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**State of California Division of Workers' Compensation**

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## DWCNewsline

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### **Division of Workers' Compensation releases The Lewin Group study results regarding adapting the Resource-Based Relative Value Scale (RBRVS) to California's workers' compensation physician fee schedule in advance of public meetings**

The Division of Workers' Compensation (DWC) has released a study conducted by The Lewin Group titled, "Adapting the RBRVS Methodology to the California Workers' Compensation Physician Fee Schedule." The study, which was commissioned by the DWC, was conducted to evaluate the impact of switching from the current physician fee schedule to a physician fee schedule based on the Resource-Based Relative Value Scale (RBRVS) system.

The report may be found on the DWC's Web site at [http://www.dir.ca.gov/dwc/RBRVSReport/RBRVS\\_May2008.pdf](http://www.dir.ca.gov/dwc/RBRVSReport/RBRVS_May2008.pdf), and the DWC has set two public meetings to discuss the study. The meetings will be held at the following times and places:

**Date: Monday, May 19, 2008**

**Time: 1 p.m. to 4 p.m., or until conclusion of business**

**Place: Ronald Reagan State Office Building – auditorium  
300 South Spring Street  
Los Angeles, CA 90013**

**Date: Tuesday, May 20, 2008**

**Time: 10 a.m. to 1 p.m., or until conclusion of business**

**Place: Elihu Harris State Office Building – auditorium  
1515 Clay Street  
Oakland, CA 94612**

"It's time to bring our physician fee schedule into the 21<sup>st</sup> century," said DWC Medical Director Dr. Anne Searcy. "This study, and the input we receive from the community, are important steps in that process."

The RBRVS is maintained by the Centers for Medicare and Medicaid Services (CMS) in its Medicare Fee Schedule. DWC already maintains five Medicare-based fee schedules, in addition to a Medi-Cal-based pharmaceutical fee schedule, a California medical-legal fee schedule, and the OMFS physician fee schedule. All but the medical-legal fee schedule are a part of the California Workers' Compensation Official Medical Fee Schedule (OMFS).

“Using other Medicare-based fee schedules has really helped streamline the updating process,” said Searcy. “However, in this case, we are not going to adopt Medicare’s entire physician fee schedule. We want to use their relative value units but not all of their rules.”

The current physician fee schedule requires physicians and selected health care providers to use codes and descriptors of the 1997 edition of the American Medical Association's (AMA's) Current Procedural Terminology (CPT) to bill for their services. The Lewin Group concluded that, “The use of outdated codes makes it difficult for providers and payers to understand and use the current OMFS and adds administrative costs.”

A study conducted in 1999 by UCLA found that migration to RBRVS would improve the fairness of provider payments, and that adopting the RBRVS offered advantages over other alternatives. Additionally, at least 20 states’ workers’ compensation systems, as well as a high percentage of other public and private payers, use an RBRVS-based system, which bases payments for medical treatment on the resources used to provide services. In contrast, payments in the current physician fee schedule are based on charge-based fees established several decades ago. The Lewin Group study reports on the impact of changing to an RBRVS-based fee schedule by estimating payments under both the current physician fee schedule and an RBRVS-based system for the same set of services. The study incorporated ground rules that may or may not be adopted permanently by the DWC, but which were useful for the purposes of the study.

Similarly, the study assumed budget neutrality so that “we can separate the effects of an adoption of RBRVS from the effect of any overall adjustment in payment levels.”

“When we transition to an RBRVS-based fee schedule, a very important consideration is to maintain injured workers’ access to all different types of physicians,” Searcy said. “This study evaluated the potential impacts of various options, which will help us with all of our upcoming decisions.”

To conduct the study, The Lewin Group contracted with the California Workers’ Compensation Institute (CWCI) to use medical billing data from their Industry Claims Information System (ICIS) database. The Lewin Group found that the CWCI data were representative of claims in the California workers’ compensation system when compared to data from the Workers’ Compensation Insurance Rating Bureau (WCIRB) and the DWC’s Workers’ Compensation Information System (WCIS).

In its study, The Lewin Group states that there is an implicit tradeoff among three broad goals:

- 1) Maintaining or improving access for injured workers to necessary medical services
- 2) Containing costs to payers, and
- 3) Moving toward a more equitable relative value scale.

The study also concluded that decisions about how to move to the RBRVS system needs to be made in light of these three goals.

“This study is just the first step in the process of deciding which features of an RBRVS-based physician fee schedule the DWC will eventually adopt,” said Searcy. “We really needed this first study to set a baseline against which other models can be compared.”

After receiving input from the public on this study, the DWC will have The Lewin Group generate several more models using different ground rules and model assumptions. The public will have the opportunity to provide feedback as the results of these additional models become available. DWC will consider all input before adopting a new physician fee schedule.

Labor Code section 5307.1 grants the DWC administrative director (AD) authority to revise the OMFS on a periodic basis. The last update occurred in 1999 when values for new and modified codes were added.

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## **Adapting the RBRVS methodology to the California workers' compensation physician fee schedule**

### **Key information**

The Lewin Group first estimated the impact of adopting a budget neutral RBRVS-based physician fee schedule using a single conversion factor. The conversion factor (CF) is multiplied by the Relative Value Unit (RVU) to determine payment for a service ( $CF \times RVU = \text{Payment}$ ). Medicare RBRVS currently uses a single conversion factor, maintaining the relativity among CPT codes.

When The Lewin Group examined the impact of adopting RBRVS on different types of providers, they found that a budget neutral migration would increase payments to:

- Anesthesiologists by 1.3%
- Chiropractors by 5.8%
- Multi-specialty groups by 6.1%
- Psychologists by 7.3%
- Emergency room physicians by 9.6%
- Physical medicine providers by 11.2%.

A budget neutral migration would also:

- Decrease payments to surgeons by 12.1%
- Decrease payments to neurologists by 4.9%
- Provide virtually no change for family physicians.

The researchers also looked at the impact of RBRVS adoption on different service categories. In this analysis The Lewin Group found that:

- Payments for evaluation and management (E&M) services (e.g., office visits) would increase by 20%
- Payments for surgery would decrease by 25.9%
- Since surgeons also use E&M codes, their overall reimbursement would not decrease by this much in a budget neutral model.

The Lewin Group calculated the conversion factor for the budget neutral model to be\*:

- \$44.57, which is 15.5% higher than Medicare's adjusted conversion factor of \$38.58

\* These conversion factors cannot be easily compared to the current California conversion factors as the relative values in the two systems are different.

According to a 2006 report by the Workers' Compensation Research Institute, California has the ninth lowest workers' compensation fee schedule in the country for surgery services and the sixth lowest for overall payments. Using WCRI estimates, which weights service categories differently than in The Lewin Group study:

- California paid 21% above Medicare in 2006, while the median state paid 55% above it
- Payment varied from 140% to 247% over Medicare for surgical services in states studied by The Lewin Group that had more than one conversion factor
- E&M services varied from 109% to 205% over Medicare in states with more than one conversion factor.

The Lewin Group discusses the premise that California could adopt two or more conversion factors to lessen the impact of RBRVS adaptation on provider specialties:

- Many states have a separate conversion factor for surgical services that is higher than that used for other services

Another way to lessen the immediate impact of a change to the new fee schedule is to transition to the RBRVS-based system over several years.

Another section of the report examines the use of geographic adjustment factors to pay providers at different levels depending on the area where a service was provided:

- Unlike Medicare, the California workers' compensation physician fee schedule currently sets the same maximum payment rate no matter where the provider practices.
- The study points out that although physicians in urban areas have higher practice expenses, it's in the rural areas that injured workers are more likely to have problems accessing care.

The Lewin Group also commented on four different economic indexes that could be used to update the schedule on a regular basis. Of the four, they conclude that:

- The Medicare Economic Index (MEI) "appears to be a reasonable alternative"
- The MEI has increased at an average rate of 2.6% from 2001 to 2008
- The Medicare Update, which is different than the MEI, "is not a reliable measure of the change in the cost of physician services."

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