SB 863 Fee Schedules

Presented by:
Destie Overpeck
Acting Administrative Director
Jacqueline Schauer
Industrial Relations Counsel
Division of Workers' Compensation
California Department of Industrial Relations

1

The most complete and up-to-date medical fee schedule regulations and tables are on the DWC OMFS webpage: http://www.dir.ca.gov/dwc/OMFS9904.htm (Labor Code 5307.1(g)(2)

2

SB 863 Fee Schedules

SB 863 Implementation	Status	Next Steps	Effective Date Per Labor Code
Ambulatory Surgery Center (ASC) LC § 5307.1	**Completed**	Regulations effective: Jan. 1, 2013	Jan. 1, 2013
Spinal Implant (Inpatient Fee Schedule) LC § 5307.1	**Completed**	Regulations effective: Jan. 1, 2013	Jan. 1, 2013

3

SB 863 Fee Schedules

SB 863 Implementation	Status	Next Steps	Effective Date Per Labor Code
Copy Services Fee Schedule LC § 5307.9	Study presented: 10/17/13	Post draft regulations on forum	Dec. 31, 2013
Interpreter Fee Schedule LC § 5811	Conducting study	Post study	Jan. 1, 2013

4

SB 863 Fee Schedules

SB 863 Implementation	Status	Next Steps	Effective Date Per Labor Code
Home Health Care Fee Schedule LC §§ 4600, 5307.8	Working group meeting: 10/2/12 Conducting study	Post study	July 1, 2013
Vocational Expert Fee Schedule LC § 5307.7	Working group meeting: 6/28/12	Post draft regulations on DWC forum	
Outpatient Fee Schedule LC § 5307.1	Drafting revisions	Begin formal rulemaking	

5

SB 863 Fee Schedules

SB 863 Implementation	Status	Next Steps	Effective Date Per Labor Code
Physician Fee Schedule (RBRVS) LC § 5307.1	**Completed**	Regulations effective: 1/1/14	Jan. 1, 2014

6

California Workers' Compensation Physician and Non-Physician Practitioner Fee Schedule – 2014

8 CCR § §9789.12 – 9789.19

7

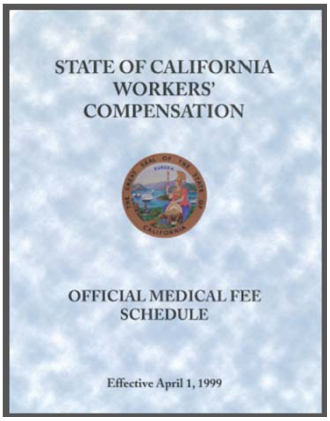
Background to the new fee schedule

- RBRVS transition has been under consideration since 1999
- SB 863 required the DWC to adopt an RBRVS-based physician fee schedule
  - Annual update of procedure codes, relative weights, inflation factor and Medicare relative value scale adjustment factor
  - Four-year transition between pre-2014 OMFS maximum and 120% of July 1, 2012 Medicare physician fees (before inflation and RVS adjustment)
  - Required inclusion of payment ground rules that differ from Medicare as appropriate for WC

8

Out with the Old…..

1999 Book
Table A May 2005
Table A Addendum Feb. 2007



9

Major Differences Pre-2014 OMFS vs. New RBRVS-Based Fee Schedule

Pre-2014 Fee Schedule	RBRVS Fee Schedule - 1/1/2014
Charge-based relative values	Resource-based relative values
Single relative value for each procedure	Work, Practice Expense, Malpractice relative values for each procedure
Same relative value/fee regardless of site of service	Practice Expense relative value usually different in "facility" vs. "non-facility"
Multiple Conversion Factors	Multiple Conversion Factors, transitioning to single CF in 2017
No geographic adjustments	Apply average statewide geographic adjustments to Work, PE, MP
Non-physician practitioners and physicians paid same rate	Nurse Practitioners and Physician Assistants paid at 85% unless "incident to" physician service (then paid at 100%)
CPT Consultation Codes for consultations	Use CPT visit codes for consultations

10

Major Differences contd.

Pre-2014 Fee Schedule	RBRVS Fee Schedule - 1/1/2014
Separate payment for consultation service and consultation report	Consultation report bundled, not separately payable unless requested by an AME/QME or by the WCAB or Administrative Director
Prolonged E&M Service without direct patient contact CPT 99358/99359 payable	Prolonged E&M Service without direct patient contact CPT 99358/99359 NOT payable; Status Code B (bundled)
Interpreter used by patient – 110% of usual value of service	No extra payment for use of interpreter by patient
Anesthesia time units – 1 unit per 15 minutes for first 4 hours and 1 unit for each 10 minutes thereafter; 5 minutes or more is a unit	Actual anesthesia minutes reported divided by 15, then round the time unit to one decimal place
Anesthesia units increased for qualifying circumstances and specified patient status codes	No additional units

11

Major Differences contd.

Pre-2014 Fee Schedule	RBRVS Fee Schedule - 1/1/2014
Physical Therapy Cascade Formula reduces 2nd – 4th procedures	Multiple Procedure Payment Reduction Formula is different and applies only to Practice Expense RVUs (not to Work RVUs, MP RVUs)
Radiology multiple procedures paid at full value	Radiology MPPR applies to specified major radiology codes (CT, MRI, Ultrasound)
Supplies and materials "beyond those usually included with the service" may be separately billed	Supplies and materials generally bundled into the payment for the procedure; not separately payable
No coding edits specifically included	National Correct Coding Initiative Edits
No E&M documentation guidelines specifically included	E&M Documentation Guidelines – 1995 and 1997 adopted

12

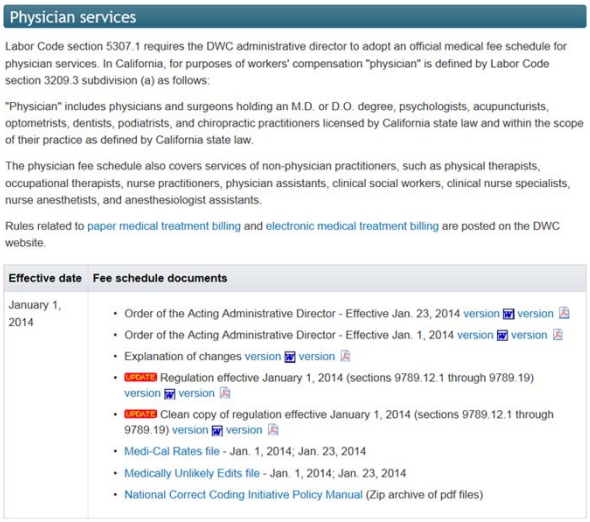
Wide Variety of Providers Subject to Fee Schedule

- **Physicians – Labor Code §3209.3**
  - M.D.s, D.O.s
  - Psychologists
  - Chiropractors
  - Acupuncturists
  - Dentists
  - Optometrists
  - Podiatrists
- **Non-Physician Practitioners**
  - Nurse Practitioners
  - Physician Assistants
  - Physical Therapists, Speech Therapists, Occupational Therapists
  - Marriage and Family Therapists
  - Certified Registered Nurse Anesthetists

http://www.dir.ca.gov/dwc/OMFS9904.htm

14

Free Access on DWC OMFS web page



Physician services

Labor Code section 5307.1 requires the DWC administrative director to adopt an official medical fee schedule for physician services. In California, for purposes of workers' compensation "physician" is defined by Labor Code section 3209.3 subdivision (a) as follows:

"Physician" includes physicians and surgeons holding an M.D. or D.O. degree, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners licensed by California state law and within the scope of their practice as defined by California state law.

The physician fee schedule also covers services of non-physician practitioners, such as physical therapists, occupational therapists, nurse practitioners, physician assistants, clinical social workers, clinical nurse specialists, nurse anesthetists, and anesthesiologist assistants.

Rules related to paper medical treatment billing and electronic medical treatment billing are posted on the DWC website.

Effective date	Fee schedule documents
January 1, 2014	• Order of the Acting Administrative Director - Effective Jan. 23, 2014 version version • Order of the Acting Administrative Director - Effective Jan. 1, 2014 version version • Explanation of changes version version • UPDATE Regulation effective January 1, 2014 (sections 9789.12.1 through 9789.19) version version • UPDATE Clean copy of regulation effective January 1, 2014 (sections 9789.12.1 through 9789.19) version version • Medi-Cal Rates file - Jan. 1, 2014; Jan. 23, 2014 • Medically Unlikely Edits file - Jan. 1, 2014; Jan. 23, 2014 • National Correct Coding Initiative Policy Manual (Zip archive of pdf files)

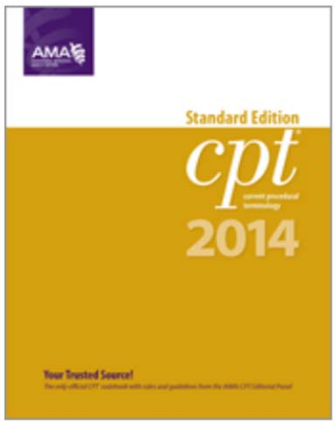
15

Procedure Coding – Mostly CPT

- AMA CPT® 2014

  https://commerce.ama-assn.org/store/

  It is incorporated by reference into fee schedule regulation. Purchase from AMA



- Other Codes Used
  - WC-specific codes (9789.12.14) WC001 – WC012
  - Physician-administered drugs use HCPCS J codes and NDC codes
  - Radiopharmaceuticals use HCPCS Q codes and A codes
- Specified Exceptions to CPT Code usage
  - Codes listed in §9789.19
- National Correct Coding Initiative (NCCI) applied

16

Medicare Physician Fee Schedule 2014 Relative Value ZIP File

- RVU File PPRRVU14_V1219
  - Relative Value Units
  - Status Codes – adapted for WC in §9789.12.8
  - Payment Policy Indicators
    - Professional Component/Technical Component Indicator
    - Surgery-related indicators (e.g. Global Days, Pre-Operative/Intra Op/Post Op percentages, Co-surgeon)
    - Multiple Procedure policy indicators
- PDF file labeled "RVUPUF14" in Zip has important information about the RVU file structure/usage

17

Fee Calculation Example

CPT® 99205 (new patient, comprehensive Hx & exam, high-complexity decision making)

Step 1: Determine if place of service is "facility" or "non-facility" **(§9789.12.2(d))** - POS code 11 "Office" is "non-facility"

POS Code and Name Description	Payment Rate Facility = F Nonfacility = NF
01 Pharmacy A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.	NF
03 School A facility whose primary purpose is education.	NF
04 Homeless Shelter A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).	NF
09 Prison/Correctional Facility A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders.	NF
11 Office Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.	NF

18

Fee Calculation Example contd.

Step 2: Select formula for non-facility site of service calculation (§9789.12.2(a))

(a) Non-facility site of service fee calculation:
[(Work RVU * Statewide Work GAF) +
(Non-Facility PE RVU * Statewide PE GAF) +
(MP RVU * Statewide MP GAF)] * Conversion Factor (CF) = Base Maximum Fee

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

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

19

Fee Calculation Example contd.

Step 3: Open the CMS' 2014 Medicare National Physician Fee Schedule Relative Value File (Zip Folder "RVU14A", then the file "PPRRVU14_V1219" (Link is set forth in §9789.19)) to identify the Non-Facility RVUs for Practice Expense, and the RVUs for Work and Malpractice

A	B	C	D	E	F	G	H	I	J	K	L
		2014 National Physician Fee Schedule Relative Value File January Release									
		CPT codes and descriptions only are copyright 2013 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.									
		Dental codes (D codes) are copyright 2013/14 American Dental Association. All Rights Reserved.									
		RELEASED 12/19/2013									
				NOT USED							
				FOR			NON-FAC		FACILITY		
			STATUS	MEDICARE	WORK	NON-FAC	NA	FACILITY	NA	MP	NON-FACILITY
HCPCS	MOD	DESCRIPTION	CODE	PAYMENT	RVU	PE RVU	INDICATOR	PE RVU	INDICATOR	RVU	TOTAL
99205		Office/outpatient visit new	A		3.17	2.35		1.32		0.26	5.78

Work RVU	Column F	3.17
Non-facility PE	Column G	2.35
Malpractice	Column K	0.26

20

Fee Calculation Example contd.

Step 4: Identify the Average Statewide Geographic Adjustment Factors to use (set forth in §9789.19)

Statewide GAFs (Other than anesthesia)	Average Statewide Work GAF: 1.040 Average Statewide Practice Expense GAF: 1.1606 Average Statewide Malpractice Expense GAF: 0.6636

Step 5: Identify the 2014 Conversion Factor to use (set forth in §9789.19). The "Evaluation and Management" code is not "anesthesia", "surgery" or "radiology"; rather it falls within the "other services"

CFs adjusted for MEI & Relative Value Scale adjustment factor	Anesthesia Conversion Factor: $33.8190 Surgery Conversion Factor: $55.2913 Radiology Conversion Factor: $53.1039 Other Services Conversion Factor: $38.3542

21

Fee Calculation Example contd.

Step 6: Apply the formula for non-facility site of service calculation (§9789.12.2(a))

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

[(3.17 * 1.040) +
(2.35 * 1.1606) +
(0.26 * 0.6636)] * $38.3542 = $237.67

Fee Calculation Example contd.

Step 7: Apply relevant ground rules, if any, to the Base Maximum Fee to determine the payable fee

Example:

The 99205 new patient visit was performed in the physician's office which is located in a Health Professional Shortage Area

Apply ground rule in 8 CCR 9789.12.6 - HPSA 10% bonus to the Base Maximum Fee determined in Step 6

Base maximum fee =	$237.67
Add HPSA 10% bonus	$ 23.77
Total maximum fee	$261.44

23

Consultations

- Pre-2014 OMFS used the CPT consultation codes; paid separately for a consultation report
- New RBRVS-based fee schedule follows the Medicare rules:
  - use CPT E&M visit codes instead of consultation codes
    - Office setting: use CPT visit codes for level of service
    - Inpatient setting: use CPT hospital care codes
  - Payment for consultant's reporting of findings to referring physician is bundled into the visit code; no separate payment
  - Consultant's report separately payable if consultation report requested by QME/AME or WCAB or AD

24

Multiple Physical Therapy / Chiropractic / Acupuncture

Pre-2014 OMFS Ground Rules

- Physical Therapy "Cascade"
  - Highest value paid 100%
  - 2nd paid at 75%
  - 3rd paid at 50%
  - 4th paid at 25%
- Does not apply to additional time codes
- Limit on number of procedures /modalities on visit w/o preauthorization

New Fee Schedule Ground Rules

- Multiple Procedure Payment Reduction (MPPR)
  - Code with highest Practice Expense (PE) Relative Value paid at 100%
  - Subsequent codes paid at 50% of PE RVU, and 100% of Work RVU, and 100% of Malpractice RVU
  - Applies to "Always Therapy", Chiro., Acupunc. codes billed on same day
  - Applies to more than 1 procedure & 1 unit
  - Limit on number of procedures / modalities on visit w/o preauthorization

25

Surgery Global Period

- RBRVS sets RVUs for "global surgical package"
  - Global Fee covers surgical procedure, immediate pre- and postsurgical services and follow-up E&M services
  - Zero, 10, 90 day global period specified in the Medicare National Physician Fee Schedule Relative Value File, Global Days column
- Global surgical package applied to procedures identified in the Global Days column regardless of setting

26

Surgery Global Period contd.

- Global Fee assumes one surgeon; if multiple physicians provide care during 10 or 90 day global period, fee is split
  - Surgery billed with modifier 54 (surgical care only) or modifier 55 (postoperative management only)
  - Columns of Relative Value File "Pre Op", "Intra Op" and "Post Op" list percentages for pre-, intra-, and postoperative care of total RVUs
- Split global payment does not apply to procedures with 000 in "Glob Days" column

27

Services Paid in addition to global surgery fee

- Initial evaluation by the surgeon to determine need for major procedure
- Visits during the global period unrelated to the diagnosis for which the surgical procedure is performed
- Diagnostic tests and procedures
- Clearly distinct surgical procedures during the postoperative period
- Treatment for postoperative complications which require return trip to operating room

28

Schedule Differs from Medicare Rule: E&M Exception to Global Surgery

Labor Code §5307.1(a)(2)(B): fee schedule shall include ground rules that differ from Medicare as appropriate including payment of E&M services during a global period of surgery

- Primary Treating Physician's Progress Reports (PR-2) are separately reimbursable during the global period (8 CCR §9789.16.4(b))
- Physician may separately bill one or more E&M codes for medically necessary services that exceed the number of visits that are listed for the global surgery code in the Medicare Physician Fee Schedule "Physician Time File" (8 CCR §9789.16.4(a))

29

How to use the Physician Time File

- Access the Medicare Physician Time File "CY 2014 PFS Physician Time.xls" (Link is in 8 CCR 9789.19)
- Example CPT® 25515 Open treatment of radial shaft fracture, includes internal fixation, when performed
  - Find 25515 in column A "Cpt_code"

CY 2014 PFS Physician Time.xls [Read-Only] [Compatibility Mode]

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
1	Cpt_code	Pre_Evaluati	Pre_Positio	Pre_Service	Median_Intr	Immediate_r	_99204	_99211	_99212	_99213	_99214	_99215	_99231	_99232	_99233	_99238	_99239	_99291	_99292	Total_time
1394	25515	40.00	10.00	10.00	60.00	30.00	0.00	0.00	2.00	2.00	0.00	0.00	0.00	0.00	0.00	0.50	0.00	0.00	0.00	247.00
1395	25520	65.00	0.00	0.00	30.00	25.00	0.00	0.00	5.00	0.00	0.00	0.00	0.00	0.00	0.00	0.50	0.00	0.00	0.00	219.00
1396	25525	45.00	10.00	15.00	70.00	20.00	0.00	0.00	1.00	3.00	0.00	0.00	1.00	0.00	0.00	1.00	0.00	0.00	0.00	303.00
1397	25526	45.00	10.00	15.00	115.00	30.00	0.00	0.00	3.00	2.00	0.00	0.00	1.00	0.00	0.00	1.00	0.00	0.00	0.00	367.00

  - Add number of visits for all E&M services shown on 25515 row in the Physician Time File
  - Add [column I 99212] 2.00 **+** [column J 99213] 2.00 **+** [column P 99238] 0.50 **=** 4.50. Round up to 5.0 Physician can bill for medically necessary E&M visits in excess of 5 that occur in global period

Surgery Multiple Procedure Payment Reduction

Pre-2014 OMFS

- Multiple procedures at one surgical session
  - Major (highest value) - 100%
  - 2nd - 50%
  - 3rd – 25%
  - 4 or more procedures – Global Fee billed By Report

New RBRVS-based Fee Schedule

- Multiple procedures at one surgical session
  - Major (highest value) - 100%
  - 2nd thru 5th - 50%
  - Procedures beyond 5th billed By Report (paid no less than 50%)
- Medicare National Physician Fee Schedule Relative Value File designates procedures subject to the reduction by entry of "2" in the "Mult Proc" column

31

Radiology

- Radiology Diagnostic Imaging Multiple Procedure Payment Reduction
  - Applies to Diagnostic Imaging Codes on Medicare Physician Fee Schedule Final Rule Addendum F (noted as "4" in the "Mult Proc" column of the Relative Value File)
  - MPPR applies to both Professional Component only, Technical Component only, and to PC and TC of global services (procedures in same session/same day/same patient by one or more physicians in same group practice)
    - 100% for each PC and TC with highest payment
    - 75% for subsequent PC services
    - 50% for subsequent TC services
- Radiology Consultations: only one interpretation of x-ray payable; physician must prepare signed written report

32

Anesthesia

- Methodology for anesthesia services is different than RBRVS
  - Uses base units and time units rather than Work, PE, MP RVUs
  - Base units - Medicare zip file "2014 Anesthesia Base Units by CPT Code" (link is in 8 CCR §9789.19)
- Maximum anesthesia fee formula (8 CCR §9789.18.1):

  [Base Unit + Time Unit] * CF * Statewide Anesthesia GAF = Base Maximum Fee
- Apply any applicable ground rules to the base maximum fee
  - Personally performed rate 100%
  - Medically directed rate 50%
  - Medically supervised rate 3 base units per procedure
  - HPSA 10% bonus payment if service in a HPSA

Physician-Administered Drugs

- Physician-administered drugs, biologicals, vaccines, or blood products are separately payable
- "Administer" means the direct application of a drug or device to the body of a patient by injection, inhalation, ingestion, or other means.
- Maximum fee: "Basic Rate" for the HCPCS code on the Medi-Cal Rates file for the date of service minus $4.46
  - Medi-Cal Rates file uses Medicare's Average Sales Price plus 6%, or the Medi-Cal pharmacy rate when the ASP +6% is not available
  - Injection administration determined under the RBRVS (generally bundled into procedure payment; paid separately only if injection is only service provided at the visit)

34

Reports / WC-Specific Codes §§9789.12.14, 9789.19

WC001	Doctor's First Report of Occupational Illness or Injury (Form 5021) (Section 9789.14(a)(1))	Not separately payable
WC002	Treating Physician's Progress Report (PR-2 or narrative equivalent in accordance with § 9785) (Section 9789.14(b)(1))	$11.91
WC003	Primary Treating Physician's Permanent and Stationary Report (Form PR-3) (Section 9789.14(b)(2))	$38.68-for first page $23.80 each additional page. Maximum of six pages absent mutual agreement ($157.68)
WC004	Primary Treating Physician's Permanent and Stationary Report (Form PR-4) (Section 9789.14(b)(3))	$38.68 for first page $23.80 each additional page. Maximum of seven pages absent mutual agreement ($181.48)
WC005	Psychiatric Report requested by the WCAB or the Administrative Director, other than medical-legal report. Use modifier -32 (Section 9789.14(b)(4))	$38.68 for first page, $23.80 each additional page. Maximum of six pages absent mutual agreement ($157.68)
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)	$38.68 for first page $23.80 each additional page. Maximum of six pages absent mutual agreement ($157.68)
WC008	Chart Notes (Section 9789.14(c))	$10.26 for up to the first 15 pages. $0.25 for each additional page after the first 15 pages
WC009	Duplicate Reports (Section 9789.14(d))	$10.26 for up to the first 15 pages. $0.25 for each additional page after the first 15 pages
WC010	Duplication of X-Ray	$5.13 per x-ray
WC011	Duplication of Scan	$10.26 per scan
WC012	Missed Appointments. This code is designated for communication only. It does not imply that compensation is owed.	No Fee Prescribed / Non Reimbursable absent agreement

35

Physician Fee Schedule Updates

- Labor Code 5307.1(a)(2)(A)(ii) requires annual updates to procedure codes, relative weights and adjustment factors in subdivision (g)
  - CPT® book
  - Medicare Physician Fee Schedule Relative Value File
  - Inflation Adjustment: Medicare Economic Index
  - Relative Value Scale Budget Neutrality Adjustment
- Labor Code 5307.1(g) requires OMFS to be adjusted to conform to relevant Medicare changes within 60 days
  - Exempt from Administrative Procedure Act
  - Adopted through issuance of Administrative Director Order to be posted on DWC website

36