

**SUMMARY**

**CHANGES TO THE OFFICIAL MEDICAL FEE SCHEDULE – PHYSICIAN SERVICES**

SB 863, enacted in 2012, required the Division of Workers' Compensation to transition the Official Medical Fee Schedule for physician services to a Medicare RBRVS system over four years. At the end of the four years, the reimbursement rate will be 120% of 2012 Medicare rates. **Medicare payment rules have been adopted unless specifically noted in the regulations.** The DWC has continued some California-specific code numbers and Ground Rules that are unique to a Workers' Compensation system. The final regulations can be found on the DWC website at: <https://www.dir.ca.gov/dwc//DWCPpropRegs/OMFSPhysicianFeeSchedule/OMFSPhysicianFeeSchedule.htm>

Here is a summary of the changes.

1. The revised fee schedule is effective for medical treatment rendered on or after 1/1/2014.
2. Contracting for reimbursement rates and Ground Rules different than those contained in the OMFS is still permitted.
3. There will be a 4 year transition with the following conversion factors:

	2014	2014 w/MEI Adjustment	2015	2016	2017 (120% of Medicare)
Surgery	\$51.9750	\$52.9311	\$48.2650	\$44.5551	\$40.8451
Radiology	\$49.9188	\$50.8371	\$46.8943	\$43.8697	\$40.8451
Anesthesia	\$32.3651	\$32.9605	\$30.1400	\$27.9148	\$25.6896
All Other Services Including E&M	\$36.0537	\$36.7169	\$37.6509	\$39.2480	\$40.8451

Non-facility site of service calculation:

$$((\text{Work RVU} * \text{Statewide Work GAF}) + (\text{Non-Facility PE RVU} * \text{Statewide PE GAF}) + (\text{MP RVU} * \text{Statewide MP GAF}) * \text{Conversion Factor} = \text{Base Maximum Fee})$$

Facility site of service calculation:

$$((\text{Work RVU} * \text{Statewide Work GAF}) + (\text{Facility PE RVU} * \text{Statewide PE GAF}) + (\text{MP RVU} * \text{Statewide MP GAF}) * \text{Conversion Factor} = \text{Base Maximum Fee})$$

4. An average California Geographic Adjustment Factor (GAF) will be added to the conversion factor. SB 863 set the factor at 1.078. (The regulations list the following GAF breakdown: Work: 1.0370, Practice Expense: 1.1585, Medical Malpractice: 0.5877, and Anesthesia: 1.0212.)
5. Medicare Economic Index and the Relative Value Scale Adjustment Factor will be added to the conversion factor beginning in 2014.
6. CPT Codes will be updated annually as of 1/1/2014.

Billing of consultation codes is not permitted. DWC followed Medicare payment rules and believes the value of the consultation service is now included in the value of the E&M service.

7. California-Specific codes/modifier:
- WC001- Doctor's First Report of Occupational Illness or Injury – Form 5021 – Not reimbursable
  - WC002 Treating Physician's Progress Report – Form PR-2 - \$11.91
  
  - WC003 Primary Treating Physician's Permanent and Stationary Report – Form PR-3  
\$38.68 for the first page; \$23.80 each additional page.  
Maximum of 6 pages absent mutual agreement.
  
  - WC004 Primary Treating Physician's Permanent and Stationary Report – Form PR-4  
\$38.68 for the first page; \$23.80 each additional page.  
Maximum of 6 pages absent mutual agreement.
  
  - WC005 Psychiatric Report requested by the WCAB or AD, other than Medical-Legal report  
Use modifier -32 \$38.68 for the first page; \$23.80 each additional page.  
Maximum of 6 pages absent mutual agreement.
  
  - WC007 Consultation Reports requested by the WCAB, AD, QME, or AME in the context of a  
Medical-Legal report. **Other consultation reports are not separately reimbursable.**  
\$38.68 for the first page; \$23.80 each additional page.  
Maximum of 6 pages absent mutual agreement.
  
  - WC008 Chart Notes - \$10.26 for up to the first 15 pages. \$0.25 for each additional page.
  
  - WC009 Duplicate Reports - \$10.26 for up to the first 15 pages. \$0.25 for each additional page.
  
  - WC010 Duplication of x-rays - \$5.13 per x-ray.
  
  - WC011 Duplication of scans - \$10.26 per scan.
  
  - WC012 Missed Appointments. This code is designated for communication only. It does not  
imply that compensation is owed.

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.

8. Physicians can use either the 1995 or 1997 Evaluation & Management documentation guidelines for a specific patient encounter.
9. DWC adopted a unique New and Established Patient Definition:  
"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.”

“An established patient is a patient who has been seen previously for the same industrial injury or illness by the physician or medical group.

10. The National Correct Coding Initiative (CCI) edits will apply.
11. The Medicare multiple surgery rule will apply – 100% for the primary procedure; 50% for subsequent procedures.
12. Global Surgical Package – Consistent with the National Physician Fee Schedule Relative Value File for global days. Surgical procedures have a global package of 0,010, and 090 days. “ZZZ” codes have no global period. The global surgical package includes one day prior to surgery, intra-operative visits, complications following surgery, and post-operative visits until you reach the global follow-up days designated for the procedure.

Once the surgeon has met the number of evaluation and management visits contained in the CMS “Physician Time File” (columns G-S) he/she may bill for the additional visits. The other columns in the file are minute-based codes and are not applicable. COA recommends billing the E&M visits contained in the global surgical package using CPT code 99024 so that the carrier can track the number of E&M visits during the global surgical package. Remember to count the one pre-op visit, the intra-operative visits, and the post-operative visits.

The CMS Physician Time File can be found at: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1590-FC.html>  
Scroll down to the “CY2013 PFS Physician Time.

13. Prolonged Service Codes – DWC has adopted the Medicare Billing Rules  
Non-face-to-face time – 99358 and 99359 – are not separately billable. Medicare considers them bundled in the E&M service.  
Face-to-face time – 99354-99357 – must spend 30 minutes before time can be billed. After the first hour, the codes are billed in increments of 30 minutes.
14. Supplies – Medicare Ground Rules were adopted. Separate payment for routinely bundled supplies is not allowed. Splints and casting supplies are an exemption and are payable separately, in addition to payment for the procedure for applying the splint or cast when performed in a physician’s office.
15. Physician-administered Drugs/Biologicals/Vaccines/Blood Products are separately reimbursable. Injection services (96365-96379) are not paid for separately, if the physician is paid for any other physician fee schedule service furnished at the same time.
16. Non-physician services are reimbursed at 100% of the physician fee schedule amount if provided incident to the physician service. Incident to requires direct supervision by the physician. Otherwise, reimbursement is at 85% of what a physician is paid to perform the service.

17. 10% bonus if you practice in an officially designated Health Professional Shortage Area by the Health Resources and Services Administration.
18. Medicare Status codes have been adopted by DWC, but they have different definitions. The following Status code definitions have been adopted by DWC:

A =	Active Code. These codes are paid separately under the physician fee schedule. There will be RVUs for codes with this status.
B =	Bundled Code. Payment for covered services are always bundled into payment for other services not specified. If RVUs are shown, they are not used for payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident. (An example is a telephone call from a hospital nurse regarding care of a patient).
C =	If payable, these codes will be paid either using RVUs established by the federal OWCP or "By Report", generally following review of documentation such as an operative report.
E =	If payable: (a) HCPCS codes beginning with "J" or "P", maximum fee is determined according section 9789.13.2. (b) Other codes are paid under the applicable fee schedule contained in Section 9789.30-9789.70, or if none of those schedules is applicable the code is payable "By Report."
I =	Except as otherwise provided, not valid code for workers' compensation physician billing. See section 9789.12.3.
J =	Anesthesia Services. The intent of this value is to facilitate the identification of anesthesia services. There are no RVUs and no payment amounts for these codes in the National Physician Fee Schedule Relative Value File. Instead, the Anesthesia Base Units file is to be used to determine the base units for these codes.
M =	Measurement codes. Used for reporting purposes only.
N =	If payable, these CPT codes are paid using the listed RVUs; but if no RVUs are listed, then use federal OWCP RVUs; if neither of these, then By Report. See section 9789.12.3.
P =	Bundled/Excluded Codes. There are no RVUs and no payment amounts for these services. No separate payment should be made for them under the fee schedule. --If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident. (An example is an elastic bandage furnished by a physician incident to physician service.) --If the item or service is covered as other than incident to a physician service, it

	is excluded from the fee schedule (i.e., colostomy supplies) and should be paid under the other portions of the fee schedule.
R =	If payable, these codes will be paid pursuant to section 9789.12.3.
T =	Injections. There are RVUS and payment amounts for these services, but they are only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the physician services for which payment is made.
X =	No RVUS or payment amounts are shown for these codes. If payable, these codes are paid under the applicable fee schedule contained in Sections 9789.30 - 9789.70, or if none of those schedules is applicable the code is payable "By Report." (Examples of services payable under another fee schedule are ambulance services and clinical diagnostic laboratory services.)

19. Radiology Consultations – only 1 interpretation of an x-ray procedure shall be reimbursed. This interpretation must directly contribute to the diagnosis and treatment of the patient. The physician must prepare a signed written report of his or her interpretation results of the x-ray. The professional component of the x-ray service is billed with modifier -26. Reimbursement for a second reading shall only be allowed under usual circumstance such as a questionable finding.

20. Radiology Diagnostic Imaging Multiple Procedures

Specified diagnostic imaging procedures are designated 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) 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).
- (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.

21. Physical Therapy Services

DWC adopted the Medicare billing rules for billing physical and occupational therapy services and retained some California-specific rules.

22. Diagnostic Codes

The DWC plans to implement ICD-10 as of October, 2014.

Dated: December 1, 2013