

**STATE OF CALIFORNIA  
DEPARTMENT OF INDUSTRIAL RELATIONS  
Division of Workers' Compensation**

**NOTICE OF PROPOSED RULEMAKING**

**Subject Matter of Regulations: Workers' Compensation – Official Medical Fee Schedule:  
Physician Fee Schedule**

**TITLE 8, CALIFORNIA CODE OF REGULATIONS  
Sections 9789.12.1 et seq.**

**NOTICE IS HEREBY GIVEN** that the Acting Administrative Director of the Division of Workers' Compensation, pursuant to the authority vested in her by Labor Code sections 59, 133, 4603.5, 5307.1 and 5307.3 proposes to adopt sections 9789.12.1 through Section 9789.19, in Article 5.3 of Division 1, Chapter 4.5, Subchapter 1, of title 8, California Code of Regulations, relating to the Official Medical Fee Schedule – Physician Fee Schedule.

**PROPOSED REGULATORY ACTION**

The Division of Workers' Compensation, proposes to adopt new regulations in Article 5.3 of Chapter 4.5, Subchapter 1, Division 1, of Title 8, California Code of Regulations. The regulations implement Labor Code section 5307.1 by adopting a fee schedule based upon the federal Resource-Based Relative Value Scale for physicians and nonphysician practitioners. When adopted, the proposed regulations will constitute 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 1/1/2014
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 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 Section 5307.4.

This Notice and the accompanying Initial Statement of Reasons 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.

## **PUBLIC HEARING**

A public hearing has been scheduled to permit all interested persons the opportunity to present statements or arguments, oral or in writing, with respect to the subjects noted above. The hearing will be held at the following time and place:

**Date:** July 17, 2013  
**Time:** 10:00 a.m. to 5:00 p.m. or conclusion of business  
**Place:** Elihu M. Harris State Building, Auditorium  
1515 Clay Street,  
Oakland, CA 94612

In order to ensure unimpeded access for disabled individuals wishing to present comments and facilitate the accurate transcription of public comments, camera usage will be allowed in only one area of the hearing room. To provide everyone a chance to speak, public testimony will be limited to 10 minutes per speaker and should be specific to the proposed regulations. Testimony which would exceed 10 minutes may be submitted in writing.

Please note that public comment will begin promptly at 10:00 a.m. and will conclude when the last speaker has finished his or her presentation. If public comment concludes before the noon recess, no afternoon session will be held.

The Acting Administrative Director requests, but does not require that, any persons who make oral comments at the hearings also provide a written copy of their comments. Equal weight will be accorded to oral comments and written materials.

## ACCESSIBILITY

The State Office Buildings and Auditoriums are accessible to persons with mobility impairments. Alternate formats, assistive listening systems, sign language interpreters, or other type of reasonable accommodation to facilitate effective communication for persons with disabilities, are available upon request. Please contact the Statewide Disability Accommodation Coordinator at 1-866-681-1459 (toll free), or through the California Relay Service by dialing 711 or 1-800-735-2929 (TTY/English) or 1-800-855-3000 (TTY/Spanish) as soon as possible to request assistance.

## WRITTEN COMMENT PERIOD

Any interested person, or his or her authorized representative, may submit written comments relevant to the proposed regulatory action to the Department of Industrial Relations, Division of Workers' Compensation. The written comment period closes at **5:00 p.m., on July 17, 2013**. The Division of Workers' Compensation will consider only comments received at the Division by that time. Equal weight will be accorded to oral comments presented at the hearing and written materials.

Submit written comments concerning the proposed regulations prior to the close of the public comment period to:

Maureen Gray  
Regulations Coordinator  
Department of Industrial Relations  
Division of Workers' Compensation  
Post Office Box 420603  
San Francisco, CA 94142

Written comments may be submitted by facsimile transmission (FAX), addressed to the above-named contact person at (510) 286-0687. Written comments may also be sent electronically (via e-mail) using the following e-mail address: [dwcrules@dir.ca.gov](mailto:dwcrules@dir.ca.gov).

Unless submitted prior to or at the public hearing, Ms. Gray must receive all written comments no later than **5:00 p.m. on July 17, 2013**.

## AUTHORITY AND REFERENCE

The Acting Administrative Director is undertaking this regulatory action pursuant to the authority vested in her by Labor Code sections 59, 133, 4603.5, 5307.1, and 5307.3.

Reference is to Labor Code sections 4600, 5307.11 and 5307.1.

## INFORMATIVE DIGEST AND POLICY STATEMENT OVERVIEW

Existing law establishes a workers' compensation system, administered by the Administrative Director of the Division of Workers' Compensation, to compensate an employee for injuries sustained in the course of his or her employment. Labor Code section 4600 requires an employer to provide medical, surgical, chiropractic, acupuncture, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatus, including orthotic and prosthetic devices and services, that is reasonably required to cure or relieve the injured worker from the effects of his or her injury. Under existing law, payment for medical treatment shall be no more than the maximum amounts set by the Administrative Directive in the Official Medical Fee Schedule (OMFS) or the amounts set pursuant to a contract. (Labor Code sections 5307.1, 5307.11.) The current physician fee schedule is adopted in title 8, California Code of Regulations sections 9789.10 and 9789.11, and includes a 1999 OMFS book, Table A effective May 14, 2005 (listing rates for procedures which incorporate a legislatively mandated 5% fee reduction) and Table A Addendum effective February 15, 2007.

In September of 2012, the California legislature passed Senate Bill 863 (Statutes of 2012, Chapter 363), a sweeping reform bill that, among other things, amended Labor Code section 5307.1. The new provisions of the statute direct 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.

Senate Bill 863 also specifies that beginning January 1, 2014, and continuing until the time the administrative director has adopted a fee schedule in accordance with the RBRVS, maximum fees for physician and nonphysician practitioner services “shall be in accordance with the fee-related structure and rules of the Medicare payment system”, except that:

- An average statewide geographic adjustment factor of 1.078 shall apply in lieu of Medicare’s locality-specific geographic adjustment factors
- Specified conversion factors for surgery, radiology, anesthesia, and “all other services” will be applicable instead of the Medicare conversion factors during each year of the four-year transition

period

Objective and Anticipated Benefits of the Proposed Regulation:

The objective of the regulations is to adopt an RBRVS-based fee schedule for physician and nonphysician services, and to adopt the components of the fee schedule that are necessary to determine the reasonable maximum fee for medical services. The policy is to adopt Medicare payment policies and ground rules that are related to determining proper payment, and to adopt rules that differ from Medicare where necessary for the special circumstances of workers' compensation. The Acting Administrative Director anticipates that there are many benefits to be attained from adopting the RBRVS-based fee schedule, and the benefits will be enhanced by adopting the schedule prior to the "default" fee caps that will automatically apply on January 1, 2014 if a regulation is not adopted. The benefits include, but are not limited to, the following:

- Relative Value Units used in the RBRVS are updated annually, and are established, maintained and revised by CMS with input from a broad range of medical specialty groups
- Regular updating can be done more efficiently by linking updates in the procedure codes and relative values to the annual updates published by CMS
- Reimbursement is based on the resources used to provide the service, which aligns the financial incentives inherent in the fee schedule with value-based care
- Adoption of most Medicare payment rules improves accuracy of payment as the ground rules and RVUs operate in a complementary fashion to establish appropriate reimbursement, for example by avoiding duplicate payment for overlapping expense inherent in multiple procedures
- Adoption of payment rules in the regulations increases clarity; the default schedule specifying "in accordance with the fee-related structure and rules of Medicare" could lead to more disputes
- Adoption of the regulation is preferable to the "default" as the regulation adopts rules that differ from Medicare where appropriate for workers' compensation including:
  - allowing separate payment of evaluation and management services during the global period if visits exceed the number reimbursed in the physician time file
  - payment of Primary Treating Physician's Progress Report (PR-2) during the global surgery period
  - separate payment of consultation reports requested by the Workers' Compensation Appeals Board or Administrative Director or requested in the context of a medical-legal evaluation
  - payment of the Health Professional Shortage Area Bonus at the time of payment of the service rather than quarterly
- Adoption of conversion factors in the regulations improves accuracy over the "default" fee caps, as the proposed conversion factors were derived by the Acting Administrative Director's consultant RAND with updated and more representative data
- Adoption of the regulations prior to January 1, 2014 will allow the public to implement the new RBRVS fee schedule at one time, rather than implementing the "default" and then having to make system changes to implement the Administrative Director's adopted RBRVS fee schedule in the future

Determination of Inconsistency/Incompatibility with Existing State Regulations:

The Acting Administrative Director has determined that this proposed regulation is not inconsistent or incompatible with existing regulations.

The Administrative Director now proposes to adopt the RBRVS-based fee schedule for physician and nonphysician practitioners as specified by SB 863. The proposed regulations implement, interpret, and make specific Labor Code section 5307.1 as follows:

**Section 9789.12.1 Physician Fee Schedule: Official Medical Fee Schedule for Physician and Non-Physician Practitioner Services – For Services Rendered On or After 1/1/2014:** sets forth the scope and applicability of the Physician Fee Schedule.

**Section 9789.12.2 Calculation of the Maximum Reasonable Fee - Services Other than Anesthesia:** sets forth the formulas for calculating the maximum fee for physician and nonphysician practitioner services other than anesthesia. One formula is for physician services rendered in a “facility” and one formula is for physician services rendered in a “nonfacility.” The regulation sets forth the place of service codes and identifies each location as “facility” or “nonfacility.” The 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.

**Section 9789.12.3 Status Codes C, I, N and R:** sets 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.

**Section 9789.12.4 “By Report” - Reimbursement for Unlisted Procedures / Procedures Lacking RBRVUs:** sets forth instructions to bill an unlisted procedure code using the appropriate CPT “unlisted procedure code.” The section provides that a non-reimbursable report is required to support a billing for an “unlisted” procedure that utilizes CPT unlisted procedure codes. 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.

**Section 9789.12.5 Conversion Factors:** sets 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 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 Adjust Factor, if any.

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

**Section 9789.12.7 CMS’ National Physician Fee Schedule Relative Value File / Relative Value Units (RVUs):** requires use of the CMS National Physician Fee Schedule Relative Value File which is effective for the date of service to determine maximum reasonable fees and cross references section 9789.19 for the Relative Value File by date of service.

**Section 9789.12.8 Status Codes:** adopts the Status Code Indicators that are used in the National Physician Fee Schedule Relative Value File, but sets forth modified definitions of the status codes where needed for use in the workers’ compensation context.

**Section 9789.12.9 Professional Component/Technical Component Indicator:** adopts 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.

**Section 9789.12.10 Coding; Current Procedural Terminology ©, Fourth Edition:** adopts 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.

**Section 9789.12.11 Evaluation and Management: Coding – New Patient; Documentation:** adopts 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.”

**Section 9789.12.12 Consultation Services Coding – use of visit codes:** requires 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.

**Section 9789.12.13 Correct Coding Initiative:** requires use of the National Correct Coding Initiative 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.

**Section 9789.12.14 California-Specific Codes:** sets forth non-CPT codes developed by the Division in the Physician Fee Schedule where needed for workers' compensation, and sets forth the fee, if any. The codes are primarily related to workers' compensation medical reports and medical records.

**Section 9789.12.15 California Specific Modifier:** sets forth one modifier created for use for California workers' compensation, in addition to applicable CPT modifiers: -30 Consultation Service During Medical-Legal Evaluation.

**Section 9789.13.1 Supplies:** provides that separate payment for routinely bundled supplies is not allowed. Cross-references to section 9789.13.2 regarding payment for physician-administered drugs/biological/vaccines/blood products. 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.

**Section 9789.13.2 Physician-Administered Drugs:** specifies that physician-administered drugs, biological, vaccines, 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.

**Section 9789.13.3 Physician-Dispensed Drugs:** cross-references to section 9789.40 Pharmaceutical Fee Schedule and Labor Code section 5307.1 for maximum prices for physician-dispensed drugs.

**Section 9789.14. Reimbursement for Reports, Duplicate Reports, Chart Notes** identifies 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) 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 request by the WCAB or the Administrative Director, consultation reports request by the QME or AME in the context of a medical-legal evaluation.)

**Section 9789.15.1 Non-Physician Practitioner (NPP) – Payment Methodology:** states 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.

**Section 9789.15.2 Non-Physician Practitioner (NPP) – “Incident To” Services:** 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 consider to be under “direct personal supervision”, and what is considered a “physician directed clinic”.

**Section 9789.15.3 Qualified Non-physician Anesthetist Services:** the section applies to both certified registered nurse anesthetists (CRNAs) and anesthesia assistants (AAs). 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.

**Section 9789.15.4 Physical Medicine / Chiropractic / Acupuncture Multiple Procedure Payment Reduction; Pre-Authorization for Specified Procedure/Modality Services:** adopts the Medicare Multiple Procedure Payment Reduction (“MPPR”) for “Always Therapy” Codes, and specifies that acupuncture codes and chiropractic manipulation codes are also subject to the MPPR. Sets forth the MPPR formula: where multiple procedures or units are furnished to the same patient on the same day, the code with the highest Practice Expense component is paid in full, for the second and subsequent units and procedures: the Practice Expense component is paid at 50% of the RVU, and the Work and Malpractice components are paid in full. The section references section 9789.19 for a list of codes on the Medicare “Always Therapy” list, by date of service. The section also sets forth caps on the number of procedures and modalities provided at one visit that are presumed reasonable limitations on reimbursement unless pre-authorization and pre-negotiated fee arrangement has been obtained.

**Section 9789.15.5 Ophthalmology Multiple Procedure Reduction:** sets 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 Technical Component (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.

**Section 9789.15.6 6 Diagnostic Cardiovascular Procedures – Multiple Procedure Reduction:** sets 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 Technical Component (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.

**Section 9789.16.1 Surgery – Global Fee:** sets forth the definition of the global surgical package, indicates how surgical procedures with a global period are identified in the National Physician Fee Schedule Relative Value File, and sets forth the components included and those not included in the global surgical package. The section includes rules related to minor surgeries and endoscopies, physicians performing less than the full global package, and determination of the duration of the global period. The section specifies that a Primary Treating Physician’s Progress Report (PR-2) is payable during the global period. The section states that for workers’ compensation the global period will not apply to codes with the “YYY” indicator in the Global Days column of the fee schedule Relative Value File. In Medicare, “YYY” indicates that the global period is determined by the Medicare contractor.

**Section 9789.16.2 Surgery – Billing Requirements for Global Surgeries:** sets forth rules relating to the modifiers to be used with surgical codes that have a global period. The section sets forth rules for identifying procedures where the physician performs only a portion of the services that are included in the global package. The section explains how to code return trips to the operating room for complications, staged or related procedures, unrelated procedures or visits during the postoperative period, significant evaluation and management on the day of a procedure, critical care services, and unusual services. The section sets forth the manner to identify the dates of service on the paper or electronic bill. The section sets forth rules regarding how the HPSA bonus applies for a surgical procedure with a global period.

**Section 9789.16.3 Surgery – Global Fee – Miscellaneous Rules:** sets forth a variety of rules relating to the surgical procedures with a global period, including the relationship to the Correct Coding Initiative, payment of claims from physicians who furnish less than the complete global package, and payment for return trips to the operating room for complications.

**Section 9789.16.4 Surgery – Global Fee; Exception: Circumstances Allowing E&M Code During the Global Period:** sets forth a rule that a separate evaluation and management service can be billed during the global period for medically necessary services that exceed the number of visits listed for the global surgical code in the Medicare Physician Time File. The section cross references to section 9789.19 for the Physician Time File by date of service. The section also sets forth a rule that allows Progress Reports (PR-2) required by section 9785 to be separately reimbursed during the global period.

**Section 9789.16.5 Surgery – Multiple Surgeries and Endoscopies:** sets forth rules relating to billing and payment for multiple surgeries performed on the same day. Payment is based on the lower of the

actual charge or the fee schedule amount reduced by the formula: 100% of the highest value procedure, 50% of the fee schedule amount for the 2<sup>nd</sup> through 5<sup>th</sup> procedures and payment By Report for procedures exceeding six. The section sets forth rules relating to billing and payment for multiple related endoscopies. If an endoscopic procedure is billed with only its base procedure, the base procedure is not separately payable. Where multiple related endoscopies are performed, the full value of the highest valued endoscopy is paid, plus the difference between the next highest and the base endoscopy. The section has rules relating to payment of multiple related and unrelated endoscopies and surgical procedure, multiple procedures of equal value, multiple procedures including bilateral surgeries, and multiple surgical procedures and multiple interventional radiological procedures.

**Section 9789.16.6 Surgery – Bilateral Surgeries:** sets forth billing and payment rules for “bilateral surgeries” where the procedures are performed on both sides of the body during the same operative session or on the same day. The section specifies the use of modifier -50 and identifies the relevant indicators in the Bilateral Surgery column of the National Physician Fee Schedule Relative Value File. The section specifies that the global surgery rules are applicable to bilateral procedures.

**Section 9789.16.7 Surgery – Co-surgeons and Team Surgeons:** sets forth the billing and payment rules for surgeries involving co-surgeons and team surgeons. The section includes direction on the use of modifiers and identifies relevant indicators in the Co-Surgeon and Team Surgeon columns of the National Physician Fee Schedule Relative Value File. The section specifies that co-surgeons are each paid the lower of the billed amount or 62.5% of the fee schedule amount. The section specifies that team surgeons shall be paid on a “by report” basis. The global surgical package rules apply to each of the physicians participating in a co-surgery or team surgery.

**Section 9789.16.8 Surgery – Assistants-at-Surgery:** sets forth the payment level for an assistant-at-surgery as 16% of the amount otherwise applicable for the surgical payment. The section identifies the relevant indicators on the National Physician Fee Schedule Relative Value File, specifies when an assistant-at-surgery is not payable.

**Section 9789.17.1 Radiology Diagnostic Imaging Multiple Procedures:** sets 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.

**Section 9789.17.2 Radiology Consultations:** sets forth billing and payment rules for interpretation of an x-ray procedure, and specifies the distinction between a review of an x-ray which does not warrant separate payment and an interpretation which does receive separate payment. The section specifies the requirements for billing and reimbursement of a second x-ray interpretation. The section specifies that CPT 76140 is not to be used.

**Section 9789.18.1 Payment for Anesthesia Services - General Payment Rule:** sets 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.

**Section 9789.18.2 Anesthesia - Personally Performed Rate:** sets 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.

**Section 9789.18.3 Anesthesia - Medically Directed Rate:** sets 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.

**Section 9789.18.4 Anesthesia – Definition of Concurrent Medically Directed Anesthesia Procedures:** sets 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.

**Section 9789.18.5 Anesthesia - Medically Supervised Rate:** sets 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.

**Section 9789.18.6 Anesthesia – Multiple Anesthesia Procedures:** sets 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.

**Section 9789.18.7 Anesthesia – Medical and Surgical Services Furnished in Addition to Anesthesia Procedure:** states 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.

**Section 9789.18.8 Anesthesia – Time and Calculation of Anesthesia Time Units:** sets 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.

**Section 9789.18.9 Anesthesia – Base Unit Reduction for Concurrent Medically Directed Procedures:** sets forth the method for reducing the number of base units for each concurrent procedure medically directed by the physician.

**Section 9789.18.10 Anesthesia – Monitored Anesthesia Care:** sets 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.

**Section 9789.18.11 Anesthesia – Monitored Claims Modifiers:** requires 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.

**Section 9789.18.12 Anesthesia – and Medical/Surgical Service Provided by the Same Physician:** provides 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.

**Section 9789.19 Update Table:** sets 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.

## **DISCLOSURES REGARDING THE PROPOSED REGULATORY ACTION**

The Administrative Director has made the following initial determinations:

- Significant statewide adverse economic impact directly affecting business, including the ability of California businesses to compete with businesses in other states: None.
- Adoption of these regulations will not: (1) create or eliminate jobs within the State of California, (2) create new businesses or eliminate existing businesses within the State of California, or (3) affect the expansion of businesses currently doing business in California.
- Effect on Housing Costs: None.
- The Division of Workers' Compensation is aware of cost impacts that a representative private person or business would necessarily incur in reasonable compliance with the proposed action. Claims administrators will incur costs to convert to a new physician fee schedule system and staff training costs. However, it is difficult to estimate the costs as they will vary greatly depending on how the claims administrator implements its medical bill payment system. The updated physician fee schedule is anticipated to create offsetting savings that are hard to quantify. The current fee schedule has been extremely difficult to update and uses very old coding which omits many procedures. The adoption of the RBRVS-based system is anticipated to reduce disputes as coding keeps up with current national coding requirements, and adoption of current coding will bring many more procedures under the fee schedule cap. In addition it will be updated frequently,

reducing disputes and increasing accuracy.

Medical providers will incur some training costs relating to billing under the new RBRVS system. There should also be savings achieved for providers by reduction in billing disputes due to updated coding. The effect of the RBRVS-based fee schedule on medical providers will vary depending on the mix of services provided by the physician. The RAND report “Implementing a RB-RVS Fee Schedule for Physician Services,” (Wynn, 2013) sets forth details of the estimated impact of the RBRVS fee schedule on various provider types. In addition, providers will benefit by the inflation increase built into the fee schedule.

### **EFFECT ON SMALL BUSINESS**

The Administrative Director has determined that the proposed regulations will affect small business, primarily medical providers. Costs may be incurred by providers billing under the new medical fee schedule, however there will also be offsetting benefits due to updated coding and decreased disputes. The impacts to providers will vary depending on the mix of services performed.

### **DISCLOSURES REGARDING THE PROPOSED ACTION**

- Costs or savings to state agencies: The state will experience the same costs and savings as other employers.
- Costs/savings in federal funding to the State: None.
- Local Mandate: None. The proposed regulations will not impose any new mandated programs or increased service levels on any local agency or school district. The potential costs imposed on all public agency employers by these proposed regulations, although not a benefit level increase, are not a new State mandate because the regulations apply to all employers, both public and private, and not uniquely to local governments. The Acting Administrative Director has determined that the proposed regulations will not impose any new mandated programs on any local agency or school district. The California Supreme Court has determined that an increase in workers’ compensation benefit levels does not constitute a new State mandate for the purpose of local mandate claims because the increase does not impose unique requirements on local governments. See *County of Los Angeles v. State of California* (1987) 43 Cal.3d 46. The potential costs imposed on all public agency employers and payors by these proposed regulations, although not a benefit level increase, are similarly not a new State mandate because the regulations apply to all employers and payors, both public and private, and not uniquely to local governments.
- Cost to any local agency or school district that is required to be reimbursed under Part 7 (commencing with Section 17500) of Division 4 of the Government Code: None.
- Other nondiscretionary costs/savings imposed upon local agencies: None. To the extent that local agencies and school districts are self-insured employers who must reimburse physicians or other

providers for medical treatment for industrially injured employees, they will be subject to the same cost impacts as all other employers in the state. These impacts are discussed in more detail elsewhere in this Notice.

## **CONSIDERATION OF ALTERNATIVES**

The Acting Administrative Director invites interested persons to present statements or arguments with respect to alternatives to the proposed regulations at the scheduled hearing or during the written comment period.

### **AVAILABILITY OF INITIAL STATEMENT OF REASONS, TEXT OF PROPOSED REGULATIONS, RULEMAKING FILE AND DOCUMENTS SUPPORTING THE RULEMAKING FILE / INTERNET ACCESS**

An Initial Statement of Reasons and the text of the proposed regulations have been prepared and are available from the contact person named in this notice. The entire rulemaking file will be made available for inspection and copying at the address indicated below. However, documents subject to copyright may be inspected but not copied.

As of the date of this notice, the rulemaking file consists of the notice; the initial statement of reasons; the proposed text of the regulations; and the documents incorporated by reference.

In addition, the Notice, Initial Statement of Reasons, and proposed text of regulations may be accessed and downloaded from the Division's website at:

[http://www.dir.ca.gov/dwc/rulemaking/dwc\\_rulemaking\\_proposed.html](http://www.dir.ca.gov/dwc/rulemaking/dwc_rulemaking_proposed.html)

Any interested person may inspect a copy or direct questions about the proposed regulations and any supplemental information contained in the rulemaking file. The rulemaking file will be available for inspection at the Department of Industrial Relations, Division of Workers' Compensation, 1515 Clay Street, 18<sup>th</sup> Floor, Oakland, California, between 9:00 a.m. and 4:30 p.m., Monday through Friday, unless the state office is closed for a state holiday. Copies of the proposed regulations, initial statement of reasons and any information contained in the rulemaking file may be requested in writing to the contact person.

## **CONTACT PERSON**

Nonsubstantive inquiries concerning this action, such as requests to be added to the mailing list for rulemaking notices, requests for copies of the text of the proposed regulations, the Initial Statement of Reasons, and any supplemental information contained in the rulemaking file may be requested in writing at the same address. The contact person is:

Maureen Gray  
Regulations Coordinator  
Department of Industrial Relations  
Division of Workers' Compensation

Post Office Box 420603  
San Francisco, CA 94142  
E-mail: [mgray@dir.ca.gov](mailto:mgray@dir.ca.gov)

The telephone number of the contact person is (510) 286-7100.

### **BACKUP CONTACT PERSON / CONTACT PERSON FOR SUBSTANTIVE QUESTIONS**

In the event the contact person is unavailable, or to obtain responses to questions regarding the substance of the proposed regulations, inquiries should be directed to the following backup contact person:

Jacqueline Schauer, Industrial Relations Counsel  
Department of Industrial Relations  
Division of Workers' Compensation  
Post Office Box 420603  
San Francisco, CA 94142  
E-mail: [jschauer@dir.ca.gov](mailto:jschauer@dir.ca.gov)

The telephone number of the backup contact persons is (510) 286-7100.

### **FORMAT OF REGULATORY TEXT**

The entire text of the regulation is proposed as new regulatory adoption. There will not be any underscore/strikethrough formatting in the original proposal as all language is new.

### **AVAILABILITY OF CHANGES FOLLOWING PUBLIC HEARING**

If the Acting Administrative Director makes changes to the proposed regulations as a result of the public hearing and public comment received, the modified text with changes clearly indicated will be made available for public comment for at least 15 days prior to the date on which the regulations are adopted.

### **AVAILABILITY OF THE FINAL STATEMENT OF REASONS**

Upon its completion, the Final Statement of Reasons will be available and copies may be requested from the contact person named in this notice or may be accessed on the website:

[http://www.dir.ca.gov/dwc/rulemaking/dwc\\_rulemaking\\_proposed.html](http://www.dir.ca.gov/dwc/rulemaking/dwc_rulemaking_proposed.html)

### **AUTOMATIC MAILING**

A copy of this Notice will automatically be sent to those interested persons on the Acting Administrative Director's mailing list.

If adopted, the regulations as adopted will appear in title 8, California Code of Regulations, commencing with section 9789.12.1.