

**STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION**

INITIAL STATEMENT OF REASONS

**Subject Matter of Regulations: Official Medical Fee Schedule
Physician Fee Schedule
Services rendered on or after January 1, 2014**

**TITLE 8, CALIFORNIA CODE OF REGULATIONS
SECTIONS 9789.12.1 through 9789.19**

1. Proposed section 9789.12.1 Physician Fee Schedule: Official Medical Fee Schedule for Physician and Non-Physician Professional Provider Services – For Services Rendered On or After January 1, 2014
2. Proposed section 9789.12.2 Calculation of the Maximum Reasonable Fee - Services Other than Anesthesia
3. Proposed section 9789.12.3 Status Codes C, I, N and R
4. Proposed section 9789.12.4 “By Report” - Reimbursement for Unlisted Procedures / Procedures Lacking RBRVUs
5. Proposed section 9789.12.5 Conversion Factors
6. Proposed section 9789.12.6 Health Professional Shortage Area Bonus Payment: Primary Care; Mental Health
7. Proposed section 9789.12.7 CMS’ National Physician Fee Schedule Schedule Relative Value File / Relative Value Units (RVUs)
8. Proposed section 9789.12.8 Status Codes
9. Proposed section 9789.12.9 Professional Component/Technical Component Indicator
10. Proposed section 9789.12.10 Coding; Current Procedural Terminology ©, Fourth Edition
11. Proposed section 9789.12.11 Evaluation and Management: Coding – New Patient; Documentation
12. Proposed section 9789.12.12 Consultation Services Coding – use of visit codes

13. Proposed section 9789.12.13 Correct Coding Initiative
14. Proposed section 9789.12.14 California-Specific Codes
15. Proposed section 9789.12.15 California-Specific Modifiers
16. Proposed section 9789.13.1 Supplies
17. Proposed section 9789.13.2 Physician-Administered Drugs
18. Proposed section 9789.13.3 Physician-Dispensed Drugs
19. Proposed section 9789.14 Reimbursement for Reports, Duplicate Reports, Chart Notes
20. Proposed section 9789.15.1 Non-Physician Practitioner (NPP) – Payment Methodology
21. Proposed section 9789.15.2 Non-Physician Practitioner (NPP) – “Incident To” Services
22. Proposed section 9789.15.3 Qualified Non-physician Anesthetist Services
23. Proposed section 9789.15.4 Physical Medicine / Chiropractic / Acupuncture Multiple Procedure Payment Reduction; Pre-Authorization for Specified Procedure/Modality Services
24. Proposed section 9789.15.5 Ophthalmology Multiple Procedure Reduction
25. Proposed section 9789.15.6 Diagnostic Cardiovascular Procedures
26. Proposed section 9789.16.1 Surgery – Global Fee
27. Proposed section 9789.16.2 Surgery – Billing Requirements for Global Surgeries
28. Proposed section 9789.16.3 Surgery – Global Fee – Miscellaneous Rules
29. Proposed section 9789.16.4 Surgery – Global Fee; Exception: Circumstances Allowing E&M Code During the Global Period.
30. Proposed section 9789.16.5 Surgery – Multiple Surgeries and Endoscopies
31. Proposed section 9789.16.6 Surgery – Bilateral Surgeries
32. Proposed section 9789.16.7 Surgery – Co-surgeons and Team Surgeons
33. Proposed section 9789.16.8 Surgery – Assistants-at-Surgery

34. Proposed section 9789.17.1 Radiology Diagnostic Imaging Multiple Procedures
35. Proposed section 9789.17.2 Radiology Consultations
36. Proposed section 9789.18.1 Payment for Anesthesia Services - General Payment Rule
37. Proposed section 9789.18.2 Anesthesia - Personally Performed Rate
38. Proposed section 9789.18.3 Anesthesia - Medically Directed Rate
39. Proposed section 9789.18.4 Anesthesia - Definition of Concurrent Medically Directed Anesthesia Procedures
40. Proposed section 9789.18.5 Anesthesia - Medically Supervised Rate
41. Proposed section 9789.18.6 Anesthesia - Multiple Anesthesia Procedures
42. Proposed section 9789.18.7 Anesthesia - Medical and Surgical Services Furnished in Addition to Anesthesia Procedure
43. Proposed section 9789.18.8 Anesthesia - Time and Calculation of Anesthesia Time Units
44. Proposed section 9789.18.9 Anesthesia - Base Unit Reduction for Concurrent Medically Directed Procedures
45. Proposed section 9789.18.10 Anesthesia - Monitored Anesthesia Care
46. Proposed section 9789.18.11 Anesthesia Claims Modifiers
47. Proposed section 9789.18.12 Anesthesia and Medical/Surgical Service Provided by the Same Physician
48. Proposed section 9789.19 Update Table

AN IMPORTANT PROCEDURAL NOTE ABOUT THIS RULEMAKING:

The Physician Fee Schedule component of the Official Medical Fee Schedule "establish(es) or fix(es) rates, prices, or tariffs" within the meaning of Government Code section 11340.9(g) and is therefore not subject to Chapter 3.5 of the Administrative Procedure Act (commencing at Government Code section 11340) relating to administrative regulations and rulemaking.

This rulemaking proceeding to amend the Physician Fee Schedule is being conducted under the administrative director's rulemaking power under Labor Code sections 133, 4603.5, 5307.1 and

5307.3. This regulatory proceeding is subject to the procedural requirements of Labor Code sections 5307.1 and 5307.4.

This Initial Statement of Reasons and the accompanying Notice of Rulemaking are being prepared to comply with the procedural requirements of Labor Code section 5307.4 and for the convenience of the regulated public to assist the regulated public in analyzing and commenting on this non-APA rulemaking proceeding.

BACKGROUND TO REGULATORY PROCEEDING

History of the Physician Fee Schedule

Pursuant to Labor Code section 5307.1 the administrative director of the Division of Workers' Compensation adopts the physician fee schedule to establish maximum reasonable fees for medical services provided by physicians and nonphysician practitioners in the workers' compensation system.¹ The term "physician" is uniquely defined by California workers' compensation law to include: physicians and surgeons holding an M.D. or D.O. degree; psychologists; acupuncturists; optometrists; dentists; podiatrists; and chiropractors (Labor Code Section 3209.3). The nonphysician practitioners include a variety of providers, including physical therapists, occupational therapists, nurse practitioners, physician assistants, and certified registered nurse anesthetists.

The physician fee schedule was originally adopted in 1965. Its relative value scale is a modification of the California Relative Value Scale (CRVS) that was developed by the California Medical Association (CMA) in 1956 and last revised in 1974. This relative value scale was among the first in the country, and its values are based on historic physician charges for services. The fee schedule was updated in 1994, 1996 and 1999 using charge-based data through a contract with Medicode, Inc.

The Move Toward Adoption of the RBRVS – Administrative Action

Beginning in 1999, the Industrial Medical Council (IMC)² undertook the groundwork for a major restructuring of the physician fee schedule and a migration to the federal Resource Based-Relative Value Scale (RBRVS) used in Medicare. Adoption of the RBRVS was supported by a 1999 study commissioned by the IMC to evaluate alternatives for replacing the CRVS. The study was authored by UCLA and concluded that migration to a resource-based relative value scale would improve fairness of payments and that adopting the RBRVS offered advantages over other alternatives. (see "Physician Fee Schedule Studies" at <http://www.dir.ca.gov/dwc/dwcrep.htm>).

¹ Labor Code section 5307.11 allows a health care provider or facility to contract for reimbursement rates that are different than those in the physician fee schedule.

² The IMC was a state-appointed board of physicians with a statutory mandate, *inter alia*, to advise the administrative director on the physician fee schedule. The statutory authority for the existence of the IMC was repealed in 2003.

Thereafter, the IMC hired the Lewin Group to undertake the modeling studies and data analysis to support the conversion to RBRVS. Data for the study were obtained from the California Workers' Compensation Institute (CWCI). The Lewin Group completed an initial impact analysis and began identification of transition strategies, geographic adjustment factors, and other options for adoption of the RBRVS. (<http://www.dir.ca.gov/dwc/dwcrep.htm>) In addition, the Lewin Group completed two studies of evaluation and management services (one regarding Physician Work and one involving Practice Expense.) (<http://www.dir.ca.gov/dwcldwcrep.htm>)

In 2003, the California legislature passed Senate Bill 228 (Statutes of 2003, Chapter 639), which interrupted the revision of the physician fee schedule, reduced existing reimbursement for most physician services by 5% (with Medicare as a floor), and froze future revisions until no earlier than January 1, 2006. In February 2007, the administrative director adopted a revision, raising the maximum fees for ten common Evaluation and Management Codes by an average of 23%. In October of 2007, the Lewin Group commenced a new study of the impact of adopting RBRVS, issuing reports in December of 2008 and March of 2010. The Division of Workers' Compensation drafted regulatory proposals and conducted a pre-rulemaking process to seek public comment on the draft regulations.

Adoption of the RBRVS – Statutory Mandate

In September of 2012, the California legislature passed Senate Bill 863 (Statutes of 2012, Chapter 363), which amended Labor Code section 5307.1. The statute directs the administrative director to “adopt and review periodically an official medical fee schedule based on the resource-based relative value scale for physician services and nonphysician practitioner services,” provided:

- Liability for medical treatment, including issues of reasonableness, necessity, frequency, and duration shall be determined in accordance with Labor Code section 4600
- The fee schedule is updated annually to reflect changes in procedure codes, relative weights and the adjustment factors in subdivision (g) (the Medicare Economic Index and any relative value scale adjustment factor)
- The maximum reasonable fees paid shall not exceed 120% of the estimated annualized aggregate fee prescribed in the Medicare physician fee schedule as it appeared on 7/1/2012 (before application of the Medicare Economic Index and any relative value scale adjustment factor)
- Any service provided to injured workers that is not covered under Medicare shall be included at its rate of payment established by the administrative director
- There is a 4-year transition between the estimated aggregate maximum allowable under the OMFS physician schedule prior to 1/1/2014 and the maximum allowable based on 120% of the Medicare conversion factors
- The physician fee schedule includes ground rules that differ from Medicare payment ground rules, including, as appropriate, payment of consultation codes and payment of evaluation and management services provided during a global period of surgery.

Under Labor Code section 5307.1, on January 1, 2014, and until the administrative director adopts a physician fee schedule in accordance with the RBRVS, maximum reasonable fees for

physician and nonphysician practitioner services will “be in accordance with the fee-related structure and rules of the Medicare payment system for physician services and nonphysician practitioner services, except that an average statewide geographic adjustment factor of 1.078 shall apply in lieu of Medicare’s location specific geographic adjustment factors...”

The Division has retained the services of the RAND Corporation, RAND Center for Health and Safety in the Workplace to provide consultation and technical assistance on the implementation of the RBRVS-based system. The RAND Working Paper: *Implementing a RB-RVS Fee Schedule for Physician Services, An Assessment of Policy Options for the California Workers’ Compensation Program* (WR993), June 2013, provides a discussion of policy issues and options, and provides an analysis of impacts that may be expected from implementation of the RBRVS and related payment rules. Pursuant to Labor Code section 5307.1, the acting administrative director is undertaking this rulemaking action to adopt an RBRVS-based fee schedule for physician and non-physician practitioners. These regulations implement, interpret, and make specific Labor Code section 5307.1 which requires the adoption of an RBRVS-based schedule.

TECHNICAL, THEORETICAL, OR EMPIRICAL STUDIES, REPORTS, OR DOCUMENTS

The Division relied upon the following technical, theoretical, or empirical studies, reports, decisions or similar documents in proposing the above-identified regulations:

1. Wynn Barbara, Liu Hangsheng, Mulcahy Andrew, Okeke Edward, Iyer Neema, Painter Lawrence, *Implementing a RB-RVS Fee Schedule for Physician Services An Assessment of Policy Options for the California Workers’ Compensation Program*, Working Paper, RAND, 2013
2. CMS *Benefits Policy Manual*, Chapter 15
3. CMS *Claims Processing Manual*, Chapter 12
4. CMS letter dated June 26, 2012, to Toby Douglas, CA Department of Health Care Services regarding payment methodology for physician administered drugs & Transmittal and Notice of Approval of State Plan Material
5. CMS Manual System Transmittal 1149 – *Multiple Procedure Payment Reduction (MPPR) on the Technical Component (TC) of Diagnostic Cardiovascular and Ophthalmology Procedures*
6. CMS Manual System Transmittal 2565 – *Reasonable Charge Update for 2013 for Splints, Casts, and Certain Intraocular Lenses*
7. CMS *National Physician Fee Schedule Relative Value File Calendar Year 2013 Explanation*
8. CMS Physician Fee Schedule Final Rule for CY 2010 (74 FR 61738, CMS-1413-FC, November 25, 2009)
9. CMS Physician Fee Schedule Final Rule CY 2013 explanation of Direct Practice Expense Inputs Used To Create Resource-Based Practice Expense Relative Value Units
10. CMS Physician Fee Schedule Final Rule CY 2013 (77 FR 68892, CMS-1590-FC, November 16, 2012)
11. *1995 Documentation Guidelines for Evaluation and Management Services*
12. *1997 Documentation Guidelines for Evaluation and Management Services*

13. Kominski G., Pourat N., Black J., *The Use of Relative Value Scales for Provider Reimbursement in State Workers Compensation Programs*, UCLA Center for Health Policy Research, August 1999
14. Kominski G., Pourat N., Black J., *The Use of Relative Value Scales for Provider Reimbursement in State Workers Compensation Programs, Appendix 1: Detailed State Interviews Concerning Their Use of Relative Value Scales for Workers Compensation*
15. MLN Matters, Number MM4215, *Consultation Services Current Procedural Terminology (CPT) Codes 99241-99255 (01/2006)*
16. Dobson/DaVanzo, KNG Health Consulting, *Adapting the RBRVS Methodology to the California Workers' Compensation Physician Fee Schedule, First Report, Revised*, December 19, 2008, The Lewin Group
17. *Adapting the RBRVS Methodology to the California Workers' Compensation Physician Fee Schedule: Supplemental Report*, The Lewin Group, March 3, 2010
18. *California Workers' Compensation RBRVS Study*, The Lewin Group, October 8, 2002
19. Dobson Al, DaVanzo Joan, Consunji Maria, Gilani Jawaria, *A Study of the Relative Work Content of Evaluation and Management Codes*, The Lewin Group, April 29, 2003
20. Dobson Al, DaVanzo Joan, Koenig Lane, Seigel Jonathan, Gilani Jawaria, Ho Silver, *A Study of the Practice Expenses Associated with the Provision of Evaluation and Management Services*, The Lewin Group, May 13, 2003
21. Medicare Prescription Drug, Improvement, and Modernization Act of 2003
22. Medicare Payment Advisory Commission Staff Presentation (selected slides), March 7, 2013
23. Medicare Payment Advisory Commission, *Medicare Payment to Advanced Practice Nurses and Physician Assistants*, June 2002
24. National Health Exchange Services (NHXS), *What private payers do to your claim: repricing and claims editing*, AMA, 2005
25. Office of the Inspector General, *Consultations in Medicare: Coding and Reimbursement*, March 2006
26. Office of the Inspector General, *Coding Trends of Medicare Evaluation and Management Services*, May 2012
27. Office of the Inspector General, *Replacing Average Wholesale Price: Medicaid Drug Payment Policy*, July 2011
28. Braun Peter, McCall Nancy, *Methodological Concerns with the Medicare RBRVS Payment System and Recommendations*, RTI, December 2011
29. MLN Matters, Number MM7747, *Application of the Multiple Procedure Payment Reduction (MPPR) on Imaging Services to Physicians in the Same Group Practice*, 01/2013
30. Wynn, Barbara, O., *Adopting Medicare Fee Schedules: Considerations for the California Workers' Compensation Program*, RAND, 2003
31. Wynn Barbara, Hilborne Lee, Hussey Peter, Sloss Elizabeth, Murphy Erin, *Medicare Payment Differentials across Ambulatory Settings*, RAND, July 2008
32. Report of the National Commission, *Physician Payment Reform*, March 2013
33. *Medicare RBRVS 2013 The Physician's Guide*, American Medical Association
34. *2013 RVS Update Process*, American Medical Association

SPECIFIC TECHNOLOGIES OR EQUIPMENT REQUIRED (if applicable)

No specific technologies or equipment are required by these proposed regulations.

FACTS ON WHICH THE AGENCY RELIES IN SUPPORT OF ITS INITIAL DETERMINATION THAT THE REGULATIONS WILL NOT HAVE A SIGNIFICANT ADVERSE IMPACT ON BUSINESS

The acting administrative director has determined that these proposed regulations will not have a significant adverse impact on business.

Initial estimates by RAND indicate the total payments under the physician fee schedule will increase from the current fee schedule when the fee schedule transitions to the RBRVS system as mandated by Labor Code section 5307.1(a)(2). There will, however, be many offsetting savings, discussed in more detail below.

The proposed physician fee schedule would impact medical providers, insurers, and self-insured employers. There are both costs and savings that would result from adoption of the RBRVS as required by Labor Code section 5307.1(a)(2)(A).

Costs

There will be some costs to payers and providers to convert to an entirely new fee schedule. However, there are costs inherent, but extremely difficult to quantify, in keeping the current OMFS. The present fee schedule is extremely out of date, and does not cover many medical procedures, leaving them unregulated by the fee schedule. This creates the possibility of excessive billing, or improper denial of payment, and leads to disputes and increased costs of dispute resolution.

Labor Code section 5307.1(a)(2)(A)(iv) requires the administrative director to include a “four-year transition between the estimated aggregate maximum allowable amount under the official medical fee schedule for physician services prior to January 1, 2014, and the maximum allowable amount based on the resource-based relative value scale at 120 percent of the Medicare conversion factors as adjusted.” According to the 2013 RAND RB-RVS report, “[o]ver the 4-year period, total allowable fees are estimated to increase 19.6 percent. The increase represents that combined effect of inflation (which increases the rates 8 percent over the period) and the transition from current OMFS payment levels in the aggregate for all services other than anesthesia at 111 percent of Medicare to 120 percent of Medicare in 2017.”³ This increase is inherent to the statutory structure. The costs to an individual provider will vary depending on the mix of services provided, since the maximum reimbursement for procedures would be redistributed to align the payment based on resources needed to perform the service instead of relying on charge based data which is what the current fee schedule is founded on. The increased

³ Wynn, et al., *Implementing a RB-RVS Fee Schedule for Physician Services, An Assessment of Policy Options for the California Workers' Compensation Program*, 2013, p. 29.

payment rates resulting from transitioning to the RBRVS at 120% of Medicare (as adjusted pursuant to statute) would help buffer the re-distributional effect of moving to RBRVS and supports the retention of physicians in the system.

Savings

There are many areas of savings to be achieved by adoption of the proposed physician fee schedule. Currently the physician fee schedule uses outdated coding, mostly from 1997. There are new medical procedures that have developed since that time that are not in the fee schedule, and thus have no set maximum reimbursement. Bringing the coding current will result in caps on maximum reimbursement rates for these procedures. The updated coding will reduce disputes over the reasonable value of services, resulting in less cost devoted to dispute resolution activities. Using updated CPT coding should also reduce the administrative burden of billing and receiving payment for physician services. Utilizing a “pure” RBRVS with a single conversion factor (after the 4 year transition) aligns payment with resources required for each procedure and helps reduce incentives to perform procedures due to misvalued reimbursement levels. This can reduce costs and improve quality of care in the long term.

SUMMARY OF PROPOSED CHANGES

Proposed Section 9789.12.1 Physician Fee Schedule: Official Medical Fee Schedule for Physician and Non-Physician Professional Provider Services – For Services Rendered On or After January 1, 2014

Specific Purpose:

The purpose of section 9789.12.1 is to set forth the scope and applicability of the Physician Fee Schedule.

Necessity:

This section is necessary for several reasons. The Physician Fee Schedule is one of a number of fee schedules which comprise the Division’s Official Medical Fee Schedule (OMFS). This section describes how the Physician Fee Schedule relates to the other parts of the OMFS. In addition, there will be more than one version of the physician fee schedule which is applicable depending on the date of service. This section informs the workers’ compensation community that this fee schedule will be applicable for services rendered on or after January 1, 2014, whereas earlier physician fee schedules will be applicable depending on which fee schedule is in effect at the time the service was rendered. Finally, it is necessary to inform the workers’ compensation community that maximum fees for services rendered by physicians and non-physician practitioners are governed by this physician fee schedule.

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section.

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

Specific Purpose:

This section sets forth the formulas to determine reasonable maximum fees for services other than anesthesia. This section provides separate formulas to calculate reasonable maximum fees for services depending on the site of service (“facility” vs. “non-facility”). This section also clarifies that reimbursement for physician and non-physician practitioner fees will be based on the lesser of the actual charge or the calculated rate established by this fee schedule.

Necessity:

This section is necessary because it informs the workers’ compensation community how to calculate the reasonable maximum fees for physician and non-physician practitioner services (depending on place of service) under this fee schedule. It is also necessary to instruct that the lesser of the physician’s or non-physician practitioner’s actual charge or fee calculated in accordance with this fee schedule, will be the amount of reimbursement.

Consideration of Alternatives: At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section.

Proposed section 9789.12.3 Status Codes C, I, N and R

Specific Purpose:

The purpose for this section is to set forth methods for workers’ compensation of pricing codes that have Medicare Status Code C (“Carriers price the code”), Status Code I (“Not valid for Medicare purposes”), Status Code N (“Non-covered services”), and Status Code R (“Restricted Coverage”) in the CMS’ National Physician Fee Schedule RBRVS file.

Necessity:

The reasons why a physician and non-physician practitioner service may not have an assigned RVU value under the Medicare fee schedule is identified through its status code, which indicates whether the CPT code is included in the fee schedule and if it is covered, whether it is separately payable. Services not covered by Medicare are designated by status code N. Some of these services, such as chiropractic extraspinal manipulation and acupuncture procedures, however, are paid for in workers’ compensation. The AMA’s Relative Value Update Committee establishes

the RVUs for some services that Medicare does not cover and CMS publishes them as a courtesy in Addendum B of the annual fee schedule update. Similarly, status code I services are not valid for Medicare purposes because Medicare uses another code for the reporting and payment of the services. For example, the consultation visit codes are designated with a status indicator code “I” by Medicare. This is because Medicare pays for the consultations under the evaluation and management visit codes. Some of the services with status indicator code “I”, including the consultation visit codes have RVUs assigned to them but most do not. More discussion regarding consultation visits will be discussed under section 9789.12.12.

This section is necessary to inform the workers’ compensation community how to calculate the reasonable maximum fees for physician and non-physician practitioner services that Medicare designates as status Codes C, I, N and R, including those codes which do not have any RVUs assigned by Medicare.

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section.

The 2013 RAND RB-RVS study, p.16 considered the following alternatives for valuing physician and non-physician practitioner services with status codes C, N, or R:

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

2013 RAND RB-RVS report, p. 16, addressed the following criteria when weighing the above alternatives.

Ease of Administration. Assigning RVUs to codes that are currently valued using By Report documentation will reduce the burden on claims administrators, because the reimbursement price will be based on appropriate units.

Standardized Payments. Payment for services with an assigned value will be standardized and based on relative resources required to perform the service, rather than relying on documentation of costs. This allows for reducing the potential for claims disputes.

Automatic Updates. Payment for services with assigned RVUs can be updated more easily by updating the conversion factors. Assigned dollar values could also be updated using the Medicare Economic Index.

Equitable to OMFS allowance for other services. Services assigned relative values at a level compared to other CPT codes in the OMFS, creates more equitable allowances for services furnished.

The acting administrative director has determined that the best approach is to use established RVUs where possible, and use “By Report” as the last method of pricing. With certain exceptions, the acting administrator is proposing to adopt the federal Office of Workers’ Compensation Program (OWCP) fee schedule to assign RVUs to the status code C, R, and N services that do not have RVUs under the RBRVS. The OWCP reviews state workers’ compensation fee schedules and establishes prices based on the mid-range of state fee schedule amounts. There are several advantages to using this fee schedule. First, the values are updated annually and are available in a public use file on the OWCP website. Second, the OWCP fee schedule lists relative values that will be used with the state workers’ compensation conversion factors. Third, the OWCP fee schedule is used in California to pay for services to injured workers under the Federal Employees Compensation Act. Establishing the general hierarchy of Medicare RVUs, OWCP, BR, will tend to reduce disputes by pricing as many codes as possible, minimizing the number of un-priced services.

Section 9789.12.4 “By Report” - Reimbursement for Unlisted Procedures / Procedures Lacking RBRVUs

Specific Purpose:

The purpose of this section is to set forth instructions to bill an unlisted procedure code using the appropriate CPT “unlisted procedure code.” The section provides that a billing for a procedure that utilizes CPT unlisted procedure codes must be billed “By Report” (report not separately reimbursable.) The section also provides that CPT codes with status indicator codes C, N, or R, that do not have RVUs assigned under either the CMS’ National Physician Fee Schedule RBRVS file or under the OWCP, shall be billed by report, unless otherwise provided in the Physician Fee Schedule. The section clarifies that CPT codes that do not have an RVU value in the National Physician Fee Schedule file, and that are payable under other sections of the official medical fee schedule are not payable on a “By Report” basis. The section sets forth factors that are considered in determining the value of a “By Report” procedure.

Necessity:

This section is necessary to set forth the methodology for setting the rate or price for physician and non-physician practitioner service procedures that are unlisted in the CPT or do not have relative values assigned.

Because an “unlisted CPT” code is typically assigned for new and emerging technologies or procedures, there is no relative value assigned, and it would be difficult to develop comparable payments based on similar procedures. So, the By Report payment methodology is employed, and the payment rules need to be established to ensure reasonable payments are established.

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section.

Section 9789.12.5 Conversion Factors

Specific Purpose:

The purpose of this section is to set forth the methodology for determining conversion factors for anesthesia, surgery, radiology, and “all other” service categories, during the four-year transition period from 2014 to 2017, and how the conversion factors will be applied to the CPT codes. The section cross references to section 9789.19 which sets forth conversion factors by date of services. (For services on or after January 1, 2014, section 9789.19 sets out the following conversion factors: anesthesia - \$32.645; surgery - \$52.478; radiology \$50.101; “all other” service categories - \$35.94.) The section also sets forth that in 2017, and thereafter, there will be two conversion factors: anesthesia conversion factor for CPT codes in the anesthesia section and other services conversion factor for all other codes in the CPT. The section provides that for calendar year 2018, and annually thereafter, the anesthesia conversion factor and the other services conversion factor shall be updated by the Medicare Economic Index inflation rate and by the relative value scale adjustment factor, if any. (Labor Code section 5307.1 subdivisions (a)(2)(A), (g).)

Necessity: This section is necessary to establish an essential element of the payment methodology used to establish reasonable maximum payment rates for physician and non-physician practitioner services by procedure.

The use of the conversion factor (CF) to determine the maximum reasonable reimbursement rate for physician and non-physician practitioner services is a pivotal component of the RBRVS payment system mandated by Labor Code section 5307.1. The CF converts the relative value units into an actual dollar amount. The dollar multiplier (CF) is updated on an annual basis according to Labor Code section 5307.1(g)(1)(A)(iii).

Labor Code section 5307.1 requires the acting administrative director to include in the physician fee schedule a four-year transition between the estimated aggregate maximum allowable amount under the OMFS for physician and non-physician practitioner services prior to January 1, 2014, and the maximum allowable amount based on the resource-based relative value scale at 120 percent of the Medicare conversion factors as adjusted pursuant to Labor Code section 5307.1.

RAND analyzed the WCIS data to determine the appropriate CFs to achieve a uniform four year transition to a single CF, except for anesthesia services, at 120 percent of the 2012 Medicare CF as updated according to Labor Code section 5307.1. The estimated CF for 2014 is set forth in this fee schedule, and once the true update values are published by Medicare, this fee schedule will be updated by administrative director order pursuant to Labor Code section 5307.1(g)(2). The conversion factors for 2015 and forward will be adopted by administrative director order once the Medicare Economic Index update value, and the relative value scale adjustment factor, if any, for the relevant year is finalized by Medicare.

The 2013 RAND RB-RVS study, p. 27, estimated conversion factors for the four year transition is as follows:

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

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

RAND also estimated what the impact of the RBRVS implementation will have on maximum allowable fees by service type, provider specialty, and during the transition period.

Table 5.1 Impact of RBRVS Implementation on Maximum Allowable Fees, by Service Type and Transition Period, p. 29

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

Table 5.2 Impact of RBRVS Implementation on Maximum Allowable Fees, by Provider Specialty and Transition Period, p. 30

Provider specialty	OMFS		RBRVS 2014		RBRVS 2015		RBRVS 2016		RBRVS 2017	
	Total allowable fees (\$ millions)	Percent of total	Total allowable fees (\$ millions)	Percent change	Total allowable fees (\$ millions)	Percent change	Total allowable fees (\$ millions)	Percent change	Total allowable fees (\$ millions)	Percent change
Practice groups										
Multi-specialty	45.96	4.6	50.84	10.6	52.73	14.7	55.15	20.0	60.48	31.6
Single-specialty	2.94	0.3	2.88	-2.1	2.95	0.3	3.05	3.6	3.30	12.2
Individual providers										
Family medicine or general practice	211.16	21.3	213.12	0.9	221.00	4.7	231.11	9.4	253.29	20.0
Surgery	135.15		122.79	-9.1	123.19	-8.8	124.64	-7.8	132.16	-2.2
		13.7								
Physical therapist	63.16	6.4	86.61	37.1	92.42	46.3	99.30	57.2	111.93	77.2
Radiology	56.72	5.7	48.69	-14.2	47.07	-17.0	45.76	-19.3	46.57	-17.9
Physical medicine & rehabilitation	46.27	4.7	58.19	25.8	62.10	34.2	66.72	44.2	75.16	62.4
Psychiatry	37.96	3.8	35.55	-6.3	38.08	0.3	41.05	8.1	46.40	22.2
Occupational medicine	36.50	3.7	41.54	13.8	43.44	19.0	45.80	25.5	50.57	38.5
Chiropractic providers	34.69	3.5	35.19	1.4	37.56	8.3	40.36	16.3	45.46	31.0
Anesthesiology	27.49	2.8	26.02	-5.4	25.36	-7.8	24.86	-9.6	24.80	-9.8
Internal medicine	19.96	2.0	19.02	-4.7	19.65	-1.6	20.47	2.6	22.38	12.1
Neurology	13.53	1.4	9.76	-27.9	10.35	-23.6	11.05	-18.4	12.37	-8.6
Acupuncturist	11.84	1.2	10.88	-8.1	11.60	-2.0	12.45	5.2	13.97	18.0
Occupational therapist*	7.99	0.8	11.16	39.7	11.93	49.4	12.84	60.8	14.50	81.6
Emergency medicine	7.46	0.8	8.11	8.6	8.48	13.6	8.93	19.7	9.88	32.3
Podiatrist	4.58	0.5	5.42	18.4	5.51	20.2	5.64	23.2	6.07	32.5
Pathology	1.28	0.1	1.02	-20.1	1.09	-15.3	1.16	-9.5	1.30	1.3
Other	225.32	22.8	215.31	-11.5	222.83	-1.1	232.55	3.2	253.41	12.5
Total	989.96	100.0	1001.48	1.2	1036.89	4.7	1082.68	9.4	989.96	100.0

Consideration of Alternatives: At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section.

The use of the conversion factor (CF) to determine the maximum reasonable reimbursement rate for physician and non-physician practitioner services is a pivotal component of the RBRVS payment system mandated by Labor Code section 5307.1. The relative value units (RVUs) for each physician and non-physician practitioner service are established based on the resources associated with the physician’s or non-physician practitioner’s work (the time and skill required for the procedure), practice expense (the staff time and costs of maintaining an office), and

malpractice expenses. The RVUs compare the resources required for one service to those required for other services. The conversion factor determines overall fee schedule payment rates. Finally, the third component is a geographic adjustment factor that adjusts for geographic differences in the costs of maintaining a physician practice. The conversion factor is a dollar amount that converts the RVUs for a service into a payment rate.

Except for anesthesia services which has its own CF, Medicare uses a single CF for setting the payment rate for physician and non-physician practitioner services. The RBRVS, which consists of a set of relative value units (RVUs) for over 7,000 medical procedures, was originally adopted by Medicare in 1992 with the publication of the Medicare Fee Schedule. The system of relative values was developed by researchers from the Department of Health Policy and Management at Harvard University. Medicare has made major revisions to the system since its implementation and is required to conduct a comprehensive review of its relative values every five years. The RBRVS has gone through an extensive process of external validation and public rule making. In addition, Medicare is required to review and update the relative values periodically. Because of these favorable attributes, diverse payers have adopted the Medicare RBRVS or systems based on it. The American Medical Association⁴ collected data in the summer of 2006 from 127 different public and private payers, representing 123 million covered lives. The survey showed that 77% of the respondents use the RBRVS, including many Medicaid agencies, private payers, and workers' compensation plans.

Using a single conversion factor ensures a more accurate and fair way to pay for physician and non-physician practitioner services, since the RBRVS is based on actual resources and valued according to the relative resource usage among physician and non-physician practitioner procedure CPT codes. The RBRVS is a payment system which is maintained with the goal of providing an accurate, comprehensive standard, uniformly covering all medical services.

To retain multiple conversion factors after the 4 year transition is not consistent with the goal of aligning payments with resource requirements of providing a physician and non-physician practitioner service. Instead it would perpetuate the existing discrepancies between payments and costs of providing services. Adoption of multiple conversion factors will distort the relative payment rates which form the basic foundation of the RBRVS system, and disrupt the balance between different physician and non-physician practitioner service procedures.

A RAND⁵ report considered the alternatives of adopting a single conversion factor as opposed to multiple conversion factors. For the reasons stated above, RAND did not recommend adopting multiple conversion factors to maintain current payment levels by type of service in order to reduce redistributions that would occur in adopting the Medicare RBRVS.

California lawmakers decided transitioning to a single conversion factor is the appropriate alternative to adopt. Senate Bill 863, which amended Labor Code 5307.1, set forth a default payment methodology to commence January 1, 2014, and continuing until the time the

⁴ 2013 Medicare RBRVS *The Physician's Guide*, American Medical Association, p. 157 et seq.

⁵ Wynn, Barbara, O., *Adopting Medicare Fee Schedules, Considerations for the California Workers' Compensation Program*, RAND, 2003

administrative director has adopted a physician fee schedule in accordance the RBRVS. The default physician fee schedule sets forth a four year transition using multiple conversion factors which results in a single conversion factor to be applied to all services, with the exception of anesthesia.

Because Labor Code section 5307.1 requires the maximum reasonable fees paid shall not exceed 120 percent of estimated annualized aggregate fees prescribed in the Medicare payment system for physician and non-physician practitioner services, adopting multiple conversion factors would require the administrative director to analyze and adjust for budget neutrality on a regular basis, significantly increasing administrative burden and costs on the DWC and the workers' compensation community. More importantly, some physician and non-physician practitioner services would need to receive a reduced payment in order to allow other services to have an increased payment. This would require conducting studies on a regular basis to provide an empirical foundation for modifying the payment rate for relative resources established by the RBRVS for each physician and non-physician practitioner services CPT code.

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

Specific Purpose:

This section adopts the Medicare Health Professional Shortage Area (HPSA) 10% bonus payment for services provided in an area designated by the US Dept. of Health & Human Services Health Resources and Services Administration (HRSA) as a primary care health professional shortage area or a mental health shortage area. The section specifies that the mental health HPSA bonus will only be paid when services are performed by a psychiatrist. When a service is performed in a zip code that falls within both a primary care and mental health HPSA, only one bonus will be paid on the service. The section specifies the use of modifier "AQ" where the place of service is eligible for the bonus but does not appear on the Medicare "automatic" bonus zip code file. The section provides that the claims administrator shall pay to 10% bonus together with the payment for the underlying service.

Necessity:

This section is necessary to set forth the payment rules to determine if a service is eligible to receive the HPSA bonus. It is necessary to diverge from the Medicare rule regarding the timing of the bonus payment for administrative efficiency. Medicare pays the bonus quarterly. For workers' compensation the acting administrative director has determined that it is more efficient to pay together with the underlying service. Providers will more easily be able to confirm that they receive the bonus, and claims administrators will not have to set up a separate tracking system for quarterly payments.

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section.

Medicare adjusts for geographic differences using nine payment localities (GPCIs) in California. The purpose of these geographic adjustments is to improve payment accuracy by accounting for the differences in input prices that providers face in each locality. In addition to geographic adjustment factor discussed above, Medicare specifically addresses access in underserved areas by providing the HPSA bonus in these primary care health professional shortage areas. Because the proposed physician fee schedule anticipates adopting Medicare's geographic adjustments (GPCIs), it would be reasonable that HPSA bonus payments would also be made, as they are complementary components of the geographic adjustment to be made for payment of physician and non-physician practitioner services based on locality.

Section 9789.12.7 CMS' National Physician Fee Schedule Relative Value File / Relative Value Units (RVUs)

Specific Purpose:

The purpose of this section is to require use of the CMS National Physician Fee Schedule Relative Value File which is in effect for the date of service to determine maximum reasonable fees and to cross reference to section 9789.19 for the Relative Value File by date of service.

Necessity: Pursuant to Labor Code section 5307.1(a)(2)(C) the physician fee schedule adopted by the administrative director must be in accordance with the resource based relative value scale (RBRVS). The CMS National Physician Fee Schedule Relative Value File contains the relative values for the RBRVS, and, therefore, must be adopted as an essential component for setting payment rates based on the RBRVS. In addition to the RVUs, the file contains many columns of data that are essential to determining the proper payment amount.

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section.

Adoption of the CMS National Physician Fee Schedule Relative Value File contains the required relative values mandated by Labor Code section 5307.1(a)(2)(C) for use in determining the payment rate for services provided under the physician fee schedule.

Section 9789.12.8 Status Codes

Specific Purpose:

This section adopts the Status Code Indicators that are used in the National Physician Fee Schedule Relative Value File, but sets forth different definitions of the status codes where needed for use in the workers' compensation context.

Necessity:

This section is necessary because status indicator codes are integral to instructing the workers' compensation community on how to properly determine the reimbursement rate for the physician and non-physician practitioner service code. There are several reasons why codes for physician and non-physician practitioner services may not have assigned RVU values under the Medicare fee schedule. The reason applicable to a given code is identified through its status code, which indicates whether the CPT code is payable under Medicare, and if so, how it is paid; and if not, the reason why. Some definitions are different from Medicare's because there are certain physician and non-physician practitioner services that are not paid for by Medicare but are paid for in workers' compensation, or paid for using a different methodology. For example, Medicare does not pay for acupuncture CPT procedures and lists status code "N" "Non-covered Services", but workers' compensation does reimburse for these CPTs, so the descriptor for status code "N" is altered to set forth the workers' compensation payment methodology.

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section.

Section 9789.12.9 Professional Component/Technical Component Indicator

Specific Purpose: The purpose of this section is to adopt the professional component/technical component indicator based upon the definitions used by CMS for the National Physician Fee Schedule Relative Value File, with minor modification where needed for use in the workers' compensation context.

Necessity: This section is necessary because professional component/technical component indicators are integral to the schema for determining the reimbursement rate for the physician and non-physician practitioner service codes based on the RBRVS.

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section. The professional component/technical component indicators are essential factors that must be followed when

determining the appropriate payment rate for the physician and non-physician practitioner services CPT code.

Section 9789.12.10 Coding; Current Procedural Terminology ©, Fourth Edition

Specific Purpose:

The purpose of this section is to adopt the Current Procedural Terminology ©, Fourth Edition (“CPT”), published by the American Medical Association, including coding, modifiers, guidelines, appendices and other information. However, where provisions of the Physician Fee Schedule conflict with CPT, the Physician Fee Schedule provisions take precedence. The section cross-references to section 9789.19 for the version of CPT to use by date of service, for a listing of CPT codes not to be used for workers’ compensation billing, and for codes to bill splint and cast materials. The section cross-references to section 9789.13.2 for coding requirements for physician-administered drugs, biologicals, blood products, and vaccines.

Necessity:

The CPT is critical to establishing the prices using the RBRVS system. The RBRVS uses the CPT and components such as modifiers to assign relative values to physician and non-physician practitioner services. It is also necessary at times to diverge from the CPT to accommodate the specific needs of the workers’ compensation system. For instance, the workers’ compensation community is instructed not to use CPT code 99075 (medical testimony) because it would be paid for under a different fee schedule (section 9795 - Medical-Legal fee schedule). The rationale for proposing the coding and payment methodologies for splint and cast materials, physician-administered drugs, biologicals, blood products, and vaccines will be discussed in their respective proposed sections.

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section. The CPT is critical to the RBRVS schema that must be adopted.

Section 9789.12.11 Evaluation and Management: Coding – New Patient; Documentation

Specific Purpose:

The purpose of this section is to adopt definitions of “new patient” and “established patient” that diverge from the CPT definitions in order to tailor them for workers’ compensation by allowing a “new patient” visit for a patient with a new industrial injury or illness. The section requires medical providers to document the appropriate level of evaluation and management service by using either the “1995 Documentation Guidelines for Evaluation & Management Services,” or the “1997 Documentation Guidelines for Evaluation and Management Services.”

Necessity:

The 2013 CPT defines a new patient as, someone “who has not received any professional services from the physician/qualified health care professional or another physician/ qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.”

The 2013 CPT defines an established patient as someone “who has received professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.”

The difference in workers’ compensation is that when a worker presents with a new injury, the level or intensity of work is the same as seeing a new patient regardless if the worker has been seen by a provider of the same specialty and subspecialty belonging to the same practice group within the past three years.

Therefore, it is necessary provide a workers’ compensations specific definition of new patient as follows, “[a] “new patient” is one who is new to the physician or medical group or an established patient with a new industrial injury or illness. Only one new patient visit is reimbursable to a single physician or medical group per specialty for evaluation of the same patient relating to the same incident, injury or illness.” The definition of established patient is defined as “[a]n “established patient” is a patient who has been seen previously for the same industrial injury or illness by the physician or medical group.” The acting administrative director has determined that this divergence from Medicare and CPT is necessary to adequately compensate for the increased work involved in treating a new workers’ compensation injury.

Adoption of E&M guidelines is necessary to provide a standardized framework for proper documentation of E&M services in order to facilitate proper coding which is used to determine the appropriate reimbursement rate for the E&M visit. Clear and concise medical record documentation is critical to providing patients with quality care and is required in order for providers to receive accurate and timely payment for furnished services.

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section.

The documentation guidelines were developed to work with the RBRVS. The guidelines have been adopted by other payers, including the Washington State workers’ compensation program.

The 2013 RAND RB-RVS, report, p. 83, discusses the fact that the CMS documentation guidelines provide a common operational definition of the level of evaluation and management service, and that there is a need for such guidelines in California. According to the RAND study, WCRI data indicate workers’ compensation providers tend to bill a higher intensity visit level

than providers in other states. A common standard can reduce friction between providers and payers.

Section 9789.12.12 Consultation Services Coding – use of visit codes

Specific Purpose:

The purpose of this section is to require use of CPT evaluation and management “visit codes” rather than CPT “consultation codes” for physician consultations in outpatient settings, and to require use of hospital care codes or nursing facility care codes, as appropriate, for physician consultations performed in inpatient and nursing facility settings. The section specifies that consultation reports are bundled into the underlying evaluation and management visit code and are not separately payable, except that a report will be separately reimbursable where the consultation is requested by the Workers’ Compensation Appeals Board or the administrative director, and a report will be separately reimbursable where the consultation is requested by a Qualified Medical Evaluator or Agreed Medical Evaluator in the context of a medical-legal evaluation.

Necessity:

This section is necessary to instruct how consultation services should be coded to determine the appropriate maximum reimbursement for these services. It is also necessary to identify the workers’ compensation-specific reports that are separately payable since Medicare bundles reimbursement for consultation reporting within the RVUs for the E&M service. Because certain reports are unique to workers’ compensation, this section provides for separate payment of workers’ compensation required reports (consultation reports requested by the Workers’ Compensation Appeals Board or the administrative director and consultation reports requested by the Qualified Medical Evaluator or Agreed Medical Evaluator, in the context of a medical-legal evaluation.)

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section.

The current OMFS has separate allowances for consultations and for other E&M services. In addition, a report by the consulting physician is separately reimbursable. The ground rule in the 1999 OMFS book states that a consultation is “a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or appropriate source.” OMFS, 1999, p. 11.

In 2010, Medicare finalized its proposal to eliminate payment for consultation codes and redistribute the savings to the new and established office visits, and the initial hospital and initial

nursing facility visits. According to the 2010 Medicare physician fee schedule final rule⁶, this redistribution of savings results in approximately a 6 percent increase in the new and established office visits and a 0.3 percent increase in the initial hospital and nursing facility visits. The increase in these E&M visits is reflected in all procedures that have E&M as part of their global period (e.g. global surgery).

Medicare eliminated use of the consultation codes for a variety of reasons, including:

- inconsistent use of the consultation codes by physicians
- a large proportion of services improperly billed as consultations⁷
- documentation requirements very similar between E&M visits and consultations⁸
- indications that the physician work is clinically similar
- OIG's findings that the consultation codes may be overvalued relative to the E&M codes for initial hospital care and new patient office/outpatient visits

The elimination of the consultation codes for Medicare use was made budget neutral by increasing the work RVUs for new and established office visits by approximately 6 percent and for initial hospital and facility visits by approximately 0.3 percent (which also affected the incremental work RVUs for the E&M codes that are built into the global surgical codes).

Although the Medicare Physician Fee Schedule does not use the consultation codes, the annual update includes relative values for the consultation codes in recognition that the RBRVS is used by other payers.

RAND's 2013 RB-RVS report analyzes three alternatives. The following RAND table summarizes the differences in OMFS allowances under three fee schedule alternatives. Section A shows the current distribution of the consultation codes in the WCIS. Section B shows the results of crosswalking the current OMFS codes into their 2013 equivalents. The follow-up inpatient consultation codes were cross-walked to the codes for subsequent hospital and nursing home care and the confirmatory consultations were cross-walked to the office and initial inpatient consultation codes. RAND found that relative to the current OMFS, allowances would be 22 percent higher if the RBRVS recognized the consultation codes at 1.20 of the published RVUs. Section C crosswalks the services into their CPT equivalents under Medicare rules (i.e., visit codes). Relative to the current OMFS, RAND found the allowances would be 95 percent of the amounts payable under the current OMFS before consideration of differences in the payment

⁶ *Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010* (CMS-1413-FC; 74 FR 61738; November 25, 2009)

⁷ In March 2006, the Office of the Inspector General (OIG) published a report with the purpose of assessing whether Medicare payments for consultation services were appropriate. It found approximately 75 percent of services paid as consultations did not meet applicable program requirements resulting in improper payments (e.g. billed as the wrong type or level of consultation, services did not meet the definition of a consultation, and improperly paid claims due to a lack of appropriate documentation.) *Consultations In Medicare: Coding And Reimbursement*, Department of Health and Human Services, Office Of Inspector General, 2006

⁸ The change was to allow any form of written communication, including submitting a copy of the evaluation report taken directly from the medical record submitted without a letter format.

rules for consultation reports. The aggregate payments for 2013 consultation codes are 27 percent higher than if the fee schedule were to follow the Medicare ground rules.

Not including the separate payment to be made for workers' compensation required reports, RAND estimates that the aggregate payments for both the consultation visits and reports total \$62.7 million under the OMFS compared to \$36.01 million under the RBRVS Medicare payment rules, which is approximately 57 percent of total OMFS allowances for consultations.

Section 5307.1(a)(2)(A)(iii) limits aggregate payments to 120 percent of the aggregate fees under the Medicare system. Consultations are covered by Medicare but paid under different CPT codes (i.e., the E&M visit codes). Therefore, if the Medicare rules are not adopted, a budget neutral adjustment would be needed to limit aggregate fees to 120 percent of the amount payable under Medicare.

2013 RAND RB-RVS Study, Table 6.12 Comparison of Allowances under Current OMFS and Alternatives under the RB-RVS, p. 53

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

RAND's 2013 RB-RVS report identified three alternatives for consideration: follow Medicare rules, follow Medicare rules but continue to pay separately for consultative reports, and pay for consultation codes but eliminate separate payment for consultative reports since they are part of the defined service and reason for higher relative values. The acting administrative director considered a fourth alternative which is to follow Medicare payment ground rules, but, allow separate payment for workers' compensation-specific consultation reports (consultation reports requested by the Workers' Compensation Appeals Board or the administrative director and consultation reports requested by the Qualified Medical Examiner (QME) or Agreed Medical Evaluator (AME) in the context of medical-legal evaluation). The acting administrative director concluded the fourth alternative is the most appropriate for workers' compensation, as follows.

1) Follow Medicare payment ground rules – The advantages of selecting this alternative is that the physician fee schedule payment rules will be consistent with Medicare rules and assigned RVUs, and will reduce opportunity for coding inconsistencies.

The acting administrative director determined that this would not be appropriate. For routine consultations required for medical treatment purposes there is no workers' compensation-specific requirement for a formalized report, and there is no apparent reason to treat these differently than consultation services using visit codes as in Medicare. However, there is a need to recognize the type of reporting required where there are special workers' compensation mandates. Adhering strictly to Medicare would not recognize the need to handle the reporting differently in this circumstance.

2) Use E&M visit codes only but allow consultative reports – This alternative addresses the concern that consultative reports might be undervalued in visit codes, and it would pay for the actual consultative reports.

The acting administrative director determined that this alternative would be contrary to Medicare rules and would require a budget neutrality adjustment (estimated to be \$40 per report). This alternative would also add administrative burden. In addition, for routine medical treatment consultations there is no requirement to report back to the referring provider in any particular manner. Thus the reporting/documentation requirement is substantially the same as that in Medicare where a consultant must communicate his/her findings and opinions back to the referring doctor.

3) Allow consultation codes – This alternative could address concerns expressed by some physician specialty groups.

The acting administrative director determined that the disadvantages of this outweigh the advantages. This alternative would require budget neutrality adjustments which would complicate the fee schedule updating and would increase administrative burden of monitoring correct coding. This alternative would require reducing the RVUs assigned to E&M visit codes which were increased by Medicare when the consultation codes usage was discontinued. This reduction in E&M visit code RVUs would also be required to avoid duplicate payments.

4) Follow Medicare payment ground rules requiring use of visit codes instead of consultation codes, but, allow separate payment for workers' compensation specific consultation reports (consultation reports requested by the Workers' Compensation Appeals Board or the administrative director and consultation reports requested by the Qualified Medical Examiner (QME) or Agreed Medical Evaluator (AME) in the context of medical-legal evaluation).

The acting administrative director proposes to adopt this alternative because this alternative achieves the best balance by following Medicare payment ground rules (using E&M codes instead of CPT consultation codes, bundling medical consultation reports) and paying separately for workers' compensation-specific consultation reports. It would pay for the extra work required to produce workers' compensation specific reports, eliminating the concern of loss of access. There would be no requirement to adjust for budget neutrality or eliminate duplicate payment.

Section 9789.12.13 Correct Coding Initiative

Specific Purpose:

The purpose of this section is to require use of the National Correct Coding Initiative (NCCI) physician coding edits and medically unlikely edits to determine appropriate payment, except for when the fee schedule's payment ground rules differ from Medicare's payment ground rules. The section also provides that claims administrators shall use the National Correct Coding Initiative Coding Policy Manual for Medicare Services. The section cross-references section 9789.19 for the NCCI by date of service.

Necessity:

Adoption of NCCI is necessary to provide a standardized framework for proper coding of procedures which is used to determine the appropriate reimbursement rate for the physician and non-physician practitioner services.

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section.

The NCCI was developed to control improper coding leading to inappropriate payment in Medicare claims. The NCCI edits consist of two types: 1. procedure-to-procedure edits that define pairs of codes that should not be reported together for a variety of reasons; and 2. medically unlikely edits, which are units of service edits, that define for each code identified, the allowable number of units of service. The units of service in excess of this value are not feasible for the service under normal conditions.

According to RAND's 2013 RB-RVS report, adopting the NCCI edits can reduce the number of inappropriate payments. An AMA sponsored study found that application of NCCI-type edits resulted in savings of \$0.03 for every dollar in physician charges.⁹

The CCI edits assure services are coded using consistent rules known to both payers and providers. Having all parties use the same ground rules should reduce a source of friction over what the proper maximum payment rate should be for a given service.

The California Orthopedic Association (COA) submitted a comment on the DWC Forum, suggesting the acting administrative director adopt the American Association of Orthopedic Surgeons' (AAOS) Global Service Data bundling edits. COA asserts these edits are superior because they are compiled by orthopedic surgeons who are coding experts and are more comprehensive. COA contends that, as opposed to the AAOS edits, the NCCI edits were developed primarily for high volume codes and do not include all possible combinations of correct coding edits or types of unbundling that exist. The lack of an NCCI edit, however, does not excuse incorrect coding. RAND considered the alternative of adopting the AAOS edits and made the following observations: 1) using one set of internally consistent edits for all services is preferable to using two different sets of edits. The latter might have inconsistencies that would need to be reconciled; 2) the NCCI edits are consistent with the Medicare payment rules underlying the RBRVS; and 3) the AAOS guidelines would need to be purchased whereas an electronic version of the NCCI is available for free download.

One concern with adoption of NCCI edits is the possible administrative burden on providers, but these edits are used by Medicare, Medi-Cal, and many commercial payers, so costs of adoption for providers are likely to be low. Providers probably already have experience with NCCI edits based on billing experiences with other payers. While there may be an increase in the number of claims reviewed resulting in higher administrative costs, standardization may lead to processing efficiencies that reduce costs.

As discussed above, the acting administrative director has found the benefits of adopting the NCCI edits to the workers' compensation system outweigh the disadvantages, and will improve accuracy of reimbursement.

Section 9789.12.14 California-Specific Codes

Specific Purpose:

The purpose of this section is to set forth non-CPT codes developed by the Division in the Physician Fee Schedule where needed for workers' compensation, and set forth the fee, if any. The codes are primarily related to workers' compensation medical reports and medical records

⁹ *What private payers do to your claim: repricing and claims editing*, National Health Exchange Services, 2005

Necessity:

This section is necessary to address payment for services that are not payable under the RBRVS, but require payment under workers' compensation.

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section.

Medicare bundles payment for reports and supplies into the payment for E&M services. There are, however, certain WC-required reports that should be separately reimbursable, since these reports are not Medicare-covered reports and are specific to workers' compensation system needs. Because these reports are not covered by Medicare, separate payment for these reports does not require an adjustment to remain within 120 percent of Medicare aggregate allowances.

For example, workers' compensation required consultation reports performed in the context of medical-legal evaluations or other mandated consultations would now be paid using a California specific code, WC007 (with modifiers), instead of CPT code 99080 under the current fee schedule. Medical consultation reports would now be bundled into the payment for the primary procedure. Another example is workers' compensation required report, Primary Treating Physician's Progress Reports (PR-2), currently paid using code 99081, and would now be separately paid using California specific code WC002.

The acting administrative director proposes to adopt the Medicare payment ground rules and bundle medical treatment reports that are an integral part of the medical treatment. If the acting administrative director deviated from these payment ground rules, she would be required to adjust the E&M allowance to eliminate duplicate payment for reports, modify the NCCI edits, and possibly make a budget neutral adjustment as well. The acting administrative director, however, proposes to continue separate payment of work-related reports, because these are workers' compensation related reports and are not Medicare covered services. The 120 percent limitation on aggregate fees is not affected by the separate payment for the reports.

Section 9789.12.15 California Specific Modifier

Specific Purpose:

The purpose of this section is to set forth one modifier created for use for California workers' compensation, in addition to applicable CPT modifiers: -30 Consultation Service During Medical-Legal Evaluation.

Necessity:

Since California specific code WC007 would be used for two different types of report, this modifier -30 would be necessary to distinguish the payment for the consultation reports requested by the Qualified Medical Evaluator or Agreed Medical Evaluator in the context of a medical-legal evaluation from payment for consultation reports requested by the Workers' Compensation Appeals Board or the administrative director (modifier -32).

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision. Since no existing 2013 CPT modifier is suitable for identifying this type of report, the acting administrative director proposes to adopt California-specific modifier -30.

Section 9789.13.1 Supplies

Specific Purpose:

The purpose of this section is to provide that separate payment for routinely bundled supplies is not allowed, and to cross-reference to section 9789.13.2 regarding payment for physician-administered drugs/biological/vaccines/blood products. The section specifies that splints and casting materials are separately payable in addition to the procedure and cross-references to section 9789.19 for maximum payment amounts, by date of service.

Necessity: This amendment is necessary to clarify that the physician fee schedule would follow Medicare's payment rules pertaining to how supplies are reimbursed. Under the current physician fee schedule, supplies and materials normally necessary to perform services are not separately reimbursable. The current schedule states that supplies and materials provided over and above those typically included with office visits or other services may be charged for separately using CPT code 99070.

Under Medicare, with certain exceptions, supplies and materials are not separately payable, because the practice expense RVUs include the cost for supplies for procedures performed in an office. Supplies are not payable for procedures performed in a facility because the facility is reimbursed for these costs in the facility fee. In office-based procedures, the only exceptions to this payment rule are separate payment for injectable drugs, drugs used during radiologic procedures, biologicals, and casting materials. CPT code 99070 is not payable under Medicare payment rules.

This section adopts Medicare's payment rules regarding supplies. It is necessary to do so in order to avoid duplicate payment since the costs of supplies are generally bundled into the procedure. Casting materials and splints are not bundled into the RVUs so it is necessary to follow the Medicare rule and allow separate payment for those items.

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section.

The 2013 RAND RB-RVS report addressed some of the comments received from the February 2013 DWC Forum pertaining to how supplies should be paid. Numerous physical therapists favored supplies furnished during physical therapy visits receive separate payment, because workers' compensation patients use more supplies. No basis was provided by any commenter to support their position. RAND consulted a physical therapist who is disinterested in the physician fee schedule, and was informed there is no apparent reason why workers' compensation patients would require more supplies during a visit.

Another commenter requested separate payment continue for surgical trays. Under RBRVS, however, the practice expense RVUs include the costs of equipment and supplies furnished during an in-office service.

A separate allowance for surgical trays, physical therapy supplies, or any other supplies bundled under the RBRVS would result in a duplicate payment, and require budget neutrality adjustments.

An advantage to bundling payment for supplies is that it will reduce the administrative burden.

The 2013 RAND RB-RVS report (p. 46) considered two alternatives. The first would follow Medicare rules without modification, and the second alternative would make a separate payment for atypically high supply costs.

Alternative: Follow Medicare: The advantages for adopting Medicare rules without modification are 1. administrative burden and bill processing costs should decrease; 2. providers would be discouraged from providing potentially unnecessary supplies; and 3. is consistent with Medicare payment rules. Bundling supplies into the payment for the primary services would encourage providers to reduce internal costs through low-cost options, where clinically appropriate. Bundling reduces the administrative costs and burden associated with routinely billing these supplies separately.

Alternative: Outlier Payments: Allow payments for supplies above a threshold. Payment for supplies above this threshold would be reimbursed By Report using code 99070. This alternative would bundle all supplies but the unusually high cost supplies. This alternative would discourage providers from providing potentially unnecessary supplies, but still protect against potential access issues. The disadvantages are that it will create higher administrative burden and would result in some level of duplicate payment which would require budget neutrality adjustments.

The acting administrative director proposes to adopt the first alternative, follow Medicare payment rules, as the benefits outweigh those of the second alternative.

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

Specific Purpose:

The purpose of the section is to specify that physician-administered drugs, biologicals, vaccines, and blood products are separately payable. The section sets forth the code types to be used for vaccines (NDC and CPT codes), and physician-administered drugs, biologicals and blood products (NDC and J-codes.) The section specifies that maximum reimbursement shall be determined using the “Basic Rate” set forth on the Medi-Cal Rates file on the Medi-Cal website for the date of service. The section specifies that Medi-Cal sets the rates based on Medicare’s “average sales price plus 6 percent formula”, and for products not priced by Medicare, uses the Medi-Cal Pharmacy Fee Schedule rate (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)). The section specifies that the injection administration fee of \$4.46 should be subtracted from the published rate because payment for the injection administration will be determined under the RBRVS. The section states that 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. Injection services are paid separately only if no other physician fee schedule service is being paid. Chemotherapy injections are paid separately in addition to the visit on the same day. The section states that separate payment may be made for various physician-administered radiopharmaceuticals and directs use of specified HCPCS A-codes and Q-codes. The section states that: “Administer” means the direct application of a drug or device to the body of a patient by injection, inhalation, ingestion, or other means.

Necessity:

It is necessary to establish maximum reasonable fees for drugs, biologicals, vaccines or blood products that are administered by the physician since the products are not bundled into procedures but are separately payable. For the injection service itself, it is necessary to specify that an injection service is separately payable only if it is the only physician service provided at that visit in order to conform to the Medicare rule. Under the RBRVS, reimbursement for the injection service is bundled into the evaluation and management service provided on the same visit. The acting administrative director has determined that adopting the Medi-Cal Rates file will provide the most comprehensive and appropriate pricing for drugs, biologicals, vaccines or blood products. The Medi-Cal Rates file primarily uses the Medicare rate, Average Sales Price (“ASP”) plus 6% for most products, and fills in with the Medi-Cal Pharmacy Fee Schedule rates for items not priced by the Medicare methodology. (The current OMFS uses Average Wholesale Price (“AWP”) as a benchmark; it is increasingly viewed as a flawed benchmark because “pharmaceutical transactions often involve proprietary rebates, volume discounts, and

other adjustments”¹⁰ which are not reflected in the AWP.) The RAND 2013 RB-RVS Study describes the Medi-Cal approach which uses Medicare ASP as the primary source:

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

As described above, Medicare currently pays ASP plus 6% for most drugs and AWP minus 5% for special categories of PAD. There may be some PAD that are not currently priced by Medicare. MediCal pays the same as Medicare when a Medicare rate is available and uses its pharmacy rate of reimbursement when Medicare does not have a listed rate.
2013 RAND RB-RVS Study, p. 65.

The acting administrative director has determined that adopting the Medi-Cal approach is the most effective and appropriate pricing mechanism for physician-administered drugs, biologicals, vaccines or blood products. It is necessary to deduct the administration fee of \$4.46 from the price in the Medi-Cal Rates file to avoid duplicative payment since an injection fee will be paid where appropriate under the Medicare RBRVS ground rules.

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section.

Section 9789.13.3 Physician-Dispensed Drugs

Specific Purpose:

The purpose of this section is to cross-reference to section 9789.40 Pharmaceutical Fee Schedule and Labor Code section 5307.1 for maximum prices for physician-dispensed drugs.

Necessity:

This section is necessary to direct the workers’ compensation community to the pharmaceutical fee schedule for reimbursement for physician-dispensed drugs. It is intended to assist the public in distinguishing between the physician-administered drugs covered in section 9789.13.2 and the physician-dispensed drugs covered by the pharmaceutical fee schedule in section 9789.40.

¹⁰ 2013 RAND RB-RVS Study, p. 65.
Official Medical Fee Schedule – Physician Fee Schedule
Proposed Regulations
Initial Statement of Reasons (June, 2013)

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section.

Section 9789.14. Reimbursement for Reports, Duplicate Reports, Chart Notes

Specific Purpose:

The purpose of this section is to identify which reports are **not** separately reimbursable (Doctor's First Report of Occupational Illness or Injury Form 5021, Consultation Reports (except as specified), report by a secondary physician to a primary treating physician, Physician's Return to Work and Voucher Report (DWC-AD Form 10133.36)) and which reports **are** separately reimbursable (Primary Treating Physician's Progress Report (Form PR-2), Primary Treating Physician's Permanent and Stationary Report (Form PR-3)(Form PR-4), Psychiatric Report Requested by the WCAB or the administrative director, consultation reports requested by the WCAB or the administrative director, consultation reports requested by the QME or AME in the context of a medical-legal evaluation.)

Necessity:

This section is necessary to inform the workers' compensation community which reports are not separately payable because the reports are bundled into an underlying CPT and which reports are separately payable.

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section.

Medicare bundles payment for reports and supplies into the payment for the underlying service. There are, however, certain WC-required reports that should be separately reimbursable, since these reports are not Medicare-covered reports and involve reporting required for workers' compensation issues. Because these reports are not covered by Medicare, separate payment for these reports does not require an adjustment to remain within 120 percent of Medicare aggregate allowances.

For example, workers' compensation required consultation reports performed in the context of medical-legal evaluations or other mandated consultations would now be paid using a California specific code, WC007 (with modifiers), instead of CPT code 99080 under the current fee schedule. Medical consultation reports would now be bundled into the payment for the primary procedure. Another example is workers' compensation required report, Primary Treating Physician's Progress Reports (PR-2), currently paid using code 99081, and would now be separately paid using California specific code WC002.

The acting administrative director proposes to adopt the Medicare payment ground rules and bundle medical treatment reports that are an integral part of the medical treatment. If the acting administrative director departed from these payment ground rules, she would be required to adjust the E&M allowance to eliminate duplicate payment for reports, modify the NCCI edits, and possibly make a budget neutral adjustment as well. The acting administrative director, however, proposes to continue separate payment of work-related reports, because these are workers' compensation related reports and are not Medicare covered services. The 120 percent limitation on aggregate fees is not affected by the separate payment for the reports.

Section 9789.15.1 Non-Physician Practitioner (NPP) – Payment Methodology

Specific Purpose:

The purpose of this section is to state that physician assistants, nurse practitioners, clinical nurse specialists, shall be paid 85% of what a physician is paid under the Physician Fee Schedule and clinical social workers are paid at 75% of what a physician is paid under the Physician Fee Schedule. Maximum fees for services provided by NPPs employed by the physician that are incident to the physician service shall be at 100 percent of the physician fee schedule amount as though the physician personally performed the services. The section specifies that an NPP that actively assists a physician in performing a surgical procedure and furnishes more than just ancillary services may report the AS modifier and is eligible for payment as assistant-at-surgery: 85% of what a physician would be paid (16%), i.e. 13.6% of the amount paid to a physician for assistant-at-surgery services.

Necessity:

This section is necessary to set forth the payment methodology for setting the maximum reimbursement rates for non-physician practitioners.

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section.

The current fee schedule does not distinguish between physician and non-physician practitioners rendering services within their legal scope of practice, and sets the maximum allowable fees for similar services at the same amount. Medicare payment rules, however, sets the maximum allowable fees at 85 percent of the allowed amount for physician services for services rendered by nurse practitioners, clinical nurse specialists, and physician assistants. Medicare pays clinical social workers at 75 percent of the allowed amount for a psychiatrist. When services provided in a physician's office or clinic, by these non-physician practitioners are billed as "incident to" the professional services of a physician, physicians are paid the full fee schedule amount as though they personally performed the service. Under "incident to", care is provided by a team, with

the non-physician practitioner providing the direct patient care services and the physician taking overall responsibility for the care of the patient.

According to the 2013 RAND RB-RVS report (p. 37), aside from Medicare, other health care payers also “pay non-physician practitioners at a specified fraction of physician payment levels”.

A 2002 Medicare Payment Advisory Commission (MedPAC) study¹¹ examined the payment differentials and concluded that there was too much uncertainty regarding differences between physician and NPP services to recommend any changes to the Medicare payment differentials at that time.

MedPAC found that the imprecise billing of codes made it difficult to determine whether the same service is being provided. Physicians may see sicker patients, and also may be better prepared to diagnose and treat patients with severe illness of an acute, chronic, or recurrent nature.

MedPAC ultimately concluded it was appropriate to continue to pay 100% of the physician fee schedule for incident to services. “The higher reimbursement physician practices receive when billing incident to for the services of qualified non-physician practitioners accounts for the team approach to care, including the continued responsibility of the physician in caring for patients seen by NPPs.” (p. 14)

The approach of other payers is varied. The MedPAC report found that payment and coverage policies for private payers vary, and can even differ from contract to contract. Some plans reimburse non-physician services at 100 percent of the amount paid for physician services, some follow Medicare practices, and some do not cover the services of NPPs.

The 2013 RAND RB-RVS report found state workers’ compensation programs use a range of payment methodologies for setting payment rates for services rendered by non-physician practitioners, although most adopt the Medicare approach or a variation of the Medicare approach. All of the states surveyed by RAND adopted an approach that included a non-physician practitioner payment rate that was a fraction of the physician payment rate.

¹¹ *Medicare Payment to Advanced Practice Nurses and Physician Assistants*, Medicare Payment Advisory Commission (MedPAC), June 2002
Official Medical Fee Schedule – Physician Fee Schedule
Proposed Regulations
Initial Statement of Reasons (June, 2013)

8 CCR §§ 9789.21.1 through 9789.19

- 36 -

2013 RAND RB-RVS report, Table 6.4 WC Non-physician Practitioner Payment Policies (p. 39)

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

¹ PA or NP as Surgical Assistant: Payment will be 75% of 25% of the surgeon's allowable fee

² PA or NP as Surgical Assistant: Payment will be 13% of the surgeon's allowable fee, or the practitioner's usual and customary charge, whichever is less

³ PA or NP as Surgical Assistant: Payment will be 15% of the surgeon's allowable fee

⁴ Social worker evaluation - 30 minutes

⁵ Uses locked in CF of 33.9764

⁶ Uses Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) CF

The 2013 RAND RB-RVS study (p. 42) also found that non-physician practitioners will experience a significant increase in payment rates from the current OMFS physician fee schedule payment rates *regardless* of whether payment is at 100 percent or 85 percent of the RBRVS allowances.

The acting administrative director considered the following alternative payment methodologies.

Alternative 1: Retain status quo policy where non-physician practitioners are paid the same fees as physicians. The advantage is that it will minimize disruption to the current handling of claims. The disadvantages include the possible overpayment if services provided by physicians and non-physician practitioners differ in the product and services provided, and in the outcome and quality of services. This alternative would also require an offsetting reduction for other services under the budget neutrality rules.

Alternative 2: Adopt the Medicare payment policies including the “incident to” payment rule. This alternative provides a better match of payment to services provided if services by physicians and non-physician practitioners differ in product and quality. Selecting this payment policy will also be in alignment with other state workers’ compensation program policies. Finally, RAND’s study found that even if services rendered by non-physician practitioners were to receive 85 percent of physician service payment rates, the non-physician practitioners will still be receiving a significant increase in payment rates from

the current OMFS physician fee schedule. The acting administrative director believes increased concern for loss of access should not become an issue. The disadvantage is the possible administrative burden in monitoring “incident to” distinction.

Alternative 3: Adopt the Medicare payment policy only with respect to the work component and pay the practice expense component at 100 percent. This alternative may provide a better reflection of reimbursement values if the physician and non-physician practitioner provide different products and quality, but have comparable office expenses. The disadvantages, however, are that it would add to administrative burden and require an offsetting reduction in payment for other services under the budget neutrality rules.

The acting administrative director is proposing to adopt alternative 2, because the benefits outweigh the disadvantages, and will not cause any added concern regarding access, since non-physician practitioners should realize a significant increase in the payment rates over what they are currently reimbursed under the current OMFS physician fee schedule.

The 2013 RAND RB-RVS study provided a comparison of the impacts of the first alternative (reimburse 100% of the physician payment amount) and the second alternative (adopt the Medicare payment policies including the “incident to” payment rule). According to RAND, “[s]etting the allowances at 100 percent of the RBRVS allowances for physicians would increase aggregate allowances an estimated \$3.78 million in 2014 and \$4.31 million in 2017. This represents a 0.40 percent increases in total aggregate allowances for all services under the RBRVS that are paid using RVUs in 2014 and a 0.38 percent increase in 2017.” (p. 43)

2013 RAND RB-RVS report, Table 6.7 Comparison of Total Allowances for Non-Practitioner Services under Proposed Policy and Current Policy (\$ millions) (p. 44)

Total RB-RVS for All Services ¹		Total RB-RVS Amounts under Proposed Policy (85% of Medicare X 1.2)		Total RB-RVS Amounts Based on 100% of Medicare x 1.2	
2014	2017	Using Medicare Rules in 2014	Total RB-RVS Amounts Using Medicare Rules in 2017	Total RB-RVS Amounts at 100 % in 2014	Total RB-RVS Amounts at 100 % in 2017
1,001.48	1184.00	21.40	24.40	25.18	28.70

¹ 95.5 percent of the amounts shown are based on RVUs

Section 9789.15.2 Non-Physician Practitioner (NPP) – “Incident To” Services

Specific Purpose:

The purpose of this section is to set forth rules to determine when services provided by a NPP are “incident to” a physician’s service in a physician’s office (whether located in a separate office suite or within an institution) or in a patient’s home. In order to qualify as “incident to” service, the service would need to be an integral, although incidental, part of the physician’s professional service, commonly rendered without charge or included in the physician’s bill, of a type that are commonly furnished in the physician’s office or

clinic, and furnished by the physician or by auxiliary personnel under the physician's direct supervision. Payment for NPP services rendered in an inpatient hospital or skilled nursing facility (SNF) are made to the hospital or SNF. Therefore, "incident to" services would not be billed separately nor payable under the physician fee schedule. This section clarifies what services are considered "commonly furnished", when services are considered to be under "direct personal supervision", and what is considered a "physician directed clinic".

Necessity:

This section is necessary to conform to the Medicare payment rules for determining the payment rate for services rendered by non-physician practitioners.

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section.

As discussed in Section 9789.15.1, above, the acting administrative director is proposing to adopt the Medicare payment rules for determining the payment rate for services rendered by non-physician practitioners. Medicare's "incident to" payment rules are an integral part of the payment methodology for services rendered by non-physician practitioners. Again, any divergence from Medicare would require a budget neutrality adjustment.

Section 9789.15.3 Qualified Non-physician Anesthetist Services

Specific Purpose:

The purpose of this section is to set forth the payment methodology to be used by certified registered nurse anesthetists (CRNAs) and anesthesia assistants (AAs) when determining the payment rate for their services. The section also defines anesthesia time, sets forth the method for calculating payment for services furnished in a variety of circumstances, and sets forth the modifiers to be used.

Necessity:

This section is necessary to conform to the Medicare payment rules for determining the payment rate for services rendered by qualified non-physician anesthetists.

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section.

As discussed in Section 9789.15.1, above, the acting administrative director is proposing to adopt the Medicare payment rules for determining the payment rate for services rendered by non-physician practitioners. Medicare's qualified non-physician anesthetist

services payment rules are an integral part of the payment methodology for services rendered by non-physician practitioners. Again, any divergence from Medicare would require a budget neutrality adjustment.

Section 9789.15.4 Physical Medicine / Chiropractic / Acupuncture Multiple Procedure Payment Reduction; Pre-Authorization for Specified Procedure/Modality Services

Specific Purpose:

The purpose of the section is to adopt the Medicare physical therapy Multiple Procedure Payment Reduction (“MPPR”) and to adapt it for workers’ compensation. The Medicare MPPR for “Always Therapy” Codes applies when more than one code or more than one unit is provided to the same patient on the same day as follows: Full payment is made for the procedure code with the highest Practice Expense component. For the second and subsequent codes or units of the same code, the PE is reduced by 50%; the Work and Malpractice RVUs are paid at full value. The regulation is adapted for workers’ compensation by applying the MPPR to the chiropractic manipulation codes and the acupuncture codes in addition to the “Always Therapy” codes. Another purpose of the regulation is to provide that specified “caps” are presumed reasonable limitations on reimbursement for services provided at one visit unless pre-authorization and a pre-negotiated fee arrangement has been obtained. The limitations to be applied (unless preauthorization is obtained) include the following: (1) When billing for treatment consisting of physical medicine modalities only: no more than two codes on the same visit; (2) When billing for physical medicine modality, procedure, or acupuncture codes, no more than 60 minutes on the same visit; (3) Where modalities and procedures are billed: no more than 4 codes total on the same visit.

Necessity:

It is necessary to adopt the Medicare MPPR for physical therapy in order to avoid duplicative payment. CMS analyzes the PE components for physical therapy procedures and determines that there are areas of overlapping PE when more than one procedure is performed at a visit. If the full RVUs for PE were paid for multiple physical therapy procedures there would be double reimbursement for the same expenses. RAND modeled the impact of the RBRVS, and applied the MPPR to chiropractic codes and acupuncture codes in addition to the “Always Therapy” codes. In Medicare, chiropractic services are extremely limited, and acupuncture is not a covered benefit, but in workers’ compensation chiropractic and acupuncture may frequently be billed together with physical therapy codes.

The acting administrative director has determined that it is necessary to adopt the “presumptive fee cap” on the number of procedures reimbursed without prior authorization in order guard against excessive payment for physical medicine, chiropractic, and acupuncture procedures. The presumptive “soft cap” on the procedures is modeled on caps on reimbursement that have been present in the workers’

compensation fee schedule since 1994.¹² The proposed regulation merely continues the rules as presumptions, allowing preauthorization of procedures in excess of the cap. Medicare uses annual payment caps on physical therapy and speech therapy (combined \$1900 for 2013) and occupational therapy (\$1900 for 2013), with an exceptions process for medically necessary treatment above the cap. The acting administrative director has determined that the Medicare annual cap would not be appropriate for workers' compensation, but continuation of the per-visit soft cap on the number of procedures is a necessary measure to avoid excessive payment for physical medicine procedures.

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section.

Section 9789.15.5 Ophthalmology Multiple Procedure Reduction

Specific Purpose:

The purpose of this section is to set forth the Multiple Procedure Payment Reduction (MPPR) on ophthalmology procedures that applies when multiple services are furnished to the same patient on the same day. The MPPR applies to TC-only services and to the TC of global services. Full payment is made for the TC service with the highest payment. Payment is made at 80 percent for subsequent TC services. Where applicable, the MPPR is applied first, then the reduced amount is compared with the OPSS cap.

Necessity: This section is necessary to conform to Medicare payment rules.

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section.

Section 3134 of the Affordable Care Act added section 1848(c)(2)(K) of the Social Security Act which specifies that the Secretary of Health and Human Services shall identify potentially misvalued codes by examining multiple codes that are frequently billed in conjunction with furnishing a single service. As a further step in implementing this provision, Medicare examined and has decided to expand the multiple procedure payment reduction (MPPR) payment policy by applying MPPRs to the technical component of diagnostic cardiovascular and ophthalmology procedures.

The acting administrative director is proposing to adopt Medicare's payment rules of applying the MPPR to ophthalmology procedures. There is no evidence to justify deviating from the Medicare payment rules for workers' compensation cases. Diverting from Medicare would require a budget neutrality adjustment to eliminate duplicate payment.

¹² Official Medical Fee Schedule, 1994, p. 263.
Official Medical Fee Schedule – Physician Fee Schedule
Proposed Regulations
Initial Statement of Reasons (June, 2013)

Section 9789.15.6 Diagnostic Cardiovascular Procedures – Multiple Procedure Reduction

Specific Purpose:

The purpose of this section is to set forth the Multiple Procedure Payment Reduction (MPPR) on diagnostic cardiovascular procedures that applies when multiple services are furnished to the same patient on the same day. The MPPR applies to TC-only services, and to the TC of global services. Full payment is made for the TC service with the highest payment. Payment is made at 75 percent for subsequent TC services. Where applicable, the MPPR is applied first, then the reduced amount is compared with the OPSS cap.

Necessity: This section is necessary to conform to Medicare payment rules.

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section.

Section 3134 of the Affordable Care Act added section 1848(c)(2)(K) of the Social Security Act which specifies that the Secretary of Health and Human Services shall identify potentially misvalued codes by examining multiple codes that are frequently billed in conjunction with furnishing a single service. As a further step in implementing this provision, Medicare examined and has decided to expand the multiple procedure payment reduction (MPPR) payment policy by applying MPPRs to the technical component of diagnostic cardiovascular and ophthalmology procedures.

The acting administrative director is proposing to adopt Medicare's payment rules of applying the MPPR to diagnostic cardiovascular procedures. There is no evidence to justify deviating from the Medicare payment rules for workers' compensation cases. Diverting from Medicare will require a budget neutrality adjustment, to eliminate duplicate payment.

Section 9789.16.1 Surgery – Global Fee

Specific Purpose:

The purpose of the section is to adopt the Medicare global surgical package, specify how the global period is identified in the National Physician Fee Schedule Relative Value file, define the components that fall within the global period, and specify services not included.

Necessity:

Labor Code section 5307.1(a)(2)(A) requires the administrative director to adopt “an official medical fee schedule based on the resource-based relative value scale for physician services and nonphysician practitioner services....” It is necessary to adopt the Medicare global surgery periods in order to properly price surgical services under the RBRVS system since the “surgical package” is a fundamental aspect of the development of the relative value units for the procedures that are assigned a global period of 10 or 90 days. In the 2013 Medicare Physician Fee Schedule Final Rule [p. 68911], CMS describes the global surgical package, which has existed since the RBRVS was established:

We applied the concept of payment for a global surgical package under the PFS at its inception on January 1, 1992 (56 FR 59502). For each global surgical procedure, we establish a single payment, which includes payment for a package of all related services typically furnished by the surgeon furnishing the procedure during the global period. Each global surgery is paid on the PFS as a single global surgical package. Each global surgical package payment rate is based on the work necessary for the typical surgery and related pre- and post-operative work. The global period may include 0, 10, or 90 days of postoperative care, depending on the procedure. For major procedures, those with a 90-day global period, the global surgical package payment also includes services typically furnished the day prior to the day of surgery.

The “global surgical package” concept has been used in California workers’ compensation at least as far back as 1987. The Official Medical Fee Schedule¹³, stated as follows in the “Surgery Ground Rules”:

Listed values for all surgical procedures include the surgery, local infiltration, digital block or topical anesthesia when used and the normal *uncomplicated* follow-up care for the period indicated in days in the column headed “Follow-up Days.”

Under most circumstances, including ordinary referrals, the immediate pre-operative visit in the hospital or elsewhere necessary to examine the patient, complete the hospital records and initiate the treatment program is included in the listed value for the surgical procedure.

The current workers’ compensation Official Medical Fee Schedule contains global surgery days that are based upon the 1997 Medicare Physician Fee Schedule.¹⁴ The 2013 RAND RB-RVS Study, p. 57, notes that: “WC’s current global periods closely align with those of CMS under the MPFS in terms of duration. The key difference is that CMS global periods have been revised over time while OMFS global periods have not.”

¹³ Official Medical Fee Schedule For Services Rendered Under the Workers’ Compensation Law (1987), p. 40.

¹⁴ Official Medical Fee Schedule, (1999), p. 100.
Official Medical Fee Schedule – Physician Fee Schedule
Proposed Regulations
Initial Statement of Reasons (June, 2013)

It is necessary for the regulation to adopt the updated Medicare global days to correlate with the Medicare RVUs which are assigned in light of the global package of services being reimbursed for each procedure. However, the acting administrative director has determined that the rule to be adopted for workers' compensation should diverge from Medicare in two respects: the Primary Treating Physician's Progress Report (Form PR-2) should be separately payable if it occurs during the global period, and Evaluation and Management services shall be separately payable for those visits during the global period that are in excess of the number of visits included in the Medicare Physician Time File for the surgical procedure code. These rules will be discussed in further detail below in relation to Section 9789.16.4 which sets forth workers' compensation exceptions to the global surgical package.

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section.

The acting administrative director has considered two other alternatives set forth in the 2013 RAND RBRVS Study: 1) Allow separate billing of post-surgical E&M visits, and 2) Adopt the CMS MPFS rule and integrate ALL post-surgical visits into the global period. The acting administrative director has determined that each of these alternatives has disadvantages that far outweigh the potential advantages.

The first alternative, to allow separate billing of all post-surgical E&M visits, would have many drawbacks. Medicare determines the RVUs for each surgical procedure with global days by determining the resources typically used for the procedure, and builds in reimbursement for the post-surgical E&M visits. If the regulation were to allow separate payment of all E&M visits in addition to the global surgical package payment, there would be duplicate payment since E&M reimbursement is already included in the package.

Diverging from the Medicare rule which bundles post-surgical E&M visits into the global surgery RVU poses another serious problem, in that it would result in payment in excess of 120% of Medicare, necessitating an offsetting adjustment. Labor Code section 5307.1(a)(2)(A)(iii) specifies that under the physician fee schedule adopted by the administrative director "The maximum reasonable fees paid shall not exceed 120 percent of estimated annualized aggregate fees prescribed in the Medicare payment system for physician services as it appeared on July 1, 2012, before application of the adjustment factor provided in subdivision (g) [the Medicare inflation adjustment and any relative value scale adjustment.]" Since the conversion factor proposed is calculated to result in payment at 120% of Medicare, if a rule were adopted that allowed unbundling of all E&M visits, the separate payment for those visits in addition to the global fee would result in total payments exceeding the 120% limit.

The 2013 RAND RB-RVS Study, p. 60, indicates that "Empirical data are not available to decompose the global RVUs into separate and appropriate RVUs for the surgery from

the post-operative E&M services.” The detailed discussion of the data limitations leads the acting administrative director to conclude that there is not a valid approach to determine the amount of offsetting adjustment that would be required to prevent unbundling of E&M codes from resulting in payments exceeding the 120% cap.

The acting administrative director has also considered the alternative of strictly following Medicare and bundling all post-surgical E&M visits into the global payment. The acting administrative director has considered whether it would be appropriate to deviate from the Medicare global surgery rule in light of Labor Code section 5307.1 subdivision (a)(2)(B), which states: “The official medical fee schedule shall include payment ground rules that differ from Medicare payment ground rules, including, as appropriate, payment of consultation codes and payment evaluation and management services provided during a global period of surgery.” In evaluating whether it is appropriate to adopt a rule which differs from the Medicare global surgery period, the lack of data limits the depth of analysis that is possible. The 2013 RAND RB-RVS Study, p. 59, notes that since both Medicare and workers’ compensation use a global surgery period, there is a lack of data regarding the details of the services provided in the global period:

Because both Medicare and WC use global periods, data are not available to determine whether WC patients require more follow-up visits. Because WC patients have a shorter length of stay than Medicare patients, it is likely they have fewer inpatient visits associated with inpatient surgeries. It is also likely that more surgeries are performed on an outpatient basis than inpatient. Data are not available to determine the impact that this might have on the number and intensity of post-operative office visits and whether fewer hospital visits offset any additional office visits. However, because WC patients are younger and healthier, they are likely to require fewer follow-up visits for medical reasons.

There is some evidence that the RVUs for E&M services exceed the services actually rendered. Two studies by the Office of the Inspector General raised questions about the valuation of E&M services included in the global surgery RVUs. The Medicare Physician Fee Schedule 2013 Final Rule states:

In its report on eye and ocular surgeries, ‘National Review of Evaluation and Management Services Included in Eye and Ocular Adnexa Global Surgery Fees for Calendar Year 2005’ (A-05-07-00077), the OIG reviewed a sample of 300 eye and ocular surgeries, and counted the actual number of face-to-face services in the surgeons’ medical records to establish whether the surgeon furnished postoperative E/M services. The OIG findings show that surgeons typically furnished fewer E/M services in the post-operative period than were identified with the global surgical package payment for each procedure. A smaller percentage of surgeons furnished more E/M services than were identified with the global surgical package payment. The OIG could only review the number of face-to-face services and was not able to review the level of the E/M services that the surgeons furnished due to a lack of documentation in surgeons’ medical

records. The OIG concluded that the RVUs for the global surgical package are too high because they include the work of E/M services that are not typically furnished within the global period for the reviewed procedures.

[¶]

...In May 2012, the OIG published a report titled “Musculoskeletal Global Surgery Fees Often Did Not Reflect the Number of Evaluation and Management Services Provided” (A-05-09-00053). For this investigation, the OIG sampled 300 musculoskeletal global surgeries and again found that, for the majority of sampled surgeries, physicians furnished fewer E/M services than were identified as part of the global period for that service. Once again, a smaller percentage of surgeons furnished more E/M services than were identified with the global surgical package payment. The OIG concluded that the RVUs for the global surgical package are too high because they include the work of E/M services that are not typically furnished within the global period for the reviewed procedures.

Federal Register, Vol. 77, No. 222, November 16, 2012, p. 68912

It is possible that issues related to workers’ compensation may lead to additional visits. The 2013 RAND RB-RVS Study, p.59, notes the possibility that extra services are needed for workers’ compensation:

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

Since physicians are not currently able to bill for E&M visits during the global period in either workers’ compensation or Medicare, there is a lack of data to precisely assess the degree to which the global surgery packages adequately reflect the evaluation and management work in workers’ compensation post-surgical periods. Reviewing the available information and the policy considerations set forth in the 2013 RAND RB-RVS Study, the acting administrative director has determined that it would be appropriate to allow a physician to be separately paid for evaluation and management visits that exceed the number of visits set forth for the surgical procedure in the Medicare Physician Time File. This approach will accommodate the concerns that: 1) there may be workers’ compensation-specific issues that engender a need for more visits, but also takes into account the fact that reimbursement for some E&M is embedded in the global fee, 2) there may be more visits embedded in the global fee than are typically provided, and 3) there is a 20% premium over Medicare in the workers’ compensation conversion factor.

Section 9789.16.2 Surgery – Billing Requirements for Global Surgeries.

Specific Purpose:

The purpose of the section is to adopt the Medicare billing and payment rules relating to procedure codes and modifiers. The purpose is to specify codes and modifiers to use to report a variety of circumstances relating to the surgical package of services, including information which would identify performance of only a part of the surgical package or information which would show the procedure is outside of the surgical package. The section is also intended to prescribe rules relating to how the “date of service” is to be reported. The section also is intended to provide a rule relating to billing where the surgical package is entirely or partly performed in the Health Professional Shortage Area (HPSA).

Necessity:

It is necessary to adopt the Medicare rules relating to billing the surgical services in order to ensure that the claims administrator receiving a bill will be able to determine the services that were rendered. The coding and modifiers identify circumstances that are crucial to determining the appropriate level of payment and whether particular services are bundled into the global surgical package or are separately reimbursable. The regulation is based upon the Medicare Claims Processing Manual, Chapter 12.

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section.

Section 9789.16.3 Surgery –Global Fee – Miscellaneous Rules

Specific Purpose:

The purpose of the regulation is to identify the relationship between the Correct Coding Initiative and the global surgical rules, and to specify that CCI edits are to be applied first, and then global surgery edits are to be applied. The section is also intended to specify how to determine the appropriate payment amount where less than the global package is billed. The section is also intended to provide specific payment instructions for payment of a return trip to the operating room for treatment of complications.

Necessity:

It is necessary to adopt the Medicare rules relating to application of the Correct Coding Initiative to surgical services in order to ensure that the claims administrator receiving a bill will be able to determine the proper payment. It is necessary to specify how to pay claims for less than the full surgical package so that each physician performing the service will be properly paid, and so that there will not be an overpayment where less than the full service was performed. In order for providers and payers to determine the

proper payment amount, it is necessary to specify that the National Physician Fee Schedule Relative Value File Columns labeled “Pre Op”, “Intra Op” and “Post Op” will be used to determine the percentages for pre-, intra-, and postoperative care of the total RVUs for surgical procedures with a global period. It is also necessary to specify how to determine the amount of payment for treatment of complications, and to set forth a rule to describe the effect of a complication on the multiple surgery and bilateral surgery rules. The regulation is based upon the Medicare Claims Processing Manual, Chapter 12.

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section.

Section 9789.16.4 Surgery – Global Fee; Exception: Circumstances Allowing E&M Code During the Global Period; Primary Treating Physician’s Progress Report (PR-2).

Specific Purpose:

This section is intended to adopt an appropriate rule that differs from Medicare by allowing separate reimbursement of evaluation and management services where the number of visits exceeds the number of visits reimbursed in the global surgical package. The section also is intended to differ from Medicare by allowing separate reimbursement for a report during the global surgery period if the report is a Primary Treating Physician’s Progress Report (Form PR-2.)

Necessity:

Labor Code section 5307.1(a)(2)(B) provides that “The official medical fee schedule shall include payment ground rules that differ from Medicare payment ground rules, including, as appropriate, payment of consultation codes and payment evaluation and management services provided during a global period of surgery.” This section is necessary to implement that provision in the Labor Code.

During a pre-rulemaking public forum, some stakeholders have raised a concern that the global billing rules may not provide adequate reimbursement for follow-up care during the global period, and assert that workers’ compensation patients require more resources. The acting administrative director has considered this issue, and has reviewed the RAND RB-RVS Study and the CMS Physician Fee Schedule Final rule for 2013. As pointed out in the RAND study: “...because WC patients are younger and healthier, they are likely to require fewer follow-up visits for medical reasons.” 2013 RAND RB-RVS Study, p. 59. In addition, the Office of Inspector General has found in two studies that the RVUs attributable to work in the post-operative portion of the global period may actually be excessive. Federal Register, Vol. 77, No. 222, November 16, 2012, p. 68912. In addition, the workers’ compensation fee schedule will pay 20% above the Medicare rate, which may provide a cushion if there is not a complete match between workers’ compensation post-surgical resources and the post-surgical RVUs built into the global payment.

Considering these and other factors, the acting administrative director has determined that it is not appropriate to completely eliminate the global concept for post-surgical services as some stakeholders have argued. However, the acting administrative director believes that there may be some different or additional work required because of workers' compensation-related issues. She has determined that it is appropriate to allow separate reimbursement in the post-surgical portion of the global period for visits in excess of the number of visits contained in the Medicare Physician Time File. In addition, where the surgeon is the primary treating physician, the work of issuing the Progress Report (PR-2) during the global period is appropriately reimbursed separately as it is a specific workers' compensation requirement. (See the discussion of "necessity" and "consideration of alternatives" above relating to Section 9789.16.1 for detail on the acting administrative director's determination to adopt a rule that differs from Medicare.)

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section.

Section 9789.16.5 Surgery – Multiple Surgeries and Endoscopies

Specific Purpose:

The purpose of the section is to adopt the Medicare payment rules relating to multiple surgeries and endoscopies including the multiple procedure payment reduction formulas that apply to each. The rule is intended to provide direction on identifying the multiple procedures and endoscopies in the National Physician Fee Schedule Relative Value file, and specifies the application of the multiple procedure reduction.

Necessity:

It is necessary to adopt the Medicare rules relating to multiple surgeries and endoscopies in order to establish the proper payment for procedures. The CMS sets the RVUs for the procedures in conjunction with the multiple procedure rules. It is necessary to adopt these rules as part of adopting the RBRVS in order to avoid duplicate payment.

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section.

Section 9789.16.6 Surgery – Bilateral Surgeries

Specific Purpose:

The purpose of the section is to adopt the Medicare payment rules relating to bilateral surgeries, and to distinguish "bilateral surgeries" from surgical procedures that are

identified as bilateral in their descriptors. The rule is intended to provide direction on identifying the bilateral procedures in the National Physician Fee Schedule Relative Value file. The Section is intended to adopt the Medicare bilateral surgery payment reduction formula.

Necessity:

It is necessary to adopt the Medicare rules relating to bilateral surgeries in order to establish the proper payment for procedures. The CMS sets the RVUs for the procedures in conjunction with the bilateral surgery rules. It is necessary to adopt these rules as part of adopting the RBRVS in order to avoid duplicate payment.

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section.

Section 9789.16.7 Surgery – Co-surgeons and Team Surgeons.

Specific Purpose:

The purpose of the section is to adopt the Medicare payment rules relating to Co-surgeons and Team Surgeons, and to distinguish this from the situation in which surgeons of different specialties each perform a different procedure. The rule is intended to provide direction on identifying procedures in the National Physician Fee Schedule Relative Value file that are subject to the payment rules for Co-surgeons and Team Surgeons. The Section is intended to adopt the Medicare Co-surgeons and Team Surgeons payment rules: Co-surgeons are paid the lower of the billed amount or 62.5% of the fee schedule amount. Team Surgeons are paid on the “By Report” basis. The rule is also intended to adopt the Medicare rule that the global surgical package applies to Co-surgeons and team surgeons.

Necessity:

It is necessary to adopt the Medicare rules relating to Co-surgeons and Team Surgeons in order to establish the proper payment for procedures. The CMS sets the RVUs for the procedures in conjunction with the rules related to Co-surgeons and Team Surgeons. It is necessary to adopt these rules as part of adopting the RBRVS in order to avoid duplicate payment.

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section.

Section 9789.16.8 Surgery – Assistants-at-Surgery

Specific Purpose:

The purpose of the section is to adopt the Medicare payment rules relating to assistants-at-surgery services performed by physicians and by non-physician practitioners. The section is intended to provide direction on identifying the procedures in the National Physician Fee Schedule Relative Value file that have rules relating to payment of assistants-at-surgery. The section is intended to adopt the Medicare assistant-at-surgery payment formula which specifies that a physician assistant-at-surgery is paid 16% of the amount otherwise payable for the surgical payment.

Necessity:

It is necessary to adopt the Medicare rules relating to assistants-at-surgery in order to establish the proper payment for procedures. The CMS sets the RVUs for the procedures in conjunction with the assistants-at-surgery rules. It is necessary to adopt these rules as part of adopting the RBRVS in order to avoid duplicate payment, and in order to avoid paying for assistants-at-surgery during procedures that do not warrant such services.

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section.

Section 9789.17.1 Radiology Diagnostic Imaging Multiple Procedures

Specific Purpose:

The purpose of this section is to set forth the multiple procedure payment reduction (MPPR) for the professional (PC) and technical (TC) components of certain radiological imaging procedures when multiple services are furnished by one or more physicians of the same practice group (same Group National Provider Identifier (NPI)), to the same patient, in the same session, on the same day. It applies to both PC-only services, TC-only services, and to the PC and TC of global services. Full payment is made for each PC and TC service with the highest payment under the physician fee schedule. Payment is made at 75 percent for subsequent PC services, and 50 percent for subsequent TC services. The section references section 9789.19 for the diagnostic imaging procedures subject to the radiology diagnostic imaging multiple procedures discount, description of the diagnostic imaging family indicators, and diagnostic imaging family indicators for procedure, by date of service.

Necessity:

It is necessary to adopt the Medicare rules relating to radiology diagnostic imaging multiple procedures in order to establish the proper payment for procedures. The CMS sets the RVUs for the procedures in conjunction with the radiology diagnostic imaging

multiple procedures rules. It is necessary to adopt these rules as part of adopting the RBRVS in order to avoid duplicate payment.

Consideration of Alternatives:

The acting administrative director is proposing to adopt Medicare's payment rules of applying the MPPR to radiology diagnostic imaging multiple procedures. There is no evidence to justify deviating from the Medicare payment rules for workers' compensation cases. Diverting from Medicare will require a budget neutrality adjustment to prevent duplicate payments.

Section 3134 of the Affordable Care Act added section 1848(c)(2)(K) of the Social Security Act which specifies that the Secretary of Health and Human Services shall identify potentially misvalued codes by examining multiple codes that are frequently billed in conjunction with furnishing a single service. Medicare examined and decided to apply the multiple procedure payment reduction (MPPR) payment policy to the radiology diagnostic imaging services.

Section 9789.17.2 Radiology Consultations

Specific Purpose:

The purpose of the section is to adopt the Medicare rule that only one interpretation of an x-ray may be reimbursed. It is also intended to distinguish a reimbursable "interpretation," that must include a signed written report, from a review of x-ray findings which would not meet the conditions for separate reimbursement. The section specifies that a second interpretation would be reimbursable only under unusual circumstances, such as a questionable finding on the initial interpretation which necessitates a second opinion. The section directs the use of modifier -77 to indicate the repeat interpretation. The section also states that CPT Code 76140 is not to be used.

Necessity:

It is necessary to adopt the Medicare rule in order to avoid duplicate payment for multiple interpretations of the same x-ray. A "review" of an x-ray that is not a formal interpretation with a report is not separately reimbursable, as it is considered to be bundled into the other services being performed by the physician. This is consistent with the CPT 2013 Radiology Guidelines which require a report as follows: "A written report signed by the interpreting individual should be considered an integral part of a radiologic procedure or interpretation." CPT ® 2013, Professional Edition, p. 375. In order to avoid double payment for an interpretation, where a repeat interpretation is medically necessary, it must be billed using the CPT code that represents the radiologic procedure performed, with a -77 modifier to indicate repeat, and a -26 to indicate the professional component only. Similarly, the instruction to refrain from using CPT Code 76140 ("Consultation on X-ray examination made elsewhere, written report") is necessary to avoid duplicate payment. Medicare lists CPT Code 76140 with Status Code "I" in the National Physician Fee Schedule Relative Value File, which signifies that Medicare uses

another code for billing the procedure. In order to avoid duplicate payment, and more appropriately price the physician service of interpreting the x-ray and writing the report, the physician would use the code for the x-ray procedure, along with appropriate modifiers.

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section.

Section 9789.18.1 Payment for Anesthesia Services - General Payment Rule

Specific Purpose:

The purpose of this section is to set forth the basic calculation of the fee schedule amount for physician anesthesia services: allowable base units and time units multiplied by the anesthesia conversion factor. The section specifies that Medicare's Anesthesia Base Units by CPT Code file will be used to determine the base units.

Necessity:

This section is necessary to set forth the basic payment methodology for determining the payment rate for anesthesia services. This section is necessary to conform to Medicare's payment methodology.

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section. The acting administrative director is proposing to adopt Medicare's payment rules and methodology since there is no evidence to justify deviating from the Medicare payment rules for workers' compensation cases. Diverting from Medicare will require a budget neutrality adjustment.

Labor Code section 5307.1(a)(2) includes anesthesia in the RBRVS fee schedule provisions. Under the RBRVS, anesthesia services payment methodology is different from how the rest of the services are paid. Anesthesia is paid according to base values and time values.

RAND's 2013 RB-RVS report, p. 21, determined that "[a]cross all procedures, the time values will be lower under the RB-RVS than under the current fee schedule because the RB-RVS payment rules for calculating the units are more precise". Deviating from the Medicare payment rules, to maintain the current payment rules, would require a budget neutrality adjustment. The acting administrative director has determined that more precise time values are preferable to the current system, and the method proposed conforms to the Medicare rule.

Section 9789.18.2 Anesthesia - Personally Performed Rate

Specific Purpose:

The purpose of this section is to set forth the method for determining payment for anesthesia reimbursement at the “personally performed” rate and the circumstances that warrant that rate. The section states that the anesthesia calculation will recognize the base unit for the anesthesia code and one time unit per 15 minutes of anesthesia time when the personally performed rate is applicable.

Necessity:

This section is necessary to set forth the payment methodology for determining the payment rate for anesthesia services when the service is personally performed by a physician. This section is necessary to conform to Medicare’s payment methodology.

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section. The acting administrative director is proposing to adopt Medicare’s payment rules and methodology since there is no evidence to justify deviating from the Medicare payment rules for workers’ compensation cases. Since Labor Code section 5307.1(a)(2) includes anesthesia in the RBRVS fee schedule provisions, diverging from Medicare will require a budget neutrality adjustment.

Section 9789.18.3 Anesthesia - Medically Directed Rate

Specific Purpose:

The purpose of this section is to set forth the reimbursement for anesthesia where the physician’s service is medical direction of the anesthesia: 50% of the allowance for the service performed by the physician alone. The section sets forth the criteria for a physician’s service to constitute “medical direction” and specifies documentation necessary to establish payment at the medically directed rate.

Necessity:

This section is necessary to set forth the payment rules for determining the payment rate for anesthesia services when the physician service is medical direction. This section is necessary to conform to Medicare’s payment methodology.

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section. The acting administrative director is proposing to adopt Medicare’s payment rules and methodology

since there is no evidence to justify deviating from the Medicare payment rules for workers' compensation cases. Since Labor Code section 5307.1(a)(2) includes anesthesia in the RBRVS fee schedule provisions, diverging from Medicare will require a budget neutrality adjustment.

Section 9789.18.4 Anesthesia – Definition of Concurrent Medically Directed Anesthesia Procedures

Specific Purpose:

The purpose of this section is to set forth a definition of concurrent medical direction to include the maximum number of procedures that the physician is medically directing when the procedures overlap each other.

Necessity:

This section is necessary to clarify the meaning of concurrency in the context of the payment rules for determining the payment rate for anesthesia services when the physician service is medical direction. This section is necessary to conform to Medicare's payment methodology.

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section. The acting administrative director is proposing to adopt Medicare's payment rules and methodology since there is no evidence to justify deviating from the Medicare payment rules for workers' compensation cases. Since Labor Code section 5307.1(a)(2) includes anesthesia in the RBRVS fee schedule provisions, diverging from Medicare will require a budget neutrality adjustment.

Section 9789.18.5 Anesthesia - Medically Supervised Rate

Specific Purpose:

The purpose of this section is to set forth the reimbursement to the anesthesiologist when he or she is involved in furnishing more than four procedures concurrently: three base units per procedure. An additional time unit may be recognized if the physician can document that he or she was present at induction.

Necessity:

This section is necessary to set forth the payment rules for determining the payment rate for anesthesia services when the anesthesiologist is involved in furnishing more than four procedures concurrently or is performing other services while directing the concurrent procedures. This section is necessary to conform to Medicare's payment methodology.

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section. The acting administrative director is proposing to adopt Medicare's payment rules and methodology since there is no evidence to justify deviating from the Medicare payment rules for workers' compensation cases. Since Labor Code section 5307.1(a)(2) includes anesthesia in the RBRVS fee schedule provisions, diverging from Medicare will require a budget neutrality adjustment.

Section 9789.18.6 Anesthesia – Multiple Anesthesia Procedures

Specific Purpose:

The purpose of this section is to set forth the billing and payment rules for anesthesia provided during multiple procedures. The section states that the maximum fee is determined based on the base unit of the anesthesia procedure with the highest base unit value and time units based on the actual anesthesia time of the multiple procedures.

Necessity:

This section is necessary to set forth the payment rules for determining the payment rate for anesthesia services associated with multiple anesthesia procedures. This section is necessary to conform to Medicare's payment methodology.

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section. The acting administrative director is proposing to adopt Medicare's payment rules and methodology since there is no evidence to justify deviating from the Medicare payment rules for workers' compensation cases. Since Labor Code section 5307.1(a)(2) includes anesthesia in the RBRVS fee schedule provisions, diverging from Medicare will require a budget neutrality adjustment.

Section 9789.18.7 Anesthesia – Medical and Surgical Services Furnished in Addition to Anesthesia Procedure

Specific Purpose:

The purpose of this section is to state that payment may be made under the fee schedule for specific medical and surgical services furnished by the anesthesiologist as long as these services are reasonable and medically necessary and provided that other rebundling and ground rule provisions do not preclude separate payment.

Necessity:

This section is necessary to set forth the payment rules for when specific medical and surgical services are furnished by the anesthesiologist in conjunction with the anesthesia procedure. This section is necessary to conform to Medicare's payment methodology.

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section. The acting administrative director is proposing to adopt Medicare's payment rules and methodology since there is no evidence to justify deviating from the Medicare payment rules for workers' compensation cases. Since Labor Code section 5307.1(a)(2) includes anesthesia in the RBRVS fee schedule provisions, diverging from Medicare will require a budget neutrality adjustment.

Section 9789.18.8 Anesthesia – Time and Calculation of Anesthesia Time Units

Specific Purpose:

The purpose of this section is to set forth the rules for calculating anesthesia time, when it begins and ends, and provides that time units are computed by dividing the actual reported anesthesia time by 15 minutes, then rounded to one decimal place.

Necessity:

This section is necessary to set forth the payment rules for calculating anesthesia time which is an essential component of the basic payment methodology for determining the payment rate for anesthesia services. This section is necessary to conform to Medicare's payment methodology.

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section. The acting administrative director is proposing to adopt Medicare's payment rules and methodology since there is no evidence to justify deviating from the Medicare payment rules for workers' compensation cases. Since Labor Code section 5307.1(a)(2) includes anesthesia in the RBRVS fee schedule provisions, diverging from Medicare will require a budget neutrality adjustment.

Section 9789.18.9 Anesthesia – Base Unit Reduction for Concurrent Medically Directed Procedures

Specific Purpose:

The purpose of this section is to set forth the method for reducing the number of base units for each concurrent procedure medically directed by the physician.

Necessity:

This section is necessary to set forth the payment rules for calculating the base unit reduction for concurrent medically directed procedures. This section is necessary to conform to Medicare's payment methodology.

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section. The acting administrative director is proposing to adopt Medicare's payment rules and methodology since there is no evidence to justify deviating from the Medicare payment rules for workers' compensation cases. Since Labor Code section 5307.1(a)(2) includes anesthesia in the RBRVS fee schedule provisions, diverging from Medicare will require a budget neutrality adjustment.

Section 9789.18.10 Anesthesia – Monitored Anesthesia Care

Specific Purpose:

The purpose of this section is to set forth the definition of monitored anesthesia care, provides for use of modifier QS, and states that monitored anesthesia care shall be reimbursed on the same basis as other anesthesia services personally performed or medically directed, as applicable.

Necessity:

This section is necessary to set forth the payment rules for monitored anesthesia care. This section is necessary to conform to Medicare's payment methodology.

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section. The acting administrative director is proposing to adopt Medicare's payment rules and methodology since there is no evidence to justify deviating from the Medicare payment rules for workers' compensation cases. Since Labor Code section 5307.1(a)(2) includes anesthesia in the RBRVS fee schedule provisions, diverging from Medicare will require a budget neutrality adjustment.

Section 9789.18.11 Anesthesia – Monitored Claims Modifiers

Specific Purpose:

The purpose of this section is to require physicians to 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.

Necessity:

This section is necessary to set forth the payment rules for proper coding of anesthesia services for purposes of determining the appropriate payment rate. This section is necessary to conform to Medicare's payment methodology.

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section. The acting administrative director is proposing to adopt Medicare's payment rules and methodology since there is no evidence to justify deviating from the Medicare payment rules for workers' compensation cases. Since Labor Code section 5307.1(a)(2) includes anesthesia in the RBRVS fee schedule provisions, diverging from Medicare will require a budget neutrality adjustment.

Section 9789.18.12 Anesthesia – and Medical/Surgical Service Provided by the Same Physician

Specific Purpose:

The purpose of this section is to provide that conscious sedation codes 99143 to 99145 may be billed as long as the procedure it is billed with is not listed in Appendix G of CPT. The section sets forth rules for billing and payment when a second physician other than the health care professional performing the diagnostic or therapeutic services provides moderate sedation in the facility setting or nonfacility setting. The section sets forth rule for determining payment where the anesthesiologist or CRNA provides anesthesia for diagnostic or therapeutic nerve blocks or injections and a different provider performs the block or injection. The section provides that local anesthesia is not separately payable as it is bundled into the payment for the underlying medical or surgical service.

Necessity:

This section is necessary to set forth the payment rules for when medical/surgical service is provided by the same physician. This section is necessary to conform to Medicare's payment methodology.

Consideration of Alternatives:

At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed section. The acting administrative director is proposing to adopt Medicare's payment rules and methodology since there is no evidence to justify deviating from the Medicare payment rules for workers' compensation cases. Since Labor Code section 5307.1(a)(2) includes anesthesia in the RBRVS fee schedule provisions, diverging from Medicare will require a budget neutrality adjustment.

Section 9789.19 Update Table

Specific Purpose:

The purpose of this section is to set forth a table of documents incorporated by reference that are used in physician billing and payment. The table specifies the document name and provides a link to access the document. For several entries the updated data itself is included in the table: the conversion factors, California Specific Codes, List of CPT Codes that Shall Not Be Used.

Necessity: This section is necessary to provide a list of documents and data that would be incorporated by reference and updated by administrative order. These documents and data are necessary to determine the appropriate payment rate by date of service under the physician fee schedule.

Consideration of Alternatives: At this time, the acting administrative director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.