Physician Fee Schedule Regulations
Title 8, California Code of Regulations
Division 1, Chapter 4.5
Subchapter 1 Administrative Director – Administrative Rules

Article 5.3 Official Medical Fee Schedule

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

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

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

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

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

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

(b) Facility site of service fee calculation:

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

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

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

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

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

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

POS Code and Name Description	Payment Rate Facility = F Nonfacility = NF
01 Pharmacy A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.	NF
03 School A facility whose primary purpose is education.	NF
04 Homeless Shelter A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).	NF
09 Prison/Correctional Facility A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders.	NF
11 Office Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.	NF
12 Home Location, other than a hospital or other facility, where the patient receives care in a private residence.	NF
13 Assisted Living Facility Congregate residential facility with self-contained living units providing assessment of each resident’s needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.	NF
14 Group Home A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).	NF

15 Mobile Unit A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.	NF
16 Temporary Lodging A short-term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code.	NF
17 Walk-in Retail Health Clinic A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services.	NF
18 Place of Employment/Worksite A location, not described by any other POS code, owned or operated by a public or private entity where the patient is employed, and where a health professional provides on-going or episodic occupational medical, therapeutic or rehabilitative services to the individual.	NF
20 Urgent Care Facility Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.	NF
21 Inpatient Hospital A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.	F
22 Outpatient Hospital A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.	F
23 Emergency Room-Hospital A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.	F
24 Ambulatory Surgical Center A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.	F
31 Skilled Nursing Facility A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.	F
32 Nursing Facility A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.	NF
33 Custodial Care Facility A facility which provides room, board and other personal assistance services, generally on a longterm basis, and which does not include a medical component.	NF
34 Hospice	F

A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.	
41 Ambulance—Land A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.	F
42 Ambulance—Air or Water An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.	F
49 Independent Clinic A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.	NF
51 Inpatient Psychiatric Facility A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.	F
52 Psychiatric Facility-Partial Hospitalization A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.	F
53 Community Mental Health Center A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.	F
54 Intermediate Care Facility/Mentally Retarded A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or skilled nursing facility (SNF).	NF
55 Residential Substance Abuse Treatment Facility A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.	NF
56 Psychiatric Residential Treatment Center A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.	F
57 Non-residential Substance Abuse Treatment Facility A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.	NF
60 Mass Immunization Center A location where providers administer pneumococcal pneumonia and influenza	NF

virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.	
61 Comprehensive Inpatient Rehabilitation Facility A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.	F
62 Comprehensive Outpatient Rehabilitation Facility A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.	NF
65 End-Stage Renal Disease Treatment Facility A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.	NF
71 State or Local Public Health Clinic A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician.	NF
72 Rural Health Clinic A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.	NF
81 Independent Laboratory A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.	NF
99 Other Place of Service Other place of service not identified above.	NF

(e) See section 9789.19, by date of service, for the average statewide GAFs.

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

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

§ 9789.12.3 Status Codes C, I, N and R

(a) Except as otherwise provided in this fee schedule, for physician and nonphysician practitioner services billed using Current Procedural Terminology (CPT) codes, the RVUs listed in the Centers for Medicare and Medicaid Services (CMS') National Physician Fee Schedule Relative Value File will be utilized regardless of status code.

~~(b) When procedures with status indicator codes C, N, or R, do not have RVUs assigned under the CMS' National Physician Fee Schedule Relative Value File, the RVUs listed in the federal Office of Workers' Compensation Program (OWCP) fee schedule will be~~

~~utilized regardless of status code. When the OWCP fee schedule lists total RVUs without separately providing RVUs for work, practice expense, or malpractice expense, the average statewide geographic adjustment factor shall be applied. See section 9789.19 for the location of the OWCP RVUs and average statewide geographic adjustment factor, by date of service.~~

(~~c~~b) When procedures with status indicator codes C, N, or R, do not have RVUs assigned under ~~either~~ the CMS' National Physician Fee Schedule Relative Value File ~~or under the federal OWCP fee schedule~~, these services shall be reimbursed By Report.

(~~d~~c)(1) CPT codes with status indicator code I, where Medicare uses another CPT code for reporting and payment for these services shall be reimbursed according to the other CPT code used by Medicare.

(2) Healthcare Common Procedure Coding System (HCPCS) "J" procedures with status indicator I shall be reimbursed according to section 9789.13.2.

(3) CPT codes with status indicator code I, where Medicare uses HCPCS "J" code for reporting and payment for these services, shall be reimbursed according to section 9789.13.2.

(4) Maximum reasonable fee for procedures with status indicator code I, that do not meet the criteria of subdivisions (~~d~~c)(1), (~~d~~c)(2), or (~~d~~c)(3) shall be determined as follows:
(A) use the RVUs listed in the CMS' National Physician Fee Schedule Relative Value File;
~~(B) If (d)(4)(A) is not applicable, use the RVUs listed in the federal Office of Workers' Compensation Program (OWCP) fee schedule. When the OWCP fee schedule lists total RVUs without separately providing RVUs for work, practice expense, or malpractice expense, the average statewide geographic adjustment factor shall be applied. See section 9789.19 for the location of the OWCP RVUs and average statewide geographic adjustment factor, by date of service;~~
(~~C~~B) If (~~d~~c)(4)(A) ~~or (B) are~~ is not applicable, use the applicable fee schedule contained in sections 9789.30-9789.70;
(~~D~~C) If (~~d~~c)(4)(A)~~, (B),~~ or (~~C~~B) are not applicable, payable By Report.

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

§ 9789.12.4 "By Report" - Reimbursement for Unlisted Procedures / Procedures Lacking RBRVUs

(a) An unlisted procedure shall be billed using the appropriate unlisted procedure code from the CPT. The procedure shall be billed by report (report not separately reimbursable), justifying that the service was reasonable and necessary to cure or relieve from the effects of the industrial injury or illness. Pertinent information should include

an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort and equipment necessary to provide the service.

(b) (1) In accordance with section 9789.12.3, when procedures with status indicator codes C, N, or R, do not have RVUs assigned under ~~either~~ the CMS' National Physician Fee Schedule Relative Value File ~~or under the OWCP fee schedule~~, these services shall be billed by report, justifying that the service was reasonable and necessary to cure or relieve from the effects of the industrial injury or illness. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort and equipment necessary to provide the service.

(2) CPT codes that: 1) appear in the CMS' National Physician Fee Schedule Relative Value File, and 2) do not have an RVU assigned for the service, and 3) that are payable under a fee schedule contained in section 9789.30 - 9789.70, are not payable under the physician fee schedule on a "By Report" basis.

(c) In determining the value of a By Report procedure, consideration may be given to the value assigned to a comparable procedure or analogous code. The comparable procedure or analogous code should reflect similar amount of resources, such as practice expense, time, complexity, expertise, etc. as required for the procedure performed.

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

§ 9789.12.8 Status Codes

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

A =	Active Code. These codes are paid separately under the physician fee schedule. There will be RVUs for codes with this status.
B =	Bundled Code. Payment for covered services are always bundled into payment for other services not specified. If RVUs are shown, they are not used for payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident. (An example is a telephone call from a hospital nurse regarding care of a patient).
C =	If payable, these codes will be paid ~~either using RVUs established by the federal OWCP or~~ "By Report", generally following review of documentation such as an operative report.
E =	If payable: (a) HCPCS codes beginning with "J" or "P", maximum fee is determined according section 9789.13.2. (b) Other codes are paid under the applicable fee schedule contained in Section 9789.30-9789.70, or if none of those schedules is applicable

	the code is payable "By Report."
I =	Except as otherwise provided, not valid code for workers' compensation physician billing. See section 9789.12.3.
J =	Anesthesia Services. The intent of this value is to facilitate the identification of anesthesia services. There are no RVUs and no payment amounts for these codes in the National Physician Fee Schedule Relative Value File. Instead, the Anesthesia Base Units file is to be used to determine the base units for these codes.
M =	Measurement codes. Used for reporting purposes only.
N =	If payable, these CPT codes are paid using the listed RVUs; but if no RVUs are listed, ~~then use federal OWCP RVUs; if neither of these,~~ then By Report. See section 9789.12.3.
P =	Bundled/Excluded Codes. There are no RVUs and no payment amounts for these services. No separate payment should be made for them under the fee schedule. --If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident. (An example is an elastic bandage furnished by a physician incident to physician service.) --If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (i.e., colostomy supplies) and should be paid under the other portions of the fee schedule.
R =	If payable, these codes will be paid pursuant to section 9789.12.3.
T =	Injections. There are RVUS and payment amounts for these services, but they are only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the physician services for which payment is made.
X =	No RVUS or payment amounts are shown for these codes. If payable, these codes are paid under the applicable fee schedule contained in Sections 9789.30 - 9789.70, or if none of those schedules is applicable the code is payable "By Report." (Examples of services payable under another fee schedule are ambulance services and clinical diagnostic laboratory services.)

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

§ 9789.19 Update Table

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

Document	Services Rendered On or After 1/1/2014
Anesthesia Base Units by CPT Code	2013anesBASEfin
California-Specific Codes	WC001 – Not reimbursable WC002 - $11.91 WC003 - $38.68 for first page $23.80 each additional page. Maximum of six pages absent mutual agreement ($157.68) WC004 - $38.68 for first page $23.80 each additional page. Maximum of seven pages absent mutual agreement ($181.48) WC005 - $38.68 for first page, $23.80 each additional page. Maximum of six pages absent mutual agreement ($157.68) WC007 - $38.68 for first page $23.80 each additional page. Maximum of six pages absent mutual agreement ($157.68) WC008 - $10.26 for up to the first 15 pages. $0.25 for each additional page after the first 15 pages. WC009 - $10.26 for up to the first 15 pages. $0.25 for each additional page after the first 15 pages. WC010 - $5.13 per x-ray WC011 - $10.26 per scan WC012 - No Fee Prescribed / Non Reimbursable absent agreement
CCI Edits: Medically Unlikely Edits	http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html in the document "Practitioner Services MUE Table – Updated 4/1/2013."
CCI Edits: National Correct Coding Initiative Policy Manual for Medicare Services	NCCI Policy Manual for Medicare Services - Effective January 1, 2013 [ZIP, 696KB]
CCI Edits: Physician CCI Edits	Physician CCI Edits v19.1 effective April 1, 2013 (659,304 records). The last row contains edit column 1 = 39599 and column 2 = 49570 Physician CCI Edits v19.0 effective April 1, 2013 (576,593 records). The first row contains edit column 1 = 40490 and column 2 = C8950
CMS' Medicare National Physician Fee Schedule Relative Value File [Zip],	RVU13C

~~excluding ANES2013 file~~ • RVUPUF13 (Excluding Attachment A) • PPRRVU13.V0215_04162013 • OPPSCAP ~~• 13LOCCO~~ Excluding: 13LOCCO ANES2013 GPCI2013	
CMS Pub 100-04 Medicare Claims Processing: Casting and Splint Supplies	Transmittal 2565 (Change Request 8051)
Conversion Factors adjusted for MEI and Relative Value Scale adjustment factor, if any	Anesthesia Conversion Factor: $32.9605 Surgery Conversion Factor: $52.9311 Radiology Conversion Factor: $50.8371 Other Services Conversion Factor: $36.7169
Current Procedural Terminology (CPT®)	CPT 2014 https://commerce.ama-assn.org/store/
Current Procedural Terminology CPT codes that shall not be used	Do not use CPT codes: 27215 (Use G0412 and Surgery CF) 27216 (Use G0413 and Surgery CF) 27217 (Use G0414 and Surgery CF) 27218 (Use G0415 and Surgery CF) 76140 (see §9789.17.2) 80100 through 80104 (see clinical lab fee schedule, § 9789.50) 90889 (See §9789.14. Use codeWC005 code) 97014 (Use G0283 and Other Services CF) 99075 (see Medical-Legal fee schedule, §9795) 99080 (see §9789.14) 99241 through 99245 (see §9789.12.12) 99251 through 99255 (see §9789.12.12) 99455 and 99456.
Diagnostic Cardiovascular Procedure CPT codes subject to the MPPR	RVU13C, PPRRVU13_V0503, Number “6” in Column labeled “Multiple Procedure (Modifier 51); PPRRVU13_V0503
Diagnostic Imaging Family Indicator Description	National Physician Fee Schedule Relative Value File Calendar Year 2013 http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU13C.html RVUPUF13 (Word document)
Diagnostic Imaging Family Indicator for Procedure	http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-

	Value-Files-Items/RVU13C.html PPRRVU13_V0503, column AB, labeled, "Diagnostic Imaging Family Indicator".
DWC Pharmaceutical Fee Schedule	http://www.dir.ca.gov/dwc/OMFS9904.htm#8
~~Federal Office of Workers' Compensation Program (OWCP) fee schedule RVUs~~	~~2012 OWCP Fee Schedule, "CPT, HCPCS, ADA & OWCP codes with RVU and conversion factors" fs12_code_rvu_cf.xls~~
Health Professional Shortage Area zip code data files	2013 Primary Care HPSA [ZIP, 102KB] 2013 Mental Health HPSA [ZIP, 246KB]
Health Resources and Services Administration: HPSA shortage area query (By State & County) (By Address)	 http://hpsafind.hrsa.gov/ http://datawarehouse.hrsa.gov/geoHPSAAdvisor/GeographicHPSAAdvisor.aspx
Incident To Codes	RVU13C, PPRRVU13_V0503, with PC/TC indicator number "5"; PPRRVU13_V0503
Medi-Cal Rates - DHCS	http://files.medi-cal.ca.gov/pubsdoco/Rates/rates_download.asp
Medicare Economic Index	Estimated 2014 annual increase: 1.011; Estimated 2014 cumulative increase: 1.0184
Ophthalmology Procedure CPT codes subject to the MPPR	RVU13C, PPRRVU13_V0503, Number "7" in Column labeled "Multiple Procedure (Modifier 51); PPRRVU13_V0503
Physical Therapy Multiple Procedure Payment Reduction: "Always Therapy" Codes; and Acupuncture and Chiropractic Codes	RVU13C, PPRRVU13_V0503, Number "5" in Column labeled "Multiple Procedure; PPRRVU13_V0503 In addition, CPT codes: 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943
Physician Time	CY 2013 PFS Physician Time [ZIP, 473KB]
Radiology Diagnostic Imaging Multiple Procedures	http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU13C.html PPRRVU13_V0503, number "4" in column S, labeled, "Mult Proc".
Relative Value Scale Adjustment Factor Adopted by CMS	2013 RVS Budget Neutrality Adjustment Factor: 0.99932
Statewide GAFs (Other than	Average Statewide Work GAF: 1.0370

anesthesia)	Average Statewide Practice Expense GAF: 1.1585 Average Statewide Malpractice Expense GAF: 0.5877
Statewide GAF (Anesthesia)	Average Statewide Anesthesia GAF: 1.0212
~~Statewide GAF (Consolidated Work, Practice Expense, Malpractice Expense, for use with OWCP Consolidated RVU)~~	~~Average Statewide GAF: 1.080~~
The 1995 Documentation Guidelines for Evaluation & Management Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf
The 1997 Documentation Guidelines for Evaluation and Management Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf.

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