**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

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

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

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

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

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

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

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

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

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

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

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

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

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

Key: RVU = Relative Value Unit
GPCI = Geographic Practice Cost Index (by locality corresponding to the county where service was provided)
Work = Physician Work
PE = Practice Expense
MP = Malpractice Expense

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

(b) Facility site of service fee calculation:

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

[(Work RVU * Statewide Work GAF) +
(Facility PE RVU * Statewide PE GAF) +

(MP RVU * Statewide MP GAF)] * Conversion Factor = Base Maximum Fee

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

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

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

Key: RVU = Relative Value Unit
GPCI = Geographic Practice Cost Index (by locality corresponding to the county where service was provided)
Work = Physician Work
PE = Practice Expense
MP = Malpractice Expense

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

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

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

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

| POS Code and Name<br>Description | Payment Rate<br>Facility = F |
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| | Nonfacility = NF |
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| 01 Pharmacy<br>A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients. | NF |
| 02 Telehealth<br>The location where health services and health related services are provided or received, through a telecommunication system.<br>(Effective for services on or after March 1, 2017) | F |
| 03 School<br>A facility whose primary purpose is education. | NF |
| 04 Homeless Shelter<br>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<br>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<br>Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis. | NF |
| 12 Home or Private Residence of Patient<br>Location, other than a hospital or other facility, where the patient receives care in a private residence. | NF |
| 13 Assisted Living Facility<br>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<br>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<br>A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services. | NF |
| 16 Temporary Lodging | NF |

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| 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. | |
| 17 Walk-in Retail Health Clinic<br>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<br>A location, not described by any other POS code, owned or operated by a public or private entity where the patient is employed, and where a health professional provides on-going or episodic occupational medical, therapeutic or rehabilitative services to the individual. | NF |
| 19 Off Campus-Outpatient Hospital<br>A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.<br>(Effective for Services on or after January 1, 2016) | F |
| 20 Urgent Care Facility<br>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<br>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<br>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.<br>(Effective for Services prior to January 1, 2016) | F |
| 22 On Campus-Outpatient Hospital<br>A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.<br>(Effective for Services on or after January 1, 2016) | F |
| 23 Emergency Room-Hospital<br>A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided. | F |
| 24 Ambulatory Surgical Center<br>A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis. | F |

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| 31 Skilled Nursing Facility<br>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<br>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<br>A facility which provides room, board and other personal assistance services, generally on a longterm basis, and which does not include a medical component. | NF |
| 34 Hospice – for inpatient care<br>A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided. | F |
| 41 Ambulance—Land<br>A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured. | F |
| 42 Ambulance—Air or Water<br>An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured. | F |
| 49 Independent Clinic<br>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<br>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<br>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<br>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 | F |

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| considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services. | |
| 54 Intermediate Care Facility/Mentally Retarded<br>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<br>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<br>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<br>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<br>A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting. | NF |
| 61 Comprehensive Inpatient Rehabilitation Facility<br>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<br>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<br>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 |

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| 71 State or Local Public Health Clinic<br>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<br>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<br>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<br>Other place of service not identified above. | NF |

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

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

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

(B) Determination of Payment Locality for Radiology Services, Pathology Services, and Other Diagnostic Procedures:
(i) Global Service Code – If the global diagnostic code (no modifier TC and no modifier -26) is billed, the provider must report the name and address, including the ZIP code, of where the test was furnished on the bill for the global diagnostic service code. For example, when the global diagnostic service code is billed for chest x-ray as described by CPT code 71045 (no modifier TC and no modifier -26), the locality is determined by the ZIP code applicable to the testing facility.

In order to bill for a global diagnostic service code, the same physician or supplier entity must furnish both the TC and the PC of the diagnostic service and the TC and PC must be furnished within the same payment locality.
(ii) Separate Billing of Professional Interpretation:
If the physician or supplier entity does not furnish both the TC and PC of the diagnostic service, or if the physician or supplier entity furnishes both the TC and PC but the professional interpretation was furnished in a different payment locality from where the TC was furnished, the professional interpretation of a diagnostic test must be separately billed with modifier -26 by the interpreting physician. The interpreting physician must report the name and address, including ZIP code, of the location where professional interpretation was furnished on the bill. If the professional interpretation was furnished at an unusual and infrequent location, for example, a hotel, the locality of the professional interpretation is determined based on where the interpreting physician most commonly practices.

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

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

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

§ 9789.12.3 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, these services shall be reimbursed By Report.

(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 (c)(1), (c)(2), or (c)(3) shall be determined as follows:
(A) use the RVUs listed in the CMS' National Physician Fee Schedule Relative Value File;
(B) If (c)(4)(A) is not applicable, use the applicable fee schedule contained in sections 9789.30-9789.70;
(C) If (c)(4)(A) or (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 the CMS' National Physician Fee Schedule Relative Value File, 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.

§ 9789.12.5 Conversion Factors

(a) The conversion factors to be used for determining maximum reasonable fees are set forth in section 9789.19, by date of service.

(b) (1) Commencing January 1, 2014, there shall be a four-year transition between:

"OMFS Budget Neutral CF": the estimated aggregate maximum allowable amount under the official medical fee schedule for physician services prior to January 1, 2014, and

"120% RBRVS 2012 CF": the maximum allowable amount based on the resource-based relative value scale at 120 percent of the Medicare conversion factor in effect in July 2012.

(2) During the transition, the conversion factors before adjustment shall be as follows:

| Type of Service | OMFS Budget-Neutral CF | 120% 2012 Medicare | 2014 (75 Percent OMFS/ 25 Percent 120 % Medicare) | 2015 (50 Percent OMFS/ 50 Percent 120 % Medicare) | 2016 (25 Percent OMFS/ 75Percent 120 % Medicare) | 2017 (120% Medicare) |
|---|---|---|---|---|---|---|
| Anesthesia | 34.5903 | 25.6896 | 32.3651 | 30.1400 | 27.9148 | 25.6896 |
| Surgery | 55.6849 | 40.8451 | 51.9750 | 48.2650 | 44.5551 | 40.8451 |

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| Radiology | 52.9434 | 40.8451 | 49.9188 | 46.8943 | 43.8697 | 40.8451 |
| All other services | 34.4566 | 40.8451 | 36.0537 | 37.6509 | 39.2480 | 40.8451 |

(3) The conversion factors specified in subdivision (b)(2) shall be adjusted by the cumulative changes in MEI and the Relative Value Scale Adjustment Factor, if any, between 2012 and each transition year. See section 9789.19 for annual and cumulative MEI, and Relative Value Scale Adjustment Factor, by date of service.

(4) (A) During years 2014 through 2016:
(1) The anesthesia conversion factor shall be applied to CPT codes in the Anesthesia section of the CPT;
(2) The surgery conversion factor shall be applied to CPT codes in the Surgery section of the CPT;
(3) The radiology conversion factor shall be applied to CPT codes in the Radiology section of the CPT;
(4) The “other services” conversion factor shall be applied to CPT codes in the Evaluation and Management, Medicine, and Pathology and Laboratory sections of the CPT, to the extent the services are payable under this fee schedule.

(B) In 2017, and thereafter, there will be two conversion factors: Anesthesia and Other Services.

(c) For calendar year 2018, and annually thereafter, the Anesthesia conversion factor and the Other Services conversion factor in effect in the prior calendar year shall be updated by the Medicare Economic Index inflation rate and by the Relative Value Scale Adjustment Factor, if any.

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

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

(a) Physicians who provide professional services in a Geographic Health Professional Shortage Area (HPSA) are eligible for a 10-percent bonus payment. Eligibility for receiving the 10 percent bonus payment is based on whether the specific location at which the service is furnished is within an area that is designated as a Geographic HPSA by the Health Resources and Services Administration (HRSA), within the United States Department of Health & Human Services.

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

psychiatrists furnishing services in mental health Geographic HPSAs are eligible to receive bonus payments.

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

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

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

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

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

To determine whether a modifier is needed, physicians must review the information provided on the CMS web site or the HRSA web site for Geographic HPSA designations to determine if the location where they render services is

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

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

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

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

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

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

The National Physician Fee Schedule Relative Value File which is published on the CMS website shall be utilized to determine the maximum reasonable fees. See section 9789.19 for Relative Value File by date of service.

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

§ 9789.12.8 Status Codes

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

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

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| | --If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (i.e., colostomy supplies) and should be paid under the other portions of the fee schedule. |
| Q = | Therapy functional information code (used for required Medicare reporting purposes only; not used for workers' compensation). |
| R = | If payable, these codes will be paid pursuant to section 9789.12.3. |
| T = | Injections. There are RVUS and payment amounts for these services, but they are only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the physician services for which payment is made. |
| X = | No RVUS or payment amounts are shown for these codes. If payable, these codes are paid under the applicable fee schedule contained in Sections 9789.30 - 9789.70, or if none of those schedules is applicable the code is payable "By Report." (Examples of services payable under another fee schedule are ambulance services and clinical diagnostic laboratory services.) |

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

§ 9789.12.9 Professional Component (PC)/Technical Component (TC) Indicator

The Medicare PC/TC Indicators have been adapted for workers' compensation and have the following meanings:

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| 0 = | Physician Service Codes--Identifies codes that describe physician services. Examples include visits, consultations, and surgical procedures. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. Modifiers 26 and TC cannot be used with these codes. The RVUS include values for physician work, practice expense and malpractice expense. There are some codes with no work RVUs. |
| 1 = | Diagnostic Tests for Radiology Services--Identifies codes that describe diagnostic tests. Examples are pulmonary function tests or therapeutic radiology procedures, e.g., radiation therapy. These codes have both a professional and technical component. Modifiers 26 and TC can be used with these codes. The total RVUs for codes |

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| | reported with a 26 modifier include values for physician work, practice expense, and malpractice expense. The total RVUs for codes reported with a TC modifier include values for practice expense and malpractice expense only. The total RVUs for codes reported without a modifier include values for physician work, practice expense, and malpractice expense. |
| 2 = | Professional Component Only Codes--This indicator identifies stand-alone codes that describe the physician work portion of selected diagnostic tests for which there is an associated code that describes the technical component of the diagnostic test only and another associated code that describes the global test. An example of a professional component only code is CPT code 93010--Electrocardiogram; Interpretation and Report. Modifiers 26 and TC cannot be used with these codes. The total RVUs for professional component only codes include values for physician work, practice expense, and malpractice expense. |
| 3 = | Technical Component Only Codes--This indicator identifies stand-alone codes that describe the technical component (i.e., staff and equipment costs) of selected diagnostic tests for which there is an associated code that describes the professional component of the diagnostic test only. An example of a technical component only code is CPT code 93005-Electrocardiogram; Tracing Only, without interpretation and report. It also identifies codes that are covered only as diagnostic tests and therefore do not have a related professional code. Modifiers 26 and TC cannot be used with these codes. The total RVUs for technical component only codes include values for practice expense and malpractice expense only. |
| 4 = | Global Test Only Codes--This indicator identifies stand-alone codes that describe selected diagnostic tests for which there are associated codes that describe (a) the professional component of the test only, and (b) the technical component of the test only. Modifiers 26 and TC cannot be used with these codes. The total RVUs for global procedure only codes include values for physician work, practice expense, and malpractice expense. The total RVUs for global procedure only codes equals the sum of the total RVUs for the professional and technical components only codes combined. |
| 5 = | Incident To Codes--This indicator identifies codes that describe services covered incident to a physician's service when they are provided by auxiliary personnel employed by the physician and working under his or her direct personal supervision. These |

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| | services are not payable when they are provided to hospital inpatients or patients in a hospital outpatient department. Modifiers 26 and TC cannot be used with these codes. |
| 6 = | Laboratory Physician Interpretation Codes--This indicator identifies clinical laboratory codes for which separate payment for interpretations by laboratory physicians may be made. Actual performance of the tests is paid for under the lab fee schedule. Modifier TC cannot be used with these codes. The total RVUs for laboratory physician interpretation codes include values for physician work, practice expense, and malpractice expense. |
| 7 = | Physical therapy service, for which payment may not be made---Payment may not be made if the service is provided to either a patient in a hospital outpatient department or to an inpatient of the hospital by an independently practicing physical or occupational therapist. |
| 8 = | Physician interpretation codes--This indicator identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for hospital inpatient. This applies to CPT codes 88141 and 85060. No TC billing is recognized because payment for the underlying clinical laboratory test is made to the hospital, generally through the Hospital Fee Schedule payment rate.<br><br>No payment is recognized for CPT codes 88141 and 85060 furnished to hospital outpatients or non-hospital patients. The physician interpretation is paid through the clinical laboratory fee schedule payment for the clinical laboratory test. |
| 9 = | Not Applicable--Concept of a professional/technical component does not apply. |

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

§ 9789.12.10 Coding; Current Procedural Terminology ©, Fourth Edition

(a) The coding, modifiers, guidelines, appendices and all other provisions of *Current Procedural Terminology* ©, Fourth Edition ("*CPT*"), published by the American Medical Association are applicable to the bills submitted for physician and non-physician practitioner services, except: (1) any provision in the Physician Fee Schedule that conflicts with a provision in *CPT* will take

precedence over the *CPT*, and (2) as otherwise specified in regulation. See section 9789.19 for the version of the CPT by date of service.

(b) Copies of *Current Procedural Terminology* ©, Fourth Edition may be purchased from the American Medical Association:

Order Department
American Medical Association
P.O. Box 930876
Atlanta, GA 31193-0876

Or over the internet at:
www.amapress.com or https://commerce.ama-assn.org/store/

Or through the American Medical Association's toll free order line: (800) 621-8335.

(c) See section 9789.19 for CPT codes that shall not be used for reporting of or payment for physician services, by date of service.

(d) For coding requirements for physician-administered drugs, biologicals, blood products, and vaccines, see section 9789.13.2.

(e) For HCPCS codes to bill splint and cast materials, see section 9789.19, by date of service.

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

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

(a) For purposes of workers' compensation billing, the following definitions of "new patient" and "established patient" will be used instead of the CPT definitions:
(1) 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.
(2) An "established patient" is a patient who has been seen previously for the same industrial injury or illness by the physician or medical group.

(b) To properly document and determine the appropriate level of evaluation and management service, physicians and qualified non-physician practitioners must use either one of the following guidelines but not a combination of the two guidelines for a patient encounter. If the physician's or qualified non-physician

practitioner's documentation for a medically necessary service conforms to either one of the guidelines, the maximum reasonable fee shall be according to the documented level of service:

(1) The "1995 Documentation Guidelines for Evaluation & Management Services," *or*

(2) The "1997 Documentation Guidelines for Evaluation and Management Services."

Both guidelines are incorporated by reference and are available on Medicare's website, or will be made available upon request to the Administrative Director.

The 1995 version is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf

The 1997 version is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf.

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

§ 9789.12.12 Consultation Services Coding - Use of Visit Codes

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

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

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

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

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

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

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

§ 9789.12.13 Correct Coding Initiative

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

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

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

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

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

§ 9789.12.14 California Specific Codes

Physicians and non-physician practitioners shall use the "California Specific Codes" listed below. Maximum reasonable fees for services performed by physicians and non-physician practitioners within their scope of practice shall be no more than the fee listed in section 9789.19, by date of service. The fees shall be updated annually in accordance with the Medicare Economic Index.

| CA Code | Procedure |
|---|---|
| WC001 | Doctor's First Report of Occupational Illness or Injury (Form 5021) (Section 9789.14(a)(1)) |
| WC002 | Treating Physician's Progress Report (PR-2 or narrative equivalent in accordance with § 9785) (Section 9789.14(b)(1)) |
| WC003 | Primary Treating Physician's Permanent and Stationary Report (Form PR-3) (Section 9789.14(b)(2)) |
| WC004 | Primary Treating Physician's Permanent and Stationary Report (Form PR-4) (Section 9789.14(b)(3)) |
| WC005 | Psychiatric Report requested by the WCAB or the Administrative Director, other than medical-legal report. Use modifier -32 (Section 9789.14(b)(4)) |
| WC006 | [Reserved] |
| WC007 | Consultation Reports Requested by the Workers' Compensation Appeals Board or the Administrative Director (Use modifier -32) Consultation Reports requested by the QME or AME in the context of a medical-legal evaluation (Section 9789.14(b)(5)). (Use modifier -30) |
| WC008 | Chart Notes (Section 9789.14(c)) |
| WC009 | Duplicate Reports |

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| | (Section 9789.14(d)) |
| WC010 | Duplication of X-Ray |
| WC011 | Duplication of Scan |
| WC012 | Missed Appointments. This code is designated for communication only. It does not imply that compensation is owed. |

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

§ 9789.12.15 California Specific Modifier

The following modifier is to be appended to the applicable CPT Code or California Specific code in addition to any applicable CPT modifier.

-30 Consultation Service During Medical-Legal Evaluation: Services or procedures performed by a consultant at the request of a QME or AME in the context of a medical-legal evaluation where those services are paid under the Physician Fee Schedule.

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

§ 9789.13.1 Supplies

(a) Separate payment for routinely bundled supplies is not allowed.

(b) See section 9789.13.2 regarding payment for physician-administered drugs/biological/vaccines/blood products.

(c) Splints and casting supplies are payable separately in addition to payment for the procedure for applying the splint or cast, performed in a physician's office. See section 9789.19 for the splint and cast HCPCS codes and maximum payment amounts, by date of service. For services on or after April 1, 2014, maximum fees for splints and casting supplies are determined by the Durable Medical Equipment, Prosthetics, Orthotics, Supplies fee schedule.

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

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

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

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

(2) The maximum reimbursement shall be determined using the “Basic Rate” for the HCPCS code contained on the Medi-Cal Rates file for the date of service. The Medi-Cal fee schedule reimburses drug products, vaccines and immunizations at the Medicare rate of reimbursement when established and published by the Centers for Medicare & Medicaid Services (CMS) or the Medi-Cal pharmacy rate of reimbursement when the Medicare rate is not available. The Medicare rate is currently defined as average sales price (ASP) plus 6 percent. The pharmacy rate is currently defined as the lower of (1) the average wholesale price (AWP) minus 17 percent; (2) the federal upper limit (FUL); or (3) the maximum allowable ingredient cost (MAIC).

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

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

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

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

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

(c) Physician-administered radiopharmaceuticals. When furnished to patients in settings in which a technical component is payable, separate payments may be made for low osmolar contrast material used during intrathecal radiologic

procedures (HCPCS Q-codes Q9965-9967), pharmacologic stressing agents used in connection with nuclear medicine and cardiovascular stress testing procedures HCPCS A-codes A4641, A4642, A9500-A9507, A9600), radionuclide used in connection nuclear medicine procedures furnished to beneficiaries in settings in which TCs are payable.

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

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

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

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

§ 9789.13.3 Physician-Dispensed Drugs

The maximum reimbursement for physician-dispensed drugs is determined pursuant to the Pharmaceutical Fee Schedule set forth in section 9789.40 and pursuant to the provisions of Labor Code section 5307.1.

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

§ 9789.14 Reimbursement for Reports, Duplicate Reports, Chart Notes

This section governs reimbursement of all reports other than those which are payable under the medical-legal fee schedule, found at section 9793 et seq.

(a) Treatment Reports Not Separately Reimbursable.

The following treatment reports are not separately reimbursable as the appropriate fee is included within the underlying Evaluation and Management service, Physical Therapy Evaluation service or Occupational Therapy Evaluation service for an office visit:

(1) Doctor's First Report of Occupational Illness or Injury (Form 5021) issued in accordance with section 9785(e). Use Code WC001;

(2) Consultation Reports, except as specified in subdivision (b)(5).

(3) Report by a secondary physician to the primary treating physician.

(4) Physician's Return-to-Work & Voucher Report (DWC-AD 10133.36) issued in accordance with section 9785 subdivision (i) (reimbursement is bundled into payment for PR-3 or PR-4).

(b) Treatment Reports That Are Separately Reimbursable.

The following treatment reports are separately reimbursable.

(1) Primary Treating Physician's Progress Report (Form PR-2), issued in accordance with section 9785(f), using DWC form PR-2, its narrative equivalent, or letter format where allowed by section 9785. Use Code WC002.

(2) Primary Treating Physician's Permanent and Stationary Report (Form PR-3) issued in accordance with section 9785(h). Use Code WC003.

(3) Primary Treating Physician's Permanent and Stationary Report (Form PR-4) issued in accordance with section 9785(h). Use Code WC004.

(4) Psychiatric Report Requested by the WCAB or the Administrative Director, other than a medical-legal report. Use Code WC005, modifier -32.

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

(c) Chart Notes. Requests for chart notes shall be in writing and shall be separately reimbursable. Chart note requests shall be made only by the claims administrator. Use Code WC008 to bill for requested chart notes "By Report".

(d) Duplicate Reports. A primary treating physician has fulfilled his or her reporting duties by sending one copy of a required report to the claims administrator or to a person designated by the claims administrator to be the recipient of the required report. Requests for duplicate reports related to billings shall be made only by the claims administrator and shall be in writing. Duplicate reports are separately reimbursable. Use Code WC009 to bill for duplicate reports "By Report".

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

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

(a) For purposes of this section, NPP services means services provided by physician assistants, nurse practitioners, clinical nurse specialists, and clinical social workers.

(b) Except for clinical social workers, maximum fees for NPP services shall be 85 percent of what a physician is paid under the Official Medical Fee Schedule - Physician Fee Schedule. Maximum fees for clinical social workers shall be 75 percent of what a physician is paid under the Official Medical Fee Schedule- Physician Fee Schedule. Maximum fees for NPP assistant-at-surgery services are set according to Section 9789.15.1(c). 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.

(c) When a NPP actively assists a physician in performing a surgical procedure and furnishes more than just ancillary services, the NPP's services are eligible for payment as assistant-at-surgery services. Maximum fees for covered NPP assistant-at-surgery services shall be 85 percent of what a physician is paid under the Official Medical Fee Schedule - Physician Fee Schedule. Since physicians are paid at 16 percent of the surgical payment amount for assistant-at-surgery services, the actual payment amount that NPPs receive for assistant-at-surgery services is 13.6 percent of the amount paid to physicians. The AS modifier must be reported when billing NPP assistant-at-surgery services.

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

§ 9789.15.2 – Non-Physician Practitioner (NPP) – "Incident To" Services

(a) Non-institutional Setting.

For purposes of this section a non-institutional setting means all settings other than a hospital or skilled nursing facility.

(1) Services that are furnished incident to a physician's are commonly included in the physician's bills, and for which no separate payment is made. Diagnostic tests and pneumococcal, influenza, and hepatitis B vaccines need not also meet the incident to requirement in this section.

(2) NPPs may provide services without direct physician supervision and bill directly for these services. When their services are provided under direct physician supervision, their services may be covered as incident to services, in which case the incident to requirements would apply.

(3) To be covered incident to the services of a physician, services must be:

(A) An integral, although incidental, part of the physician's professional service;

(B) Commonly rendered without charge or included in the physician's bill;

(C) Of a type that are commonly furnished in physician's offices or clinics;

(D) Furnished by the physician or by auxiliary personnel under the physician's direct supervision.

(b) Institutional Setting.

Hospital services incident to physician's services rendered to outpatients and partial hospitalization services incident to such services are subject to the incident to requirements. Payment for these services is made to a hospital.

(c) Incident To Physician's Professional Services

Incident to a physician's professional services means that the services are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness. See section 9789.19 for "incident to" codes by date of service.
(1) Services Commonly Furnished in Physicians' Offices.

Services commonly furnished in physicians' offices are covered under the incident to provision. Charges for such services must be included in the physicians' bills. Where services are of a type not considered medically appropriate to provide in the office setting, they would not be covered under the incident to provision.

(2) Direct Personal Supervision.

(A) Services incident to the professional services of a physician in private practice is limited to situations in which there is direct physician supervision of auxiliary/ NPP personnel. The incident to services must represent an expense incurred by the physician or legal entity billing for the services.

(B) Where a physician supervises auxiliary/NPP personnel to assist him/her in rendering services to patients and includes the charges for their services in his/her own bills, the services of such personnel are considered incident to the physician's service if there is a physician's service rendered to which the services of such personnel are an incidental part and there is direct supervision by the physician.

(C) To be considered incident to, each occasion of service by auxiliary/NPP personnel needs also to always be the occasion of the actual rendition of a

personal professional service by the physician. Such a service could be considered to be incident to when furnished during a course of treatment where the physician performs an initial service and subsequent services of a frequency which reflect his/her active participation in and management of the course of treatment. However, the direct supervision requirement must still be met with respect to every non-physician service.

(D) Direct supervision in the office setting does not mean that the physician must be present in the same room with his or her aide. However, the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the aide is performing services.

(E) If auxiliary/NPP personnel perform services outside the office setting, e.g., in a patient's home or in an institution (other than hospital or skilled nursing facility (SNF)), their services are covered incident to a physician's service only if there is direct supervision by the physician. For example, if a nurse accompanied the physician on house calls and administered an injection, the nurse's services are covered. If the same nurse made the calls alone and administered the injection, the services are not covered (even when billed by the physician) since the physician is not providing direct supervision.

(F) The availability of the physician by telephone and the presence of the physician somewhere in the institution does not constitute direct supervision for services provided by auxiliary/NPP personnel in an institution (e.g., nursing, or convalescent home).

(G) There is no payment for services of physician-employed auxiliary/NPP personnel as services incident to physician service.

(H) A NPP who performs a specific medical procedure without physician supervision may receive separate payment for the service as a NPP's service.

(d) Incident to physician's services in clinic.
Services incident to a physician's service in a physician directed clinic or group association are generally the same as those described in this subsection.

A physician directed clinic is one where:

(1) A physician (or a number of physicians) is present to perform medical (rather than administrative) services at all times the clinic is open;

(2) Each patient is under the care of a clinic physician; and

(3) The non-physician services are under medical supervision.

(4) In highly organized clinics, particularly those that are departmentalized, direct physician supervision may be the responsibility of several physicians as opposed to an individual attending physician. In this situation, medical management of all services provided in the clinic is assured. The physician ordering a particular service need not be the physician who is supervising the service.

(5) When the auxiliary/NPP personnel perform services outside the clinic premises, the services are covered only if performed under the direct supervision of a clinic physician. If the clinic refers a patient for auxiliary/NPP services performed by personnel who are not supervised by clinic physicians, such services are not incident to a physician's service.

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

§ 9789.15.3 Qualified Non-physician Anesthetist Services

(a) This subsection applies to certified registered nurse anesthetists (CRNAs) and certified anesthesiologist assistants (AAs). The term "qualified non-physician anesthetist" refers to both CRNAs and AAs.

(b) The maximum fee for anesthesia services furnished by qualified non-physician anesthetists is the fee determined by this section and section 9789.18.1.

(c) Anesthesia time means the time during which a qualified non-physician anesthetist is present with the patient. It starts when the qualified non-physician anesthetist begins to prepare the patient for anesthesia services in the operating room or an equivalent area and ends when the qualified non-physician anesthetist is no longer furnishing anesthesia services to the patient, that is, when the patient may be placed safely under postoperative care. Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service. In counting anesthesia time, the qualified non-physician anesthetist can add blocks of time around an interruption in anesthesia time as long as the qualified non-physician anesthetist is furnishing continuous anesthesia care within the time periods around the interruption.

(d) The following modifiers are used when billing for anesthesia services:

(1) QX - Qualified non-physician anesthetist with medical direction by a physician.

(2) QZ - CRNA without medical direction by a physician.

(3) QS - Monitored anesthesiology care services (can be billed by a qualified non-physician anesthetist or a physician).

(4) QY - Medical direction of one qualified non-physician anesthetist by an anesthesiologist.

(e) Where a single anesthesia procedure involves both a physician medical direction service and the service of the medically directed qualified non-physician anesthetist, the payment amount for the service of each is 50 percent of the allowance otherwise recognized had the service been furnished by the anesthesiologist alone. The modifier to be used for current procedure identification is QX.

Where the qualified non-physician anesthetist and the anesthesiologist are involved in a single anesthesia case, and the physician is performing medical direction, the service is billed in accordance with the following procedures:

(1) For the single medically directed service, the physician will use the modifier "QY" (Medical Direction Of One Qualified Non-physician Anesthetist By An Anesthesiologist).

(2) For the anesthesia service furnished by the medically directed qualified non-physician anesthetist, the qualified non-physician anesthetist will use the current modifier "QX."

(3) In unusual circumstances when it is medically necessary for both the qualified non-physician anesthetist and the anesthesiologist to be completely and fully involved during a procedure, full payment for the services of each provider is allowed. The physician would report using the "AA" modifier and the qualified non-physician anesthetist would use "QZ," or the modifier for a nonmedically directed case.

Documentation must be submitted by each physician and qualified non-physician practitioner to support payment of the full fee.

(f) Payment can be made to a teaching CRNA who supervises a single case involving a student nurse anesthetist where the CRNA is continuously present. The CRNA reports the service using the usual "QZ" modifier. This modifier designates that the teaching CRNA is not medically directed by an anesthesiologist. No payment shall be made for the service provided by a student nurse anesthetist.

(g) The teaching CRNA, not under the medical direction of a physician, can be paid for his/her involvement in each of two concurrent cases with student nurse anesthetists. Payment is allowed at the regular fee schedule rate if the teaching CRNA is involved with two concurrent student nurse anesthetist cases. The CRNA reports the anesthesia service using the "QZ" modifier.

To bill the anesthesia base units, the CRNA must be present with the student nurse anesthetist during the pre and post anesthesia care for each of the two cases.
To bill anesthesia time for each case, the teaching CRNA must continue to devote his/her time to the two concurrent cases and not be involved in other activities. The teaching CRNA can decide how to allocate his or her time to optimize patient care in the two cases based on the complexity of the anesthesia case, the experience and skills of the student nurse anesthetist, the patient's health status and other factors.
The teaching CRNA must document his/her involvement in the cases with the student nurse anesthetists.

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

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

(a) (1) The Medicare Multiple Procedure Payment Reduction ("MPPR") for "Always Therapy" Codes shall be applied when more than one of the following codes is billed on the same day: codes on the Medicare "Always Therapy" list, acupuncture codes, chiropractic manipulation codes.

(2) Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. The MPPR applies to the Practice Expense ("PE") payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Full payment is made for the unit or procedure with the highest PE payment. Full payment is made for the work and malpractice components and 50 percent payment is made for the PE for subsequent units and procedures, furnished to the same patient on the same day.

(3) For therapy services furnished by a group practice or "incident to" a physician's service, the MPPR applies to all services furnished to a patient on the same day, regardless of whether the services are provided in one therapy discipline or multiple disciplines, for example, physical therapy, occupational therapy, or speech-language pathology.

(4) The MPPR applies to acupuncture codes and chiropractic manipulation codes and to the procedures listed in the "Separately Payable Always Therapy Services Subject to the Multiple Procedure Payment Reduction (MPPR)" file of the Medicare Physician Fee Schedule Final Rule. The listed procedures will also have a Multiple Procedure value of "5" on the National Physician Fee Schedule Relative Value File.

(5) See section 9789.19 for the location of the list of codes on the Medicare "Always Therapy" code list, by date of service.

(b) In addition to the MPPR, the following 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 pre-authorization must be provided by an authorized agent of the claims administrator to the physician or qualified non-physician practitioner. The fee agreement and pre-authorization must be memorialized in writing prior to performing the medical services.

(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.

For the purpose of this subdivision "modality" means a service that is listed in the CPT Medicine section, Physical Medicine and Rehabilitation under the sub-heading of "Modalities". For the purpose of this subdivision "procedure" means a service that is listed in the CPT Medicine section, Physical Medicine and Rehabilitation under the sub-headings "Therapeutic Procedures," "Other Procedures," and under the headings "Acupuncture" and "Chiropractic Manipulative Treatment."

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

§ 9789.15.5 Ophthalmology Multiple Procedure Reduction

(a) The Multiple Procedure Payment Reduction (MPPR) on ophthalmology procedures applies when multiple services are furnished to the same patient on the same day. The MPPRs apply 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 furnished by the same physician (or by multiple physicians in the same group practice, i.e., same Group National Provider Identifier (NPI)) to the same patient on the same day. The MPPR does not apply to professional component (PC) services. See section 9789.19 for the location of the list of codes subject to the MPPR on ophthalmology procedures, by date of service.

(b) For services subject to both the multiple procedure payment reduction and the OPPS cap on imaging, the MPPR shall be applied first, then the reduced

amount will be compared with the OPPS cap, and the lower amount shall be used.

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

§ 9789.15.6 Diagnostic Cardiovascular Procedures – Multiple Procedure Reduction

(a) The Multiple Procedure Payment Reduction (MPPR) on diagnostic cardiovascular procedures 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 furnished by the same physician (or by multiple physicians in the same group practice, i.e., same Group National Provider Identifier (NPI)) to the same patient on the same day. The MPPR does not apply to professional component (PC) services. See section 9789.19 for the location of the list of codes subject to the MPPR on diagnostic cardiovascular procedures, by date of service.

(b) For services subject to both the multiple procedure payment reduction and the OPPS cap on imaging, the MPPR shall be applied first, then the reduced amount will be compared with the OPPS cap, and the lower amount shall be used.

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

§9789.16.1 Surgery – Global Fee

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

(1) Definition of a Global Surgical Package. The National Physician Fee Schedule Relative Value File, Global Days column (labeled “Glob Days”), provides the postoperative periods that apply to each surgical procedure. The payment rules for surgical procedures apply to codes with entries of 000, 010, 090. For workers’ compensation, the global period will not apply to codes with “YYY”.
(A) Codes with “000” in the Global Days column are minor procedures or endoscopies with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount;

evaluation and management services on the day of the procedure are generally not payable.
(B) Codes with “010” in the Global Days column are minor procedures or endoscopies with preoperative relative values on the day of the procedure and postoperative relative values during a 10 day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during the 10-day postoperative period generally not payable.
(C) Codes with “090” in the Global Days column are major surgeries with a 1-day preoperative period and 90-day postoperative period included in the fee schedule amount.
(D) Codes with “ZZZ” are surgical codes related to another service and are always included in the global period of the other service. They are add-on codes that are always billed with another service. There is no postoperative work included in the fee schedule payment for the “ZZZ” codes. Payment is made for both the primary and the add-on codes, and the global period assigned is applied to the primary code.

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

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

(G) Miscellaneous Services - Items such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes.

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

(4) Minor Surgeries and Endoscopies. Visits by the same physician on the same day as a minor surgery or endoscopy are included in the payment for the procedure, unless a significant, separately identifiable service is also performed. A postoperative period of 10 days applies to some minor surgeries. The postoperative period for these procedures is indicated in the Global Days column of the National Physician Fee Schedule Relative Value File. If the Global Days column entry is "010", no separate payment is allowed for postoperative visits or

services within 10 days of the surgery that are related to recovery from the procedure. If a diagnostic biopsy with a 10-day global period precedes a major surgery on the same day or in the 10-day period, the major surgery is payable separately. Services by other physicians are not included in the global fee for a minor procedure except as otherwise excluded. If the Global Days column entry is “000”, postoperative visits beyond the day of the procedure are not included in the payment amount for the surgery. Separate payment is made in this instance.

(5) Physicians Furnishing Less Than the Full Global Package. There are occasions when more than one physician provides services included in the global surgical package. It may be the case that the physician who performs the surgical procedure does not furnish the follow-up care. Payment for the postoperative, postdischarge care is split between two or more physicians where the physicians agree on the transfer of care. When more than one physician furnishes services that are included in the global surgical package, the sum of the amount approved for all physicians may not exceed what would have been paid if a single physician provides all services, except where permitted. When either modifier
“-54” or “-55” is used, a percentage of the fee schedule is applied as appropriate. The percentages for pre-, intra-, and postoperative care of the total RVUs for major surgical procedures and for minor surgeries with a postoperative period of 10 days may be found in the columns Preoperative Percentage (“Pre Op”), Intraoperative Percentage (“Intra Op”), and Postoperative Percentage (“Post Op”), respectively, of the National Physician Fee Schedule Relative Value File. The intra-operative percentage includes postoperative hospital visits. Split global care does apply to procedures with “000” in the Global Days column of the National Physician Fee Schedule Relative Value File.

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

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

§9789.16.2 Surgery - Billing Requirements for Global Surgeries.

To ensure the proper identification of services that are, or are not, included in the global package, the following procedures apply.

(a) Procedure Codes and Modifiers

Use of the modifiers in this section apply to both major procedures with a 90-day postoperative period and minor procedures with a 10-day postoperative period (and/or a zero day postoperative period in the case of modifiers “-22” and “-25”).

(1) Physicians Who Furnish the Entire Global Surgical Package.

Physicians who perform the surgery and furnish all of the usual pre-and postoperative work bill for the global package by entering the appropriate CPT code for the surgical
procedure only. Billing is not allowed for visits or other services that are included in the global package.

(2) Physicians in Group Practice.

When different physicians in a group practice participate in the care of the patient, the group bills for the entire global package if the physicians reassign benefits to the group. The physician who performs the surgery is shown as the performing (rendering) physician.

(3) Physicians Who Furnish Part of a Global Surgical Package

Where physicians agree on the transfer of care during the global period, the following modifiers are used:
• “-54” for surgical care only; or
• “-55” for postoperative management only.

Both the bill for the surgical care only and the bill for the postoperative care only, will contain the same date of service and the same surgical procedure code, with the services distinguished by the use of the appropriate modifier.

Physicians need not specify on the claim that care has been transferred. However, the date on which care was relinquished or assumed, as applicable, must be shown on the claim. This should be indicated in the remarks field/free text segment on the claim form/format. Both the surgeon and the physician providing the postoperative care must keep a copy of the written transfer agreement in the beneficiary’s medical record.

Where a transfer of postoperative care occurs, the receiving physician cannot bill for any part of the global services until he/she has provided at least one service. Once the physician has seen the patient, that physician may bill for the period beginning with the date on which he/she assumes care of the patient.

EXCEPTIONS:
• Where a transfer of care does not occur, occasional post-discharge services of a physician other than the surgeon are reported by the appropriate evaluation and management code. No modifiers are necessary on the claim.

• If the transfer of care occurs immediately after surgery, the physician other than the surgeon who provides the in-hospital postoperative care bills using subsequent hospital care codes for the inpatient hospital care and the surgical code with the "-55" modifier for the post-discharge care. The surgeon bills the surgery code with the "-54" modifier.
• Physicians who provide follow-up services for minor procedures performed in emergency departments bill the appropriate level of office visit code. The physician who performs the emergency room service bills for the surgical procedure without a modifier.
• If the services of a physician other than the surgeon are required during a postoperative period for an underlying condition or medical complication, the other physician reports the appropriate evaluation and management code. No modifiers are necessary on the claim. An example is a cardiologist who manages underlying cardiovascular conditions of a patient.

(4) Evaluation and Management Service Resulting in the Initial Decision to Perform Surgery.

Evaluation and management services on the day before major surgery or on the day of major surgery that result in the initial decision to perform the surgery are not included in the global surgery payment for the major surgery and, therefore, may be paid separately.

In addition to the CPT evaluation and management code, modifier "-57" (decision for surgery) is used to identify a visit which results in the initial decision to perform surgery.

If evaluation and management services occur on the day of surgery, use modifier "-57," not "-25." The "-57" modifier is not used with minor surgeries because the global period for minor surgeries does not include the day prior to the surgery. Moreover, where the decision to perform the minor procedure is typically done immediately before the service, it is considered a routine preoperative service and a visit is not separately payable in addition to the procedure.

(5) Return Trips to the Operating Room During the Postoperative Period for Treatment of Complications.
When treatment for complications requires a return trip to the operating room, physicians must bill the CPT code that describes the procedure(s) performed during the return trip. If no such code exists, use the unlisted procedure code in the correct series, e.g., 47999 or 64999. The procedure code for the original surgery is not used except when the identical procedure is repeated. In addition to the CPT code, use CPT modifier "-78" for return trips (return to the operating room for a related procedure during a postoperative period).

The physician may also need to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent

procedure is related to the first procedure, and requires the use of the operating room, report this circumstance by adding the modifier “-78” to the related procedure.

(6) Staged or Related Procedures. Use modifier “-58” for staged or related surgical procedures done during the postoperative period of the first procedure. This modifier is not used to report the treatment of a problem that requires a return to the operating room.

Modifier “-58” is added to the staged procedure when the performance of a procedure or service during the postoperative period was:
(A) Planned prospectively or at the time of the original procedure;
(B) More extensive than the original procedure; or
(C) For therapy following a diagnostic surgical procedure.
A new postoperative period begins when the next procedure in the series is billed.

(7) Unrelated Procedures or Visits During the Postoperative Period.

CPT modifiers “-79” and “-24” are used for visits and other procedures which are furnished during the postoperative period of a surgical procedure, but which are not included in the payment for the surgical procedure.

(A) Modifier “-79” reports an unrelated procedure by the same physician during a postoperative period. A new postoperative period begins with the unrelated procedure.
(B) Modifier “-24” reports an unrelated evaluation and management service by same physician during a postoperative period. Services submitted with the “-24” modifier must be sufficiently documented to establish that the visit was unrelated to the surgery. A diagnosis code that clearly indicates that the reason for the encounter was unrelated to the surgery is acceptable documentation. A physician who is responsible for postoperative care using modifier “-55” should also use modifier “-24” to report any unrelated visits.

(8) Significant Evaluation and Management on the Day of a Procedure. Modifier “-25” is used for evaluation and management services on the day of a procedure for which separate payment may be made. It is used to report a significant, separately identifiable evaluation and management service by the same physician on the day of a procedure. The physician may need to indicate that on the day a procedure or service that is identified with a CPT code was performed, the patient’s condition required a significant, separately identifiable evaluation and management service above and beyond the usual preoperative and postoperative care associated with the procedure or service that was performed. This circumstance may be reported by adding the modifier “-25” to the appropriate level of evaluation and management service.

(9) Critical Care. Critical care services provided during a global surgical period for a seriously injured or burned patient are not considered related to a surgical procedure and may be paid separately under the following circumstances. Preoperative and postoperative critical care may be paid in addition to a global fee if:
(A) The patient is critically ill and requires the constant attendance of the physician; and
(B) The critical care is above and beyond, and, in most instances, unrelated to the specific anatomic injury or general surgical procedure performed. Such patients are potentially unstable or have conditions that could pose a significant threat to life or risk of prolonged impairment.

In order for these services to be paid, two reporting requirements must be met:
• Codes 99291/99292 and modifier "-25" (for preoperative care) or "-24" (for postoperative care) must be used; and
• Documentation that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed must be submitted. A diagnosis which clearly indicates that the critical care was unrelated to the surgery, is acceptable documentation.

(10) Unusual Circumstances. Surgeries for which services performed are significantly greater than usually required may be billed with the "-22" modifier added to the CPT code for the procedure. Surgeries for which services performed are significantly less than usually required may be billed with the "-52" modifier. The biller must provide:
• A concise statement about how the service differs from the usual; and
• An operative report with the claim.
Modifier "-22" should only be reported with procedure codes that have a global period of 0, 10, or 90 days. There is no such restriction on the use of modifier "-52."

(b) Date(s) of Service

Physicians, who bill for the entire global surgical package or for only a portion of the care, must enter the date on which the surgical procedure was performed in the "From/To" date of service field. This will enable the claims administrator to relate all appropriate billings to the correct surgery. Physicians who share postoperative management with another physician must submit additional information showing when they assumed and relinquished responsibility for the postoperative care. If the physician who performed the surgery relinquishes care at the time of discharge, he or she need only show the date of surgery when billing with modifier "-54."

However, if the surgeon also cares for the patient for some period following discharge, the surgeon must show the date of surgery and the date on which postoperative care was relinquished to another physician. The physician

providing the remaining postoperative care must show the date care was assumed. This information should be shown in Item 19 on the paper Form CMS-1500, or as specified in the ANSI ASC X12N 005010X222A1 Health Care Claim Payment/Advice (837) for electronic claims.

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

§9789.16.3 Surgery – Global Fee – Miscellaneous Rules

(a) Relationship to Correct Coding Initiative (CCI)

The CCI edits allow the claims administrator to detect instances of fragmented billing for certain intra-operative services and other services furnished on the same day as the surgery that are considered to be components of the surgical procedure and, therefore,
included in the global surgical fee. When both correct coding and global surgery edits apply to the same claim, the claims administrator shall first apply the correct coding edits, then, apply the global surgery edits to the correctly coded services.

(b) Claims From Physicians Who Furnish Less Than the Global Package (Split Global Care)

(1) For surgeries that are billed with either modifier “-54” or “-55,” the claims administrator shall pay the applicable percentage of the fee schedule payment. Columns labeled “Pre Op”, “Intra Op” and “Post Op” of the National Physician Fee Schedule Relative Value File, list the percentages for pre-, intra-, and postoperative care of the total RVUs for major surgical procedures and for minor surgeries with a postoperative period of 10 days. The intra-operative percentage includes postoperative hospital visits.

(2) Where more than one physician bills for the postoperative care, the claims administrator will apportion the postoperative percentage according to the number of days each physician was responsible for the patient’s care by dividing the postoperative allowed amount by the number of post-op days and that amount is multiplied by the number of days each physician saw the patient.

EXAMPLE
Dr. Jones bills for procedure “42145-54” performed on March 1 and states that he cared for the patient through April 29. Dr. Smith bills for procedure “42145-55” and states that she assumed care of the patient on April 30. The percentage of the total fee amount for the postoperative care for this procedure is determined to be 17 percent and the length of the global period is 90 days. Since Dr. Jones provided postoperative care for the first 60 days, he will receive 66 2/3 percent of the total fee of 17 percent since 60/90 = .6666. Dr. Smith’s 30 days of service entitle her to 30/90 or .3333 of the fee.

6666 x .17 = .11333 or 11.3%; and
3338 x .17 = .057 or 5.7%.

Thus, Dr. Jones will be paid at a rate of 11.3 percent (66.7 percent of 17 percent). Dr. Smith will be paid at a rate of 5.7 percent (33.3 percent of 17 percent).

(3) Procedures with a “000” entry in “Glob Days” column have an entry of “0.0000” in the Pre Op, Intra Op and Post Op columns. Split global care does not apply to these procedures.

(c) Payment for Return Trips to the Operating Room for Treatment of Complications

When a CPT code billed with modifier “-78” describes the services involving a return trip to the operating room to deal with complications, the claims administrator shall pay the value of the intra-operative services of the code that describes the treatment of the complications. Refer to the Intra Op column of the National Physician Fee Schedule Relative Value File to determine the percentage of the global package for the intra-operative services. The fee schedule amount is multiplied by this percentage and rounded to the nearest cent.

When a procedure with a “000” global period is billed with a modifier “-78,” representing a return trip to the operating room to deal with complications, the claims administrator shall pay the full value for the procedure, since these codes have no pre-, post-, or intra-operative values.

When an unlisted procedure is billed because no code exists to describe the treatment for complications, the claims administrator shall base payment on a maximum of 50 percent of the value of the intra-operative services originally performed. If multiple surgeries were originally performed, the claims administrator shall base payment on no more than 50 percent of the value of the intra-operative services of the surgery for which the complications occurred. The claims administrator shall multiply the fee schedule amount for the original surgery by the intra-operative percentage for the procedure, and then multiply that figure by 50 percent to obtain the maximum payment amount.
[.50 X (fee schedule amount x intra-operative percentage)]. Round to the nearest cent.

If additional procedures are performed during the same operative session as the original surgery to treat complications which occurred during the original surgery, the claims administrator shall pay the additional procedures as multiple surgeries. Only surgeries that require a return to the operating room are paid under the complications rules.

If the patient is returned to the operating room after the initial operative session, but on the same day as the original surgery for one or more additional procedures as a result of complications from the original surgery, the complications rules apply to each procedure required to treat the complications from the original surgery. The multiple surgery rules would not also apply.

If the patient is returned to the operating room during the postoperative period of the original surgery, not on the same day of the original surgery, for multiple procedures that are required as a result of complications from the original surgery, the complications rules would apply. The multiple surgery rules would also not apply.

If the patient is returned to the operating room during the postoperative period of the original surgery, not on the same day of the original surgery, for bilateral procedures that are required as a result of complications from the original surgery, the complication rules would apply. The bilateral rules would not apply.

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

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

(a) Notwithstanding sections 9789.16.2 – 9789.16.3, where a surgical code is subject to a global period, the provider may separately bill an E&M service during the global period in the following circumstance.

The provider may bill one or more evaluation and management codes for medically necessary services that exceed the number of visits that are listed for the global surgical code in the Medicare Physician Fee Schedule's "Physician Time File". See section 9789.19 for the Physician Time File, by date of service.

Calculation shall be made as follows: For the surgical procedure subject to the global days, add the number of visits for all E&M services shown on that row in the Physician Time File. Round up if the total number of visits includes a half visit. If the physician provides E&M services in excess of the total number of E&M visits shown for the surgical code, medically necessary E&M services in excess of that number may be separately billed.

(b) The Primary Treating Physician's Progress reports (PR-2 or the equivalent allowed by section 9785) are separately reimbursable even if the change in the patient's condition or treatment warranting a progress report occurs during the surgical global follow-up period.

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

Reference: Sections 4600, 5307.1 and 5307.11, Labor Code.

§9789.16.5 Surgery – Multiple Surgeries and Endoscopies

(a) General
Multiple surgeries are separate procedures performed by a single physician or physicians in the same group practice on the same patient at the same operative session or on the same day for which separate payment may be allowed. Co-surgeons, surgical teams, or assistants-at-surgery may participate in performing multiple surgeries on the same patient on the same day.

Multiple surgeries are distinguished from procedures that are components of or incidental to a primary procedure. These intra-operative services, incidental surgeries, or components of more major surgeries are not separately billable.

(b) Billing Instructions

The following procedures apply when billing for multiple surgeries by the same physician on the same day.
• Report the more major surgical procedure without the multiple procedures modifier "-51."
• Report additional surgical procedures performed by the surgeon on the same day with modifier "-51."

There may be instances in which two or more physicians each perform distinctly different, unrelated surgeries on the same patient on the same day (e.g., in some multiple trauma cases). When this occurs, the payment adjustment rules for multiple surgeries
may not be appropriate. In such cases, the physician does not use modifier "-51" unless one of the surgeons individually performs multiple surgeries.

(c) Determining Maximum Payment for Multiple Surgeries

The Multiple Procedure ("Mult Proc") column of the National Physician Fee Schedule Relative Value File contains a "2" to indicate procedures that are subject to the surgery multiple procedure payment reduction.

If a procedure is performed on the same day as another procedure, base the payment on the lower of (a) the actual charge, or (b) the fee schedule amount for the procedure reduced by the applicable percentage.

Rank the procedures subject to the multiple surgery rule (indicator "2") in descending order by fee schedule amount and apply the appropriate reduction to this code:
(A) 100 percent of the fee schedule amount for the highest valued procedure; and

(B) 50 percent of the fee schedule amount for the second through the fifth highest valued procedures; or
(C) if more than five procedures with indicator “2” are billed, pay for the first five according to (A) and (B) above and pay “by report” for the sixth and subsequent procedures. Payment determined on a “by report” basis should never be lower than 50 percent of the full payment amount. Pay by the unit for services that are already reduced (e.g. 17003).

In cases of multiple interventional radiological procedures, both the radiology code and the primary surgical code are paid at 100 percent of the fee schedule amount. The subsequent surgical procedures are paid at the standard multiple surgical percentages (50 percent, 50 percent, 50 percent and 50 percent).

(d) Determining Maximum Payment for Endoscopies

Endoscopy
The Multiple Procedure (“Mult Proc”) column of the National Physician Fee Schedule Relative Value File contains a “3” to indicate procedures that are subject to special rules for multiple endoscopic procedures. For each endoscopic procedure with an indicator of “3”, the Endoscopic Base Code (“Endo Base”) column indicates the related base endoscopy code. Those codes that share a base code are in the same “family” and are “related.”

Two codes billed: Endoscopic procedure and related base endoscopic procedure billed
If an endoscopic procedure is reported with only its base procedure, the base procedure is not separately payable. Payment for the base procedure is included in the payment for the other endoscopy.

Multiple Related Endoscopic procedures billed

If Multiple Procedure column contains an indicator of “3,” and multiple endoscopies are billed, pay the full value of the highest valued endoscopy, plus the difference between the next highest and the base endoscopy. Access the Endo Base column to determine the base endoscopy.

EXAMPLE [dollar amounts are for illustration only]

In the course of performing a fiber optic colonoscopy (CPT code 45378), a physician performs a biopsy on a lesion (code 45380) and removes a polyp (code 45385) from a different part of the colon. The physician bills for codes 45380 and 45385. The value of codes 45380 and 45385 have the value of the diagnostic colonoscopy (45378) built in. Rather than paying 100 percent for the highest valued procedure (45385) and 50 percent for the next (45380), pay the full value of the higher valued endoscopy (45385), plus the difference between the next highest endoscopy (45380) and the base endoscopy (45378).

Assume the following fee schedule amounts for these codes:
45378 - $255.40
45380 - $285.98
45385 - $374.56

Pay the full value of 45385 ($374.56), plus the difference between 45380 and 45378 ($30.58), for a total of $405.14.

Multiple Related and Unrelated Endoscopies or Other Surgical Procedures Billed
Apply the following rules where endoscopies are performed on the same day as unrelated endoscopies or other surgical procedures:
• Two unrelated endoscopies (e.g., 46606 and 43217): Apply the usual multiple surgery rules;
• Two sets of unrelated endoscopies (e.g., 43202 and 43217; 46606 and 46608): Apply the special endoscopy rules to each series and then apply the multiple surgery rules. Consider the total payment for each set of endoscopies as one service;
• Two related endoscopies and a third, unrelated procedure: Apply the special endoscopic rules to the related endoscopies, and, then apply the multiple surgery rules. Consider the total payment for the related endoscopies as one service and the unrelated endoscopy as another service.

(e) Multiple Procedures of Equal Value
If two or more multiple surgeries are of equal value, rank them in descending dollar order billed and base payment on the percentages listed above (i.e., 100 percent for the first billed procedure, 50 percent for the second, etc.)

(f) Multiple Procedures Including Bilateral Surgeries
If any of the multiple surgeries are bilateral surgeries, consider the bilateral procedure at 150 percent as one payment amount, rank this with the remaining procedures, and apply the appropriate multiple surgery reductions.

(g) Multiple Surgical Procedures and Multiple Interventional Radiological Procedures
In cases of multiple interventional radiological procedures, both the radiology code and the primary surgical code are paid at 100 percent of the fee schedule amount. The subsequent surgical procedures are paid at the standard multiple surgical percentages (50 percent, 50 percent, 50 percent and 50 percent.)

(h) Ranking of Same Day Multiple Surgeries When One Surgery Has a “-22” Modifier and Additional Payment is Allowed

If the patient returns to the operating room after the initial operative session on the same day as a result of complications from the original surgery, the complications rules apply to each procedure required to treat the complications from the original surgery. The multiple surgery rules would not apply.

However, if the patient is returned to the operating room during the postoperative period of the original surgery, not on the same day of the original surgery, for multiple procedures that are required as a result of complications from the original surgery, the complications rules would apply. The multiple surgery rules would also not apply.
Multiple surgeries are defined as separate procedures performed by a single physician or physicians in the same group practice on the same patient at the same operative session or on the same day for which separate payment may be allowed. Co-surgeons, surgical teams, or assistants-at-surgery may participate in performing multiple surgeries on the same patient on the same day.

Multiple surgeries are distinguished from procedures that are components of or incidental to a primary procedure. These intra-operative services, incidental surgeries, or components of more major surgeries are not separately billable.

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

§9789.16.6 Surgery – Bilateral Surgeries.

(a) Bilateral surgeries are procedures performed on both sides of the body during the same operative session or on the same day.

The terminology for some procedure codes includes the terms “bilateral” (e.g., code 27395; Lengthening of the hamstring tendon; multiple, bilateral) or “unilateral or bilateral” (e.g., code 52290; cystourethroscopy; with ureteral meatotomy, unilateral or bilateral). The payment adjustment rules for bilateral surgeries do not apply to procedures identified by CPT as “bilateral” or “unilateral or bilateral” since the fee schedule reflects any additional work required for bilateral surgeries. The Bilateral Surgery (“Bilat Surg”) column of the National Physician Fee Schedule Relative Value File indicates whether the bilateral payment adjustment rules apply to a surgical procedure.

(b) Billing Instructions for Bilateral Surgeries
(1) If a procedure is not identified by its terminology as a bilateral procedure (or unilateral or bilateral), report the procedure with modifier “-50.” (NOTE: This differs from the CPT coding guidelines which indicate that bilateral procedures should be billed as two line items.)

If a procedure is identified by the terminology as bilateral (or unilateral or bilateral), as in codes 27395 and 52290, do not report the procedure with modifier “-50”.

(A) If the Bilateral Surgery column of the National Physician Fee Schedule Relative Value File contains an indicator of “0,” “2,” or “3,” the payment

adjustment rules for bilateral surgeries do not apply. Payment is determined by the lower of the billed amount or 100 percent of the fee schedule amount unless other payment adjustment rules apply.

NOTE: Some codes which have a bilateral indicator of “0” in the Bilateral Surgery column may be performed more than once on a given day. These are services that would never be considered bilateral and thus should not be billed with modifier “-50.” Where such a code is billed on multiple line items or with more than 1 in the units field and the claims administrator has determined that the code may be reported more than once, bypass the “0” bilateral indicator and refer to the multiple surgery field for pricing.

(B) If Bilateral Surgery column of the National Physician Fee Schedule Relative Value File contains an indicator of “1,” the standard payment adjustment for bilateral procedures apply. Payment is determined by the lower of the billed amount or 150 percent of the fee schedule amount. (Multiply the payment amount for the surgery by 150 percent.)

(c) The global surgery rules are applicable to bilateral procedures.

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

§9789.16.7 Surgery – Co-surgeons and Team Surgeons.

(a) General

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

(b) Billing Instructions / Determination of Maximum Payment

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

(1) If two surgeons (each in a different specialty) are required to perform a specific procedure, each surgeon bills for the procedure with a modifier “-62.” Co-surgery also refers to surgical procedures involving two surgeons performing the parts of
the procedure simultaneously, i.e., heart transplant or bilateral knee replacements. Documentation of the medical necessity for two surgeons is required for certain services identified in the Co-Surgeons (“Co Surg”) column of the National Physician Fee Schedule Relative Value File. If the surgery is billed

with a “-62” modifier and the Co-Surgeons column contains an indicator of “1,” any documentation submitted with the claim should be reviewed to identify support for the need for co-surgeons. If the documentation supports the need for co-surgeons, base payment for each physician on the lower of the billed amount or 62.5 percent of the fee schedule amount. If the surgery is billed with a “-62” modifier and the Co-Surgeons column contains an indicator of “2,” payment rules for two surgeons apply. The claims administrator shall base payment for each physician on the lower of the billed amount or 62.5 percent of the fee schedule amount. If the surgery is billed with a “-62” modifier and the Co-Surgeons column contains an indicator of “0,” payment for co-surgeons is not allowed.

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

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

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

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

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

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

NOTE: A fee may have been established for some surgical procedures that are billed with the “-66” modifier. In these cases, all physicians on the team must agree on the percentage of the payment amount each is to receive. If the claims administrator receives a bill with a “-66” modifier after the claims administrator

has paid one surgeon the full payment amount (on a bill without the modifier), deny the subsequent claim.

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

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

§9789.16.8 Surgery – Assistants-at-Surgery.

For assistant-at-surgery services performed by physicians, the fee schedule amount equals 16 percent of the amount otherwise applicable for the surgical payment.

Procedures billed with the assistant-at-surgery physician modifiers -80, -81, -82, or the AS modifier for physician assistants, nurse practitioners and clinical nurse specialists, are
subject to the assistant-at-surgery policy.

If the Assistant at Surgery ("Asst Surg") column of the National Physician Fee Schedule Relative Value File contains an indicator of "0" the physician or non-physician practitioner must submit documentation to establish medical necessity for use of an assistant at surgery. If the Assistant at Surgery column contains an indicator of "1", assistant-at-surgery is not payable. If the Assistant at Surgery column contains indicator "2", the assistant at surgery may be paid.

Payment is not generally allowed for an assistant surgeon when payment for either two surgeons (modifier "-62") or team surgeons (modifier "-66") is appropriate.

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

§9789.17.1 Radiology Diagnostic Imaging Multiple Procedures

(a) Specified diagnostic imaging procedures are designated in the "Diagnostic Imaging Service Subject to the Multiple Procedure Payment Reduction (MPPR)" file of the CMS Physician Fee Schedule final rule, and in the CMS National Physician Fee Schedule Relative Value excel file, to indicate that the Multiple Procedure Payment Reduction (MPPR) shall be applied to the professional component (PC) and technical component (TC) of the procedure, when multiple services are furnished to the same patient, in the same session, on the same day, by one or more physicians in the same group practice. The MPPR shall apply to both PC-only services, TC-only services, and to the PC and TC of global services. If the procedure is reported in the same session, on the same day, and

furnished to the same patient, by one or more physicians in the same group practice (same Group National Provider Identifier (NPI)), the maximum reimbursement shall be determined as follows:

(1) Full payment is made for each PC and TC with the highest payment under the physician fee schedule.

(2) (A) For services rendered prior to March 1, 2017 payment is made at 75 percent for subsequent PC services furnished to the same patient, in the same session, on the same day, by one or more physicians in the same group practice (NPI).

(B) For services rendered on or after March 1, 2017, payment is made at 95 percent for subsequent PC services furnished to the same patient, in the same session, on the same day, by one or more physicians in the same group practice (NPI).

(3) Payment is made at 50 percent for subsequent TC services furnished to the same patient, in the same session, on the same day, by one or more physicians in the same group practice (NPI).

(4) The individual PC and TC services with the highest payments under the physician fee schedule of globally billed services must be determined in order to calculate the MPPR.

(b) See 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.

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

9789.17.2 Radiology Consultations

(a)(1) Only one interpretation of an x-ray procedure shall be reimbursed. This interpretation of an x-ray procedure must directly contribute to the diagnosis and treatment of the patient. The physician must prepare a signed written report of his or her interpretation of the results of the x-ray. The professional component of the x-ray procedure shall be paid using modifier -26. A professional component billing based on a *review* of the findings of these x-ray procedures, without a complete written report similar to that which would be prepared by a specialist in the field, does not meet the conditions for separate payment of the service.

(2) Reimbursement for a second interpretation shall only be allowed under unusual circumstances (for which documentation is provided), such as a

questionable finding for which the physician performing the initial interpretation believes another physician's expertise is needed or a changed diagnosis resulting from a second interpretation of the results of the procedure. This second interpretation shall be identified through the use of modifier "-77".

(b) Do not use CPT 76140 (consultation on X-ray examination made elsewhere, written report).

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

§9789.17.3 Additional Payment Reductions for Certain Diagnostic Imaging Services

(a) For services rendered on or after March 1, 2017, payment of X-ray imaging services that are taken using film is made at:
(1) 80 percent of a technical component-only service;
(2) 80 percent of the technical component of a global service.
Services for X-rays using film must be identified through the use of modifier "FX." For services subject to both the multiple procedure payment reduction (MPPR) set forth in section 9789.17.1, and the "FX" modifier reduction on imaging, the "FX" modifier reduction should be applied before the MPPR for radiology diagnostic imaging procedures.

(b) For services rendered on or after January 1, 2018, payment for imaging services that are X-rays taken using computed radiography is made at:
(1) 93 percent of a technical component-only service;
(2) 93 percent of the technical component of a global service.
Imaging services that are X-rays taken using computed radiography must be identified through the use of the modifier "FY." For services subject to both the multiple procedure payment reduction (MPPR) set forth in section 9789.17.1, and the "FY" modifier reduction on imaging, the "FY" modifier reduction should be applied before the MPPR for radiology diagnostic imaging procedures. Computed radiography technology is defined for purposes of this subdivision as cassette-based imaging which utilizes an imaging plate to create the image involved.

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

§ 9789.18.1 Payment for Anesthesia Services - General Payment Rule

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

§ 9789.18.2 Anesthesia - Personally Performed Rate

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

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

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

(c)The physician is involved in the training of physician residents in a single anesthesia case, two concurrent anesthesia cases involving residents or a single anesthesia case involving a resident that is concurrent to another case paid under the medical direction rules. The teaching anesthesiologist, or different anesthesiologists in the same anesthesia group, must be present during all critical or key portions of the anesthesia service or procedure involved. The teaching anesthesiologist (or another anesthesiologist with whom the teaching physician has entered into an arrangement) must be immediately available to furnish anesthesia services during the entire procedure. The documentation in the patient's medical records must indicate the teaching physician's presence during all critical or key portions of the anesthesia procedure and the immediate availability of another teaching anesthesiologist as necessary;

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

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

(f) The physician and the CRNA (or AA) are involved in one anesthesia case and the services of each are found to be medically necessary. Documentation must

be submitted by both the CRNA and the physician to support payment of the full fee for each of the two providers. The physician reports the “AA” modifier and the CRNA reports the “QZ” modifier for a nonmedically directed case.

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

§ 9789.18.3 Anesthesia - Medically Directed Rate

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

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

(2) Prescribes the anesthesia plan;

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

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

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

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

(7) Provides indicated-post-anesthesia care.

(b) The physician must participate only in the most demanding procedures of the anesthesia plan, including, if applicable, induction and emergence. The physician must document in the medical record that he or she performed the pre-anesthetic examination and evaluation. Physicians must also document that they provided indicated post-anesthesia care, were present during some portion of the anesthesia monitoring, and were present during the most demanding procedures, including induction and emergence, where indicated.

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

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

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

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

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

## §9789.18.4 Anesthesia - Definition of Concurrent Medically Directed Anesthesia Procedures

Concurrency is defined with regard to the maximum number of procedures that the physician is medically directing within the context of a single procedure and whether these other procedures overlap each other.

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

## §9789.18.5 Anesthesia - Medically Supervised Rate

Only three base units per procedure is allowed when the anesthesiologist is involved in furnishing more than four procedures concurrently or is performing other services while directing the concurrent procedures. An additional time unit may be recognized if the physician can document he or she was present at induction.

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

§9789.18.6 Anesthesia - Multiple Anesthesia Procedures

(a) Physicians and non-physician practitioners shall bill for the anesthesia services associated with multiple bilateral surgeries by reporting the anesthesia procedure with the highest base unit value with the multiple procedure modifier "-51." The total time for all procedures shall be reported in the line item with the highest base unit value.

(b) If the same anesthesia CPT code applies to two or more of the surgical procedures, billers enter the anesthesia code with the "-51" modifier and the number of surgeries to which the modified CPT code applies.

(c) Payment can be made under the fee schedule for anesthesia services associated with multiple surgical procedures or multiple bilateral procedures. 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.

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

§ 9789.18.7 Anesthesia - Medical and Surgical Services Furnished in Addition to Anesthesia Procedure

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. These services may be furnished in conjunction with the anesthesia procedure to the patient or may be furnished as single services, e.g., during the day of or the day before the anesthesia service. These services include the insertion of a Swan Ganz catheter, the insertion of central venous pressure lines, emergency intubation, and critical care visits.

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

§ 9789.18.8 Anesthesia -Time and Calculation of Anesthesia Time Units

(a) Anesthesia time is defined as the period during which an anesthesia practitioner is present with the patient. It starts when the anesthesia practitioner begins to prepare the patient for anesthesia services in the operating room or an equivalent area and ends when the anesthesia practitioner is no longer

furnishing anesthesia services to the patient, that is, when the patient may be placed safely under postoperative care. Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service. In counting anesthesia time, the anesthesia practitioner can add blocks of time around an interruption in anesthesia time as long as the anesthesia practitioner is furnishing continuous anesthesia care within the time periods around the interruption.

(b) Time units are computed by dividing the actual reported anesthesia time by 15 minutes. Round the time unit to one decimal place.

(c) Time units are not allowed for CPT code 01996.

For purposes of this section, “anesthesia practitioner” means a physician who performs the anesthesia service alone, a CRNA who is not medically directed, or a CRNA or AA, who is medically directed. The physician who medically directs the CRNA or AA would ordinarily report the same time as the CRNA or AA reports for the CRNA service.

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

§9789.18.9 Anesthesia - Base Unit Reduction for Concurrent Medically Directed Procedures

If the physician medically directs concurrent medically directed procedures, reduce the number of base units for each concurrent procedure as follows.

(a) For two concurrent procedures, the base unit on each procedure is reduced 10 percent.

(b) For three concurrent procedures, the base unit on each procedure is reduced 25 percent.

(c) For four concurrent procedures, the base on each concurrent procedure is reduced 40 percent.

(d) If the physician medically directs concurrent procedures and any of the concurrent procedures are cataract or iridectomy anesthesia, reduce the base units for each cataract or iridectomy procedure by 10 percent.

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

§9789.18.10 Anesthesia - Monitored Anesthesia Care

The physician or non-physician practitioner shall be reimbursed for reasonable and medically necessary monitored anesthesia care services on the same basis as other anesthesia services. Anesthesiologists use modifier QS to report

monitored anesthesia care cases. Monitored anesthesia care involves the intra-operative monitoring by a physician or qualified individual under the medical direction of a physician or of the patient's vital physiological signs in anticipation of the need for administration of general anesthesia or of the development of adverse physiological patient reaction to the surgical procedure. It also includes the performance of a pre-anesthetic examination and evaluation, prescription of the anesthesia care required, administration of any necessary oral or parenteral medications (e.g., atropine, demerol, valium) and provision of indicated postoperative anesthesia care. Payment is made under the fee schedule using the payment rules in section 9789.18.2 if the physician personally performs the monitored anesthesia care case or under the rules in section 9789.18.3 if the physician medically directs four or fewer concurrent cases and monitored anesthesia care represents one or more of these concurrent cases.

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

§9789.18.11 Anesthesia Claims Modifiers

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

Specific anesthesia modifiers include:

AA - Anesthesia Services performed personally by the anesthesiologist;

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

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

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

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

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

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

QY - Medical direction of one qualified non-physician anesthetist by an anesthesiologist;

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

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

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

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

(a) For services rendered before March 1, 2017, 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 (Summary of Codes that Include Moderate Conscious Sedation.)

(b) For services rendered before March 1, 2017, when a second physician other than the health care professional performing the diagnostic or therapeutic services provides moderate sedation in the facility setting for the procedures listed in Appendix G, the second physician may bill 99148 to 99150. When these services are performed by the second physician in the nonfacility setting, CPT codes 99148 to 99150 are not to be reported.

(c) If the anesthesiologist or CRNA provides anesthesia for diagnostic or therapeutic nerve blocks or injections and a different provider performs the block or injection, then the anesthesiologist or CRNA may report the anesthesia service using CPT code 01991. The service must meet the criteria for monitored anesthesia care. If the anesthesiologist or CRNA provides both the anesthesia service and the block or injection, then the anesthesiologist or CRNA may report the anesthesia service using the conscious sedation code and the injection or block. However, the anesthesia service must meet the requirements for conscious sedation and if a lower level complexity anesthesia service is provided, then the conscious sedation code shall not be reported.

(d) If the physician performing the medical or surgical procedure also provides a level of anesthesia lower in intensity than moderate or conscious sedation, such as a local or topical anesthesia, then the conscious sedation code shall not be reported and no payment shall be allowed. There is no CPT code for the performance of local anesthesia as payment for this service is considered to be bundled into the payment for the underlying medical or surgical service.

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

§ 9789.19 Update Table

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

| Document | Services Rendered On or After 1/1/2014 |
|---|---|
| Adjustment Factors (These factors have been incorporated into the conversion factors listed below) | For all services other than anesthesia:<br>2014 Total RVS adjustment factor: 1.0477<br>2014 RVU budget neutrality factor: 1.00046<br>2014 RVU rescaling adjustment factor: 1.04718<br>2014 Annual increase in the MEI: 1.008<br>2014 Cumulative adjustment factor: 1.0638<br><br>For anesthesia services:<br>2014 Total RVS adjustment factor: 1.0291<br>2014 RVU budget neutrality factor: 1.00046<br>2014 RVU rescaling adjustment factor: 1.04718<br>2014 anesthesia practice expense adjustment factor: 0.9823<br>2014 Annual increase in the MEI: 1.008<br>2014 Cumulative adjustment factor: 1.0449 |
| Anesthesia Base Units by CPT Code | 2014anesBASEfin |
| California-Specific Codes | WC001 – Not reimbursable<br>WC002 - $11.91<br>WC003 - $38.68 for first page<br>$23.80 each additional page. Maximum of six pages absent mutual agreement ($157.68)<br>WC004 - $38.68 for first page<br>$23.80 each additional page. Maximum of seven pages absent mutual agreement ($181.48)<br>WC005 - $38.68 for first page, $23.80 each additional page. Maximum of six pages absent mutual agreement ($157.68)<br>WC007 - $38.68 for first page<br>$23.80 each additional page. Maximum of six pages absent mutual agreement ($157.68)<br>WC008 - $10.26 for up to the first 15 pages. $0.25 for each additional page after the first 15 pages.<br>WC009 - $10.26 for up to the first 15 pages. $0.25 for each additional page after the first 15 pages.<br>WC010 - $5.13 per x-ray<br>WC011 - $10.26 per scan<br>WC012 - No Fee Prescribed/Non Reimbursable absent agreement |

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| CCI Edits:<br>Medically Unlikely Edits | For services rendered on or after 1/1/2014, use: "Practitioner Services MUE Table – Updated 10/1/2013."<br><br>For services rendered on or after 1/23/2014, use: "Practitioner Services MUE Table – Updated 1/1/2014."<br><br>For services rendered on or after 4/1/2014, use: "Practitioner Services MUE Table – Updated 4/1/2014."<br><br>For services rendered on or after 7/1/2014, use: "Practitioner Services MUE Table – Updated 7/1/2014."<br><br>For services rendered on or after 10/1/2014, use: "Practitioner Services MUE Table – Updated 10/1/2014."<br><br>Copies of the MUE Tables are posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm<br><br>CMS posts only the most recent version of the Practitioner Services MUE Table on the web at: http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html . |
| CCI Edits:<br>National Correct Coding Initiative Policy Manual for Medicare Services | NCCI Policy Manual for Medicare Services - Effective January 1, 2014 [ZIP, 749KB]<br><br>Copy of the 1/1/2014 Manual is posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm |
| CCI Edits:<br>Physician CCI Edits | For services rendered on or after January 1, 2014:<br>Physician CCI Edits v19.3 (819,852 records). The last row contains edit column 1 = 39599 and column 2 = 49570<br>Physician CCI Edits v19.3 (710,236 records). The first row contains edit column 1 = 40490 and column 2 = C8950<br><br>For services rendered on or after April 15, 2014: |

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| | Physician CCI Edits v20.1 effective April 1, 2014 (851,137 records). The last row contains edit column 1 = 39599 and column 2 = 49570<br><br>Physician CCI Edits v20.1 effective April 1, 2014 (744,393 records). The first row contains edit column 1 = 40490 and column 2 = C8950<br><br>For services rendered on or after July 1, 2014:<br><br>Physician CCI Edits v20.2 effective July 1, 2014 (863,712 records). The last row contains edit column 1 = 39599 and column 2 = 49570<br><br>Physician CCI Edits v20.2 effective July 1, 2014 (752,547 records). The first row contains edit column 1 = 40490 and column 2 = C8950<br><br>For services rendered on or after October 1, 2014:<br><br>Physician CCI Edits v20.3 effective October 1, 2014 (864,930 records). The last row contains edit column 1 = 39599 and column 2 = 49570<br><br>Physician CCI Edits v20.3 effective October 1, 2014 (756,576 records). The first row contains edit column 1 = 40490 and column 2 = C8950 |
| CMS' Medicare National Physician Fee Schedule Relative Value File [Zip] | For services rendered on or after January 1, 2014:<br>RVU14A [Zip]<br>• RVUPUF14 (Excluding Attachment A)<br>• PPRRVU14_V1219<br>• OPPSCAP_V1219<br>Excluding:<br>14LOCCO<br>ANES 2014_V0103<br>CY 2014 GPCI _12172013<br><br>For services rendered on or after April 15, 2014:<br>RVU14B [Zip]<br>• RVUPUF14 (Excluding Attachment A)<br>• PPRRVU14_V0324<br>• OPPSCAP_V0324<br>Excluding:<br>14LOCCO |

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| | ANES_2014_V0103<br>CY 2014 GPCI_12172013<br><br>For services rendered on or after July 1, 2014:<br>RVU14C [Zip 3MB]<br>• RVUPUF14 (Excluding Attachment A)<br>• PPRRVU14_V0515<br>• OPPSCAP_V0515<br>Excluding:<br>14LOCCO<br>ANES 2014_V0103<br>CY 2014 GPCI_12172013<br><br>For services rendered on or after October 1, 2014:<br>RVU14D [Zip 3MB]<br>• RVUPUF14 (Excluding Attachment A)<br>• PPRRVU14_V0815_v4<br>• OPPSCAP_V0815<br>Excluding:<br>14LOCCO<br>ANES 2014_V0103<br>CY 2014 GPCI_12172013 |
| CMS Pub 100-04 Medicare Claims Processing: Casting and Splint Supplies | For services rendered on or after 1/1/2014, use:<br>Transmittal 2837 (Change Request 8523)<br><br>For services rendered on or after 4/1/2014, use:<br>the OMFS Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS) Fee Schedule applicable to the date of service |
| Conversion Factors adjusted for MEI and Relative Value Scale adjustment factor, if any | Anesthesia Conversion Factor: $33.8190<br>Surgery Conversion Factor: $55.2913<br>Radiology Conversion Factor: $53.1039<br>Other Services Conversion Factor: $38.3542 |
| Current Procedural Terminology (CPT®) | CPT 2014<br>https://commerce.ama-assn.org/store/ |
| Current Procedural Terminology<br>CPT codes that shall not be used | Do not use CPT codes:<br>27215 (Use G0412 and Surgery CF)<br>27216 (Use G0413 and Surgery CF)<br>27217 (Use G0414 and Surgery CF)<br>27218 (Use G0415 and Surgery CF)<br>76140 (see §9789.17.2) |

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| | 80100 through 80104 (see clinical lab fee schedule, §9789.50)<br>90889 (See §9789.14. Use codeWC005 code)<br>97014 (Use G0283 and Other Services CF)<br>99075 (see Medical-Legal fee schedule, §9795)<br>99080 (see §9789.14)<br>99241 through 99245 (see §9789.12.12)<br>99251 through 99255 (see §9789.12.12)<br>99455 and 99456. |
| Diagnostic Cardiovascular Procedure CPT codes subject to the MPPR | For services rendered on or after January 1, 2014: RVU14A, PPRRVU14_V1219, Number "6" in Column labeled "Mult Proc" (Modifier 51) also Addendum I, Diagnostic Cardiovascular Services Subject to The Multiple Procedure Payment Reduction (MPPR) CY 2014 CMS 1600 FC: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1600-FC.html?DLPage=1&DLSort=3&DLSortDir=descending<br><br>For services rendered on or after April 15, 2014: RVU14B, PPRRVU14_V0324, Number "6" in Column labeled "Mult Proc" (Modifier 51) also Addendum I, Diagnostic Cardiovascular Services Subject to The Multiple Procedure Payment Reduction (MPPR) CY 2014 CMS 1600 FC<br><br>For services rendered on or after July 1, 2014: RVU14C, PPRRVU14_V0515, Number "6" in Column labeled "Mult Proc" (Modifier 51) also Addendum I, Diagnostic Cardiovascular Services Subject to The Multiple Procedure Payment Reduction (MPPR) CY 2014 CMS 1600 FC<br><br>For services rendered on or after October 1, 2014: RVU14D, PPRRVU14_V0815_v4, Number "6" in Column labeled "Mult Proc" (Modifier 51) also Addendum I, Diagnostic Cardiovascular Services Subject to The Multiple Procedure Payment Reduction (MPPR) CY 2014 CMS 1600 FC |

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

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| | Procedure Payment Reduction (MPPR) CY2014 CMS 1600 FC<br><br>For services rendered on or after October 1, 2014:<br>RVU14D, PPRRVU14_V0815_v4, column AB, labeled, "Diagnostic Imaging Family Indicator". Also Addendum F, Diagnostic Imaging Service Subject to the Multiple Procedure Payment Reduction (MPPR) CY2014 CMS 1600 FC |
| DWC Pharmaceutical Fee Schedule | http://www.dir.ca.gov/dwc/OMFS9904.htm#8 |
| Geographic Health Professional Shortage Area zip code data files | 2014 Primary Care HPSA [ZIP, 97KB]<br><br>2014 Mental Health HPSA [ZIP, 222KB] |
| Health Resources and Services Administration: Geographic HPSA shortage area query<br><br>(By State & County)<br><br>(By Address) | <br><br><br><br>http://hpsafind.hrsa.gov/<br><br>http://datawarehouse.hrsa.gov/geoHPSAAdvisor/GeographicHPSAAdvisor.aspx |
| Incident To Codes | For services rendered on or after January 1, 2014:<br>RVU14A, PPRRVU14_V1219, with PC/TC indicator number "5"<br><br>For services rendered on or after April 15, 2014:<br>RVU14B, PPRRVU14_V0324, with PC/TC indicator number "5"<br><br>For services rendered on or after July 1, 2014:<br>RVU14C, PPRRVU14_V0515, with PC/TC indicator number "5"<br><br>For services rendered on or after October 1, 2014:<br>RVU14D, PPRRVU14_V0815_v4, with PC/TC indicator number "5" |
| Medi-Cal Rates – DHCS | For services rendered on or after 1/1/2014, use:<br>Medi-Cal Rates file - Updated 12/15/2013 |

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| | For services rendered on or after 1/23/2014, use:<br>Medi-Cal Rates file - Updated 1/15/2014<br><br>For services rendered on or after 2/15/2014, use:<br>Medi-Cal Rates file - Updated 2/15/2014<br><br>For services rendered on or after 3/15/2014, use:<br>Medi-Cal Rates file - Updated 3/15/2014<br><br>For services rendered on or after 6/15/2014, use:<br>Medi-Cal Rates file - Updated 6/15/2014<br><br>For services rendered on or after 7/15/2014, use:<br>Medi-Cal Rates file - Updated 7/15/2014<br><br>For services rendered on or after 8/15/2014, use:<br>Medi-Cal Rates file - Updated 8/15/2014<br><br>For services rendered on or after 9/15/2014, use:<br>Medi-Cal Rates file - Updated 9/15/2014<br><br>For services rendered on or after 10/15/2014, use:<br>Medi-Cal Rates file - Updated 10/15/2014<br><br>For services rendered on or after 11/15/2014, use:<br>Medi-Cal Rates file - Updated 11/15/2014<br>For services rendered on or after 12/15/2014, use:<br>Medi-Cal Rates file - Updated 12/15/2014<br><br>For services rendered on or after 1/15/2015, use:<br>Medi-Cal Rates file - Updated 1/15/2015<br><br>For services rendered on or after 2/15/2015, use:<br>Medi-Cal Rates file - Updated 2/15/2015<br><br>Copies of the Medi-Cal Rates files (without CPT descriptors) are posted on the DWC website:<br>http://www.dir.ca.gov/dwc/OMFS9904.htm |
| Ophthalmology Procedure CPT codes subject to the MPPR | For services rendered on or after January 1, 2014: RVU14A, PPRRVU14_V1219, Number “7” in Column labeled “Multiple Procedure” (Modifier 51). Also Addendum J, Diagnostic Ophthalmology Services Subject to the Multiple Procedure Payment Reduction (MPPR) CY 2014 CMS 1600 FC |

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

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| | Multiple Procedure Payment Reduction (MPPR) CY 2014 CMS 1600 FC<br><br>In addition, CPT codes: 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943<br><br>For services rendered on or after October 1, 2014: RVU14D, PPRRVU14_V0815_v4 , Number “5” in Column labeled “Mult Proc”. Also Addendum H, Separately Payable Always Therapy Services Subject to the Multiple Procedure Payment Reduction (MPPR) CY 2014 CMS 1600 FC<br><br>In addition, CPT codes: 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943 |
| Physician Time | CY 2014 PFS Physician Time [ZIP, 504KB] |
| Radiology Diagnostic Imaging Multiple Procedures | For services rendered on or after January 1, 2014: RVU14A, PPRRVU14_V1219, number “4” in column S, labeled, “Mult Proc”<br><br>For services rendered on or after April 15, 2014: RVU14B, PPRRVU14_V0324 , number “4” in column S, labeled, “Mult Proc”<br><br>For services rendered on or after July 1, 2014: RVU14C, PPRRVU14_V0515 , number “4” in column S, labeled, “Mult Proc”<br>For services rendered on or after October 1, 2014: RVU14D, PPRRVU14_V0815_v4 , number “4” in column S, labeled, “Mult Proc” |
| Statewide GAFs (Other than anesthesia) | Average Statewide Work GAF: 1.040<br>Average Statewide Practice Expense GAF: 1.1606<br>Average Statewide Malpractice Expense GAF: 0.6636 |
| Statewide GAF (Anesthesia) | Average Statewide Anesthesia GAF: 1.0313 |
| The 1995 Documentation Guidelines for Evaluation & Management Services | https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf |

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

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

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

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

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

| Document/Data | Services Rendered On or After March 1, 2015 & Mid-year Updates |
|---|---|
| | Practitioner PTP Edits v21.2 effective July 1, 2015 (821,537 records). The first row contains edits column 1 = 40490 and column 2 = 00170<br><br>For services rendered on or after October 1, 2015:<br><br>Practitioner PTP Edits v21.3 effective October 1, 2015 (880,855 records). The last row contains edits column 1 = 39599 and column 2 = 49570<br><br>Practitioner PTP Edits v21.3 effective October 1, 2015 (832,093 records). The first row contains edits column 1 = 40490 and column 2 = 00170<br><br>Access the Physician CCI Edits on the CMS website: http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html<br><br>Note: the Physician CCI Edits excel file maintained by CMS contains effective date and deletion date (if any) for each column 1/column 2 pair. Therefore, the most recent file is the only file posted on the CMS website, and covers all time periods. |
| CMS' Medicare National Physician Fee Schedule Relative Value File [Zip] | For services rendered on or after March 1, 2015:<br>RVU15A (Updated 01/08/15) [ZIP, 2MB]<br>• RVUPUF15 (Excluding Attachment A)<br>• PPRRVU15_V1223c<br>• OPPSCAP_V1223<br>Excluding:<br>15LOCCO<br>ANES 2015_V122314<br>CY2015_GPCIs<br>For services rendered on or after May 1, 2015:<br>RVU15B [ZIP, 3MB]<br>• RVUPUF15 (Excluding Attachment A)<br>• PPRRVU15_V0213_Current<br>• OPPSCAP_V0217<br>Excluding:<br>15LOCCO<br>Anes_2015_122314<br>Anes_Conv_122314_fmt |

| Document/Data | Services Rendered On or After March 1, 2015 & Mid-year Updates |
|---|---|
| | CY2015_GPCIs<br><br>For services rendered on or after July 1, 2015:<br>RVU15C [ZIP, 5MB] (Except the 0.5% update is not adopted)<br>• RVUPUF15 (Excluding Attachment A)<br>• PPRRVU15_UP05_V0622<br>• OPPSCAP_UP05_V0619<br>Excluding:<br>15LOCCO<br>Anes_2015_122314<br>ANES_2015_UP05_V0701<br>CY2015_GPCIs<br>PPRRVU15_UP0.V0515<br>OPPSCAP_UP0_V0515<br><br>For services rendered on or after October 1, 2015:<br>RVU15D [ZIP, 5MB] (Except the 0.5% update is not adopted)<br>• RVUPUF15 (Excluding Attachment A)<br>• PPRRVU15_OCT05_V1001<br>• OPPSCAP_UP05_V0815<br>Excluding:<br>15LOCCO<br>Anes_2015_122314<br>ANES_2015_UP05_V0701<br>CY2015_GPCIs<br>OPPSCAP_UP0_V0815<br>PPRRVU15_OCT_V1001 |
| Conversion Factors adjusted for MEI and Relative Value Scale adjustment factor | Anesthesia Conversion Factor: $31.5290<br>Surgery Conversion Factor: $51.6570<br>Radiology Conversion Factor: $50.1900<br>Other Services Conversion Factor: $40.2970 |
| Current Procedural Terminology (CPT®) | CPT 2015<br>https://commerce.ama-assn.org/store/ |
| Current Procedural Terminology<br>CPT codes that shall not be used | Do not use CPT codes:<br>27215 (Use G0412 and Surgery CF)<br>27216 (Use G0413 and Surgery CF)<br>27217 (Use G0414 and Surgery CF)<br>27218 (Use G0415 and Surgery CF) |

| Document/Data | Services Rendered On or After March 1, 2015 & Mid-year Updates |
|---|---|
| | 76140 (see §9789.17.2)<br>90889 (See §9789.14. Use codeWC005 code)<br>97014 (Use G0283 and Other Services CF)<br>99075 (see Medical-Legal fee schedule, §9795)<br>99080 (see §9789.14)<br>99241 through 99245 (see §9789.12.12)<br>99251 through 99255 (see §9789.12.12)<br>99455 and 99456. |
| Diagnostic Cardiovascular Procedure CPT codes subject to the MPPR | For services rendered on or after March 1, 2015: RVU15A, PPRRVU15_V1223c, Number "6" in Column labeled "Mult Proc" (Modifier 51), also listed in CY 2015 PFS Final Rule Multiple Procedure Payment Reduction Files [Zip, 44KB], in the document CY_2015_PFS_1612-F_ Diagnostic Cardiovascular Services Subject To the Multiple Procedure Payment Reduction (MPPR)<br><br>For services rendered on or after May 1, 2015: RVU15B, PPRRVU15_V0213_Current, Number "6" in Column labeled "Mult Proc" (Modifier 51), also listed in CY 2015 PFS Final Rule Multiple Procedure Payment Reduction Files [Zip, 44KB], in the document CY_2015_PFS_1612-F_ Diagnostic Cardiovascular Services Subject To the Multiple Procedure Payment Reduction (MPPR)<br><br>For services rendered on or after July 1, 2015: RVU15C, PPRRVU15_UP05_V0622, Number "6" in Column labeled "Mult Proc" (Modifier 51), also listed in CY 2015 PFS Final Rule Multiple Procedure Payment Reduction Files [Zip, 44KB], in the document CY_2015_PFS_1612-F_ Diagnostic Cardiovascular Services Subject To the Multiple Procedure Payment Reduction (MPPR)<br><br>For services rendered on or after October 1, 2015: RVU15D, PPRRVU15_OCT05_V1001, Number "6" in Column labeled "Mult Proc" (Modifier 51), also listed in CY 2015 PFS Final Rule Multiple Procedure Payment Reduction Files [Zip, 44KB], in the document |

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

| Document/Data | Services Rendered On or After March 1, 2015 & Mid-year Updates |
|---|---|
| | RVU15B, PPRRVU15_V0213_Current, number “88” in column AB, labeled, “Diagnostic Imaging Family Indicator”, also listed in CY 2015 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 44KB], in the document CY_2015_PFS_1612-F_Diagnostic Imaging Services Subject To the Multiple Procedure Payment Reduction (MPPR)<br><br>For services rendered on or after July 1, 2015: RVU15C, PPRRVU15_UP05_V0622, number “88” in column AB, labeled, “Diagnostic Imaging Family Indicator”, also listed in CY 2015 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 44KB], in the document CY_2015_PFS_1612-F_Diagnostic Imaging Services Subject To the Multiple Procedure Payment Reduction (MPPR)<br><br>For services rendered on or after October 1, 2015: RVU15D, PPRRVU15_OCT05_V1001, number “88” in column AB, labeled, “Diagnostic Imaging Family Indicator”, also listed in CY 2015 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 44KB], in the document CY_2015_PFS_1612-F_Diagnostic Imaging Services Subject To the Multiple Procedure Payment Reduction (MPPR) |
| Diagnostic Imaging Multiple Procedures Subject to the MPPR | For services rendered on or after March 1, 2015: RVU15A, PPRRVU15_V1223c, number “4” in column S, labeled, “Mult Proc”, also listed in CY 2015 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 44KB], in the document CY_2015_PFS_1612-F_Diagnostic Imaging Services Subject To the Multiple Procedure Payment Reduction (MPPR)<br><br>For services rendered on or after May 1, 2015: RVU15B, PPRRVU15_V0213_Current, number “4” in column S, labeled, “Mult Proc”, also listed in CY 2015 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 44KB], in the document CY_2015_PFS_1612-F_Diagnostic Imaging Services Subject To the Multiple Procedure Payment Reduction (MPPR)<br>For services rendered on or after July 1, 2015: |

| Document/Data | Services Rendered On or After March 1, 2015 & Mid-year Updates |
|---|---|
| | RVU15C, PPRRVU15_UP05_V0622, number "4" in column S, labeled, "Mult Proc", also listed in CY 2015 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 44KB], in the document CY_2015_PFS_1612-F_Diagnostic Imaging Services Subject To the Multiple Procedure Payment Reduction (MPPR)<br><br>For services rendered on or after October 1, 2015: RVU15D, PPRRVU15_OCT05_V1001, number "4" in column S, labeled, "Mult Proc", also listed in CY 2015 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 44KB], in the document CY_2015_PFS_1612-F_Diagnostic Imaging Services Subject To the Multiple Procedure Payment Reduction (MPPR) |
| DWC Pharmaceutical Fee Schedule | http://www.dir.ca.gov/dwc/OMFS9904.htm#8 |
| Geographic Health Professional Shortage Area zip code data files | 2015 Primary Care HPSA [ZIP, 88KB]<br>2015 Mental Health HPSA [ZIP, 185KB] |
| Health Resources and Services Administration: Geographic HPSA shortage area query<br><br>(By State & County)<br><br>(By Address) | <br><br><br><br>http://hpsafind.hrsa.gov/<br><br>http://datawarehouse.hrsa.gov/geoHPSAAdvisor/GeographicHPSAAdvisor.aspx |
| Incident To Codes | For services rendered on or after March 1, 2015: RVU15A, PPRRVU15_V1223c, with PC/TC indicator number "5"<br><br>For services rendered on or after May 1, 2015: RVU15B, PPRRVU15_V0213_Current, with PC/TC indicator number "5"<br><br>For services rendered on or after July 1, 2015: |

| Document/Data | Services Rendered On or After March 1, 2015 & Mid-year Updates |
|---|---|
| | RVU15C, PPRRVU15_UP05_V0622, with PC/TC indicator number "5"<br><br>For services rendered on or after October 1, 2015: RVU15D, PPRRVU15_OCT05_V1001, with PC/TC indicator number "5" |
| Medi-Cal Rates – DHCS | Pursuant to section 9789.13.2, the Medi-Cal Rates file's "Basic Rate" is used in calculating maximum fee for physician-administered drugs, biologicals, vaccines or blood products, by date of service.<br><br>For services rendered on or after March 1, 2015, use: Medi-Cal Rates file - Updated 2/15/2015<br><br>For services rendered on or after March 15, 2015, use: Medi-Cal Rates file - Updated 3/15/2015<br><br>For services rendered on or after April 15, 2015, use: Medi-Cal Rates file - Updated 4/15/2015<br><br>For services rendered on or after May 15, 2015, use: Medi-Cal Rates file - Updated 5/15/2015<br><br>For services rendered on or after June 15, 2015, use: Medi-Cal Rates file - Updated 6/15/2015<br><br>For services rendered on or after July 15, 2015, use: Medi-Cal Rates file - Updated 7/15/2015<br><br>For services rendered on or after August 15, 2015, use: Medi-Cal Rates file - Updated 8/15/2015<br><br>For services rendered on or after September 15, 2015, use:<br>Medi-Cal Rates file - Updated 9/15/2015<br><br>For services rendered on or after October 15, 2015, use:<br>Medi-Cal Rates file - Updated 10/15/2015<br><br>For services rendered on or after November 15, 2015, use: |

| Document/Data | Services Rendered On or After March 1, 2015 & Mid-year Updates |
|---|---|
| | Medi-Cal Rates file - Updated 11/15/2015<br><br>For services rendered on or after December 15, 2015, use:<br>Medi-Cal Rates file - Updated 12/15/2015<br><br>Copies of the Medi-Cal Rates files (without CPT descriptors) are posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm |
| Ophthalmology Procedure CPT codes subject to the MPPR | For services rendered on or after March 1, 2015: RVU15A, PPRRVU15_V1223c, Number "7" in Column labeled "Mult Proc" (Modifier 51). Also listed in CY 2015 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 44KB], in the document CY_2015_PFS_1612-F Diagnostic Ophthalmology Services Subject to the Multiple Procedure Payment Reduction (MPPR)<br><br>For services rendered on or after May 1, 2015: RVU15B, PPRRVU15_V0213_Current, Number "7" in Column labeled "Mult Proc" (Modifier 51). Also listed in CY 2015 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 44KB], in the document CY_2015_PFS_1612-F Diagnostic Ophthalmology Services Subject to the Multiple Procedure Payment Reduction (MPPR)<br><br>For services rendered on or after July 1, 2015: RVU15C, PPRRVU15_UP05_V0622, Number "7" in Column labeled "Mult Proc" (Modifier 51). Also listed in CY 2015 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 44KB], in the document CY_2015_PFS_1612-F Diagnostic Ophthalmology Services Subject to the Multiple Procedure Payment Reduction (MPPR)<br><br>For services rendered on or after October 1, 2015: RVU15D, PPRRVU15_OCT05_V1001, Number "7" in Column labeled "Mult Proc" (Modifier 51). Also listed in CY 2015 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 44KB], in the document CY_2015_PFS_1612-F Diagnostic Ophthalmology |

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

| Document/Data | Services Rendered On or After March 1, 2015 & Mid-year Updates |
|---|---|
| | In addition, CPT codes: 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943 |
| Physician Time | CY 2015 PFS Final Rule Physician Time Updated 01/20/15 [ZIP 478KB] |
| Statewide GAFs (Other than anesthesia) | Average Statewide Work GAF: 1.0420<br>Average Statewide Practice Expense GAF: 1.1621<br>Average Statewide Malpractice Expense GAF: 0.7388 |
| Statewide GAF (Anesthesia) | Average Statewide Anesthesia GAF: 1.0391 |
| Splints and Casting Supplies | For services rendered on or after March 1, 2015, use:<br><br>The OMFS Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS) Fee Schedule applicable to the date of service. |
| The 1995 Documentation Guidelines for Evaluation & Management Services | https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf |
| The 1997 Documentation Guidelines for Evaluation and Management Services | https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf. |

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

| Document/Data | Services Rendered On or After January 1, 2016 & Mid-year Updates |
|---|---|
| Adjustment Factors (These factors have been incorporated into the conversion factors listed below) | For services rendered on or after January 1, 2016:<br><br>For all services other than anesthesia:<br>2016 Cumulative adjustment factor: 1.0818<br>2016 RVU budget neutrality adjustment factor: 0.9998 |

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

| Document/Data | Services Rendered On or After January 1, 2016 & Mid-year Updates |
|---|---|
| | WC005 - $39.42 for first page, $24.25 each additional page. Maximum of six pages absent mutual agreement ($160.69)<br>WC007 - $39.42 for first page<br>$24.25 each additional page. Maximum of six pages absent mutual agreement ($160.69)<br>WC008 - $10.45 for up to the first 15 pages. $0.25 for each additional page after the first 15 pages.<br>WC009 - $10.45 for up to the first 15 pages. $0.25 for each additional page after the first 15 pages.<br>WC010 - $5.23 per x-ray<br>WC011 - $10.45 per scan<br>WC012 - No Fee Prescribed/Non Reimbursable absent agreement |
| CCI Edits:<br>Medically Unlikely Edits | For services rendered on or after January 1, 2016, use: "Practitioner Services MUE Table – Effective 1/1/2016."<br><br>For services rendered on or after April 1, 2016, use: "Practitioner Services MUE Table – Effective 4/1/2016."<br><br>For services rendered on or after July 1, 2016, use: "Practitioner Services MUE Table – Effective 7/1/2016."<br><br>For services rendered on or after October 1, 2016, use: "Practitioner Services MUE Table – Effective 10/1/2016."<br><br>Copies of the MUE Tables are posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm<br><br>CMS posts only the most recent version of the Practitioner Services MUE Table on the web at: http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html |
| CCI Edits:<br>National Correct Coding Initiative Policy Manual for Medicare Services | For services rendered on or after January 1, 2016: "NCCI Policy Manual for Medicare Services - Effective January 1, 2016 [ZIP, 761MB] "<br><br>Copy of the 2016 Manual is posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm#7 |

| Document/Data | Services Rendered On or After January 1, 2016 & Mid-year Updates |
|---|---|
| | |
| CCI Edits:<br>Physician CCI Edits<br>(Practitioner PTP Edits) | For services rendered on or after January 1, 2016:<br><br>Practitioner PTP Edits v22.0 effective January 1, 2016 (903,287 records). The last row contains edits column 1 = 39599 and column 2 = 49570<br><br>Practitioner PTP Edits v22.0 effective January 1, 2016 (866,823 records). The first row contains edits column 1 = 40490 and column 2 = 00170<br><br>For services rendered on or after April 1, 2016:<br><br>Practitioner PTP Edits v22.1 effective April 1, 2016 (914,985 records ). The last row contains edits column 1 = 39599 and column 2 = 49570<br><br>Practitioner PTP Edits v22.1 effective April 1, 2016 (877,109 records ). The first row contains edits column 1 = 40490 and column 2 = 00170<br><br>For services rendered on or after July 1, 2016:<br><br>Practitioner PTP Edits v22.2 effective July 1, 2016 (915,436 records). The last row contains edits column 1 = 39599 and column 2 = 49570<br><br>Practitioner PTP Edits v22.2 effective July 1, 2016 (877,847 records). The first row contains edits column 1 = 40490 and column 2 = 00170<br><br>For services rendered on or after October 1, 2016:<br><br>Practitioner PTP Edits v22.3 effective October 1, 2016 (668,511 records) 0001M/36591 – 29999/G0354<br><br>Practitioner PTP Edits v22.3 effective October 1, 2016 (498,018 records) 30000/0213T - 49999/49570 |

| Document/Data | Services Rendered On or After January 1, 2016 & Mid-year Updates |
|---|---|
| | Practitioner PTP Edits v22.3 effective October 1, 2016 (489,682 records) 50010/0213T - 79999/90784<br><br>Practitioner PTP Edits v22.3 effective October 1, 2016 (179,162 records) 80003/80002 – R0075/R0070<br><br>Access the Physician CCI Edits on the CMS website: http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html<br><br>Note: the Physician CCI Edits excel file maintained by CMS contains effective date and deletion date (if any) for each column 1/column 2 pair. Therefore, the most recent file is the only file posted on the CMS website, and covers all time periods. |
| CMS' Medicare National Physician Fee Schedule Relative Value File [Zip] | For services rendered on or after January 1, 2016:<br>RVU16A (Released January 2016) [ZIP, 3MB]<br>• RVUPUF16 (Excluding Attachment A)<br>• PPRRVU16_V0122<br>• OPPSCAP_V0105<br>Excluding:<br>16LOCCO<br>ANES_V0105<br>CY2016_GPCIs<br><br>For services rendered on or after April 1, 2016:<br>RVU16B (April 2016 release) [ZIP, 3MB]<br>• RVUPUF16 (Excluding Attachment A)<br>• PPRRVU16_April_V0202<br>• OPPSCAP_V0215<br>Excluding:<br>16LOCCO<br>ANES_V0105<br>CY2016_GPCIs<br><br>For services rendered on or after July 1, 2016:<br>RVU16C (July 2016 release) [ZIP, 3MB]<br>• RVUPUF16 (Excluding Attachment A) |

| Document/Data | Services Rendered On or After January 1, 2016 & Mid-year Updates |
|---|---|
| | • PPRRVU16_V0517<br>• OPPSCAP_V0515<br>Excluding:<br>16LOCCO<br>ANES_V0105<br>CY2016_GPCIs<br><br>For services rendered on or after October 1, 2016:<br>RVU16D [ZIP, 3MB]<br>• RVUPUF16 (Excluding Attachment A)<br>• PPRRVU16_V0804<br>• OPPSCAP_V0815<br>Excluding:<br>16LOCCO<br>ANES_V0105<br>CY2016_GPCIs |
| Conversion Factors adjusted for MEI and Relative Value Scale adjustment factor | For services rendered on or after January 1, 2016:<br><br>Anesthesia Conversion Factor: $29.3852<br>Surgery Conversion Factor: $48.2013<br>Radiology Conversion Factor: $47.4598<br>Other Services Conversion Factor: $42.4599<br><br>For services rendered on or after April 1, 2016:<br><br>Anesthesia Conversion Factor: $28.8003<br>Surgery Conversion Factor: $48.1743<br>Radiology Conversion Factor: $47.4332<br>Other Services Conversion Factor: $42.4361 |
| Current Procedural Terminology (CPT®) | CPT 2016<br>https://commerce.ama-assn.org/store/ |
| Current Procedural Terminology<br>CPT codes that shall not be used | Do not use CPT codes:<br>27215 (Use G0412 and Surgery CF)<br>27216 (Use G0413 and Surgery CF)<br>27217 (Use G0414 and Surgery CF)<br>27218 (Use G0415 and Surgery CF)<br>76140 (see §9789.17.2) |

| Document/Data | Services Rendered On or After January 1, 2016 & Mid-year Updates |
|---|---|
| | 90889 (See §9789.14. Use codeWC005 code)<br>97014 (Use G0283 and Other Services CF)<br>99075 (see Medical-Legal fee schedule, §9795)<br>99080 (see §9789.14)<br>99241 through 99245 (see §9789.12.12)<br>99251 through 99255 (see §9789.12.12)<br>99455 and 99456 |
| Diagnostic Cardiovascular Procedure CPT codes subject to the MPPR | For services rendered on or after January 1, 2016: RVU16A, PPRRVU16_V0122, Number "6" in column S, labeled "Mult Proc" (Modifier 51), also listed in CY 2016 PFS Final Rule Multiple Procedure Payment Reduction Files [Zip, 39KB], in the document CMS-1631-FC_Diagnostic Cardiovascular Services Subject to MPPR<br><br>For services rendered on or after April 1, 2016: RVU16B, PPRRVU16_April_V0202, Number "6" in column S, labeled "Mult Proc" (Modifier 51), also listed in CY 2016 PFS Final Rule Multiple Procedure Payment Reduction Files [Zip, 39KB], in the document CMS-1631-FC_Diagnostic Cardiovascular Services Subject to MPPR<br><br>For services rendered on or after July 1, 2016: RVU16C, PPRRVU16_V0517, Number "6" in column S, labeled "Mult Proc" (Modifier 51), also listed in CY 2016 PFS Final Rule Multiple Procedure Payment Reduction Files [Zip, 39KB], in the document CMS-1631-FC_Diagnostic Cardiovascular Services Subject to MPPR<br><br>For services rendered on or after October 1, 2016: RVU16D, PPRRVU16_V0804, Number "6" in column S, labeled "Mult Proc" (Modifier 51), also listed in CY 2016 PFS Final Rule Multiple Procedure Payment Reduction Files [Zip, 39KB], in the document CMS-1631-FC_Diagnostic Cardiovascular Services Subject to MPPR |

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

| Document/Data | Services Rendered On or After January 1, 2016 & Mid-year Updates |
|---|---|
| | in the document CMS-1631-FC_Diagnostic Imaging Services Subject to MPPR<br><br>For services rendered on or after July 1, 2016: RVU16C, PPRRVU16_V0517, number “88” in column AB, labeled, “Diagnostic Imaging Family Indicator”, also listed in CY 2016 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 39KB], in the document CMS-1631-FC_Diagnostic Imaging Services Subject to MPPR<br><br>For services rendered on or after October 1, 2016: RVU16D, PPRRVU16_V0804, number “88” in column AB, labeled, “Diagnostic Imaging Family Indicator”, also listed in CY 2016 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 39KB], in the document CMS-1631-FC_Diagnostic Imaging Services Subject to MPPR |
| Diagnostic Imaging Multiple Procedures Subject to the MPPR | For services rendered on or after January 1, 2016: RVU16A, PPRRVU16_V0122, number “4” in column S, labeled, “Mult Proc”, also listed in CY 2016 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 39KB], in the document CMS-1631-FC_Diagnostic Imaging Services Subject to MPPR<br><br>For services rendered on or after April 1, 2016: RVU16B, PPRRVU16_April_V0202, number “4” in column S, labeled, “Mult Proc”, also listed in CY 2016 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 39KB], in the document CMS-1631-FC_Diagnostic Imaging Services Subject to MPPR<br><br>For services rendered on or after July 1, 2016: RVU16C, PPRRVU16_V0517, number “4” in column S, labeled, “Mult Proc”, also listed in CY 2016 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 39KB], in the document CMS-1631-FC_Diagnostic Imaging Services Subject to MPPR<br><br>For services rendered on or after October 1, 2016: |

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

| Document/Data | Services Rendered On or After January 1, 2016 & Mid-year Updates |
|---|---|
| | RVU16D, PPRRVU16_V0804, number “5” in column N, labeled, “PCTC IND”, (PC/TC Indicator) |
| Medi-Cal Rates – DHCS | Pursuant to section 9789.13.2, the Medi-Cal Rates file’s “Basic Rate” is used in calculating maximum fee for physician-administered drugs, biologicals, vaccines or blood products, by date of service.<br><br>For services rendered on or after January 1, 2016, use:<br>Medi-Cal Rates file - Updated 12/15/2015<br><br>For services rendered on or after January 15, 2016, use:<br>Medi-Cal Rates file - Updated 1/15/2016<br><br>For services rendered on or after February 15, 2016, use:<br>Medi-Cal Rates file - Updated 2/15/2016<br><br>For services rendered on or after March 15, 2016, use:<br>Medi-Cal Rates file - Updated 3/15/2016<br><br>For services rendered on or after April 15, 2016, use:<br>Medi-Cal Rates file - Updated 4/15/2016<br>For services rendered on or after May 15, 2016, use:<br>Medi-Cal Rates file - Updated 5/15/2016<br><br>For services rendered on or after June 15, 2016, use:<br>Medi-Cal Rates file - Updated 6/15/2016<br><br>For services rendered on or after July 15, 2016, use:<br>Medi-Cal Rates file - Updated 7/15/2016<br><br>For services rendered on or after August 15, 2016, use:<br>Medi-Cal Rates file - Updated 8/15/2016<br><br>For services rendered on or after September 15, 2016, use:<br>Medi-Cal Rates file - Updated 9/15/2016<br><br>For services rendered on or after October 15, 2016, use:<br>Medi-Cal Rates file - Updated 10/15/2016 |

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

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

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

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

| Document/Data | Services Rendered On or After March 1, 2017 & Mid-year Updates |
|---|---|
| Adjustment Factors (These factors have been incorporated into the | For services rendered on or after March 1, 2017:<br>For all services other than anesthesia:<br>2017 Cumulative adjustment factor: 1.0933 |

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

| Document/Data | Services Rendered On or After March 1, 2017 & Mid-year Updates |
|---|---|
| | Copies of the MUE Tables are posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm<br><br>For services rendered on or after April 1, 2017, use: "Practitioner Services MUE Table – Effective 4/1/2017." Copies of the MUE Tables are posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm<br><br>For services rendered on or after July 1, 2017, use: "Practitioner Services MUE Table – Effective 7/1/2017." Copies of the MUE Tables are posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm<br><br>For services rendered on or after October 1, 2017, use: "Practitioner Services MUE Table – Effective 10/1/2017."<br>Copies of the MUE Tables are posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm<br><br>CMS posts only the most recent version of the Practitioner Services MUE Table on the web at: http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html |
| CCI Edits:<br>National Correct Coding Initiative Policy Manual for Medicare Services | For services rendered on or after March 1, 2017:<br>"NCCI Policy Manual for Medicare Services - Effective January 1, 2017 [ZIP, 770KB]"<br><br>Copy of the 2017 Manual is posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm#7 |
| CCI Edits:<br>Physician CCI Edits (Practitioner PTP Edits) | For services rendered on or after March 1, 2017:<br>Practitioner PTP Edits v23.0 effective January 1, 2017 (422,052 records) 0001M/36591 – 24940/G0471<br>Practitioner PTP Edits v23.0 effective January 1, 2017 (574,135 records) 25000/01810 – 39599/49570<br>Practitioner PTP Edits v23.0 effective January 1, 2017 (436,857 records) 40490/00170 – 59897/G0347<br>Practitioner PTP Edits v23.0 effective January 1, 2017 (501,820 records) 60000/0213T – R0075/R0070 |

| Document/Data | Services Rendered On or After March 1, 2017 & Mid-year Updates |
|---|---|
| | For services rendered on or after April 1, 2017:<br>Practitioner PTP Edits v23.1 effective April 1, 2017 (474,500 records) 0001M/36591 – 25931/G0471<br>Practitioner PTP Edits v23.1 effective April 1, 2017 (502,046 records) 26010/01810 – 36909/J2001<br>Practitioner PTP Edits v23.1 effective April 1, 2017 (495,097 records) 37140/0213T – 60650/G0471<br>Practitioner PTP Edits v23.1 effective April 1, 2017 (501,223 records) 61000/0213T – R0075/R0070<br><br>For services rendered on or after July 1, 2017:<br>Practitioner PTP Edits v23.2 effective July 1, 2017 (476,159 records) 0001M/36591 – 25931/G0471 [ZIP, 13MB]<br>Practitioner PTP Edits v23.2 effective July 1, 2017 (502,166 records) 26010/01810 – 36909/J2001 [ZIP, 13MB]<br>Practitioner PTP Edits v23.2 effective July 1, 2017 (495,291 records) 37140/0213T – 60650/G0471 [ZIP, 13MB]<br>Practitioner PTP Edits v23.2 effective July 1, 2017 (503,693 records) 61000/0213T – R0075/R0070 [ZIP, 13MB]<br><br>For services rendered on or after October 1, 2017:<br>Practitioner PTP Edits v23.3 effective October 1, 2017 (476,064 records) 0001M/36591 – 25931/G0471<br>Practitioner PTP Edits v23.3 effective October 1, 2017 (502,759 records) 26010/01810 – 36909/J2001<br>Practitioner PTP Edits v23.3 effective October 1, 2017 (495,446 records) 37140/0213T – 60650/G0471<br>Practitioner PTP Edits v23.3 effective October 1, 2017 (504,589 records) 61000/0213T – R0075/R0070<br><br>Access the Physician CCI Edits on the CMS website: http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html |

| Document/Data | Services Rendered On or After March 1, 2017 & Mid-year Updates |
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| | Note: the Physician CCI Edits excel file maintained by CMS contains effective date and deletion date (if any) for each column 1/column 2 pair. Therefore, the most recent file is the only file posted on the CMS website, and covers all time periods. |
| CMS' Medicare National Physician Fee Schedule Relative Value File [Zip] | For services rendered on or after March 1, 2017:<br>RVU17A (January 2017 release) [ZIP, 3MB]<br>• RVU17A (Excluding Attachment A)<br>• PPRRVU17_V1219<br>• OPPSCAP_V1219<br>Excluding:<br>17LOCCO<br>ANES_V0101<br>CY2017_GPCIs<br><br>For services rendered on or after April 1, 2017:<br>RVU17B [ZIP, 3MB]<br>• RVU17B (Excluding Attachment A)<br>• PPRRVU17_V0209<br>• OPPSCAP_V0215<br>Excluding:<br>17LOCCO<br>ANES_V0101<br>CY2017_GPCIs<br><br>For services rendered on or after July 1, 2017:<br>RVU17C [ZIP, 3MB]<br>• RVU17C (Excluding Attachment A)<br>• PPRRVU17_JULY_V0503<br>• OPPSCAP_V0515<br>Excluding:<br>17LOCCO<br>ANES_V0101<br>CY2017_GPCIs<br><br>For services rendered on or after October 1, 2017:<br>RVU17D [ZIP, 3MB]<br>• RVUPUF17 (Excluding Attachment A)<br>• PPRRVU17_OCT<br>• OPPSCAP_OCT |

| Document/Data | Services Rendered On or After March 1, 2017 & Mid-year Updates |
|---|---|
| | Excluding:<br>17LOCCO<br>ANES_OCT<br>CY2017_GPCIs |
| Conversion Factors adjusted for MEI and Relative Value Scale adjustment factor | For services rendered on or after March 1, 2017:<br><br>Anesthesia Conversion Factor: $26.8011<br>Other Services Conversion Factor: $44.6572 |
| Current Procedural Terminology (CPT®) | CPT 2017<br>https://commerce.ama-assn.org/store/ |
| Current Procedural Terminology<br>CPT codes that shall not be used | Do not use CPT codes:<br>27215 (Use G0412)<br>27216 (Use G0413)<br>27217 (Use G0414)<br>27218 (Use G0415)<br>76140 (see §9789.17.2)<br>90889 (See §9789.14. Use codeWC005 code)<br>97014 (Use G0283)<br>99075 (see Medical-Legal fee schedule, §9795)<br>99080 (see §9789.14)<br>99241 through 99245 (see §9789.12.12)<br>99251 through 99255 (see §9789.12.12)<br>99455 and 99456 |
| Diagnostic Cardiovascular Procedure CPT codes subject to the MPPR | For services rendered on or after March 1, 2017:<br>RVU17A, PPRRVU17_V1219, Number “6” in column S, labeled “Mult Proc” (Modifier 51), also listed in CY 2017 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 42KB], in the document CMS-1654-F_Diagnostic Cardiovascular Services Subject to MPPR<br><br>For services rendered on or after April 1, 2017:<br>RVU17B, PPRRVU17_V0209, Number “6” in column S, labeled “Mult Proc” (Modifier 51), also listed in CY 2017 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 42KB], in the document CMS-1654-F_Diagnostic Cardiovascular Services Subject to MPPR<br><br>For services rendered on or after July 1, 2017:<br>RVU17C, PPRRVU17_JULY_V0503, Number “6” in column S, labeled “Mult Proc” (Modifier 51), also listed |

| Document/Data | Services Rendered On or After March 1, 2017 & Mid-year Updates |
|---|---|
| | in CY 2017 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 42KB], in the document CMS-1654-F_Diagnostic Cardiovascular Services Subject to MPPR<br><br>For services rendered on or after October 1, 2017: RVU17D, PPRRVU17_OCT, Number "6" in column S, labeled "Mult Proc" (Modifier 51), also listed in CY 2017 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 42KB], in the document CMS-1654-F_Diagnostic Cardiovascular Services Subject to MPPR |
| Diagnostic Imaging Family Indicator Description | For services rendered on or after March 1, 2017:<br>Diagnostic Imaging Family Indicator:<br>88 = Subject to the reduction<br>99 = Concept does not apply<br>RVU17A, RVU17A (PDF document)<br><br>For services rendered on or after April 1, 2017:<br>Diagnostic Imaging Family Indicator:<br>88 = Subject to the reduction<br>99 = Concept does not apply<br>RVU17B, RVU17B (PDF document)<br><br>For services rendered on or after July 1, 2017:<br>Diagnostic Imaging Family Indicator:<br>88 = Subject to the reduction<br>99 = Concept does not apply<br>RVU17C, RVU17C (PDF document)<br><br>For services rendered on or after October 1, 2017:<br>Diagnostic Imaging Family Indicator:<br>88 = Subject to the reduction<br>99 = Concept does not apply<br>RVU17D, RVUPUF17 (PDF document) |

| Document/Data | Services Rendered On or After March 1, 2017 & Mid-year Updates |
|---|---|
| Diagnostic Imaging Family Procedures Subject to the MPPR | For services rendered on or after March 1, 2017: RVU17A, PPRRVU17_V1219, number "88" in column AB, labeled, "Diagnostic Imaging Family Indicator", also listed in CY 2017 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 42KB], in the document CMS-1654-F _Diagnostic Imaging Services Subject to MPPR<br><br>For services rendered on or after April 1, 2017: RVU17B, PPRRVU17_V0209, number "88" in column AB, labeled, "Diagnostic Imaging Family Indicator", also listed in CY 2017 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 42KB], in the document CMS-1654-F _Diagnostic Imaging Services Subject to MPPR<br><br>For services rendered on or after July 1, 2017: RVU17C, PPRRVU17_JULY_V0503, number "88" in column AB, labeled, "Diagnostic Imaging Family Indicator", also listed in CY 2017 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 42KB], in the document CMS-1654-F _Diagnostic Imaging Services Subject to MPPR<br><br>For services rendered on or after October 1, 2017: RVU17D, PPRRVU17_OCT, number "88" in column AB, labeled, "Diagnostic Imaging Family Indicator," also listed in CY 2017 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 42KB], in the document CMS-1654-F _Diagnostic Imaging Services Subject to MPPR |
| Diagnostic Imaging Multiple Procedures Subject to the MPPR | For services rendered on or after March 1, 2017: RVU17A, PPRRVU17_V1219, number "4" in column S, labeled, "Mult Proc", also listed in CY 2017 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 42KB], in the document CMS-1654-F_Diagnostic Imaging Services Subject to MPPR<br><br>For services rendered on or after April 1, 2017: RVU17B, PPRRVU17_V0209, number "4" in column S, labeled, "Mult Proc", also listed in CY 2017 PFS Final |

| Document/Data | Services Rendered On or After March 1, 2017 & Mid-year Updates |
|---|---|
| | Rule Multiple Procedure Payment Reduction File [Zip, 42KB], in the document CMS-1654-F_Diagnostic Imaging Services Subject to MPPR<br><br>For services rendered on or after July 1, 2017: RVU17C, PPRRVU17_JULY_V0503, number "4" in column S, labeled, "Mult Proc", also listed in CY 2017 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 42KB], in the document CMS-1654-F_Diagnostic Imaging Services Subject to MPPR<br><br>For services rendered on or after October 1, 2017: RVU17D, PPRRVU17_OCT, number "4" in column S, labeled, "Mult Proc," also listed in CY 2017 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 42KB], in the document CMS-1654-F_Diagnostic Imaging Services Subject to MPPR |
| DWC Pharmaceutical Fee Schedule | http://www.dir.ca.gov/dwc/OMFS9904.htm#8 |
| Geographic Health Professional Shortage Area zip code data files | 2017 Primary Care HPSA [ZIP, 99KB]<br>2017 Mental Health HPSA [ZIP, 237KB]<br><br>Access the files on the CMS website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses/index.html?redirect=/hpsapsaphysicianbonuses/ |
| Health Resources and Services Administration: Geographic HPSA shortage area query<br><br>(By State & County)<br><br>(By Address) | <br><br><br><br>http://hpsafind.hrsa.gov/<br><br>http://datawarehouse.hrsa.gov/geoHPSAAdvisor/GeographicHPSAAdvisor.aspx |
| Incident To Codes | For services rendered on or after March 1, 2017: RVU17A, PPRRVU17_V1219, number "5" in column N, labeled, "PCTC IND", (PC/TC Indicator) |

| Document/Data | Services Rendered On or After March 1, 2017 & Mid-year Updates |
|---|---|
| | For services rendered on or after April 1, 2017: RVU17B, PPRRVU17_V0209, number “5” in column N, labeled, “PCTC IND”, (PC/TC Indicator)<br><br>For services rendered on or after July 1, 2017: RVU17C, PPRRVU17_JULY_V0503, number “5” in column N, labeled, “PCTC IND”, (PC/TC Indicator)<br><br>For services rendered on or after October 1, 2017: RVU17D, PPRRVU17_OCT, number “5” in column N, labeled, “PCTC IND,” (PC/TC Indicator) |
| Medi-Cal Rates – DHCS | Pursuant to section 9789.13.2, the Medi-Cal Rates file’s “Basic Rate” is used in calculating maximum fee for physician-administered drugs, biologicals, vaccines or blood products, by date of service.<br><br>For services rendered on or after March 1, 2017 use: Medi-Cal Rates file - Updated 2/15/2017<br><br>For services rendered on or after March 15, 2017, use: Medi-Cal Rates file - Updated 3/15/2017<br><br>For services rendered on or after April 15, 2017, use: Medi-Cal Rates file - Updated 4/15/2017<br><br>For services rendered on or after May 15, 2017, use: Medi-Cal Rates file – Updated 5/15/2017<br><br>For services rendered on or after June 15, 2017, use: Medi-Cal Rates file – Updated 6/15/2017<br><br>For services rendered on or after July 15, 2017, use: Medi-Cal Rates file – Updated 7/15/2017<br><br>For services rendered on or after August 15, 2017, use: Medi-Cal Rates file – Updated 8/15/2017<br><br>For services rendered on or after September 15, 2017, use:<br>Medi-Cal Rates file – Updated 9/15/2017 |

| Document/Data | Services Rendered On or After March 1, 2017 & Mid-year Updates |
|---|---|
| | For services rendered on or after October 15, 2017, use:<br>Medi-Cal Rates file – Updated 10/15/2017<br><br>For services rendered on or after November 15, 2017, use:<br>Medi-Cal Rates file – Updated 11/15/2017<br><br>For services rendered on or after December 15, 2017, use:<br>Medi-Cal Rates file – Updated 12/15/2017<br><br>Copies of the Medi-Cal Rates files (without CPT descriptors) are posted on the DWC website:<br>http://www.dir.ca.gov/dwc/OMFS9904.htm |
| Ophthalmology Procedure CPT codes subject to the MPPR | For services rendered on or after March 1, 2017: RVU17A, PPRRVU17_V1219, Number "7" in column S, labeled "Mult Proc" (Modifier 51). Also listed in CY 2017 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 42KB], in the CMS-1654-F_Diagnostic Ophthalmology Services Subject to MPPR<br><br>For services rendered on or after April 1, 2017: RVU17B, PPRRVU17_V0209, Number "7" in column S, labeled "Mult Proc" (Modifier 51). Also listed in CY 2017 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 42KB], in the CMS-1654-F_Diagnostic Ophthalmology Services Subject to MPPR<br><br>For services rendered on or after July 1, 2017: RVU17C, PPRRVU17_JULY_V0503, Number "7" in column S, labeled "Mult Proc" (Modifier 51). Also listed in CY 2017 PFS Final Rule Multiple Procedure Payment Reduction File [Zip, 42KB], in the CMS-1654-F_Diagnostic Ophthalmology Services Subject to MPPR<br><br>For services rendered on or after October 1, 2017: RVU17D, PPRRVU17_OCT, Number "7" in column S, labeled "Mult Proc" (Modifier 51). Also listed in CY 2017 PFS Final Rule Multiple Procedure Payment Reduction |

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

| Document/Data | Services Rendered On or After March 1, 2017 & Mid-year Updates |
|---|---|
| Physician Time | CY 2017 PFS Final Rule Physician Time [ZIP, 628KB] |
| Statewide GAFs (Other than anesthesia) | Average Statewide Work GAF: 1.0417<br>Average Statewide Practice Expense GAF: 1.1632<br>Average Statewide Malpractice Expense GAF: 0.6632 |
| Statewide GAF (Anesthesia) | Average Statewide Anesthesia GAF: 1.0374 |
| Splints and Casting Supplies | For services rendered on or after March 1, 2017, use:<br><br>The OMFS Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS) Fee Schedule applicable to the date of service. |
| The 1995 Documentation Guidelines for Evaluation & Management Services | https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf |
| The 1997 Documentation Guidelines for Evaluation and Management Services | https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf |

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

| Document/Data | Services Rendered On or After January 1, 2018 & Mid-year Updates |
|---|---|
| Adjustment Factors (These factors have been incorporated into the conversion factors listed below) | For services rendered on or after January 1, 2018:<br><br>For all services other than anesthesia:<br>2018 Cumulative adjustment factor: 1.1075<br>2018 RVU budget neutrality adjustment factor: 0.9990<br>2018 Annual increase in the MEI: 1.014<br>2017 Cumulative “other than anesthesia” adjustment: 1.0933<br><br>For anesthesia services:<br>2018 Cumulative anesthesia adjustment factor: 1.0604<br>2018 RVU budget neutrality adjustment factor: 0.9990 |

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

| Document/Data | Services Rendered On or After January 1, 2018 & Mid-year Updates |
|---|---|
| | "Practitioner Services MUE Table – Effective 07-01-2018 [ZIP, 346KB]," excluding all codes listed with Practitioner Services MUE Value of "0" (zero).<br>Excerpts of the MUE Table are posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm<br><br>For services rendered on or after October 1, 2018, use: "Practitioner Services MUE Table – Effective 10-01-2018 [ZIP, 348KB]," excluding all codes listed with Practitioner Services MUE Value of "0" (zero).<br>Excerpts of the MUE Table are posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm |
| CCI Edits:<br>National Correct Coding Initiative Policy Manual for Medicare Services | For services rendered on or after January 1, 2018:<br>"NCCI Policy Manual for Medicare Services - Effective January 1, 2018 [ZIP, 851KB]"<br><br>Copy of the 2018 Manual is posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm#7 |
| CCI Edits:<br>Practitioner Procedure to Procedure (PTP) Edits | For services rendered on or after January 1, 2018:<br>Practitioner PTP Edits v24.0 effective January 1, 2018 (511,599 records) 0001M/36591 – 25931/G0471<br>Practitioner PTP Edits v24.0 effective January 1, 2018 (507,927 records) 26010/01810 – 36909/J2001<br>Practitioner PTP Edits v24.0 effective January 1, 2018 (474,903 records) 37140/0213T – 60650/G0471<br>Practitioner PTP Edits v24.0 effective January 1, 2018 (514,837 records) 61000/0213T – R0075/R0070<br><br>For services rendered on or after April 1, 2018:<br>Practitioner PTP Edits v24.1 effective April 1, 2018 (537,183 records) 0001M/36591 – 25931/G0471<br>Practitioner PTP Edits v24.1 effective April 1, 2018 (482,358 records) 26010/01810 – 36909/J2001<br>Practitioner PTP Edits v24.1 effective April 1, 2018 (523,111 records) 37140/0213T – 60650/G0471 |

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

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

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

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

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

| Document/Data | Services Rendered On or After January 1, 2018 & Mid-year Updates |
|---|---|
| | in the document CMS-1676-F_Diagnostic Imaging Services Subject to MPPR |
| DWC Pharmaceutical Fee Schedule | http://www.dir.ca.gov/dwc/OMFS9904.htm#8 |
| Geographic Health Professional Shortage Area zip code data files | 2018 Primary Care HPSA [ZIP, 98KB]<br>2018 Mental Health HPSA [ZIP, 218KB]<br><br>Access the files on the CMS website:<br>https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses/index.html?redirect=/hpsapsaphysicianbonuses/ |
| Health Resources and Services Administration: Geographic HPSA shortage area query<br><br>(By State & County)<br><br>(By Address) | http://hpsafind.hrsa.gov/<br>http://datawarehouse.hrsa.gov/geoHPSAAdvisor/GeographicHPSAAdvisor.aspx |
| Incident To Codes | For services rendered on or after January 1, 2018:<br>RVU18A, PPRRVU18_JAN, number “5” in column N, labeled, “PCTC IND,” (PC/TC Indicator)<br><br>For services rendered on or after April 1, 2018:<br>RVU18B, PPRRVU18_APR, number “5” in column N, labeled, “PCTC IND,” (PC/TC Indicator)<br><br>For services rendered on or after July 1, 2018:<br>RVU18C1, PPRRVU18_JUL, number “5” in column N, labeled, “PCTC IND,” (PC/TC Indicator)<br><br>For services rendered on or after October 1, 2018:<br>RVU18D, PPRRVU18_OCT, number “5” in column N, labeled, “PCTC IND,” (PC/TC Indicator) |

| Document/Data | Services Rendered On or After January 1, 2018 & Mid-year Updates |
|---|---|
| Medi-Cal Rates – DHCS | Pursuant to section 9789.13.2, the Medi-Cal Rates file's "Basic Rate" is used in calculating maximum fee for physician-administered drugs, biologicals, vaccines or blood products, by date of service.<br><br>For services rendered on or after January 1, 2018, use:<br>Medi-Cal Rates file - Updated 12/15/2017<br><br>For services rendered on or after January 15, 2018, use:<br>Medi-Cal Rates file - Updated 1/15/2018<br><br>For services rendered on or after February 15, 2018, use:<br>Medi-Cal Rates file - Updated 2/15/2018<br><br>For services rendered on or after March 15, 2018, use:<br>Medi-Cal Rates file - Updated 3/15/2018<br><br>For services rendered on or after April 15, 2018, use:<br>Medi-Cal Rates file - Updated 4/15/2018<br>For services rendered on or after May 15, 2018, use:<br>Medi-Cal Rates file - Updated 5/15/2018<br><br>For services rendered on or after June 15, 2018, use:<br>Medi-Cal Rates file - Updated 6/15/2018<br><br>For services rendered on or after July 15, 2018, use:<br>Medi-Cal Rates file - Updated 7/15/2018<br><br>For services rendered on or after August 15, 2018, use:<br>Medi-Cal Rates file - Updated 8/15/2018<br><br>For services rendered on or after September 15, 2018, use:<br>Medi-Cal Rates file - Updated 9/15/2018<br><br>For services rendered on or after October 15, 2018, use:<br>Medi-Cal Rates file - Updated 10/15/2018<br><br>For services rendered on or after November 15, 2018, use:<br>Medi-Cal Rates file - Updated 11/15/2018 |

| Document/Data | Services Rendered On or After January 1, 2018 & Mid-year Updates |
|---|---|
| | For services rendered on or after December 15, 2018, use:<br>Medi-Cal Rates file - Updated 12/15/2018<br><br>Copies of the Medi-Cal Rates files (without CPT descriptors) are posted on the DWC website:<br>http://www.dir.ca.gov/dwc/OMFS9904.htm |
| Ophthalmology Procedure CPT codes subject to the MPPR | For services rendered on or after January 1, 2018:<br>RVU18A, PPRRVU18_JAN, number "7" in column S, labeled "Mult Proc" (Modifier 51). Also listed in CY 2018 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 42KB], in the document CMS-1676-F_Diagnostic Ophthalmology Services Subject to MPPR<br><br>For services rendered on or after April 1, 2018:<br>RVU18B, PPRRVU18_APR, number "7" in column S, labeled "Mult Proc" (Modifier 51). Also listed in CY 2018 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 42KB], in the document CMS-1676-F_Diagnostic Ophthalmology Services Subject to MPPR<br><br>For services rendered on or after July 1, 2018:<br>RVU18C1, PPRRVU18_JUL, number "7" in column S, labeled "Mult Proc" (Modifier 51). Also listed in CY 2018 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 42KB], in the document CMS-1676-F_Diagnostic Ophthalmology Services Subject to MPPR<br><br>For services rendered on or after October 1, 2018:<br>RVU18D, PPRRVU18_OCT, number "7" in column S, labeled "Mult Proc" (Modifier 51). Also listed in CY 2018 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 42KB], in the document CMS-1676-F_Diagnostic Ophthalmology Services Subject to MPPR |
| Physical Therapy Multiple Procedure Payment Reduction: "Always Therapy" Codes; and | For services rendered on or after January 1, 2018:<br>RVU18A, PPRRVU18_JAN, number "5" in column S, labeled "Mult Proc." Also listed in CY 2018 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 42KB], |

| Document/Data | Services Rendered On or After January 1, 2018 & Mid-year Updates |
|---|---|
| Acupuncture and Chiropractic Codes | in the document CMS-1676-F_Separately Payable Therapy Services Subject to MPPR<br><br>In addition, CPT codes: 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943<br><br>For services rendered on or after April 1, 2018: RVU18B, PPRRVU18_APR, number "5" in column S, labeled "Mult Proc." Also listed in CY 2018 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 42KB], in the document CMS-1676-F_Separately Payable Therapy Services Subject to MPPR<br><br>In addition, CPT codes: 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943<br><br>For services rendered on or after July 1, 2018: RVU18C1, PPRRVU18_JUL, number "5" in column S, labeled "Mult Proc." Also listed in CY 2018 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 42KB], in the document CMS-1676-F_Separately Payable Therapy Services Subject to MPPR<br><br>In addition, CPT codes: 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943<br>For services rendered on or after October 1, 2018: RVU18D, PPRRVU18_OCT, number "5" in column S, labeled "Mult Proc." Also listed in CY 2018 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 42KB], in the document CMS-1676-F_Separately Payable Therapy Services Subject to MPPR<br>In addition, CPT codes: 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943 |
| Physician Time | CY 2018 PFS Final Rule Physician Time [ZIP, 591KB] |
| Statewide GAFs (Other than anesthesia) | Average Statewide Work GAF: 1.041<br>Average Statewide Practice Expense GAF: 1.166<br>Average Statewide Malpractice Expense GAF: 0.605 |
| Statewide GAF (Anesthesia) | Average Statewide Anesthesia GAF: 1.034 |
| Splints and Cast | For services rendered on or after January 1, 2018, use: |

| Document/Data | Services Rendered On or After January 1, 2018 & Mid-year Updates |
|---|---|
| ing Supplies | The OMFS Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS) Fee Schedule applicable to the date of service. |
| The 1995 Documentation Guidelines for Evaluation & Management Services | https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf |
| The 1997 Documentation Guidelines for Evaluation and Management Services | https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf |

(f) Services Rendered On or After January 1, 2019. Documents listed in the following table are incorporated by reference and will be made available upon request to the Administrative Director.

| Document/Data | Services Rendered On or After January 1, 2019 & Mid-year Updates |
|---|---|
| Adjustment Factors (These factors have been incorporated into the conversion factors listed below) | For all services other than anesthesia:<br>2019 Cumulative adjustment factor: 1.1226<br>2019 RVU budget neutrality adjustment factor: 0.9986<br>2019 Annual increase in the MEI: 1.015<br>2018 Cumulative "other than anesthesia" adjustment: 1.1075<br>For anesthesia services:<br>2019 Cumulative anesthesia adjustment factor: 1.0777<br>2019 RVU budget neutrality adjustment factor: 0.9986<br>2019 Annual increase in the MEI: 1.015<br>2019 Anesthesia practice expense and malpractice adjustment factor: 1.0027<br>2018 Cumulative anesthesia adjustment: 1.0604 |
| Anesthesia Base Units by CPT Code | cms1676f_cy_2018_anesthesia_base_units.xlsx |
| California-Specific Codes | WC001 – Not reimbursable<br>WC002 - $12.65<br>WC003 - $41.06 for first page<br>$25.25 each additional page. Maximum of six pages absent mutual agreement ($167.31)<br>WC004 - $41.06 for first page |

| Document/Data | Services Rendered On or After January 1, 2019 & Mid-year Updates |
|---|---|
| | $25.25 each additional page. Maximum of seven pages absent mutual agreement ($192.56)<br>WC005 - $41.06 for first page, $25.25 each additional page. Maximum of six pages absent mutual agreement ($167.31)<br>WC007 - $41.06 for first page<br>$25.25 each additional page. Maximum of six pages absent mutual agreement ($167.31)<br>WC008 - $10.89 for up to the first 15 pages. $0.25 for each additional page after the first 15 pages.<br>WC009 - $10.89 for up to the first 15 pages. $0.25 for each additional page after the first 15 pages.<br>WC010 - $5.44 per x-ray<br>WC011 - $10.89 per scan<br>WC012 - No Fee Prescribed/Non Reimbursable absent agreement |
| CCI Edits:<br>Medically Unlikely Edits | For services rendered on or after January 1, 2019, use: "Practitioner Services MUE Table - Effective 01-01-2019 [ZIP, 350KB]," excluding all codes listed with Practitioner Services MUE Value of "0" (zero).<br><br>For services rendered on or after April 1, 2019, use: "Practitioner Services MUE Table – Effective 04-01-2019 [ZIP, 351KB]," excluding all codes listed with Practitioner Services MUE Value of "0" (zero).<br><br>For services rendered on or after July 1, 2019, use: "Practitioner Services MUE Table – Effective 07-01-2019 [ZIP, 354KB]," excluding all codes listed with Practitioner Services MUE Value of "0" (zero).<br><br>For services rendered on or after October 1, 2019, use: "Practitioner Services MUE Table – Effective 10-01-2019 [ZIP, 354KB]," excluding all codes listed with Practitioner Services MUE Value of "0" (zero).<br><br>Excerpts of the MUE Tables are posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm#7 |

| Document/Data | Services Rendered On or After January 1, 2019 & Mid-year Updates |
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| CCI Edits:<br>National Correct Coding Initiative Policy Manual for Medicare Services | "NCCI Policy Manual for Medicare Services - Effective January 1, 2019 [ZIP, 1MB]"<br><br>Copy of the 2019 Manual is posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm#7 |
| CCI Edits:<br>Practitioner Procedure to Procedure (PTP) Edits | For services rendered on or after January 1, 2019:<br>Practitioner PTP Edits v25.0 effective January 1, 2019 (556,965 records) 0001M/36591 – 26992/G0471<br>Practitioner PTP Edits v25.0 effective January 1, 2019 (489,643 records) 27000/01995 – 37790/G0471<br>Practitioner PTP Edits v25.0 effective January 1, 2019 (529,244 records) 38100/0213T – 61888/G0471<br>Practitioner PTP Edits v25.0 effective January 1, 2019 (483,364 records) : 62000/0213T – R0075/R0070<br><br>For services rendered on or after April 1, 2019:<br>Practitioner PTP Edits v25.1 effective April 1, 2019 (556,965 records) 0001M/36591 – 26992/G0471<br>Practitioner PTP Edits v25.1 effective April 1, 2019 (489,643 records) 27000/01995 – 37790/G0471<br>Practitioner PTP Edits v25.1 effective April 1, 2019 (529,244 records) 38100/0213T – 61888/G0471<br>Practitioner PTP Edits v25.1 effective April 1, 2019 (483,364 records) : 62000/0213T – R0075/R0070<br><br>For services rendered on or after July 1, 2019:<br>Practitioner PTP Edits v25.2 effective July 1, 2019 (561,060 records) 0001M/36591 – 26992/G0471<br>Practitioner PTP Edits v25.2 effective July 1, 2019 (491,324 records) 27000/01995 – 37799/96523<br>Practitioner PTP Edits v25.2 effective July 1, 2019 (531,167 records) 38100/0213T – 61888/G0471<br>Practitioner PTP Edits v25.2 effective July 1, 2019 (489,591 records) : 62000/0213T – R0075/R0070<br><br>For services rendered on or after October 1, 2019: |

| Document/Data | Services Rendered On or After January 1, 2019 & Mid-year Updates |
|---|---|
| | Practitioner PTP Edits v25.3 effective October 1, 2019 (561,144 records) 0001M/36591 – 26992/G0471<br>Practitioner PTP Edits v25.3 effective October 1, 2019 (491,337 records) 27000/01995 – 37799/96523<br>Practitioner PTP Edits v25.3 effective October 1, 2019 (531,167 records) 38100/0213T – 61888/G0471<br>Practitioner PTP Edits v25.3 effective October 1, 2019 (489,612 records) : 62000/0213T – R0075/R0070<br><br>Access the Practitioner PTP Edits on the CMS website: http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html<br><br>Note: the Practitioner PTP Edits excel file maintained by CMS contains effective date and deletion date (if any) for each column 1/column 2 pair. Therefore, the most recent file is the only file posted on the CMS website, and covers all time periods. |
| CMS' Medicare National Physician Fee Schedule Relative Value File [Zip] | For services rendered on or after January 1, 2019:<br>RVU19A (updated file 12/20/18) [ZIP, 3MB]<br>• RVU19A (Excluding Attachment A)<br>• PPRRVU19_V1213<br>• OPPSCAP_Jan<br>• 19LOCCO<br>• GPCI2019<br>Excluding:<br>ANES2019<br><br>For services rendered on or after April 1, 2019:<br>RVU19B [ZIP, 3MB]<br>• RVU19B (Excluding Attachment A)<br>• PPRRVU19_APR<br>• OPPSCAP_APR<br>• 19LOCCO<br>• GPCI2019<br>Excluding:<br>ANES2019<br><br>For services rendered on or after July 1, 2019: |

| Document/Data | Services Rendered On or After January 1, 2019 & Mid-year Updates |
|---|---|
| | RVU19C [ZIP, 3MB]<br>• RVU19C (Excluding Attachment A)<br>• PPRRVU19_JUL<br>• OPPSCAP_JUL<br>• 19LOCCO<br>• GPCI2019<br>Excluding:<br>ANES2019<br><br>For services rendered on or after October 1, 2019:<br>RVU19D [ZIP, 3MB]<br>• RVU19D (Excluding Attachment A)<br>• PPRRVU19_OCT<br>• OPPSCAP_OCT<br>• 19LOCCO<br>• GPCI2019<br>Excluding:<br>ANES2019<br><br>Access the Relative Value File on the CMS website:<br>https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html |
| Conversion Factors adjusted for MEI and Relative Value Scale adjustment factor | Anesthesia Conversion Factor: $27.6859<br><br>Other Services Conversion Factor: $45.8513 |
| Current Procedural Terminology (CPT®) | CPT 2019<br>https://commerce.ama-assn.org/store/ |
| Current Procedural Terminology<br>CPT codes that shall not be used | Do not use CPT codes:<br>27215 (Use G0412)<br>27216 (Use G0413)<br>27217 (Use G0414)<br>27218 (Use G0415)<br>76140 (see §9789.17.2)<br>90889 (See §9789.14. Use codeWC005 code) |

| Document/Data | Services Rendered On or After January 1, 2019 & Mid-year Updates |
|---|---|
| | 97014 (Use G0283)<br>97127 (Use G0515)<br>99075 (see Medical-Legal fee schedule, §9795)<br>99080 (see §9789.14)<br>99241 through 99245 (see §9789.12.12)<br>99251 through 99255 (see §9789.12.12)<br>99455 and 99456 |
| Diagnostic Cardiovascular Procedure CPT codes subject to the MPPR | For services rendered on or after January 1, 2019: RVU19A, PPRRVU19_V1213, number "6" in column S, labeled "Mult Proc" (Modifier 51), also listed in CY 2019 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 61KB], in the document CMS-1693-F_Diagnostic Cardiovascular Services Subject to MPPR<br><br>For services rendered on or after April 1, 2019: RVU19B, PPRRVU19_APR, number "6" in column S, labeled "Mult Proc" (Modifier 51), also listed in CY 2019 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 61KB], in the document CMS-1693-F_Diagnostic Cardiovascular Services Subject to MPPR<br><br>For services rendered on or after July 1, 2019: RVU19C, PPRRVU19_JUL, number "6" in column S, labeled "Mult Proc" (Modifier 51), also listed in CY 2019 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 61KB], in the document CMS-1693-F_Diagnostic Cardiovascular Services Subject to MPPR<br><br>For services rendered on or after October 1, 2019: RVU19D, PPRRVU19_OCT, number "6" in column S, labeled "Mult Proc" (Modifier 51), also listed in CY 2019 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 61KB], in the document CMS-1693-F_Diagnostic Cardiovascular Services Subject to MPPR |
| Diagnostic Imaging Family Indicator Description | For services rendered on or after January 1, 2019:<br>Diagnostic Imaging Family Indicator:<br>88 = Subject to the reduction<br>99 = Concept does not apply<br>RVU19A, RVU19 (PDF document) |

| Document/Data | Services Rendered On or After January 1, 2019 & Mid-year Updates |
|---|---|
| | For services rendered on or after April 1, 2019:<br>Diagnostic Imaging Family Indicator:<br>88 = Subject to the reduction<br>99 = Concept does not apply<br>RVU19B, RVU19B (PDF document)<br><br>For services rendered on or after July 1, 2019:<br>Diagnostic Imaging Family Indicator:<br>88 = Subject to the reduction<br>99 = Concept does not apply<br>RVU19C, RVU19C (PDF document)<br><br>For services rendered on or after October 1, 2019:<br>Diagnostic Imaging Family Indicator:<br>88 = Subject to the reduction<br>99 = Concept does not apply<br>RVU19D, PPRRVU19_OCT (PDF document) |
| Diagnostic Imaging Family Procedures Subject to the MPPR | For services rendered on or after January 1, 2019:<br>RVU19A, PPRRVU19_V1213, number “88” in column AB, labeled, “Diagnostic Imaging Family Indicator,” also listed in CY 2019 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 61KB], in the document CMS-1693-F_Diagnostic Imaging Services Subject to MPPR<br><br>For services rendered on or after April 1, 2019:<br>RVU19B, PPRRVU19_APR, number “88” in column AB, labeled, “Diagnostic Imaging Family Indicator,” also listed in CY 2019 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 61KB], in the document CMS-1693-F_Diagnostic Imaging Services Subject to MPPR<br><br>For services rendered on or after July l, 2019:<br>RVU19C, PPRRVU19_JUL, number “88” in column AB, labeled, “Diagnostic Imaging Family Indicator,” also listed in CY 2019 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 61KB], in the document CMS-1693-F_Diagnostic Imaging Services Subject to MPPR |

| Document/Data | Services Rendered On or After January 1, 2019 & Mid-year Updates |
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| | For services rendered on or after October l, 2019: RVU19D, PPRRVU19_OCT, number “88” in column AB, labeled, “Diagnostic Imaging Family Indicator,” also listed in CY 2019 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 61KB], in the document CMS-1693-F_Diagnostic Imaging Services Subject to MPPR |
| Diagnostic Imaging Multiple Procedures Subject to the MPPR | For services rendered on or after January 1, 2019: RVU19A, PPRRVU19_V1213, number “4” in column S, labeled, “Mult Proc,” also listed in CY 2019 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 61KB], in the document CMS-1693-F_Diagnostic Imaging Services Subject to MPPR<br><br>For services rendered on or after April 1, 2019: RVU19B, PPRRVU19_APR, number “4” in column S, labeled, “Mult Proc,” also listed in CY 2019 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 61KB], in the document CMS-1693-F_Diagnostic Imaging Services Subject to MPPR<br><br>For services rendered on or after July 1, 2019: RVU19C, PPRRVU19_JUL, number “4” in column S, labeled, “Mult Proc,” also listed in CY 2019 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 61KB], in the document CMS-1693-F_Diagnostic Imaging Services Subject to MPPR<br><br>For services rendered on or after October 1, 2019: RVU19D, PPRRVU19_OCT, number “4” in column S, labeled, “Mult Proc,” also listed in CY 2019 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 61KB], in the document CMS-1693-F_Diagnostic Imaging Services Subject to MPPR |
| DWC Pharmaceutical Fee Schedule | http://www.dir.ca.gov/dwc/OMFS9904.htm#8 |
| Geographic Practice Cost Index (GPCI) by locality | For services rendered on or after January 1, 2019: RVU19A |

| Document/Data | Services Rendered On or After January 1, 2019 & Mid-year Updates |
|---|---|
| (Other than anesthesia services) | • GPCI2019 Addendum E – Column B ("Locality Number"), column C ("Locality Name"), column D ("PW GPCI"), column E ("PE GPCI"), and column F ("MP GPCI") for the State of California ("CA")<br>• 19LOCCO – Column B ("Locality Number"), column C ("State"), column D ("Fee Schedule Area"), and column E ("Counties") for the State of California ("CA")<br><br>For services rendered on or after April 1, 2019:<br>RVU19B<br>• GPCI2019 Addendum E – Column B ("Locality Number"), column C ("Locality Name"), column D ("PW GPCI"), column E ("PE GPCI"), and column F ("MP GPCI") for the State of California ("CA")<br>• 19LOCCO – Column B ("Locality Number"), column C ("State"), column D ("Fee Schedule Area"), and column E ("Counties") for the State of California ("CA")<br><br>For services rendered on or after July 1, 2019:<br>RVU19C<br>• GPCI2019 Addendum E – Column B ("Locality Number"), column C ("Locality Name"), column D ("PW GPCI"), column E ("PE GPCI"), and column F ("MP GPCI") for the State of California ("CA")<br>• 19LOCCO – Column B ("Locality Number"), column C ("State"), column D ("Fee Schedule Area"), and column E ("Counties") for the State of California ("CA")<br>•<br>For services rendered on or after October 1, 2019:<br>RVU19D<br>• GPCI2019 Addendum E – Column B ("Locality Number"), column C ("Locality Name"), column D ("PW GPCI"), column E ("PE GPCI"), and column F ("MP GPCI") for the State of California ("CA")<br>• 19LOCCO – Column B ("Locality Number"), column C ("State"), column D ("Fee Schedule Area"), and column E ("Counties") for the State of California ("CA") |

| Document/Data | Services Rendered On or After January 1, 2019 & Mid-year Updates |
|---|---|
| | Access the Relative Value File on the CMS website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html<br><br>Also, see Zip Code mapping files listed below. |
| Geographic Practice Cost Index (GPCIs) by locality and anesthesia shares (Anesthesia) | For services rendered on or after January 1, 2019:<br><br>2019 Anesthesia Conversion Factors [ZIP, 18KB] (These factors have been incorporated into the conversion factors listed on section 9789.19.1, Table A)<br>• Locality-Adjusted Anesthesia Conversion Factors as a result of the CY 2019 Final Rule, excluding column G labeled, "National Anes CF of 22.2730"<br>• Anesthesia Shares<br><br>RVU19A (County to locality index)<br>• 19LOCCO – Column B ("Locality Number"), column C ("State"), column D ("Fee Schedule Area"), and column E ("Counties") for the State of California ("CA")<br><br>For services rendered on or after April 1, 2019:<br><br>2019 Anesthesia Conversion Factors [ZIP, 18KB] (These factors have been incorporated into the conversion factors listed on section 9789.19.1, Table A)<br>• Locality-Adjusted Anesthesia Conversion Factors as a result of the CY 2019 Final Rule, excluding column G labeled, "National Anes CF of 22.2730"<br>• Anesthesia Shares<br>RVU19B (County to locality index)<br>• 19LOCCO – Column B ("Locality Number"), column C ("State"), column D ("Fee Schedule Area"), and column E ("Counties") for the State of California ("CA") |

| Document/Data | Services Rendered On or After January 1, 2019 & Mid-year Updates |
|---|---|
| | For services rendered on or after July 1, 2019:<br><br>2019 Anesthesia Conversion Factors [ZIP, 18KB]<br>(These factors have been incorporated into the conversion factors listed on section 9789.19.1, Table A)<br>• Locality-Adjusted Anesthesia Conversion Factors as a result of the CY 2019 Final Rule, excluding column G labeled, "National Anes CF of 22.2730"<br>• Anesthesia Shares<br><br>RVU19C (County to locality index)<br>• 19LOCCO – Column B ("Locality Number"), column C ("State"), column D ("Fee Schedule Area"), and column E ("Counties") for the State of California ("CA")<br><br>For services rendered on or after October 1, 2019:<br><br>2019 Anesthesia Conversion Factors [ZIP, 18KB]<br>(These factors have been incorporated into the conversion factors listed on section 9789.19.1, Table A)<br>• Locality-Adjusted Anesthesia Conversion Factors as a result of the CY 2019 Final Rule, excluding column G labeled, "National Anes CF of 22.2730"<br>• Anesthesia Shares<br><br>RVU19D, (County to locality index)<br>• 19LOCCO – Column B ("Locality Number"), column C ("State"), column D ("Fee Schedule Area"), and column E ("Counties") for the State of California ("CA")<br><br>Note:<br>Access the Anesthesia Conversion Factors File on the CMS website: https://www.cms.gov/Center/Provider-Type/Anesthesiologists-Center.html<br>Access the Relative Value File on the CMS website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html<br><br>Also, see Zip Code mapping files listed below. |

| Document/Data | Services Rendered On or After January 1, 2019 & Mid-year Updates |
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| | |
| Geographic Practice Cost Index (GPCI) locality mapping<br><br>Zip Code files mapping zip codes to GPCI locality (for "other than anesthesia services" and anesthesia services) | For services rendered on or after January 1, 2019:<br><br>Zip Code to Carrier Locality File – Revised 11/14/2018 [ZIP, 4MB], Column A ("STATE"), column B ("ZIP CODE"), and column D ("LOCALITY") for the State of California ("CA")<br><br>Zip Codes requiring + 4 extension – Revised 11/14/2018 [ZIP, 1KB], for the State of California ("CA")<br><br>For services rendered on or after April 1, 2019:<br><br>Zip Code to Carrier Locality File - Revised 2/15/2019 [ZIP, 4MB], Column A ("STATE"), column B ("ZIP CODE"), and column D ("LOCALITY") for the State of California ("CA")<br><br>Zip Codes requiring +4 extension - Revised 2/15/2019 [ZIP, 1KB], for the State of California ("CA")<br><br>For services rendered on or after July 1, 2019:<br><br>Zip Code to Carrier Locality File - Revised 05/15/2019 [ZIP, 4MB], Column A ("STATE"), column B ("ZIP CODE"), and column D ("LOCALITY") for the State of California ("CA")<br><br>Zip Codes requiring +4 extension - Revised 05/15/2019 [ZIP, 1KB], for the State of California ("CA")<br><br>For services rendered on or after October 1, 2019:<br><br>Zip Code to Carrier Locality File - Revised 08/13/2019 [ZIP, 4MB], Column A ("STATE"), column B ("ZIP CODE"), and column D ("LOCALITY") for the State of California ("CA")<br><br>Zip Codes requiring +4 extension - Revised 08/13/2019 [ZIP, 1KB], for the State of California ("CA")<br><br>Note: |

| Document/Data | Services Rendered On or After January 1, 2019 & Mid-year Updates |
|---|---|
| | Access the Zip Code files on the DWC website: https://www.dir.ca.gov/dwc/OMFS9904.htm#7<br><br>CMS posts only the most recent version of the Zip Code files, which can be accessed on the CMS website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FeeScheduleGenInfo/index.html |
| Geographic Health Professional Shortage Area zip code data files | 2019 Primary Care HPSA [ZIP, 100KB]<br>2019 Mental Health HPSA [ZIP, 218KB]<br><br>Access the files on the CMS website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses/index.html?redirect=/hpsapsaphysicianbonuses/ |
| Health Resources and Services Administration: Geographic HPSA shortage area query<br><br>(By State & County)<br><br>(By Address) | <br><br><br><br>http://hpsafind.hrsa.gov/<br><br>http://datawarehouse.hrsa.gov/geoHPSAAdvisor/GeographicHPSAAdvisor.aspx |
| Incident To Codes | For services rendered on or after January 1, 2019: RVU19A, PPRRVU19_V1213, number “5” in column N, labeled, “PCTC IND,” (PC/TC Indicator)<br><br>For services rendered on or after April 1, 2019: RVU19B, PPRRVU19_APR, number “5” in column N, labeled, “PCTC IND,” (PC/TC Indicator)<br><br>For services rendered on or after July 1, 2019: RVU19C, PPRRVU19_JUL, number “5” in column N, labeled, “PCTC IND,” (PC/TC Indicator)<br><br>For services rendered on or after October 1, 2019: RVU19D, PPRRVU19_OCT, number “5” in column N, labeled, “PCTC IND,” (PC/TC Indicator) |

| Document/Data | Services Rendered On or After January 1, 2019 & Mid-year Updates |
|---|---|
| Medi-Cal Rates – DHCS | Pursuant to section 9789.13.2, the Medi-Cal Rates file's "Basic Rate" is used in calculating maximum fee for physician-administered drugs, biologicals, vaccines or blood products, by date of service.<br><br>For services rendered on or after January 1, 2019, use:<br>Medi-Cal Rates file - Updated 12/15/2018<br><br>For services rendered on or after January 15, 2019, use:<br>Medi-Cal Rates file - Updated 1/15/2019<br><br>For services rendered on or after February 15, 2019, use:<br>Medi-Cal Rates file - Updated 2/15/2019<br><br>For services rendered on or after March 15, 2019, use:<br>Medi-Cal Rates file - Updated 3/15/2019<br><br>For services rendered on or after April 15, 2019, use:<br>Medi-Cal Rates file - Updated 4/15/2019<br><br>For services rendered on or after May 15, 2019, use:<br>Medi-Cal Rates file - Updated 5/15/2019<br><br>For services rendered on or after June 15, 2019, use:<br>Medi-Cal Rates file - Updated 6/15/2019<br><br>For services rendered on or after July 15, 2019, use:<br>Medi-Cal Rates file - Updated 7/15/2019<br><br>For services rendered on or after August 15, 2019, use:<br>Medi-Cal Rates file - Updated 8/15/2019<br><br>For services rendered on or after September 15, 2019, use:<br>Medi-Cal Rates file - Updated 9/15/2019<br><br>For services rendered on or after October 15, 2019, use:<br>Medi-Cal Rates file - Updated 10/15/2019 |

| Document/Data | Services Rendered On or After January 1, 2019 & Mid-year Updates |
|---|---|
| | For services rendered on or after November 15, 2019, use:<br>Medi-Cal Rates file - Updated 11/15/2019<br><br>For services rendered on or after December 15, 2019, use:<br>Medi-Cal Rates file - Updated 12/15/2019<br><br>Copies of the Medi-Cal Rates files (without CPT descriptors) are posted on the DWC website:<br>http://www.dir.ca.gov/dwc/OMFS9904.htm |
| Ophthalmology Procedure CPT codes subject to the MPPR | For services rendered on or after January 1, 2019: RVU19A, PPRRVU19_V1213, number "7" in column S, labeled "Mult Proc" (Modifier 51). Also listed in in CY 2019 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 61KB], in the document CMS-1693-F_Diagnostic Ophthalmology Services Subject to MPPR<br><br>For services rendered on or after April 1, 2019: RVU19B, PPRRVU19_APR, number "7" in column S, labeled "Mult Proc" (Modifier 51). Also listed in in CY 2019 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 61KB], in the document CMS-1693-F_Diagnostic Ophthalmology Services Subject to MPPR<br><br>For services rendered on or after July 1, 2019: RVU19C, PPRRVU19_JUL, number "7" in column S, labeled "Mult Proc" (Modifier 51). Also listed in in CY 2019 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 61KB], in the document CMS-1693-F_Diagnostic Ophthalmology Services Subject to MPPR<br><br>For services rendered on or after October 1, 2019: RVU19D, PPRRVU19_OCT, number "7" in column S, labeled "Mult Proc" (Modifier 51). Also listed in in CY 2019 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 61KB], in the document CMS-1693-F_Diagnostic Ophthalmology Services Subject to MPPR |

| Document/Data | Services Rendered On or After January 1, 2019 & Mid-year Updates |
|---|---|
| | |
| Physical Therapy Multiple Procedure Payment Reduction: "Always Therapy" Codes; and Acupuncture and Chiropractic Codes | For services rendered on or after January 1, 2019: RVU19A, PPRRVU19_V1213, number "5" in column S, labeled "Mult Proc." Also listed in CY 2019 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 61KB], in the document CMS-1693-F_Separately Payable Therapy Services Subject to MPPR<br><br>In addition, CPT codes: 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943<br><br>For services rendered on or after April 1, 2019: RVU19B, PPRRVU19_APR, number "5" in column S, labeled "Mult Proc." Also listed in CY 2019 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 61KB], in the document CMS-1693-F_Separately Payable Therapy Services Subject to MPPR<br><br>In addition, CPT codes: 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943<br>For services rendered on or after July 1, 2019: RVU19C, PPRRVU19_JUL, number "5" in column S, labeled "Mult Proc." Also listed in CY 2019 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 61KB], in the document CMS-1693-F_Separately Payable Therapy Services Subject to MPPR<br>In addition, CPT codes: 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943<br><br>For services rendered on or after October 1, 2019: RVU19D, PPRRVU19_OCT, number "5" in column S, labeled "Mult Proc." Also listed in CY 2019 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 61KB], in the document CMS-1693-F_Separately Payable Therapy Services Subject to MPPR<br><br>In addition, CPT codes: 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943 |
| Physician Time | CY 2019 PFS Final Rule Physician Time [ZIP, 244KB] |

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

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

§9789.19.1. Table A.

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

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

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