# FREQUENTLY ASKED QUESTIONS

## OFFICAL MEDICAL FEE SCHEDULE (OMFS), INPATIENT HOSPITAL FEE SCHEDULE (IHFS) AND MEDICAL-LEGAL FEE SCHEDULE (MLFS)

**How do I get an Official Medical Fee Schedule book and how much does it cost?**

Contact THE LEGISLATIVE BILL ROOM
STATE CAPITOL, RM B-32
Sacramento, CA 95814
(916) 445-5357

It's $45. Due to copyright restrictions, Division of Workers' Compensation (DWC) will not be putting it out on a diskette. The most recent version of the OMFS is April 1, 1999.

**How do I get access to an OMFS if I do not want to buy a copy?**

Contact a state depository library (most University of California, California State University, and law school libraries) or go to the DWC district office nearest you to look at a copy. If you are going to need access to the OMFS frequently, it is recommended you purchase one.

**Who do I contact if I have questions about the OMFS?**

You may call the local DWC office found in the white pages of your phone book under State Government Offices/Industrial Relations/Workers' Compensation; DWC - Medical Unit at (6500 737-2700; e-mail us at dwc@dir.ca.gov; or write to us at P.O. Box 8888, San Francisco, CA 94142

**What elements make up the California Division of Workers' Compensation Official Medical Fee Schedule (OMFS)?**

There are seven separate fee schedules that make up the OMFS - Physician's Services (PSFS); Inpatient Hospital Services (IHFS); Hospital Outpatient Departments and Ambulatory Surgical Centers Services (HOPD/ASC); Pharmacy Services (PFS); Pathology and Laboratory Services (CDLS); Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS); and Ambulance Services (AFS).

**Where do I find the various fee schedules?**

The basic fee schedule is the 1999 Official Medical Fee Schedule book published by the Division of Workers' Compensation for dates of service on or after April 1, 1999. It included payment instructions for all medical services with the exception of Outpatient Facility Fees, Ambulance Services, and Home Health Services.

There have been updates to the OMFS, one for dates of service on or after July 21, 2002 and the others for dates of service on or after January 1, 2004. These updates are

available electronically at the Division's web site http://www.dir.ca.gov/dwc or you can get a printed copy by writing to:

Division of Workers' Compensation (Attn: OMFS - Physician Services)
P.O. Box 420603
San Francisco, CA 94142.

The January 2004 update is extensive and includes all of the changes mandated by the recently passed SB 228.

The IHFS, HOPD/ASC, CDLS, DMEPOS and AFS schedules are all based on Medicare's existing fee schedules. The California payment is set at 120% of Medicare for each of these schedules. The schedules can be found at Medicare's web site http://www.cms.hhs.gov.

The PFS is based on Medi-Cal's pharmaceutical fee schedule. The California payment is set at 100% of Medi-Cal's rates. There is a web based fee calculator located on the Division's web site at http://www.dir.ca.gov/dwc/pharmfeesched/pfs.asp.

**Who is covered by the PFS?**

All entities that fill prescriptions or dispense pharmaceuticals are subject to the PFS. This includes physicians, pharmacies, retail stores, mail-order pharmacy companies, on-line services, hospitals and ambulatory surgery centers.

**When I use the pharmacy calculator, the NDC code I put in returned a message stating "No record matches the NDC number with a price date on or before 2/2/04". What does that mean?**

It means one of two things.

First, it may indicate that the NDC code is for a drug that has been repackaged so it may be dispensed from a physician's office. Medi-Cal doesn't permit physicians to dispense drugs from their offices and so they do not have the NDC codes for those types of repackaged drugs in their database. This doesn't mean that physician's are prohibited from dispensing drugs from their office under California Workers' Compensation law.

Second, it may just be a drug that Medi-Cal doesn't have in its database at this time. Again, this doesn't mean that you can't bill for these drugs, just that Medi-Cal doesn't have them in their database.

**How does a physician get reimbursed for drugs whose NDC numbers aren't in Medi-Cal's database?**

Labor Code Section 5307.1, subdivisions (a), (d) and (e), enacted last year as part of Senate Bill 228, govern the payments for pharmaceuticals under DWC's OMFS. These sections state that:

"(a)...for pharmacy services and drugs that are not otherwise covered by a Medicare fee schedule payment for facility services, the maximum reasonable fees shall be 100% of fees prescribed in the relevant Medi-Cal payment system.

"(d)...If the administrative director determines that a pharmacy service or drug is not covered by a Medi-Cal payment system, the administrative director shall establish maximum fees for that item, provided, however, that the maximum fee paid shall not exceed 100 percent of the fees paid by Medi-Cal for pharmacy services or drugs that require comparable resources.

"(e) Prior to the adoption by the administrative director of a medical fee schedule pursuant to this section, for any treatment, facility use, product, or service not covered by a Medicare payment system, including acupuncture services, or, with regard to pharmacy services and drugs, for a 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."

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DWC is in the process of determining the proper method of reimbursing for drugs not covered by Medi-Cal. All pharmaceuticals whose NDC numbers appear in the Medi-Cal database on the DWC web site are governed by the Medi-Cal rates, regardless of who dispenses the pharmaceutical. Payment should not be denied based on the NDC number not being in the database. For NDC codes not listed, DWC will be developing an alternative methodology for setting maximum reasonable fees for pharmaceuticals. That fee schedule will be adopted after public hearings.

Until that time, and pursuant to Labor Code section 5307.1 (e), the maximum reasonable fee paid shall not exceed the fee specified in the OMFS in effect on December 31, 2003.

**Is there a required billing form, if so, what is it?**

There are standardized forms (CMS 1500 for treatment and the CMS 1450 for facilities). These forms are not mandatory. Providers may use their own forms with the required information.

**Which version of the CPT codes is in the OMFS?**

The April 1, 1999 OMFS is using the 1997 CPT codes of the American Medical Association.

**Where are the conversion factors found?**

The conversion factors are found in Appendix C of the OMFS and under Title 8, Cal Code of Regulations § 9792.

**Where's the Index?**

Due to copyright issues with the American Medical Association, we do not have an index for this edition of the fee schedule.

**How do the claims administrators and bill review companies determine payment?**

The claims administrators will be paying according to the fee schedule in use for the date of service provided. This applies to Medical-Legal, OMFS and IHFS.

**What about missed appointments?**

There is currently no provision in either the Medical-Legal fee schedule or OMFS that covers missed appointments. This does not mean that a provider cannot bill for a missed appointment. It simply means that the fee for a missed appointment needs to be adjusted between the parties. Under the OMFS the treating physician may not charge the injured worker for missed treatment appointments. All billings for missed appointments must go to the claims administrator for adjustment. The CPT code 99049 (BR) may be used to report a missed OMFS appointment. Code ML 100 may be used for a missed Medical-Legal appointment. These codes are for communication purposes only and do not imply a payment is owed.

**Which reports are reimbursable?**

The Primary Treating Physician's (P.T.P.) Progress Reports (PR-2 or equivalent), the P.T.P. Permanent and Stationary Report (PR-3, PR-4, IMC 81556, or equivalent), the Final RU-90, and any Consultation Reports. All other types of reports are not reimbursable.

**Is there a fee schedule for Home Health Services?**

There is no fee schedule for home health services. Home health providers may charge a reasonable fee for their services.

**What Constitutes A Medical/Legal (M/L) Report?**

8 CCR § 9793 provides the definitions for issues dealing with the M/L report. Briefly, only a *contested claim* or a *medical issue in dispute* qualifies for a M/L report. All other issues needing a medical report do not rise to the status of a M/L report.

A *contested claim* is one where;

- liability is rejected,
- presumption of compensability under LC § 5402 (90-day presumption),

- there is a failure to respond to a demand for payment of compensation including defendant's failure to issue notice of delay within 14 days of employer's date of knowledge pursuant to LC § 4650, or
- a disputed medical fact.

A *disputed medical fact* contests
- a medical condition
- need for treatment
- cause of a medical condition
- nature and extent of permanent disability
- QIW status

If the medical evaluation does not fit the above criteria, it is not a M/L report.

**If I'm the P.T.P. can I bill using code M/L 102 -92 when doing the P&S Report?**

**No.** The P.T.P. cannot bill a M/L for the P.T.P. P&S Report. The P.T.P. P&S Report is billable under the OMFS using the appropriate E/M code, Prolonged Service Code and Report Code.

The only time a P.T.P. writes a M/L report is when there is a contested claim or disputed medical fact (see above definitions). Most often, the claims administrator or the injured worker's attorney would be asking the P.T.P. to write a M/L report to rebut a QME's report. This usually occurs after the P.T.P. has submitted the P&S Report when one of the parties disagrees with the P.T.P.'s findings. If one party asserts the treating physician's presumption of correctness and the other gets a QME, the party who is relying on the treating physician may ask him or her to prepare a M/L report.

**Can I charge for transcription services when doing a M/L Report (AME, QME, or P.T.P.)?**

**No**. Transcription services are included in the prices set for each level of M/L examination.

**There has been misinformation circulated throughout the workers' compensation community regarding this issue**. LC § 4628 (d) is widely quoted as the justification for reimbursement for transcription services. It states that "No charges may be charged in excess of the direct charges for the physician's professional services and the reasonable costs of laboratory examinations, diagnostic studies, and other medical tests, and **reasonable costs of clerical expense necessary to producing the report**. Direct charges for the physician's professional services shall include reasonable overhead expense." What the individuals using this argument fail to realize is that 8 CCR § 9795 (b) sets forth **how** the reimbursement is to be carried out. It states "The fee for each medical-legal evaluation procedure is **all inclusive,** and includes reimbursement for the examination, review of records, **preparation of a medical-legal report,** and overhead expenses." There is applicable case law, which supports the inclusion of the transcription expenses - Mission Hills vs. WCAB, Mora Manor, SCIF (Miller) 62 CCC 539.

**The claims administrator is not paying the whole bill or portion of the bill, what can be done?**

The claims administrator has 30 working days from the date of receipt to object the entire bill or any portion of the bill. For any contested bill the claims administrator should include:

- The code used by the provider and the code believed to be reasonable by the claims administrator, and a rationale as to why the suggested code more accurately reflects the service provided.

- If the entire bill is contested, the justification should show a legal, medical or factual basis for the denial.

**The claims administrator should always pay the uncontested portion of the bill**. If the bill is not paid within the 45 working days or objected to within 30 working days, the amount of the bill may be increased by a 15% penalty and shall carry interest at the same rate as judgments in civil actions retroactive to the date of receipt of the bill.

Billing disputes between claims administrators and providers can be resolved by filing a lien (DWC Form 6 "Green" Lien) with the WCAB.

**Can Chiropractors bill using Osteopathic codes in the Physical Medicine Section of the OMFS?**

**No**. Chiropractors are not Osteopaths. Physicians must bill within their scope of practice.

**Can non-physicians use the OMFS?**

**Yes**. Any medical provider can use the OMFS if the services they provide fall within their scope of practice. Common types of non-physicians who use the OMFS are Physician Assistants, Nurse Practitioners, Physical or Occupational Therapists, Orthotists, Prosthetists, Certified Registered Nurse Anesthetists (CRNA), Marriage, Family and Child Counselors (MFCC), Licensed Clinical Social Workers (LCSW) and others.

**Are there errors in the OMFS?**

There may be. If errors are found, the parties must still use what is written in the OMFS. There are generally ways for parties to bill appropriately around errors. Errors should be brought to the attention of the DWC Administrative Director for correction in the next OMFS.

**What code do I bill if the CPT code most applicable is not in the OMFS?**

There can be revisions made to the CPT codes in-between editions of the OMFS. You may select a code that is similar to the new code or you may negotiate with the claims administrator prior to providing the service. Services are always negotiable ahead of time. There are unlisted procedure codes in each section of the OMFS which can be used for codes not currently found in the OMFS.

If you cannot reach the claims administrator prior to the provision of the service, you should justify your billing by report and provide supporting documentation.

**Can a bill reviewer change the codes I billed?**

Yes, the bill reviewer may change the codes you billed if you did not adequately document the code you selected or if you selected an inappropriate code for the service provided. The bill reviewer must list the code you originally billed along with the code that they feel is more appropriate. A specific explanation of why the code was changed must be provided.

**How do I file a lien for services?**

If the claims administrator has not paid for services provided, a medical provider may file a lien against the injured worker's claim. The provider can file liens directly or an EDEX service provider can be utilized.

To file directly, the provider must fill out the lien form (WCAB Form 6) and serve a copy on the injured worker, the claims administrator and any attorneys involved. The original lien should be filed at the WCAB office where the case is being adjudicated. If no WCAB case exists, the medical provider should not file the original with the WCAB until a case number is assigned. Sometimes the injured worker's attorney can assist the medical provider in finding out when to file the lien with the WCAB.

To get a copy of Information and Assistance Guide "How to File a Lien" contact your local DWC Information and Assistance office or DWC Headquarters (see question 3 on page 1). To use EDEX, the medical provider needs to select an EDEX vendor from the following list. Basically the EDEX vendor files the lien for the medical provider. Different vendors provide different levels of service.

APPROVED VENDORS:

| Company | Address | Phone # | Fax # | Website Address |
|---|---|---|---|---|
| CompData | P O Box 729<br>Seal Beach CA<br>90740 | (562) 493-6652 | (562) 493-1550 | http://www.compdataedex.com |
| EDEXExpress | P.O. Box 31<br>Martell, CA 95654 | (800) 778-1989 | (209) 223-2966 | http://www.edexexpress.com |
| Software Technologies Group ("SpeedComp") | P.O. Box 6886<br>Malibu, CA 90264-6886 | (310) 457-3300 | (310) 457-0500 | http://www.wcabonline.com |
| Paracle Systems Inc. | 101 First St., Ste. 273<br>Los Altos, CA<br>94022 | (650) 685-8257 | (650) 401-6051 | http://www.paracle.com |

**How do I get a lien hearing?**

If the injured worker has filed an Application for Adjudication of Claim ("Application"), the form which gives jurisdiction to the WCAB, the lien is usually heard at the same time as the

injured worker's claim. There is currently a $100 fee for filing a lien. If the lien claimant prevails in the dispute, the payor must refund the $100 lien filing fee.

If the injured worker never files an Application with the WCAB, the medical provider can file the Application. Once a case number is assigned, the lien can be filed with the WCAB. In order to get a hearing the medical provider needs to file a Declaration of Readiness to Proceed (DOR). This is the document that tells the WCAB that the parties are ready to go ahead and have the judge decide the dispute. The injured worker's case is generally dealt with first.

To get a copy of Information and Assistance Guide "How to File an Application for Adjudication of Claim" or "How to File a Declaration of Readiness to Proceed" contact your local DWC Information and Assistance office or DWC Headquarters (see question 3 on page 1).

**Who represents me at the lien hearing?**

Many medical providers represent themselves at these hearings. Sometimes they hire attorneys or hearing representatives to appear for them. In some cases the injured worker's attorney will represent the medical provider as well.

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