245 (see §9789.12.12) 99251 through 99255 (see §9789.12.12) 99455 and 99456
Diagnostic Cardiovascular Procedure CPT codes subject to the MPPR	For services rendered on or after January 1, 2016: RVU16A, PPRRVU16_V0122, Number "6" in column S, labeled "Mult Proc" (Modifier 51), also listed in CY 2016 PFS Final Rule Multiple Procedure Payment Reduction Files [Zip, 39KB], in the document CMS-1631-FC_Diagnostic Cardiovascular Services Subject to MPPR For services rendered on or after April 1, 2016: RVU16B, PPRRVU16_April_V0202, Number "6" in column S, labeled "Mult Proc" (Modifier 51), also listed in CY 2016

Document/Data	Services Rendered On or After January 1, 2016 & Mid-year Updates
	PFS Final Rule Multiple Procedure Payment Reduction Files [Zip, 39KB], in the document CMS-1631-FC_Diagnostic Cardiovascular Services Subject to MPPR For services rendered on or after July 1, 2016: RVU16C, PPRRVU16_V0517, Number "6" in column S, labeled "Mult Proc" (Modifier 51), also listed in CY 2016 PFS Final Rule Multiple Procedure Payment Reduction Files [Zip, 39KB], in the document CMS-1631-FC_Diagnostic Cardiovascular Services Subject to MPPR For services rendered on or after October 1, 2016: RVU16D, PPRRVU16_V0804, Number "6" in column S, labeled "Mult Proc" (Modifier 51), also listed in CY 2016 PFS Final Rule Multiple Procedure Payment Reduction Files [Zip, 39KB], in the document CMS-1631-FC_Diagnostic Cardiovascular Services Subject to MPPR
Diagnostic Imaging Family Indicator Description	For services rendered on or after January 1, 2016: Diagnostic Imaging Family Indicator: 88 = Subject to the reduction 99 = Concept does not apply RVU16A, RVUPUF16 (PDF document) For services rendered on or after April 1, 2016: Diagnostic Imaging Family Indicator: 88 = Subject to the reduction 99 = Concept does not apply RVU16B, RVUPUF16 (PDF document) For services rendered on or after July 1, 2016: Diagnostic Imaging Family Indicator: 88 = Subject to the reduction 99 = Concept does not apply RVU16C, RVUPUF16 (PDF document) For services rendered on or after October 1, 2016:

Document/Data	Services Rendered On or After January 1, 2016 & Mid-year Updates
	Diagnostic Imaging Family Indicator: 88 = Subject to the reduction 99 = Concept does not apply RVU16D, RVUPUF16 (PDF document)
Diagnostic Imaging Family Procedures Subject to the MPPR	For services rendered on or after January 1, 2016: RVU16A, PPRRVU16_V0122, number "88" in column AB, labeled, "Diagnostic Imaging Family Indicator", also listed in CY 2016 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 39KB], in the document CMS-1631-FC_Diagnostic Imaging Services Subject to MPPR For services rendered on or after April 1, 2016: RVU16B, PPRRVU16_April_V0202, number "88" in column AB, labeled, "Diagnostic Imaging Family Indicator", also listed in CY 2016 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 39KB], in the document CMS-1631-FC_Diagnostic Imaging Services Subject to MPPR For services rendered on or after July 1, 2016: RVU16C, PPRRVU16_V0517, number "88" in column AB, labeled, "Diagnostic Imaging Family Indicator", also listed in CY 2016 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 39KB], in the document CMS-1631-FC_Diagnostic Imaging Services Subject to MPPR For services rendered on or after October 1, 2016: RVU16D, PPRRVU16_V0804, number "88" in column AB, labeled, "Diagnostic Imaging Family Indicator", also listed in CY 2016 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 39KB], in the document CMS-1631-FC_Diagnostic Imaging Services Subject to MPPR
Diagnostic Imaging Multiple Procedures Subject to the MPPR	For services rendered on or after January 1, 2016: RVU16A, PPRRVU16_V0122, number "4" in column S, labeled, "Mult Proc", also listed in CY 2016 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 39KB], in the document CMS-1631-FC_Diagnostic Imaging Services Subject to MPPR

Document/Data	Services Rendered On or After January 1, 2016 & Mid-year Updates
	For services rendered on or after April 1, 2016: RVU16B, PPRRVU16_April_V0202, number "4" in column S, labeled, "Mult Proc", also listed in CY 2016 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 39KB], in the document CMS-1631-FC_Diagnostic Imaging Services Subject to MPPR For services rendered on or after July 1, 2016: RVU16C, PPRRVU16_V0517, number "4" in column S, labeled, "Mult Proc", also listed in CY 2016 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 39KB], in the document CMS-1631-FC_Diagnostic Imaging Services Subject to MPPR For services rendered on or after October 1, 2016: RVU16D, PPRRVU16_V0804, number "4" in column S, labeled, "Mult Proc", also listed in CY 2016 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 39KB], in the document CMS-1631-FC_Diagnostic Imaging Services Subject to MPPR
DWC Pharmaceutical Fee Schedule	http://www.dir.ca.gov/dwc/OMFS9904.htm#8
Geographic Health Professional Shortage Area zip code data files	2016 Primary Care HPSA [ZIP, 99KB] 2016 Mental Health HPSA [ZIP, 239KB] Access the files on the CMS website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses/index.html?redirect=/hpsapsaphysicianbonuses/
Health Resources and Services Administration: Geographic HPSA shortage area query (By State & County) (By Address)	http://hpsafind.hrsa.gov/ http://datawarehouse.hrsa.gov/geoHPSAAdvisor/GeographicHPSAAdvisor.aspx
Incident To Codes	For services rendered on or after January 1, 2016: RVU16A, PPRRVU16_V0122, number "5" in column N,

Document/Data	Services Rendered On or After January 1, 2016 & Mid-year Updates
	labeled, "PCTC IND", (PC/TC Indicator)\ For services rendered on or after April 1, 2016: RVU16B, PPRRVU16_April_V0202, number "5" in column N, labeled, "PCTC IND", (PC/TC Indicator) For services rendered on or after July 1, 2016: RVU16C, PPRRVU16_V0517, number "5" in column N, labeled, "PCTC IND", (PC/TC Indicator) For services rendered on or after October 1, 2016: RVU16D, PPRRVU16_V0804, number "5" in column N, labeled, "PCTC IND", (PC/TC Indicator)
Medi-Cal Rates – DHCS	Pursuant to section 9789.13.2, the Medi-Cal Rates file's "Basic Rate" is used in calculating maximum fee for physician-administered drugs, biologicals, vaccines or blood products, by date of service. For services rendered on or after ~~December 15, 2015~~January 1, 2016, use: Medi-Cal Rates file - Updated 12/15/2015 For services rendered on or after January 15, 2016, use: Medi-Cal Rates file - Updated 1/15/2016 For services rendered on or after February 15, 2016, use: Medi-Cal Rates file - Updated 2/15/2016 For services rendered on or after March 15, 2016, use: Medi-Cal Rates file - Updated 3/15/2016 For services rendered on or after April 15, 2016, use: Medi-Cal Rates file - Updated 4/15/2016 For services rendered on or after May 15, 2016, use: Medi-Cal Rates file - Updated 5/15/2016 For services rendered on or after June 15, 2016, use: Medi-Cal Rates file - Updated 6/15/2016 For services rendered on or after July 15, 2016, use: Medi-Cal Rates file - Updated 7/15/2016

Document/Data	Services Rendered On or After January 1, 2016 & Mid-year Updates
	For services rendered on or after August 15, 2016, use: Medi-Cal Rates file - Updated 8/15/2016 For services rendered on or after September 15, 2016, use: Medi-Cal Rates file - Updated 9/15/2016 For services rendered on or after October 15, 2016, use: Medi-Cal Rates file - Updated 10/15/2016 For services rendered on or after November 15, 2016, use: Medi-Cal Rates file - Updated 11/15/2016 For services rendered on or after December 15, 2016, use: Medi-Cal Rates file - Updated 12/15/2016 For services rendered on or after January 15, 2017, use: Medi-Cal Rates file – Updated 1/15/2017 For services rendered on or after February 15, 2017, use: Medi-Cal Rates file – Updated 2/15/2017 Copies of the Medi-Cal Rates files (without CPT descriptors) are posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm
Ophthalmology Procedure CPT codes subject to the MPPR	For services rendered on or after January 1, 2016: RVU16A, PPRRVU16_V0122, Number "7" in column S, labeled "Mult Proc" (Modifier 51). Also listed in CY 2016 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 39KB], in the CMS-1631-FC_Diagnostic Ophthalmology Services Subject to MPPR For services rendered on or after April 1, 2016: RVU16B, PPRRVU16_April_V0202, Number "7" in column S, labeled "Mult Proc" (Modifier 51). Also listed in CY 2016 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 39KB], in the CMS-1631-FC_Diagnostic Ophthalmology Services Subject to MPPR For services rendered on or after July 1, 2016: RVU16C, PPRRVU16_V0517, Number "7" in column S, labeled "Mult Proc" (Modifier 51). Also listed in CY 2016

Document/Data	Services Rendered On or After January 1, 2016 & Mid-year Updates
	PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 39KB], in the CMS-1631-FC_Diagnostic Ophthalmology Services Subject to MPPR For services rendered on or after October 1, 2016: RVU16D, PPRRVU16_V0804, Number "7" in column S, labeled "Mult Proc" (Modifier 51). Also listed in CY 2016 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 39KB], in the CMS-1631-FC_Diagnostic Ophthalmology Services Subject to MPPR
Physical Therapy Multiple Procedure Payment Reduction: "Always Therapy" Codes; and Acupuncture and Chiropractic Codes	For services rendered on or after January 1, 2016: RVU16A, PPRRVU16_V0122, Number "5" in column S, labeled "Mult Proc". Also listed in the CY 2016 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 39KB] in the document CMS-1631-FC_Separately Payable Therapy Services Subject to MPPR In addition, CPT codes: 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943 For services rendered on or after April 1, 2016: RVU16B, PPRRVU16_April_V0202, Number "5" in column S, labeled "Mult Proc". Also listed in the CY 2016 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 39KB] in the document CMS-1631-FC_Separately Payable Therapy Services Subject to MPPR In addition, CPT codes: 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943 For services rendered on or after July 1, 2016: RVU16C, PPRRVU16_V0517, Number "5" in column S, labeled "Mult Proc". Also listed in the CY 2016 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 39KB] in the document CMS-1631-FC_Separately Payable Therapy Services Subject to MPPR In addition, CPT codes: 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943 For services rendered on or after October 1, 2016: RVU16D, PPRRVU16_V0804, Number "5" in column S,

Document/Data	Services Rendered On or After January 1, 2016 & Mid-year Updates
	labeled "Mult Proc". Also listed in the CY 2016 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 39KB] in the document CMS-1631-FC_Separately Payable Therapy Services Subject to MPPR In addition, CPT codes: 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943
Physician Time	CY 2016 PFS Final Rule Work Time [ZIP 220KB]
Statewide GAFs (Other than anesthesia)	Average Statewide Work GAF: 1.0420 Average Statewide Practice Expense GAF: 1.1621 Average Statewide Malpractice Expense GAF: 0.7388
Statewide GAF (Anesthesia)	Average Statewide Anesthesia GAF: 1.0487
Splints and Casting Supplies	For services rendered on or after January 1, 2016, use: The OMFS Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS) Fee Schedule applicable to the date of service.
The 1995 Documentation Guidelines for Evaluation & Management Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf
The 1997 Documentation Guidelines for Evaluation and Management Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf

(d) Services Rendered On or After 3/1/2017. Documents listed in the following table are incorporated by reference and will be made available upon request to the Administrative Director.

Document/Data	Services Rendered On or After March 1, 2017 & Mid-year Updates
Adjustment Factors (These factors have been incorporated into the conversion factors listed below)	For services rendered on or after March 1, 2017: For all services other than anesthesia: 2017 Cumulative adjustment factor: 1.0933 2017 RVU budget neutrality adjustment factor: 0.99987 2017 Imaging MPPR adjustment factor: 0.9993 2017 Annual increase in the MEI: 1.012

Document/Data	Services Rendered On or After March 1, 2017 & Mid-year Updates
	2016 Cumulative "other than anesthesia" adjustment: 1.0812 For anesthesia services: 2017 Cumulative anesthesia adjustment factor: 1.0433 2017 RVU budget neutrality adjustment factor: 0.99987 2017 Imaging MPPR adjustment factor: 0.9993 2017 Annual increase in the MEI: 1.012 2016 Cumulative anesthesia adjustment: 1.0317
Anesthesia Base Units by CPT Code	2014anesBASEfin
California-Specific Codes	WC001 – Not reimbursable WC002 - $12.29 WC003 - $39.89 for first page $24.54 each additional page. Maximum of six pages absent mutual agreement ($162.59) WC004 - $39.89 for first page $24.54 each additional page. Maximum of seven pages absent mutual agreement ($187.13) WC005 - $39.89 for first page, $24.54 each additional page. Maximum of six pages absent mutual agreement ($162.59) WC007 - $39.89 for first page $24.54 each additional page. Maximum of six pages absent mutual agreement ($162.59) WC008 - $10.58 for up to the first 15 pages. $0.25 for each additional page after the first 15 pages. WC009 - $10.58 for up to the first 15 pages. $0.25 for each additional page after the first 15 pages. WC010 - $5.29 per x-ray WC011 - $10.58 per scan WC012 - No Fee Prescribed/Non Reimbursable absent agreement
CCI Edits: Medically Unlikely Edits	For services rendered on or after March 1, 2017, use: "Practitioner Services MUE Table – Effective 1/1/2017." Copies of the MUE Tables are posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm For services rendered on or after April 1, 2017, use: "Practitioner Services MUE Table – Effective 4/1/2017." Copies of the MUE Tables are posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm

Document/Data	Services Rendered On or After March 1, 2017 & Mid-year Updates
	For services rendered on or after July 1, 2017, use: "Practitioner Services MUE Table – Effective 7/1/2017." Copies of the MUE Tables are posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm For services rendered on or after October 1, 2017, use: "Practitioner Services MUE Table – Effective 10/1/2017." Copies of the MUE Tables are posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm CMS posts only the most recent version of the Practitioner Services MUE Table on the web at: http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html
CCI Edits: National Correct Coding Initiative Policy Manual for Medicare Services	For services rendered on or after March 1, 2017: "NCCI Policy Manual for Medicare Services - Effective January 1, 2017 [ZIP, 770KB]" Copy of the 2017 Manual is posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm#7
CCI Edits: Physician CCI Edits (Practitioner PTP Edits)	For services rendered on or after March 1, 2017: Practitioner PTP Edits v23.0 effective January 1, 2017 (422,052 records) 0001M/36591 – 24940/G0471 Practitioner PTP Edits v23.0 effective January 1, 2017 (574,135 records) 25000/01810 – 39599/49570 Practitioner PTP Edits v23.0 effective January 1, 2017 (436,857 records) 40490/00170 – 59897/G0347 Practitioner PTP Edits v23.0 effective January 1, 2017 (501,820 records) 60000/0213T – R0075/R0070 For services rendered on or after April 1, 2017: Practitioner PTP Edits v23.1 effective April 1, 2017 (474,500 records) 0001M/36591 – 25931/G0471 Practitioner PTP Edits v23.1 effective April 1, 2017 (502,046 records) 26010/01810 – 36909/J2001 Practitioner PTP Edits v23.1 effective April 1, 2017 (495,097 records) 37140/0213T – 60650/G0471 Practitioner PTP Edits v23.1 effective April 1, 2017 (501,223 records) 61000/0213T – R0075/R0070

Document/Data	Services Rendered On or After March 1, 2017 & Mid-year Updates
	For services rendered on or after July 1, 2017: Practitioner PTP Edits v23.2 effective July 1, 2017 (476,159 records) 0001M/36591 – 25931/G0471 [ZIP, 13MB] Practitioner PTP Edits v23.2 effective July 1, 2017 (502,166 records) 26010/01810 – 36909/J2001 [ZIP, 13MB] Practitioner PTP Edits v23.2 effective July 1, 2017 (495,291 records) 37140/0213T – 60650/G0471 [ZIP, 13MB] Practitioner PTP Edits v23.2 effective July 1, 2017 (503,693 records) 61000/0213T – R0075/R0070 [ZIP, 13MB] For services rendered on or after October 1, 2017: Practitioner PTP Edits v23.3 effective October 1, 2017 (476,064 records) 0001M/36591 – 25931/G0471 Practitioner PTP Edits v23.3 effective October 1, 2017 (502,759 records) 26010/01810 – 36909/J2001 Practitioner PTP Edits v23.3 effective October 1, 2017 (495,446 records) 37140/0213T – 60650/G0471 Practitioner PTP Edits v23.3 effective October 1, 2017 (504,589 records) 61000/0213T – R0075/R0070 Access the Physician CCI Edits on the CMS website: http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html Note: the Physician CCI Edits excel file maintained by CMS contains effective date and deletion date (if any) for each column 1/column 2 pair. Therefore, the most recent file is the only file posted on the CMS website, and covers all time periods.
CMS' Medicare National Physician Fee Schedule Relative Value File [Zip]	For services rendered on or after March 1, 2017: RVU17A (January 2017 release) [ZIP, 3MB] • RVU17A (Excluding Attachment A) • PPRRVU17_V1219 • OPPSCAP_V1219 Excluding: 17LOCCO ANES_V0101 CY2017_GPCIs For services rendered on or after April 1, 2017:

Document/Data	Services Rendered On or After March 1, 2017 & Mid-year Updates
	RVU17B [ZIP, 3MB] • RVU17B (Excluding Attachment A) • PPRRVU17_V0209 • OPPSCAP_V0215 Excluding: 17LOCCO ANES_V0101 CY2017_GPCIs For services rendered on or after July 1, 2017: RVU17C [ZIP, 3MB] • RVU17C (Excluding Attachment A) • PPRRVU17_JULY_V0503 • OPPSCAP_V0515 Excluding: 17LOCCO ANES_V0101 CY2017_GPCIs For services rendered on or after October 1, 2017: RVU17D [ZIP, 3MB] • RVUPUF17 (Excluding Attachment A) • PPRRVU17_OCT • OPPSCAP_OCT Excluding: 17LOCCO ANES_OCT CY2017_GPCIs
Conversion Factors adjusted for MEI and Relative Value Scale adjustment factor	For services rendered on or after March 1, 2017: Anesthesia Conversion Factor: $26.8011 Other Services Conversion Factor: $44.6572
Current Procedural Terminology (CPT®)	CPT 2017 https://commerce.ama-assn.org/store/
Current Procedural Terminology CPT codes that shall not be used	Do not use CPT codes: 27215 (Use G0412) 27216 (Use G0413) 27217 (Use G0414) 27218 (Use G0415) 76140 (see §9789.17.2)

Document/Data	Services Rendered On or After March 1, 2017 & Mid-year Updates
	90889 (See §9789.14. Use codeWC005 code) 97014 (Use G0283) 99075 (see Medical-Legal fee schedule, §9795) 99080 (see §9789.14) 99241 through 99245 (see §9789.12.12) 99251 through 99255 (see §9789.12.12) 99455 and 99456
Diagnostic Cardiovascular Procedure CPT codes subject to the MPPR	For services rendered on or after March 1, 2017: RVU17A, PPRRVU17_V1219, Number "6" in column S, labeled "Mult Proc" (Modifier 51), also listed in CY 2017 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 42KB], in the document CMS-1654-F_Diagnostic Cardiovascular Services Subject to MPPR For services rendered on or after April 1, 2017: RVU17B, PPRRVU17_V0209, Number "6" in column S, labeled "Mult Proc" (Modifier 51), also listed in CY 2017 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 42KB], in the document CMS-1654-F_Diagnostic Cardiovascular Services Subject to MPPR For services rendered on or after July 1, 2017: RVU17C, PPRRVU17_JULY_V0503, Number "6" in column S, labeled "Mult Proc" (Modifier 51), also listed in CY 2017 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 42KB], in the document CMS-1654-F_Diagnostic Cardiovascular Services Subject to MPPR For services rendered on or after October 1, 2017: RVU17D, PPRRVU17_OCT, Number "6" in column S, labeled "Mult Proc" (Modifier 51), also listed in CY 2017 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 42KB], in the document CMS-1654-F_Diagnostic Cardiovascular Services Subject to MPPR
Diagnostic Imaging Family Indicator Description	For services rendered on or after March 1, 2017: Diagnostic Imaging Family Indicator: 88 = Subject to the reduction 99 = Concept does not apply RVU17A, RVU17A (PDF document)

Document/Data	Services Rendered On or After March 1, 2017 & Mid-year Updates
	For services rendered on or after April 1, 2017: Diagnostic Imaging Family Indicator: 88 = Subject to the reduction 99 = Concept does not apply RVU17B, RVU17B (PDF document) For services rendered on or after July 1, 2017: Diagnostic Imaging Family Indicator: 88 = Subject to the reduction 99 = Concept does not apply RVU17C, RVU17C (PDF document) For services rendered on or after October 1, 2017: Diagnostic Imaging Family Indicator: 88 = Subject to the reduction 99 = Concept does not apply RVU17D, RVUPUF17 (PDF document)
Diagnostic Imaging Family Procedures Subject to the MPPR	For services rendered on or after March 1, 2017: RVU17A, PPRRVU17_V1219, number "88" in column AB, labeled, "Diagnostic Imaging Family Indicator", also listed in CY 2017 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 42KB], in the document CMS-1654-F _Diagnostic Imaging Services Subject to MPPR For services rendered on or after April 1, 2017: RVU17B, PPRRVU17_V0209, number "88" in column AB, labeled, "Diagnostic Imaging Family Indicator", also listed in CY 2017 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 42KB], in the document CMS-1654-F _Diagnostic Imaging Services Subject to MPPR For services rendered on or after July 1, 2017: RVU17C, PPRRVU17_JULY_V0503, number "88" in column AB, labeled, "Diagnostic Imaging Family Indicator", also listed in CY 2017 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 42KB], in the document CMS-1654-F _Diagnostic Imaging Services Subject to MPPR

Document/Data	Services Rendered On or After March 1, 2017 & Mid-year Updates
	For services rendered on or after October 1, 2017: RVU17D, PPRRVU17_OCT, number "88" in column AB, labeled, "Diagnostic Imaging Family Indicator," also listed in CY 2017 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 42KB], in the document CMS-1654-F _Diagnostic Imaging Services Subject to MPPR
Diagnostic Imaging Multiple Procedures Subject to the MPPR	For services rendered on or after March 1, 2017: RVU17A, PPRRVU17_V1219, number "4" in column S, labeled, "Mult Proc", also listed in CY 2017 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 42KB], in the document CMS-1654-F_Diagnostic Imaging Services Subject to MPPR For services rendered on or after April 1, 2017: RVU17B, PPRRVU17_V0209, number "4" in column S, labeled, "Mult Proc", also listed in CY 2017 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 42KB], in the document CMS-1654-F_Diagnostic Imaging Services Subject to MPPR For services rendered on or after July 1, 2017: RVU17C, PPRRVU17_JULY_V0503, number "4" in column S, labeled, "Mult Proc", also listed in CY 2017 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 42KB], in the document CMS-1654-F_Diagnostic Imaging Services Subject to MPPR For services rendered on or after October 1, 2017: RVU17D, PPRRVU17_OCT, number "4" in column S, labeled, "Mult Proc," also listed in CY 2017 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 42KB], in the document CMS-1654-F_Diagnostic Imaging Services Subject to MPPR
DWC Pharmaceutical Fee Schedule	http://www.dir.ca.gov/dwc/OMFS9904.htm#8
Geographic Health Professional Shortage Area zip code data files	2017 Primary Care HPSA [ZIP, 99KB] 2017 Mental Health HPSA [ZIP, 237KB]

Document/Data	Services Rendered On or After March 1, 2017 & Mid-year Updates
	Access the files on the CMS website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses/index.html?redirect=/hpsapsaphysicianbonuses/
Health Resources and Services Administration: Geographic HPSA shortage area query (By State & County) (By Address)	http://hpsafind.hrsa.gov/ http://datawarehouse.hrsa.gov/geoHPSAAdvisor/GeographicHPSAAdvisor.aspx
Incident To Codes	For services rendered on or after March 1, 2017: RVU17A, PPRRVU17_V1219, number "5" in column N, labeled, "PCTC IND", (PC/TC Indicator) For services rendered on or after April 1, 2017: RVU17B, PPRRVU17_V0209, number "5" in column N, labeled, "PCTC IND", (PC/TC Indicator) For services rendered on or after July 1, 2017: RVU17C, PPRRVU17_JULY_V0503, number "5" in column N, labeled, "PCTC IND", (PC/TC Indicator) For services rendered on or after October 1, 2017: RVU17D, PPRRVU17_OCT, number "5" in column N, labeled, "PCTC IND," (PC/TC Indicator)
Medi-Cal Rates – DHCS	Pursuant to section 9789.13.2, the Medi-Cal Rates file's "Basic Rate" is used in calculating maximum fee for physician-administered drugs, biologicals, vaccines or blood products, by date of service. For services rendered on or after March 1, 2017 use: Medi-Cal Rates file - Updated 2/15/2017 For services rendered on or after March 15, 2017, use: Medi-Cal Rates file - Updated 3/15/2017 For services rendered on or after April 15, 2017, use: Medi-Cal Rates file - Updated 4/15/2017

Document/Data	Services Rendered On or After March 1, 2017 & Mid-year Updates
	For services rendered on or after May 15, 2017, use: Medi-Cal Rates file – Updated 5/15/2017 For services rendered on or after June 15, 2017, use: Medi-Cal Rates file – Updated 6/15/2017 For services rendered on or after July 15, 2017, use: Medi-Cal Rates file – Updated 7/15/2017 For services rendered on or after August 15, 2017, use: Medi-Cal Rates file – Updated 8/15/2017 For services rendered on or after September 15, 2017, use: Medi-Cal Rates file – Updated 9/15/2017 For services rendered on or after October 15, 2017, use: Medi-Cal Rates file – Updated 10/15/2017 For services rendered on or after November 15, 2017, use: Medi-Cal Rates file – Updated 11/15/2017 For services rendered on or after December 15, 2017, use: Medi-Cal Rates file – Updated 12/15/2017 Copies of the Medi-Cal Rates files (without CPT descriptors) are posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm
Ophthalmology Procedure CPT codes subject to the MPPR	For services rendered on or after March 1, 2017: RVU17A, PPRRVU17_V1219, Number "7" in column S, labeled "Mult Proc" (Modifier 51). Also listed in CY 2017 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 42KB], in the CMS-1654-F_Diagnostic Ophthalmology Services Subject to MPPR For services rendered on or after April 1, 2017: RVU17B, PPRRVU17_V0209, Number "7" in column S, labeled "Mult Proc" (Modifier 51). Also listed in CY 2017 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 42KB], in the CMS-1654-F_Diagnostic Ophthalmology Services Subject to MPPR

Document/Data	Services Rendered On or After March 1, 2017 & Mid-year Updates
	For services rendered on or after July 1, 2017: RVU17C, PPRRVU17_JULY_V0503, Number "7" in column S, labeled "Mult Proc" (Modifier 51). Also listed in CY 2017 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 42KB], in the CMS-1654-F_Diagnostic Ophthalmology Services Subject to MPPR For services rendered on or after October 1, 2017: RVU17D, PPRRVU17_OCT, Number "7" in column S, labeled "Mult Proc" (Modifier 51). Also listed in CY 2017 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 42KB], in the CMS-1654-F_Diagnostic Ophthalmology Services Subject to MPPR
Physical Therapy Multiple Procedure Payment Reduction: "Always Therapy" Codes; and Acupuncture and Chiropractic Codes	For services rendered on or after March 1, 2017: RVU17A, PPRRVU17_V1219, Number "5" in column S, labeled "Mult Proc". Also listed in the CY 2017 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 42KB] in the document CMS-1654-F_Separately Payable Therapy Services Subject to MPPR In addition, CPT codes: 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943 For services rendered on or after April 1, 2017: RVU17B, PPRRVU17_V0209, Number "5" in column S, labeled "Mult Proc". Also listed in the CY 2017 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 42KB] in the document CMS-1654-F_Separately Payable Therapy Services Subject to MPPR In addition, CPT codes: 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943 For services rendered on or after July 1, 2017: RVU17C, PPRRVU17_JULY_V0503, Number "5" in column S, labeled "Mult Proc". Also listed in the CY 2017 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 42KB] in the document CMS-1654-F_Separately Payable Therapy Services Subject to MPPR In addition, CPT codes: 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943

Document/Data	Services Rendered On or After March 1, 2017 & Mid-year Updates
	For services rendered on or after October 1, 2017: RVU17D, PPRRVU17_OCT, Number "5" in column S, labeled "Mult Proc." Also listed in the CY 2017 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 42KB] in the document CMS-1654-F_Separately Payable Therapy Services Subject to MPPR In addition, CPT codes: 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943
Physician Time	CY 2017 PFS Final Rule Physician Time [ZIP, 628KB]
Statewide GAFs (Other than anesthesia)	Average Statewide Work GAF: 1.0417 Average Statewide Practice Expense GAF: 1.1632 Average Statewide Malpractice Expense GAF: 0.6632
Statewide GAF (Anesthesia)	Average Statewide Anesthesia GAF: 1.0374
Splints and Casting Supplies	For services rendered on or after March 1, 2017, use: The OMFS Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS) Fee Schedule applicable to the date of service.
The 1995 Documentation Guidelines for Evaluation & Management Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf
The 1997 Documentation Guidelines for Evaluation and Management Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf

(e) Services Rendered On or After 1/1/2018. Documents listed in the following table are incorporated by reference and will be made available upon request to the Administrative Director.

Document/Data	Services Rendered On or After January 1, 2018 & Mid-year Updates
Adjustment Factors (These factors have been incorporated into the conversion factors listed below)	For services rendered on or after January 1, 2018: For all services other than anesthesia: 2018 Cumulative adjustment factor: 1.1075 2018 RVU budget neutrality adjustment factor: 0.9990

Document/Data	Services Rendered On or After January 1, 2018 & Mid-year Updates
	2018 Annual increase in the MEI: 1.014 2017 Cumulative "other than anesthesia" adjustment: 1.0933 For anesthesia services: 2018 Cumulative anesthesia adjustment factor: 1.0604 2018 RVU budget neutrality adjustment factor: 0.9990 2018 Annual increase in the MEI: 1.014 2018 Anesthesia practice expense and malpractice adjustment factor: 1.0034 2017 Cumulative anesthesia adjustment: 1.0433
Anesthesia Base Units by CPT Code	cms1676f_cy_2018_anesthesia_base_units.xlsx
California-Specific Codes	WC001 – Not reimbursable WC002 - $12.46 WC003 - $40.45 for first page $24.88 each additional page. Maximum of six pages absent mutual agreement ($164.85) WC004 - $40.45 for first page $24.88 each additional page. Maximum of seven pages absent mutual agreement ($189.73) WC005 - $40.45 for first page, $24.88 each additional page. Maximum of six pages absent mutual agreement ($164.85) WC007 - $40.45 for first page $24.88 each additional page. Maximum of six pages absent mutual agreement ($164.85) WC008 - $10.73 for up to the first 15 pages. $0.25 for each additional page after the first 15 pages. WC009 - $10.73 for up to the first 15 pages. $0.25 for each additional page after the first 15 pages. WC010 - $5.36 per x-ray WC011 - $10.73 per scan WC012 - No Fee Prescribed/Non Reimbursable absent agreement
CCI Edits: Medically Unlikely Edits	For services rendered on or after January 1, 2018, use: "Practitioner Services MUE Table - Effective 1/1/18." Copy of the MUE Table is posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm For services rendered on or after April 1, 2018, use: "Practitioner Services MUE Table - Effective 4/1/18"

Document/Data	Services Rendered On or After January 1, 2018 & Mid-year Updates
	Copy of the MUE Table is posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm For services rendered on or after July 1, 2018, use: "Practitioner Services MUE Table - Effective 07-01-2018 [ZIP, 346KB]," excluding all codes listed with Practitioner Services MUE Value of "0" (zero). Excerpts of the MUE Table is posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm For services rendered on or after October 1, 2018, use: "Practitioner Services MUE Table – Effective 10-01-2018 [ZIP, 348KB]," excluding all codes listed with Practitioner Services MUE Value of "0" (zero). Excerpts of the MUE Table is posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm ~~Copies of the MUE Tables are posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm~~ ~~CMS posts only the most recent version of the Practitioner Services MUE Table on the web at: http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html~~
CCI Edits: National Correct Coding Initiative Policy Manual for Medicare Services	For services rendered on or after January 1, 2018: "NCCI Policy Manual for Medicare Services - Effective January 1, 2018 [ZIP, 851KB]" Copy of the 2018 Manual is posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm#7
CCI Edits: ~~Physician CCI Edits~~ ~~(~~Practitioner Procedure to Procedure (PTP) Edits~~)~~	For services rendered on or after January 1, 2018: Practitioner PTP Edits v24.0 effective January 1, 2018 (511,599 records) 0001M/36591 – 25931/G0471 Practitioner PTP Edits v24.0 effective January 1, 2018 (507,927 records) 26010/01810 – 36909/J2001 Practitioner PTP Edits v24.0 effective January 1, 2018 (474,903 records) 37140/0213T – 60650/G0471 Practitioner PTP Edits v24.0 effective January 1, 2018 (514,837 records) 61000/0213T – R0075/R0070 For services rendered on or after April 1, 2018:

Document/Data	Services Rendered On or After January 1, 2018 & Mid-year Updates
	Practitioner PTP Edits v24.1 effective April 1, 2018 (537,183 records) 0001M/36591 – 25931/G0471 Practitioner PTP Edits v24.1 effective April 1, 2018 (482,358 records) 26010/01810 – 36909/J2001 Practitioner PTP Edits v24.1 effective April 1, 2018 (523,111 records) 37140/0213T – 60650/G0471 Practitioner PTP Edits v24.1 effective April 1, 2018 (466,820 records) 61000/0213T – R0075/R0070 For services rendered on or after July 1, 2018: Practitioner PTP Edits v24.2 effective July 1, 2018 (539,120 records) 0001M/36591 – 26992/G0471 Practitioner PTP Edits v24.2 effective July 1, 2018 (482,378 records) 27000/01995 – 37790/G0471 Practitioner PTP Edits v24.2 effective July 1, 2018 (523,129 records) 38100/0213T – 61888/G0471 Practitioner PTP Edits v24.2 effective July 1, 2018 (467,725 records) 62000/0213T – R0075/R0070 For services rendered on or after October 1, 2018: Practitioner PTP Edits v24.3 effective October 1, 2018 (539,717 records) 0001M/36591 – 26992/G0471 Practitioner PTP Edits v24.3 effective October 1, 2018 (482,493 records) 27000/01995 – 37790/G0471 Practitioner PTP Edits v24.3 effective October 1, 2018 (523,504 records) 38100/0213T – 61888/G0471 Practitioner PTP Edits v24.3 effective October 1, 2018 (467,777 records) 62000/0213T – R0075/R0070 Access the ~~Physician CCI Edits~~ Practitioner PTP Edits on the CMS website: http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html Note: the ~~Physician CCI Edits~~ Practitioner PTP Edits excel file maintained by CMS contains effective date and deletion date (if any) for each column 1/column 2 pair. Therefore, the most recent file is the only file posted on the CMS website, and covers all time periods.
CMS' Medicare National Physician Fee Schedule Relative Value File [Zip]	For services rendered on or after January 1, 2018: RVU18A (Updated ~~11/30/17~~12/20/2017) [ZIP, 3MB] • RVU18A (Excluding Attachment A) • PPRRVU18_JAN

Document/Data	Services Rendered On or After January 1, 2018 & Mid-year Updates
	• OPPSCAP_JAN Excluding: 18LOCCO ANES2018 GPCI2018 For services rendered on or after April 1, 2018: RVU18B [ZIP, 3MB] • RVU18B (Excluding Attachment A) • PPRRVU18_APR • OPPSCAP_APR Excluding: 18LOCCO ANES2018 GPCI2018 For services rendered on or after July 1, 2018: RVU18C1 [ZIP, 3MB] • RVU18C (Excluding Attachment A) • PPRRVU18_JUL • OPPSCAP_JUL Excluding: 18LOCCO ANES2018 GPCI2018 For services rendered on or after October 1, 2018: RVU18D [ZIP, 3MB] • RVU18D (Excluding Attachment A) • PPRRVU18_OCT • OPPSCAP_OCT Excluding: 18LOCCO ANES2018 GPCI2018
Conversion Factors adjusted for MEI and Relative Value Scale adjustment factor	For services rendered on or after January 1, 2018: Anesthesia Conversion Factor: $27.2415 Other Services Conversion Factor: $45.2371
Current Procedural	CPT 2018

Document/Data	Services Rendered On or After January 1, 2018 & Mid-year Updates
Terminology (CPT®)	https://commerce.ama-assn.org/store/
Current Procedural Terminology CPT codes that shall not be used	Do not use CPT codes: 27215 (Use G0412) 27216 (Use G0413) 27217 (Use G0414) 27218 (Use G0415) 76140 (see §9789.17.2) 90889 (See §9789.14. Use codeWC005 code) 97014 (Use G0283) 97127 (Use G0515) 99075 (see Medical-Legal fee schedule, §9795) 99080 (see §9789.14) 99241 through 99245 (see §9789.12.12) 99251 through 99255 (see §9789.12.12) 99455 and 99456
Diagnostic Cardiovascular Procedure CPT codes subject to the MPPR	For services rendered on or after January 1, 2018: RVU18A, PPRRVU18_JAN, number "6" in column S, labeled "Mult Proc" (Modifier 51), also listed in CY 2018 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 42KB], in the document CMS-1676-F_Diagnostic Cardiovascular Services Subject to MPPR For services rendered on or after April 1, 2018: RVU18B, PPRRVU18_APR, number "6" in column S, labeled "Mult Proc" (Modifier 51), also listed in CY 2018 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 42KB], in the document CMS-1676-F_Diagnostic Cardiovascular Services Subject to MPPR For services rendered on or after July 1, 2018: RVU18C1, PPRRVU18_JUL, number "6" in column S, labeled "Mult Proc" (Modifier 51), also listed in CY 2018 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 42KB], in the document CMS-1676-F_Diagnostic Cardiovascular Services Subject to MPPR For services rendered on or after October 1, 2018: RVU18D, PPRRVU18_OCT, number "6" in column S, labeled "Mult Proc" (Modifier 51), also listed in CY 2018 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 42KB], in the document CMS-1676-F_Diagnostic Cardiovascular Services Subject to MPPR

Document/Data	Services Rendered On or After January 1, 2018 & Mid-year Updates
Diagnostic Imaging Family Indicator Description	For services rendered on or after January 1, 2018: Diagnostic Imaging Family Indicator: 88 = Subject to the reduction 99 = Concept does not apply RVU18A, RVU18A (PDF document) For services rendered on or after April 1, 2018: Diagnostic Imaging Family Indicator: 88 = Subject to the reduction 99 = Concept does not apply RVU18B, RVU18B (PDF document) For services rendered on or after July 1, 2018: Diagnostic Imaging Family Indicator: 88 = Subject to the reduction 99 = Concept does not apply RVU18C1, RVU18C (PDF document) For services rendered on or after October 1, 2018: Diagnostic Imaging Family Indicator: 88 = Subject to the reduction 99 = Concept does not apply RVU18D, RVU18D (PDF document)
Diagnostic Imaging Family Procedures Subject to the MPPR	For services rendered on or after January 1, 2018: RVU18A, PPRRVU18_JAN, number "88" in column AB, labeled, "Diagnostic Imaging Family Indicator," also listed in CY 2018 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 42KB], in the document CMS-1676-F_Diagnostic Imaging Services Subject to MPPR For services rendered on or after April 1, 2018: RVU18B, PPRRVU18_APR, number "88" in column AB, labeled, "Diagnostic Imaging Family Indicator," also listed in CY 2018 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 42KB], in the document CMS-1676-

Document/Data	Services Rendered On or After January 1, 2018 & Mid-year Updates
	F_Diagnostic Imaging Services Subject to MPPR For services rendered on or after July 1, 2018: RVU18C1, PPRRVU18_JUL, number "88" in column AB, labeled, "Diagnostic Imaging Family Indicator," also listed in CY 2018 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 42KB], in the document CMS-1676-F_Diagnostic Imaging Services Subject to MPPR For services rendered on or after October 1, 2018: RVU18D, PPRRVU18_OCT, number "88" in column AB, labeled, "Diagnostic Imaging Family Indicator," also listed in CY 2018 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 42KB], in the document CMS-1676-F_Diagnostic Imaging Services Subject to MPPR
Diagnostic Imaging Multiple Procedures Subject to the MPPR	For services rendered on or after January 1, 2018: RVU18A, PPRRVU18_JAN, number "4" in column S, labeled, "Mult Proc," also listed in CY 2018 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 42KB], in the document CMS-1676-F_Diagnostic Imaging Services Subject to MPPR For services rendered on or after April 1, 2018: RVU18B, PPRRVU18_APR, number "4" in column S, labeled, "Mult Proc," also listed in CY 2018 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 42KB], in the document CMS-1676-F_Diagnostic Imaging Services Subject to MPPR For services rendered on or after July 1, 2018: RVU18C1, PPRRVU18_JUL, number "4" in column S, labeled, "Mult Proc," also listed in CY 2018 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 42KB], in the document CMS-1676-F_Diagnostic Imaging Services Subject to MPPR For services rendered on or after October 1, 2018: RVU18D, PPRRVU18_OCT, number "4" in column S, labeled, "Mult Proc," also listed in CY 2018 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 42KB], in the document CMS-1676-F_Diagnostic Imaging Services

Document/Data	Services Rendered On or After January 1, 2018 & Mid-year Updates
	Subject to MPPR
DWC Pharmaceutical Fee Schedule	http://www.dir.ca.gov/dwc/OMFS9904.htm#8
Geographic Health Professional Shortage Area zip code data files	2018 Primary Care HPSA [ZIP, 98KB] 2018 Mental Health HPSA [ZIP, 218KB] Access the files on the CMS website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses/index.html?redirect=/hpsapsaphysicianbonuses/
Health Resources and Services Administration: Geographic HPSA shortage area query (By State & County) (By Address)	http://hpsafind.hrsa.gov/ http://datawarehouse.hrsa.gov/geoHPSAAdvisor/GeographicHPSAAdvisor.aspx
Incident To Codes	For services rendered on or after January 1, 2018: RVU18A, PPRRVU18_JAN, number "5" in column N, labeled, "PCTC IND," (PC/TC Indicator) For services rendered on or after April 1, 2018: RVU18B, PPRRVU18_APR, number "5" in column N, labeled, "PCTC IND," (PC/TC Indicator) For services rendered on or after July 1, 2018: RVU18C1, PPRRVU18_JUL, number "5" in column N, labeled, "PCTC IND," (PC/TC Indicator) For services rendered on or after October 1, 2018: RVU18D, PPRRVU18_OCT, number "5" in column N, labeled, "PCTC IND," (PC/TC Indicator)
Medi-Cal Rates – DHCS	Pursuant to section 9789.13.2, the Medi-Cal Rates file's "Basic Rate" is used in calculating maximum fee for physician-administered drugs, biologicals, vaccines or blood products, by date of service. For services rendered on or after ~~December 15, 2017~~January

Document/Data	Services Rendered On or After January 1, 2018 & Mid-year Updates
	1, 2018, use: Medi-Cal Rates file – Updated 12/15/2017 For services rendered on or after January 15, 2018, use: Medi-Cal Rates file - Updated 1/15/2018. For services rendered on or after February 15, 2018, use: Medi-Cal Rates file - Updated 2/15/2018. For services rendered on or after March 15, 2018, use: Medi-Cal Rates file - Updated 3/15/2018. For services rendered on or after April 15, 2018, use: Medi-Cal Rates file - Updated 4/15/2018 For services rendered on or after May 15, 2018, use: Medi-Cal Rates file - Updated 5/15/2018 For services rendered on or after June 15, 2018, use: Medi-Cal Rates file - Updated 6/15/2018 For services rendered on or after July 15, 2018, use: Medi-Cal Rates file - Updated 7/15/2018 For services rendered on or after August 15, 2018, use: Medi-Cal Rates file - Updated 8/15/2018 For services rendered on or after September 15, 2018, use: Medi-Cal Rates file - Updated 9/15/2018 Copies of the Medi-Cal Rates files (without CPT descriptors) are posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm
Ophthalmology Procedure CPT codes subject to the MPPR	For services rendered on or after January 1, 2018: RVU18A, PPRRVU18_JAN, number "7" in column S, labeled "Mult Proc" (Modifier 51). Also listed in CY 2018 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 42KB], in the document CMS-1676-F_Diagnostic Ophthalmology Services Subject to MPPR For services rendered on or after April 1, 2018: RVU18B, PPRRVU18_APR, number "7" in column S, labeled "Mult Proc" (Modifier 51). Also listed in CY 2018

Document/Data	Services Rendered On or After January 1, 2018 & Mid-year Updates
	PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 42KB], in the document CMS-1676-F_Diagnostic Ophthalmology Services Subject to MPPR For services rendered on or after July 1, 2018: RVU18C1, PPRRVU18_JUL, number "7" in column S, labeled "Mult Proc" (Modifier 51). Also listed in CY 2018 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 42KB], in the document CMS-1676-F_Diagnostic Ophthalmology Services Subject to MPPR For services rendered on or after October 1, 2018: RVU18D, PPRRVU18_OCT, number "7" in column S, labeled "Mult Proc" (Modifier 51). Also listed in CY 2018 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 42KB], in the document CMS-1676-F_Diagnostic Ophthalmology Services Subject to MPPR
Physical Therapy Multiple Procedure Payment Reduction: "Always Therapy" Codes; and Acupuncture and Chiropractic Codes	For services rendered on or after January 1, 2018: RVU18A, PPRRVU18_JAN, number "5" in column S, labeled "Mult Proc." Also listed in CY 2018 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 42KB], in the document CMS-1676-F_Separately Payable Therapy Services Subject to MPPR In addition, CPT codes: 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943 For services rendered on or after April 1, 2018: RVU18B, PPRRVU18_APR, number "5" in column S, labeled "Mult Proc." Also listed in CY 2018 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 42KB], in the document CMS-1676-F_Separately Payable Therapy Services Subject to MPPR In addition, CPT codes: 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943 For services rendered on or after July 1, 2018: RVU18C1, PPRRVU18_JUL, number "5" in column S, labeled "Mult Proc." Also listed in CY 2018 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 42KB], in the document CMS-1676-F_Separately Payable Therapy

Document/Data	Services Rendered On or After January 1, 2018 & Mid-year Updates
	Services Subject to MPPR In addition, CPT codes: 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943 For services rendered on or after October 1, 2018: RVU18D, PPRRVU18_OCT, number "5" in column S, labeled "Mult Proc." Also listed in CY 2018 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 42KB], in the document CMS-1676-F_Separately Payable Therapy Services Subject to MPPR In addition, CPT codes: 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943
Physician Time	CY 2018 PFS Final Rule Physician Time [ZIP, 591KB]
Statewide GAFs (Other than anesthesia)	Average Statewide Work GAF: 1.041 Average Statewide Practice Expense GAF: 1.166 Average Statewide Malpractice Expense GAF: 0.605
Statewide GAF (Anesthesia)	Average Statewide Anesthesia GAF: 1.034
Splints and Casting Supplies	For services rendered on or after January 1, 2018, use: The OMFS Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS) Fee Schedule applicable to the date of service.
The 1995 Documentation Guidelines for Evaluation & Management Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf
The 1997 Documentation Guidelines for Evaluation and Management Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf

(f) Services Rendered On or After January 1, 2019. Documents listed in the following table are incorporated by reference and will be made available upon request to the Administrative Director. [For purposes of this rulemaking, place-holder information is used in select columns and rows. 2019 CMS payment files, factors, and file names are not available yet, and when available will be adopted and incorporated by reference by

Administrative Director Order. Upon adoption, reference to payment files, factors, and file names will be replaced to reflect the 2019 CMS information.]

Document/Data	**Services Rendered On or After January 1, 2019 & Mid-year Updates**
Adjustment Factors (These factors have been incorporated into the conversion factors listed below)	For all services other than anesthesia: 2019 Cumulative adjustment factor: X.XXXX 2019 RVU budget neutrality adjustment factor: X.XXXX 2019 Annual increase in the MEI: X.XXX 2018 Cumulative "other than anesthesia" adjustment: X.XXXX For anesthesia services: 2019 Cumulative anesthesia adjustment factor: X.XXXX 2019 RVU budget neutrality adjustment factor: X.XXXX 2019 Annual increase in the MEI: X.XXX 2019 Anesthesia practice expense and malpractice adjustment factor: X.XXXX 2018 Cumulative anesthesia adjustment: X.XXXX
Anesthesia Base Units by CPT Code	cmsXXXXX_cy_2019_anesthesia_base_units.xlsx
California-Specific Codes	WC001 – Not reimbursable WC002 - $X.XX WC003 - $XX.XX for first page $XX.XX each additional page. Maximum of six pages absent mutual agreement ($XXX.XX) WC004 - $XX.XX for first page $XX.XX each additional page. Maximum of seven pages absent mutual agreement ($XXX.XX) WC005 - $XX.XX for first page, $XX.XX each additional page. Maximum of six pages absent mutual agreement ($XXX.XX) WC007 - $XX.XX for first page $XX.XX each additional page. Maximum of six pages absent mutual agreement ($XXX.XX) WC008 - $XX.XX for up to the first 15 pages. $0.XX for each additional page after the first 15 pages. WC009 - $XX.XX for up to the first 15 pages. $0.XX for each additional page after the first 15 pages. WC010 - $X.XX per x-ray WC011 - $XX.XX per scan WC012 - No Fee Prescribed/Non Reimbursable absent agreement

Document/Data	Services Rendered On or After January 1, 2019 & Mid-year Updates
CCI Edits: Medically Unlikely Edits	For services rendered on or after January 1, 2019: "Practitioner Services MUE Table - Effective 1/1/19," excluding all codes listed with Practitioner Services MUE Value of "0" (zero). Excerpts of the MUE Tables are posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm
CCI Edits: National Correct Coding Initiative Policy Manual for Medicare Services	"NCCI Policy Manual for Medicare Services - Effective January 1, 2019 [ZIP, XXXKB]" Copy of the 2019 Manual is posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm#7
CCI Edits: Practitioner Procedure to Procedure (PTP) Edits	For services rendered on or after January 1, 2019: Practitioner PTP Edits vxx.x effective January 1, 2019 (XXX,XXX records) XXXXX-XXXXX Practitioner PTP Edits vxx.xx effective January 1, 2019 (XXX,XXX records) XXXXX-XXXXX Practitioner PTP Edits Vxx.x effective January 1, 2019 (XXX,XXX records) XXXXX-XXXXX Practitioner PTP Edits vxx.x effective January 1, 2019 (XXX,XXX records) : XXXXX-XXXXX Access the Practitioner PTP Edits on the CMS website: http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html Note: the Practitioner PTP Edits excel file maintained by CMS contains effective date and deletion date (if any) for each column 1/column 2 pair. Therefore, the most recent file is the only file posted on the CMS website, and covers all time periods.
CMS' Medicare National Physician Fee Schedule Relative Value File [Zip]	For services rendered on or after January 1, 2019: RVU19A (XX/XX/2019) [ZIP, XMB] • RVU19A (Excluding Attachment A) • PPRRVU19_JAN • OPPSCAP_JAN • 19LOCCO • GPCI2019 Excluding: ANES2019

Document/Data	Services Rendered On or After January 1, 2019 & Mid-year Updates
	Access the Relative Value File on the CMS website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html
Conversion Factors adjusted for MEI and Relative Value Scale adjustment factor	Anesthesia Conversion Factor: $XX.XXXX Other Services Conversion Factor: $XX.XXXX
Current Procedural Terminology (CPT®)	CPT 2019 https://commerce.ama-assn.org/store/
Current Procedural Terminology CPT codes that shall not be used	Do not use CPT codes: 27215 (Use G0412) 27216 (Use G0413) 27217 (Use G0414) 27218 (Use G0415) 76140 (see §9789.17.2) 90889 (See §9789.14. Use codeWC005 code) 97014 (Use G0283) 97127 (Use G0515) 99075 (see Medical-Legal fee schedule, §9795) 99080 (see §9789.14) 99241 through 99245 (see §9789.12.12) 99251 through 99255 (see §9789.12.12) 99455 and 99456
Diagnostic Cardiovascular Procedure CPT codes subject to the MPPR	For services rendered on or after January 1, 2019: RVU19A, XXXXXXXX_JAN, number "6" in column S, labeled "Mult Proc" (Modifier 51), also listed in CY 2019 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, XXKB], in the document CMS-XXXX-X_Diagnostic Cardiovascular Services Subject to MPPR
Diagnostic Imaging Family Indicator Description	For services rendered on or after January 1, 2019: Diagnostic Imaging Family Indicator: 88 = Subject to the reduction 99 = Concept does not apply RVU19A, RVU19A (PDF document)

Document/Data	Services Rendered On or After January 1, 2019 & Mid-year Updates
Diagnostic Imaging Family Procedures Subject to the MPPR	For services rendered on or after January 1, 2019: RVU19A, XXXXXXXX_JAN, number "88" in column AB, labeled, "Diagnostic Imaging Family Indicator," also listed in CY 2019 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, XXKB], in the document CMS-XXXX-X_Diagnostic Imaging Services Subject to MPPR
Diagnostic Imaging Multiple Procedures Subject to the MPPR	For services rendered on or after January 1, 2019: RVU19A, XXXXXXXX_JAN, number "4" in column S, labeled, "Mult Proc," also listed in CY 2019 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, XXKB], in the document CMS-XXXX-X_Diagnostic Imaging Services Subject to MPPR
DWC Pharmaceutical Fee Schedule	http://www.dir.ca.gov/dwc/OMFS9904.htm#8
Geographic Practice Cost Index (GPCI) by locality (Other than anesthesia services)	For services rendered on or after January 1, 2019: RVU19A • GPCI2019 Addendum E – Column B ("Locality Number"), column C ("Locality Name"), column D ("PW GPCI"), column E ("PE GPCI"), and column F ("MP GPCI") for the State of California ("CA") • 19LOCCO – Column B ("Locality Number"), column C ("State"), column D ("Fee Schedule Area"), and column E ("Counties") for the State of California ("CA") Access the Relative Value File on the CMS website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html Also, see Zip Code mapping files listed below.
Geographic Practice Cost Index (GPCIs) by locality and anesthesia shares (Anesthesia)	For services rendered on or after January 1, 2019: 2019 Anesthesia Conversion Factors [ZIP, XXKB] (These factors have been incorporated into the conversion factors listed on section 9789.19.1, Table A) • Locality-Adjusted Anesthesia Conversion Factors as a result of the CY 2019 Final Rule, excluding column G labeled, "National Anes CF of XX.XXXX"

Document/Data	Services Rendered On or After January 1, 2019 & Mid-year Updates
	• Anesthesia Shares RVU19A (County to locality index) • 19LOCCO – Column B ("Locality Number"), column C ("State"), column D ("Fee Schedule Area"), and column E ("Counties") for the State of California ("CA") Access the Anesthesia Conversion Factors File on the CMS website: https://www.cms.gov/Center/Provider-Type/Anesthesiologists-Center.html Access the Relative Value File on the CMS website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html Also, see Zip Code mapping files listed below.
Geographic Practice Cost Index (GPCI) locality mapping Zip Code files mapping zip codes to GPCI locality (for "other than anesthesia services" and anesthesia services)	For services rendered on or after January 1, 2019: Zip Code to Carrier Locality File – XX/XX/2019 [ZIP, XMB], Column A ("STATE"), column B ("ZIP CODE"), and column D ("LOCALITY") for the State of California ("CA") Zip Codes requiring + 4 extension – XX/XX/2019 [ZIP, XKB], for the State of California ("CA") The Zip Code files can be accessed on the CMS website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FeeScheduleGenInfo/index.html
Geographic Health Professional Shortage Area zip code data files	2019 Primary Care HPSA [ZIP, XXXKB] 2019 Mental Health HPSA [ZIP, XXXKB] Access the files on the CMS website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses/index.html?redirect=/hpsapsaphysicianbonuses/
Health Resources and Services Administration: Geographic HPSA shortage	

Document/Data	Services Rendered On or After January 1, 2019 & Mid-year Updates
area query (By State & County) (By Address)	http://hpsafind.hrsa.gov/ http://datawarehouse.hrsa.gov/geoHPSAAdvisor/GeographicHPSAAdvisor.aspx
Incident To Codes	For services rendered on or after January 1, 2019: RVU19A, XXXXXXXX_JAN, number "5" in column N, labeled, "PCTC IND," (PC/TC Indicator)
Medi-Cal Rates – DHCS	Pursuant to section 9789.13.2, the Medi-Cal Rates file's "Basic Rate" is used in calculating maximum fee for physician-administered drugs, biologicals, vaccines or blood products, by date of service. For services rendered on or after January 1, 2019, use: Medi-Cal Rates file - Updated 12/15/2018 Copies of the Medi-Cal Rates files (without CPT descriptors) are posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm
Ophthalmology Procedure CPT codes subject to the MPPR	For services rendered on or after January 1, 2019: RVU19A, XXXXXXXX_JAN, number "7" in column S, labeled "Mult Proc" (Modifier 51). Also listed in CY 2019 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, XXKB], in the document CMS-XXXX-X_Diagnostic Ophthalmology Services Subject to MPPR
Physical Therapy Multiple Procedure Payment Reduction: "Always Therapy" Codes; and Chiropractic Codes	For services rendered on or after January 1, 2019: RVU19A, XXXXXXXX_JAN, number "5" in column S, labeled "Mult Proc." Also listed in CY 2019 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, XXKB], in the document CMS-XXXX-X_Separately Payable Therapy Services Subject to MPPR In addition, CPT codes: 98940, 98941, 98942, 98943
Physician Time	CY 2019 PFS Final Rule Physician Time [ZIP, XXXKB]
Splints and Casting Supplies	The OMFS Durable Medical Equipment, Prosthetics,

Document/Data	Services Rendered On or After January 1, 2019 & Mid-year Updates
	Orthotics, Supplies (DMEPOS) Fee Schedule applicable to the date of service.
The 1995 Documentation Guidelines for Evaluation & Management Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf
The 1997 Documentation Guidelines for Evaluation and Management Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf

Authority: Sections 133, 4603.5, 5307.1 and 5307.3, Labor Code.
Reference: Sections 4600, 5307.1 and 5307.11, Labor Code.

§9789.19.1. Table A.

For anesthesia services rendered on or after January 1, 2019, Table A contains the anesthesia conversion factor adjusted by Medicare locality GPCIs and anesthesia shares, which are incorporated by reference, by date of service. Table A will be updated by Administrative Director Order and will be made available at http://www.dir.ca.gov/dwc/OMFS9904.htm, or upon request to the Administrative Director at:

Division of Workers' Compensation (Attention: OMFS)
P.O. Box 420603
San Francisco, CA 94142.

Authority: Sections 133, 4603.5, 5307.1 and 5307.3, Labor Code.
Reference: Sections 4600, 5307.1 and 5307.11, Labor Code.