

GENERAL INFORMATION AND INSTRUCTIONS (8 CCR § 9789.11(a)(1)) Effective for Dates of Service ~~after January 1, 2004~~ on or after July 1, 2004.

INTRODUCTION

AUTHORITY

Pursuant to the provisions of Labor Code Sections 4603.5 and 5307.1, the Administrative Director of the Division of Workers' Compensation has adopted the Official Medical Fee Schedule as the basis for billing and payment of medical services provided injured employees under the Workers' Compensation Laws of the State of California.

This revision to the Official Medical Fee Schedule sets forth changes to the instructions and ground rules adopted by the Administrative Director. The amendments to the Official Medical Fee Schedule contained in this revision are effective for services rendered ~~after January 1, 2004~~ on or after July 1, 2004. You will need to consult the applicable prior schedule for services that were provided on or before December 31, 2003 or after January 1, 2004 but before July 1, 2004.

The text in this revision of the Official Medical Fee Schedule is formatted to identify its sources. Language from the American Medical Association's Current Procedural Terminology (CPT) is identified by non-italicized text (e.g., "American Medical Association"). Relative values and California modifications to the CPT language are identified by italics (e.g., "California Official Medical Fee Schedule").

SERVICES COVERED

Pursuant to Labor Code Section 5307.1, as amended effective January 1, 2004, the Administrative Director is required to adopt and revise periodically an Official Medical Fee Schedule that establishes, except for physician services, the reasonable maximum fees paid for medical services in accordance with the fee-related structure and rules of the relevant Medicare (administered by the Center for Medicare & Medicaid Services of the United States Department of Health) and Medi-Cal (administered by California Department of Health Services) payment systems.

The maximum reasonable fee for pharmacy and drug services that are not otherwise covered by a Medicare fee schedule payment for facility services must be 100 percent of the fees prescribed in the relevant Medi-Cal payment system. Fees for medical services and pharmacy services and drugs shall be adjusted to conform to any relevant change in the Medicare and Medi-Cal payment systems.

Beginning January 1, 2004, the maximum reimbursable fees for physician services must be reduced by five (5) percent, or in an amount to be determined by the Administrative Director, or in a different amount determined by the Administrative Director, but a fee that is at or below Medicare for the same procedure may not be reduced. "Physician service" covered by this fee schedule is defined in Title 8, California Code of Regulations Section 9789.10(j) as:

"Physician service" means professional medical service that can be provided by a physician, as defined in Section 3209.3 of the Labor Code, and is subject to reimbursement under the Official Medical Fee Schedule. For purposes of the OMFS, "physician service" includes service rendered by a physician or by a non-physician who is acting under the supervision, instruction, referral or prescription of a physician, including but not limited to a physician assistant, nurse practitioner, clinical nurse specialist, and physical therapist.

~~Inpatient facilities procedures and services~~ shall be reimbursed pursuant to Title 8, California Code of Regulations Section 9789.20, et seq.

~~Outpatient facilities procedures and services~~ shall be reimbursed pursuant to Title 8, California Code of Regulations Section 9789.30, et seq.

Nothing contained in this schedule shall preclude any hospital as defined in subdivisions (a), (b), or (f) of Section 1250 of the Health and Safety Code, or any surgical facility which is licensed under subdivision (b) of Section 1204 of the Health and Safety Code, or any ambulatory surgical center that is certified to participate in the Medicare program under Title XIX (42 U.S.C. Sec. 1395 et seq.) of the federal Social Security Act, or any surgical clinic accredited by an accrediting agency as approved by the Licensing Division of the Medical Board of California pursuant to Health and Safety Code Sections 1248.15 and 1248.4, from charging and collecting a facility fee for the use of the emergency room or operating room of the facility. Outpatient procedures and services which are included in this fee schedule and which are provided in the emergency room or operating room of a hospital or in a freestanding outpatient surgery facility shall be reimbursed in accordance with this fee schedule.

No facility except those specified in the immediately preceding paragraph may charge or collect a facility fee for services provided on an outpatient basis

Hospital treatment rooms used by physicians for providing outpatient non-emergency follow-up services are not separately reimbursable as they are included in the value of the Evaluation and Management service codes.

Pharmacy services and pharmaceuticals shall be reimbursed pursuant to Title 8, California Code of Regulations Section 9789.40.

Pathology and laboratory services shall be reimbursed pursuant to Title 8, California Code of Regulations Section 9789.50.

NOTE: THE FOLLOWING PROCEDURES IN THE PATHOLOGY AND LABORATORY SECTION OF THIS BOOK ARE PHYSICIAN SERVICES AND SHALL BE REIMBURSED

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PURSUANT TO TITLE 8, CALIFORNIA CODE OF REGULATIONS SECTION 9789.11: 9788.10, ET SEQ.:

80500
80502
85060 through 85102
86077 through 86079
87164
88000 through 88399

Durable Medical Equipment, Prosthetics, Orthotics, Supplies and Materials shall be reimbursed pursuant to Title 8, California Code of Regulations Section 9789.60.

Ambulance Services shall be reimbursed pursuant to Title 8, California Code of Regulations Section 9789.70.

NOTE: THE FOLLOWING PROCEDURES IN THE SPECIAL SERVICES AND REPORTS SECTION OF THIS BOOK WILL NOT BE VALID FOR SERVICES RENDERED ON OR AFTER JULY 1, 2004:

<u>99000</u>	<u>99001</u>
<u>99002</u>	<u>99017</u>
<u>99019</u>	<u>99020</u>
<u>99021</u>	<u>99026</u>
<u>99027</u>	

CODES, MODIFIERS and SYMBOLS

The coding for physician services in this edition of the Official Medical Fee Schedule primarily uses the procedure codes, descriptors, and modifiers of the American Medical Association's Physicians' Current Procedural Terminology (CPT) 1997, copyright 1996, American Medical Association.

The Schedule for physician services also includes codes, descriptors, and modifiers that are unique to California, or California changes to CPT codes. Unique California codes, and CPT codes modified for California, are designated in the schedule by the symbol "∞".

Codes that have been revised since the April 1, 1999 edition of the Schedule are designated by the symbol "®".

Codes that have been added since the April 1, 1999 edition of the Schedule are designated by the symbol "Δ".

FORMAT

The physician services section of the Official Medical Fee Schedule, effective ~~after January 1, 2004~~ on or after July 1, 2004, consists of six major sections. Within each section are subsections with anatomic, procedural, condition, or descriptor subheadings.

The section numbers and their sequence are as follows:

EVALUATION and MANAGEMENT	99201 to 99499
ANESTHESIOLOGY	00100 to 01999 99100 to 99140
SURGERY	10040 to 69979
RADIOLOGY (Including Nuclear Medicine & Diagnostic Ultrasound)	70010 to 79999
PATHOLOGY AND LABORATORY	80500 80502 85060 to 85102 86077 to 86079 87164 88000 to 88399
MEDICINE	90700 to 99199
PHYSICAL MEDICINE	97010 to 98778
MANIPULATIVE TREATMENT	98925 to 98943
SPECIAL SERVICES	99000 to 99199

The format division is for informational purposes only. Any provider, regardless of specialty, may use any section containing procedures performed within his or her scope of practice or license as defined by California law, except for: (1) E/M codes which are to be used 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 (However, codes 99241-99275 may be used only by physicians); (2) Physical Medicine and Rehabilitation Assessment and Evaluation codes (98770-98778) which are to be used only by physical therapists; and (3) Osteopathic Manipulation Codes (98925-98929) which are to be used only by licensed DOs and MDs. The level of E/M service should not be determined by which of the providers performed the service. No provider may use any code for a procedure outside of his or her scope of practice or license as defined by California law.

Specific "Ground Rules" are presented at the beginning of each section. These Ground Rules define items that are necessary to appropriately interpret and report the procedures and services contained in that section. For example, in the Medicine section, specific ground rules are provided for handling unlisted services or procedures, special reports, and supplies and materials provided by the physician. Ground Rules also provide explanations regarding terms that apply only to a particular

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section. For instance, Surgery *Ground Rules* provide an explanation of the use of the star (*), while in Radiology, the unique term "radiological supervision and interpretation" is defined.

FORMAT OF THE TERMINOLOGY

CPT procedure terminology has been developed as stand-alone descriptions of medical procedures. However, some of the *CPT procedures in this schedule* are not printed in their entirety but refer back to a common portion of the procedure listed in a preceding entry. This is evident when an entry is followed by one or more indentations. *For example:*

25100 Arthrotomy, wrist joint; for biopsy
25105 for synovectomy

Note that the common part of code 25100 (that part before the semicolon) should be considered part of code 25105. Therefore, the full procedure represented by code 25105 should read:

25105 Arthrotomy, wrist joint; for synovectomy

MEDICAL NECESSITY

All services and supplies provided to injured workers must be medically necessary. Medically necessary is any medical service or supply which is:

1. *Provided as remedial treatment for an on-the-job illness or injury; and*
2. *Appropriate to the patient's diagnosis and clinical conditions in relation to any industrial injury; and*
3. *Performed in an appropriate setting; and*
4. *Consistent with published medical literature and practice Ground Rules generally accepted by the practitioner's peer group.*

GENERAL INSTRUCTIONS

FEE COMPUTATION AND BILLING PROCEDURES

Under Title 8, California Code of Regulations Section ~~9789.11~~ 9788.11, the maximum allowable fee for physician services rendered ~~after January 1, 2004~~ on or after July 1, 2004 is the amount set forth in the Official Medical Fee Schedule in effect on December 31, 2003 reduced by five (5) percent. However, individual procedure codes that are reimbursed under the Official Medical Fee Schedule in effect on December 31, 2003 at a rate that is between 100% and 105% of the current Medicare

rate will be reduced between zero and 5% so that the reimbursement will not fall below the Medicare rate.

To determine the maximum allowable reimbursement for a physician service rendered ~~after January 1, 2004~~ on or after July 1, 2004 the following formula is utilized: Relative Value Unit × Conversion Factor × Percentage Reduction Calculation = Maximum Reasonable Fee before application of ground rules. Applicable ground rules set forth in the Official Medical Fee Schedule in effect on December 31, 2003 are then applied to calculate the maximum reasonable fee.

To determine the maximum allowable reimbursement for services involving the administration of anesthesia (CPT Codes 00100 through 01999) rendered ~~after January 1, 2004~~ on or after July 1, 2004, the following formula is utilized: (basic value + modifying units (if any) + time value) × (conversion factor × .95) = maximum reasonable fee.

A table adopted as Title 8, California Code of Regulations Section 9789.11(c) sets forth each individual procedure code with its corresponding relative value, conversion factor, percentage reduction calculation (between 0 and 5%), and maximum reimbursable fee.

There is no prohibition against an employer or insurer contracting with a medical provider for reimbursement rates different from those prescribed in the Official Medical Fee Schedule.

California law requires the employer (or insurer) to provide all medical care necessary to cure or relieve the effects of the employee's industrial or work related illness or injury. Accordingly, under no circumstances shall the employee be billed for the treatment for which the employee has filed a workers' compensation claim unless the medical provider has received written notice that the claim has been rejected (Labor Code Section 3751(b)).

Total reimbursement for the professional and technical components of procedures shall not exceed the listed value for the total procedure.

Billings must include each provider's professional designation and, if applicable, the license or certification number of the person providing the service and shall be limited to services allowed by the provider's authorized scope of practice.

Practitioners who are not physicians as defined by California workers' compensation law, including orthotists; prosthetists; nurse practitioners; physician assistants; marriage, family and child counselors; and licensed clinical social workers, who are acting within the scope of their license, certification or education and who have received authorization from the payer to treat an

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injured worker, may be reimbursed in accordance with this Schedule.

Nonphysicians billing under this fee schedule shall use the appropriate modifier. (See the appropriate specialty section for nonphysician modifiers).

Claims administrators shall make determinations regarding authorization for payment of medical bills in accordance with all relevant statutes and regulations, including but not limited to Labor Code Sections 4600 and 4062; Title 8, California Code of Regulations Section 9792.6; and this Official Medical Fee Schedule.

CONFIRMATION OF VERBAL AUTHORIZATION FOR PAYMENT

This policy applies only to those services listed in the Official Medical Fee Schedule which require prior authorization or to services for which the provider voluntarily seeks confirmation of authorization.

When verbal authorization for payment is given for this purpose, the claims administrator shall provide to the provider (1) a confirmation number that the provider shall place on the bill when billing for the service, or (2) a written confirmation of the verbal authorization. Confirmation shall be placed in the mail to the provider by the claims administrator within five working days of the verbal authorization.

When authorization is given either verbally or through a written authorization, the claims administrator is obligated to pay for the services authorized in accordance with the Official Medical Fee Schedule or other contractual payment arrangements previously agreed.

In the event the claims administrator subsequently determines that authorization for payment should be terminated, the claims administrator shall notify the provider in writing of this change.

SUPPLIES AND MATERIALS

Supplies and/or materials normally necessary to perform the service are not separately reimbursable. Supplies and materials provided over and above those usually included with the office or other services rendered may be charged for separately.

Examples of supplies that are usually not separately reimbursable include, but are not limited to:

applied hot or cold packs

eye patches

injections or debridement trays

steristrips

needles

needles

syringes

eye/ear trays

drapes

sterile gloves

applied eye wash or drops

creams (massage)

fluorescein

ultrasound pads and gel

tissues

urine collection kits

gauze

cotton balls/fluff

sterile water

bandaids and dressings for simple wound occlusion

head sheet

aspiration trays

tape for dressing

Exceptions to this rule include:

cast and strapping materials

sterile trays for laceration repair and more complex

surgeries

applied dressings beyond simple wound occlusion

taping supplies for sprains

iontophoresis electrodes

reusable patient specific electrodes

dispensed items such as, but not limited to, the following:

canes crutches

braces splints

slings back supports

ace wraps dressings

*TENS electrodes hot or cold packs**

** The application of hot or cold packs is not reimbursable (i.e., code 97010 has a relative value of 0.0 and is not reimbursable).*

For separately reimbursable services, equipment, or goods provided after January 1, 2004, the maximum reasonable reimbursement for durable medical equipment, supplies and materials, orthotics, prosthetics, and miscellaneous supplies and services shall not exceed one hundred twenty (120) percent of the rate set forth in the CMS' Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS) Fee Schedule, as updated in the October 2003 quarterly update. See 8 CCR Section 9789.60.

Patient instruction booklets, pamphlets, videos, or tapes are separately reimbursable using code 99071. Documentation of actual cost may be required.

Total rental cost of durable medical equipment cannot exceed the purchase cost. Prior authorization of the payer is required for rental or purchase. Prior authorization of the payer does not

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apply to emergency situations; such as, emergency room facility dispensing crutches. Documentation of actual cost may be required by the payer. Such documentation may include, if applicable, a best or preferred price list.

Note: For any supply or material not covered by the DMEPOS Fee Schedule, or other relevant Medicare payment system, the maximum reasonable fee paid shall not exceed the fee specified in the official medical fee schedule in effect on December 31, 2003. Code 99070 is used to bill for separately reimbursable supplies and materials "By Report" (BR). The provider must identify the supplies and/or materials provided. Providers may bill the payer for the purchase price of authorized materials and/or supplies; the price shall be subject to agreement by the parties. Documentation of actual cost may be required. In such circumstances, the following formulas only apply to health care providers such as physicians, physical therapists, Physician Assistants and Nurse Practitioners, dispensing items from their office or outpatient surgery facility.

- The formulas for establishing fair and reasonable fees and charges for separately reimbursable supplies and materials are:

(1) Supplies and materials other than dispensed durable medical equipment: cost (purchase price plus sales tax) plus 20% of cost up to a maximum of cost plus \$15.00 not to exceed the provider's usual and customary charge for the item.

(2) Dispensed durable medical equipment: cost (purchase price plus sales tax plus shipping and handling) plus 50% of cost up to a maximum of cost plus \$25.00 not to exceed the provider's usual and customary charge for the item.

PHARMACEUTICALS

Pharmacy services and pharmaceuticals shall be reimbursed pursuant to Title 8, California Code of Regulations Section 9789.40.

Immunizations provided under Medicine codes 90725-90749 and 90710-90711 are reimbursable "By Report" for the cost of the vaccine plus a \$15.00 injection fee. The provider shall submit the invoice for the cost of the vaccine.

Note: For any pharmacy service or drug that is not covered by a Medi-Cal payment system, the maximum reasonable fee paid shall not exceed the fee specified in the official medical fee schedule in effect on December 31, 2003. In such circumstances, reimbursement of pharmaceuticals (99070) shall be the lesser of: (1) the provider's usual charge, or (2) the fees established by the formulas for brand-name and generic

pharmaceuticals as described. This provision applies to the dispensing of all pharmaceuticals including those dispensed by a medical provider, regardless of the point of service.

"Dispense" means the furnishing of drugs upon a legal prescription from a physician, dentist or podiatrist. Over-the-counter pharmaceuticals do not warrant reimbursement of a dispensing fee.

- Pharmaceutical injection materials administered during therapeutic, diagnostic, or antibiotic injections are separately reimbursable using the Pharmaceutical Formula. A dispensing fee is not allowable with these injections.
- The formulas for establishing fair and reasonable fees and charges for brand-name and generic pharmaceuticals are:
- Brand-name Pharmaceutical Formula: average wholesale price (AWP) times 1.10 plus a \$4.00 dispensing fee.
- (2) Generic Pharmaceutical Formula: average wholesale price (AWP) times 1.40 plus a \$7.50 dispensing fee.
- When a generic pharmaceutical costs more than a brand-name pharmaceutical, according to the formulas described in this section, the fair and reasonable price will be the brand name equivalent, as calculated under the above formula. Documentation may be required.
- Providers should use NDC codes when billing for pharmaceuticals. The payer shall maintain current data regarding drug and supply pricing which is current within 90 days. Upon request by the provider, the payer shall disclose the source of the AWP, including information on any proprietary systems used by the payer to establish the AWP.

REPORTS

This section governs reimbursement of all reports other than those which are payable under the medical-legal fee schedule, found at Title 8, California Code of Regulations, Section 9795. The medical-legal fee schedule should only be used for the reimbursement of reports which are requested by a party for the purpose of proving or disproving a contested claim. Reports obtained for the purpose of determining whether to accept or contest a claim are governed by this report section.

This section covers all treatment reports required by statute or regulation, and consulting reports which are

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requested by a party. The following are the types of reports covered by this section, along with the corresponding Evaluation and Management code.

Separately reimbursable reports identified by the CPT code 99080 (Special Reports) are reimbursable using the Medicine conversion factor at 6.5 relative values (RVs) for the first page and 4.0 RVs for each additional page, up to a total of six pages; and are then reduced by 5% in accordance with Labor Code Section 5307.1(k). Reimbursement is limited to six pages except by mutual agreement of the provider and payer. Separately reimbursable reports identified by the CPT code 99081 are reimbursable using the Medicine conversion factor at 2.0 relative values (RVs) and are then reduced by 5% in accordance with Labor Code Section 5307.1(k).

Treatment Reports

The primary treating physician is required to prepare reports under Title 8, California Code of Regulations, Sections 9785 (See Appendix C). The same reimbursement levels apply to both the employee-selected and employer-selected primary treating physician unless there is a written contract. Some treatment reports are separately reimbursable; others are not.

a. Treatment Reports Not Separately Reimbursable

The following reports are not separately reimbursable. The appropriate fee is included within the underlying Evaluation and Management service for an office visit (CPT codes 99201-99215).

- **Doctor's First Report of Occupational Illness or Injury** (or other report of primary care provider with similar information);
- **Initial treatment report and plan;**
- **Treating Physician's Report of Disability Status (DWC Form RU-90)** where the physician has not been able to give an opinion regarding the employee's ability to return to the pre-injury occupation;
- **Report by a secondary physician to the primary treating physician.**

b. Separately Reimbursable Treatment Reports

The following reports are separately reimbursable (see general discussion under "Reports" above). Where an office visit is included, the report charge is payable in addition to the

underlying Evaluation and Management service for an office visit (CPT codes 99201-99215).

- **Primary Treating Physicians' Progress Reports,** reported in accordance with Title 8, California Code of Regulations Section 9785(f), using DWC Form PR-2 or its equivalent (see Appendix D), when (1) the employee's condition undergoes a previously unexpected significant change; (2) there is any significant change in the treatment plan reported in the Doctor's First Report including, but not limited to, an extension of duration or frequency of treatment, a new need for hospitalization or surgery, a new need for referral to or consultation by another physician, a change in methods of treatment or in required physical medicine services, a need for rental or purchase of durable medical equipment or orthotic devices; (3) the employee's condition permits return to modified or regular work, but the employee has not reached permanent and stationary status; (4) the employee's condition requires him or her to leave work or requires a change in work restrictions or modifications; (5) the employer reasonably requests additional appropriate information. (6) A progress report shall be submitted no later than 45 days from the submission of the last progress report even if no event described in paragraphs (1)-(5), above, has occurred. Progress reports 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. Use Code 99081.
- **Final Treating Physician's Report of Disability Status (DWC Form RU-90)** where the physician renders an opinion concluding that the employee is released to return to the pre-injury occupation or concluding that the employee's injury is likely to permanently preclude the employee from returning to the pre-injury occupation. Use Code 99080.
- **Primary Treating Physician's Final Discharge Report** where the physician determines that no further medical treatment is needed for this injury, the patient has no permanent disability, and the employee is able to return to work with no restrictions or diminished capacity related to this injury. The final discharge report must be submitted using DWC Form PR-2 or its equivalent (see Appendix D). Use Code 99081.
- **Primary Treating Physician's Permanent and Stationary Report.** When the physician determines that the employee's condition is permanent and stationary,

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the physician shall report any findings concerning the existence and extent of permanent impairment and limitations and include, where appropriate, an assessment of apportionment, causation, and any need for continuing medical care resulting from the injury. These findings must be reported using DWC Form PR-3 or IMC Form 81556 or their equivalent (see Appendix D). The report shall be in accordance with Title 8, California Code of Regulations Section 9785. Use Code 99080.

To bill for the primary treating physician's permanent and stationary report, the physician shall select the appropriate Evaluation and Management code, if any, in accordance with Evaluation and Management guideline 9 g; the report code 99080; and, when appropriate, prolonged service codes 99354-99358.

Modifier '-17' is to be used by the primary treating physician to identify a permanent and stationary evaluation and report. This modifier shall be appended to each of the following codes, as appropriate: Evaluation and Management codes, report code 99080, and prolonged service codes. (See item 8, "Modifiers", in the Evaluation and Management section for modifier '-17').

The primary treating physician shall be responsible for obtaining all of the reports of other treating physicians and shall incorporate, or comment upon, the opinions of the other treating physicians in the primary treating physician's report and attach all of the reports for submission to the claims administrator.

The primary treating physician shall submit medical reports to the claims administrator pursuant to Title 8, California Code of Regulations Section 9785. The reports shall identify any other physician(s) and nonphysician(s) who provided opinions, decisions, or services. Other treating physicians and nonphysician providers to whom the injured employee is referred shall report to the primary treating physician in the manner required by the primary treating physician.

When a claims administrator or its authorized agent requests that a provider complete a form that is not legally mandated or submit information in excess of that required pursuant to Title 8, California Code of Regulations Section 9785, the provider shall be separately reimbursed using code 99080. Attach modifier '-18' to identify these forms or reports.

c. Consultation Reports

The following reports are separately reimbursable (see general discussion under "Reports" above). Where an examination of the patient is included, the report charge is payable in addition to the underlying Evaluation and Management service for a

consultation (CPT codes 99241-99245) or confirmatory consultation (CPT codes 99271-99275) as noted below. Use Code 99080. Where there is no examination of the patient, see "Prolonged Service Codes," below.

- A report by a consulting physician, where consultation was requested on one or more medical issues by the treating physician, including a second medical opinion on the necessity or appropriateness of previously recommended medical treatment or a surgical procedure. A confirmatory consultation (CPT codes 99271-99275) may also be charged by the consulting physician.*
- A report by a consulting physician, where consultation was requested on one or more medical issues by a party, the Administrative Director, or the Workers' Compensation Appeals Board. Reports included under this section are those reports that are admissible and reimbursable in accordance with Labor Code Section 4064(c). An office consultation (CPT codes 99241-99245) may also be charged by the consulting physician.*
- A report by the treating physician, where medical information other than that required to be reported under the treatment report section above was requested by a party, the Administrative Director, or the Workers' Compensation Appeals Board. An office consultation (CPT codes 99241-99245) may also be charged by the treating physician in this circumstance.*
- A report by a consulting physician where the claim does not meet the criteria of a "contested claim" as set forth in Title 8, California Code of Regulations Section 9793(b).*
- A consultation code may not be billed when care or any part of care has been clearly transferred by the primary treating physician to another physician. (See definition of Referral under the Evaluation and Management Section page 11.)*

PROLONGED SERVICE CODES

Where appropriate, a treating or consulting physician may be paid for service which extends beyond the usual service time for a particular Evaluation and Management code. The prolonged service codes are of two types in the outpatient setting: direct (face-to-face) patient contact (CPT codes 99354 and 99355), and without direct (face-to-face) patient contact (CPT code 99358).

Where the physician is required to spend at least 30 minutes or more of direct (face-to-face) time in addition to the time set forth

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in the appropriate CPT code (e.g., at least 90 minutes in an office consultation under CPT code 99244), then CPT codes 99354 and, where appropriate, 99355 may be charged in addition to the basic charge for the appropriate Evaluation and Management code.

Where the physician is required to spend 15 or more minutes before and/or after direct (face-to-face) patient contact in reviewing extensive records, tests or in communication with other professionals, the CPT code 99358 may be charged in addition to the basic charge for the appropriate Evaluation and Management code.

CPT code 99358 may also be used where the physician is required to spend 15 or more minutes reviewing records or tests, a job analysis, an evaluation of ergonomic status, work limitations, or work capacity when there is no direct (face-to-face) contact; however, in this case, the physician is not entitled to charge an Evaluation and Management code. For example, if subsequent to an examination of the employee, a consulting physician is asked to prepare a supplemental report based on a review of additional medical records, and the physician spends 15 minutes in this review, CPT code 99358 may be charged along with CPT code 99080 for a report, but no Evaluation and Management code may be charged.

DIETARY SUPPLEMENTS

Dietary supplements such as minerals and vitamins shall not be reimbursable unless a specific dietary deficiency has been clinically established in the injured employee as a result of the industrial injury or illness.

PROCEDURES WITHOUT UNIT VALUES ("BY REPORT")

Unit values are not shown for some procedures listed in the Schedule. Fees for such procedures need to be justified by report, although a detailed clinical record is not necessary.

By Report (BR): Procedures coded BR (By Report) are services which are unusual or variable.

An unlisted service or one that is rarely provided, unusual or variable may require a report demonstrating the medical appropriateness of the service. 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. Additional items which may be included are:

- complexity of symptoms;
- final diagnosis;
- pertinent physical findings;
- diagnostic and therapeutic procedures;
- concurrent problems;
- follow-up care.

In some instances, the values of BR procedures may be determined using the value assigned to a comparable procedure. The comparable procedure should reflect the same amount of time, complexity, expertise, etc., as required for the procedure performed.

SEPARATE PROCEDURES

Some of the listed procedures are commonly carried out as an integral part of a total service and as such does not warrant a separate reimbursement. When however, such a procedure is performed independent of and is not immediately related to other services, it may be listed as a "separate procedure." Thus, when a procedure is performed alone for a specific purpose it may be considered to be a separate procedure.

STARRED PROCEDURES

The star "*" is used to identify certain surgical procedures. A description of this reporting mechanism is found in the Surgery ground rules.

SPECIAL SERVICES AND REPORTS

The procedures with code numbers 99000 through 99090 provide the reporting physician or health care provider with the means of identifying the completion of special reports and services that are an adjunct to the basic services rendered. The specific number assigned indicates the special circumstances under which a basic procedure is performed. Charges for services generally provided as an adjunct to common medical services should be billed only when circumstances clearly warrant an additional charge over and above the scheduled charges for the basic services.

CHART NOTES

Requests for chart notes shall be in writing and shall be separately reimbursable at \$10.00 for up to the first 15 pages. Pages in excess of 15 shall be reimbursable at \$0.25 per page. Chart note requests shall be made only by the claims administrator. Code 99086 is used to bill for chart notes "By Report," using these guidelines, and are subject to the 5% reduction in fees for physician services.

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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 in writing. Duplicate reports shall be separately reimbursable. Where the payer requests an additional copy of the reports, the payer shall reimburse for the duplicate report at \$10.00 for up to the first 15 pages. Pages in excess of 15 pages shall be reimbursed at \$0.25 per page. Charges for duplicate reports shall be billed using code 99087 and are subject to the 5% reduction in fees for physician services. Requests for duplicate reports shall be made only by the claims administrator.

MISSED APPOINTMENTS

Code 99049 may be used to indicate missed appointments on a By-Report (BR) basis. This code is designed for communication purposes only. It does not imply that compensation is necessarily owed.

This code applies to both treatment and consultation appointments. For Medical-Legal missed appointments use the appropriate code from the Medical-Legal Fee Schedule – Title 8, California Code of Regulations Section 9795).

MODIFIERS

A modifier provides the means by which the reporting physician or health care provider can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. The judicious application of modifiers obviates the necessity for separate procedure listings that may describe the modifying circumstance. Modifiers may be used to indicate to the recipient of a report that:

- A service or procedure has both a professional and technical component.
- A service or procedure was performed by more than one physician and/or in more than one location.
- A service or procedure has been increased or reduced.
- Only part of service was performed.
- An adjunctive service was performed.
- A bilateral procedure was performed.
- A service or procedure was provided more than once.

- Unusual events occurred.

A listing of modifiers pertinent to Evaluation and Management, Anesthesia, Surgery, Radiology, Pathology (as applicable), and Medicine is located in the Ground Rules of each section. A complete listing of modifiers is found in Appendix A.

GLOBAL SERVICE PROFESSIONAL COMPONENT AND TECHNICAL COMPONENT REIMBURSEMENT

Certain procedures are a combination of both a physician (professional) and a technical component. The listed values are total values that include both the professional and technical components. Total reimbursement for the professional and technical components combined shall not exceed the listed value for the total procedure, regardless of the site(s) where services are rendered. When both the professional and technical components of such procedures are performed by the same provider, a global service has been rendered. When the professional or technical component of a procedure is billed separately it shall be valued according to the percent of the total value indicated in the "PC/TC" column of the fee schedule. When reporting a procedure for which there is a professional/technical component split listed in this schedule use the modifier which appropriately describes the service rendered (i.e., '-26', '-27').

TIMELINESS OF PAYMENT

California Labor Code Section 4603.2(b) provides that payment for medical treatment provided or authorized by the treating physician shall be made by the employer within 45 working days (60 working days if a government entity is the employer) after receipt of each separate, itemized billing, together with any required reports (treatment and/or consultation). In the absence of a proper objection, automatic payment of penalty and interest is required.

TIME-ORIENTED PROCEDURES

When reporting services in which the listed value is predicated on the basis of time, information concerning the amount of time spent is required.

UNLISTED PROCEDURE OR SERVICE

It is recognized that there may be services or procedures performed by medical providers that are not found in the CPT codes. Therefore, a number of specific code numbers have been designated for reporting unlisted procedures. When an unlisted procedure number is used, the service or procedure should be described. Each of these unlisted procedural code numbers (with the appropriate accompanying topical entry) relates to a specific

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section of the schedule and is presented in *the Ground Rules* of that section.

DEFINITIONS

Definitions specific to a particular section of this schedule are listed in the *General Information* and ground rules of that section. General definitions follow:

Claims Administrator

A self-administered insurer providing security for the payment of compensation required by Divisions 4 and 4.5 of the Labor Code, a self-administered self-insured employer, or a third party administrator for a self-insured employer, insurer, legally uninsured employer, or joint powers authority.

Physician

Under California workers' compensation law (Labor Code Section 3209.3) "physician" includes physicians and surgeons holding an MD or DO degree, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners licensed by California state law and acting within the scope of their practice as defined by California state law.

Physical Therapist

An individual licensed by the Physical Therapy Examining Committee of California to practice physical therapy (Business and Professions Code Section 2630). Services of physical therapists are included in the Official Medical Fee Schedule as required by Labor Code Section 5307.1(a)(2).

Certified Registered Nurse Anesthetist(CRNA)

An individual licensed by the Board of Registered Nursing as a certified registered nurse anesthetist (Business and Professions Code Section 2830).

Orthotist

An individual who makes and fits orthopedic braces for the support of weakened body parts or the correction of body defects.

Prosthetist

An individual who makes and fits artificial limbs or other parts of the body.

Nurse Practitioner

An individual licensed by the Board of Registered Nursing as a registered nurse practitioner (Business and Professions Code Section 2834 et seq.)

Physician Assistant

An individual licensed by the Physician Assistant Examining Committee of the Medical Board of California as a physician assistant (Business and Professions Code Section 3500 et seq.)

Marriage, Family and Child Counselor

An individual licensed by the Board of Behavioral Science Examiners to engage in the practice of marriage, family and child counseling (Business and Professions Code Section 4980 et seq.)

Licensed Clinical Social Worker

An individual licensed by the Board of Behavioral Science Examiners as a licensed clinical social worker (Business and Professions Code Section 4996 et seq.)

Hospital Inpatient

An inpatient is a patient who is admitted to the hospital, skilled nursing facility, or intermediate care facility for bed occupancy for purposes of receiving inpatient services. A person is considered an inpatient when formally admitted as an inpatient with the expectation of remaining at least overnight and occupying a bed, even though it later develops that the patient can be discharged or transferred to another facility and did not actually use a bed overnight.

Pharmaceutical Services

Pharmaceutical services mean professional services provided by a pharmacist or medical provider in the dispensing of drugs and medical supplies on the legal prescription of a licensed practitioner.

Referral

The referral for the transfer of the total or specific care of a patient from one physician to another does not constitute a consultation.

Consultation

A consultation is a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source.

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