



California Workers' Compensation Institute

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VIA E-MAIL to DWCForums@dir.ca.gov

Division of Workers' Compensation
Post Office Box 420603
San Francisco, CA 94142
Attn: DWC Forums

RE: RBRVS Revision to Physician Section of OMFS

Adapting the RBRVS Methodology to the California Workers' Compensation Physician Fee Schedule:
Supplemental report <http://www.dir.ca.gov/dwc/RBRVSLewinReport2010/RBRVSLewinReport2010.pdf>

This 2nd Forum commentary on draft revisions to the Physicians Section of the Official Medical Fee Schedule (OMFS), including conversion factor revision, is presented on behalf of members of the California Workers' Compensation Institute (the Institute). Institute members include insurers writing 84% of California's workers' compensation premium, and self-insured employers with \$36B of annual payroll (20% of the state's total annual self-insured payroll).

Introduction

The proposed conversion factors will add 3% to medical costs; and the proposed new payments for progress reports by non-PTPs will add 9.2% to medical costs if their frequency is the same as for PTPs, or 4.6% if their frequency is half that of PTPs. The Institute questions the wisdom of increasing workers' compensation medical costs in California by an estimated 7.6% to 12.2% at a time when medical costs are already rising, unemployment is high and employers are struggling to survive.

In its March 2010 supplemental report, the Lewin Group estimated aggregate workers' compensation fees in California are 11.4% above Medicare's. If the conversion factors and payments for progress reports by non-PTPs are adopted as drafted, the estimated aggregate fees will exceed the estimated aggregate fees prescribed in the Medicare payment system for the same class of (physician) services. This is specifically prohibited in subdivision (b) of Labor Code section 5307.1, which allows the administrative director to adopt different conversion factors from those used in the Medicare payment system, "*provided the estimated aggregate fees do not exceed 120 percent of the estimated aggregate fees paid for the same class of services in the relevant Medicare payment system.*" Subsection (f) of Labor Code Section 5307.1 requires the administrative director to adopt rates or fees "*within the limits provided by this section.*"

The administrative director has stated that the increased costs that will result from the proposed changes will be offset by savings generated by the elimination of duplicate reimbursements for spinal implants, the adoption of electronic medical billing, and the adoption of a Medicare-based ambulatory surgery fee schedule. However, no savings are expected as a result of electronic medical billing in the foreseeable future. While claims administrators must spend millions of dollars to prepare to receive electronic medical bills, relatively few electronic submissions are expected. Medical providers are not required to submit their medical bills electronically; indeed, some provider organizations are

advising their members to refrain from doing so. Some savings are hoped for as a result of eliminating duplicate reimbursement for spinal surgery implants and adopting a Medicare-based ASC fee schedule, however their magnitude is not likely to come close to offsetting the increased physician payments that will result from these proposed changes. The hoped-for ~~far~~ savings can be neither counted nor counted upon. The formal regulatory process to adopt such changes has not yet been initiated, and the adoption of these changes cannot be guaranteed.

Recommendation -- The Conversion Factor

Adopt or transition to a single conversion factor that will comply with the estimated aggregate fees limitation prescribed by the statute.

Discussion

The Institute previously voiced its support for the Division's original plan to adopt a budget-neutral RBRVS schedule, retain the physical medicine cascade, and transition to a single conversion factor over a period of four years. The Division has revised its plan and now proposes to adopt multiple conversion factors. Compared to the single conversion factor advocated in the previous proposal, the multiple conversion factors in this proposal set allowances that are an average of 24% higher for surgery services, 26% higher for radiology services, and 7% lower for all other services. Assuming no change in the mix of services, the conversion factors in this draft will result in estimated aggregate fees more than 3.3% higher than the previous, budget neutral draft, not counting the increase due to the proposed changes for physician reporting costs.

The Institute objects to separate conversion factors for surgery, radiology, and for all other services because assigning separate conversion factors corrupts the relative values and subverts the foundational RBRVS principles. The Institute supports the principle of a single conversion factor and does not object to a multiple year transition. Resource-based relative values are devised to reflect the resources (time, skill, effort, judgment, risk and practice expenses) that are required for each medical service. Multiplying these resource-based relative values by a single dollar conversion factor for a fee schedule preserves their relativity. Multiplying them by different conversion factors destroys their relativity and creates financial incentives for one type of service over another, which would work to the potential detriment of the injured employee and would likely produce significant costs for California employers. By adhering to a single conversion factor, the administrative director will avoid such perverse incentives and their potential consequences.

Recommendation – Progress Report Reimbursement

Withdraw the proposal to extend progress report reimbursement to treating physicians who are not the primary treating physician.

Discussion

The Division proposes to extend reimbursement for progress reports from primary treating physicians (PTPs) to all treating physicians. The Lewin Group reports did not consider the impact of this proposal and considered reports only as a "pass-through." Based on our analysis of progress reports with dates of service from January through June of 2009, progress reports represented 15.7% of Physician Fee Schedule codes and 2.7% of the total payments. The average number of physician providers on a claim is 4.3. Only one of them is the primary treating physician (PTP) at any given time; the other 3.3 are non-primary treating physicians (non-PTPs). Assuming that non-PTPs submit progress reports at the same frequency as PTPs, 330% more progress reports will be reimbursed and total physician payments will increase by 9.2%. If non-PTPs submit progress reports at half the frequency of PTPs, 165% more progress reports will be reimbursed and total physician payments will increase by 4.6%.

Recommendation – Adopting & Updating Medicare Files Incorporated by Reference

State in the regulation the versions and effective dates of all external files, schedules, and other materials incorporated into regulation by reference, in accordance with CCR, Title 1, section 20, and thereafter adopt updates to the incorporated material by administrative order.

Discussion

The Administrative Procedure Act allows the Division to incorporate the relevant files, schedules, and other material by reference, provided the criteria of Title 1, section 20 are followed.

Section 20(a) defines “incorporation by reference” as the method whereby a regulation printed in the California Code of Regulations (CCR) makes provisions of another document part of that regulation by reference to the other document. While section 5307.1 provides the necessary statutory authority, the Division must follow section 20(c) to legally incorporate these materials.

Section 20(c) requires, among other things, that the Division demonstrate that it would be “cumbersome, unduly expensive, or otherwise impractical” to publish a relevant document in the CCR, that the document was made available upon request directly from the Division or was reasonably available to the regulated community, that the informative digest in the notice of proposed action clearly identifies the document to be incorporated by title and date of publication, and that the regulation specifies which portions of the document are being incorporated by reference.

Like Medicare, the administrative director proposes to adopt an RBRVS-based official medical fee schedule (OMFS) for physician services, into which she will incorporate CMS Medicare files and other materials by reference. When there are any relevant changes in the Medicare payment system, the provisions of Labor Code section 5307.1(g) apply, and within 60 days the administrative of director may issue an order exempt from the Administrative Procedure Act to adopt updated CMS Medicare files and other materials without going through the formal regulatory process.

The Institute thanks the Division for accepting some of its previous recommendations. In addition to the major recommendations and discussion above, the Institute offers the following additional specific recommendations by section. Recommended changes to proposed language are indicated by underline and ~~striketrough~~.

Draft OMFS Physician Section Regulations

Recommendations

Replace the proposed effective date in this section and all other sections to a date to be inserted by OAL that is a minimum of 90 days after the date the regulation is adopted.

§ 9789.12.1 Physician Fee Schedule: Official Medical Fee Schedule for Physician and Non-Physician Professional Provider Services – For Services Rendered On or After January 1, 2014 ~~xxxx~~ [OAL to insert a date a minimum of 90 days after the date this regulation is adopted].

(a) Maximum reasonable fees for physician and non-physician professional medical treatment provided pursuant to Labor Code section 4600, which is rendered on or after January 1, 2014 ~~xxxx~~ [OAL to insert a date a minimum of 90 days after the date this regulation is adopted], shall be no more than the amount determined by the Official Medical Fee Schedule for Physician and Non-Physician Professional Provider Services, consisting of the regulations set forth in Sections 9789.12.1 through 9789.19.1

(“Physician Fee Schedule.”) The Physician Fee Schedule shall not govern fees for services covered by a contract setting such fees as permitted by Labor Code section 5307.11.

(b) Maximum fees for services of a physician or non-physician professional medical services provider are governed by the Physician Fee Schedule, regardless of specialty, for services 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;
- (2) Physical Medicine and Rehabilitation Evaluation codes (97001 and 97002) which are to be used only by physical therapists;
- (3) Occupational Therapy Evaluation codes (97003 and 97004) which are to be used only by occupational therapists; **and**
- (4) Osteopathic Manipulation Codes (98925-98929) which are to be used only by licensed Doctors of Osteopathy and Medical Doctors; **and**
- (5) Other codes that specify a particular provider-type.**

Discussion

At least 90 days after the adoption date will be required for extensive programming changes to billing, bill review, clearinghouse and other vendor systems, and to related systems including WCIS, electronic billing and payment, claims, and utilization review systems. Time will also be needed for operational planning, training and implementation.

The list of exceptions in (b) also needs to include and address other codes that specify particular provider types in the code descriptions.

Recommendations

§ 9789.12. 6 Conversion Factors

Adopt or transition to a single conversion factor for surgery, radiology and “all other services” that will comply with the estimated aggregate fees limitation prescribed by the statute.

Discussion

The Institute previously voiced its support for the Division’s original plan to adopt a budget-neutral RBRVS schedule, retain the physical medicine cascade, and transition to a single conversion factor. The Division has revised its plan and now proposes to adopt three different conversion factors that will result in a significant increase in the aggregate costs of physician services. Assuming the same mix of services used by the Lewin Group in its study, the conversion factors in this draft will result in estimated aggregate fees for physician services that are more than 3.3% higher than the previous (cost neutral) draft (see Table 1), and average reimbursements that will be 24% higher for surgery services, 26% higher for radiology services, and 7% lower for all other services except anesthesia than the previous proposal, excluding an increase due to proposed changes for physician progress reports. The Lewin Group in their study pegged the current estimated aggregate cost of physician services at 111.4% of Medicare’s estimated aggregate cost. This proposal is estimated to raise the aggregate cost to 115.1% of Medicare’s, excluding additional costs proposed for physician progress reports.

Table 1 -- Conversion Factor Increases

Service Category	Current OMFS	% of OMFS	% Change from OMFS for budget neutral Triple CF w Cascade	\$s for budget neutral Triple CF w Cascade	% Increase to 2nd Forum Triple CF w cascade	\$s for 2nd Forum Triple CF w cascade
E&M	\$59,524,349	28.3%	14.0%	\$67,857,758	8.38609%	\$73,548,371
Path	\$324,061	0.2%	NA	\$0	NA	\$0
Medicine	\$52,159,370	24.8%	-15.1%	\$44,283,305	8.38609%	\$47,996,943
Spec Serv	\$16,682,959	7.9%	-2.0%	\$16,349,300	8.38609%	\$17,720,367
Surgery	\$50,031,009	23.8%	0.0%	\$50,031,009	-0.91310%	\$49,574,176
Radiology	\$24,408,774	11.6%	0.0%	\$24,408,774	13.83004%	\$21,033,031
Anesthesia	\$7,315,911	3.5%	0.0%	\$7,315,911	0.00000%	\$7,315,911
Totals	\$210,446,433	100.0%		\$210,246,057		\$217,188,799
				(Per Lewin, 111.4% of Medicare)		(3.3% > budget neutral version)
100% of Medicare would be \$188,730,751 120% of Medicare would be \$225,756,901 Budget neutral version is 111.4% of Medicare 2nd Forum version = 115.1% of Medicare (excluding new fees for non-PTP progress reports)						

Expands on tables in the Supplemental Report of the Lewin Group, dated March 2010

Subdivision (b) of Labor Code section 5307.1 specifically allows the administrative director to adopt different conversion factors from those used in the Medicare payment system as long as she ensures that “the estimated aggregate fees do not exceed 120 percent of the estimated aggregate fees paid for the same class of services in the relevant Medicare payment system” and she adopts rates or fees “within the limits provided by this section” (per subsection (f) of Labor Code Section 5307.1). Even so, the Institute objects to separate conversion factors for surgery, radiology, and for all other services because assigning separate conversion factors corrupts the relative values and thus the foundational RBRVS principles. The Institute supports the principle of a single conversion factor and does not object to a multiple year transition. Resource-based relative values are devised to reflect the resources (time, skill, effort, judgment, risk and practice expenses) that are required for each medical service. Multiplying these resource-based relative values by a single dollar conversion factor for a fee schedule preserves their relativity. Multiplying them by different conversion factors destroys their relativity and creates financial incentives for one type of service over another to the potential detriment of the injured employee and at the potential expense of California employers. By adhering to a single conversion factor, the administrative director will avoid such perverse incentives and their potential consequences.

Recommendations

§ 9789.13.2 California Specific Codes

Withdraw the proposal to extend progress report reimbursement to non-PTPs in this and other sections.

Delete “mutual agreement” and restore the existing “prior authorization” in this and other sections.

CA Code	Reference to Fee (If Any)	Procedure
WC001	Not Reimbursable	Doctor's First Report of Occupational Illness or Injury (Form 5021) (Section 9789.14.1(a)(1))
WC002	\$11.69	Primary Treating Physician's Progress Report (PR-2 or narrative equivalent submitted by the Primary Treating Physician in accordance with § 9785) (Section 9789.14.1(b)(1))
WC003	\$37.98 for first page \$23.37 each additional page. Maximum of six pages absent prior authorization mutual agreement (\$154.83)	Primary Treating Physician's Permanent and Stationary Report (Form PR-3) (Section 9789.14.1(b)(2))
WC004	\$37.98 for first page \$23.37 each additional page. Maximum of seven pages absent prior authorization mutual agreement (\$178.20)	Primary Treating Physician's Permanent and Stationary Report (Form PR-4) (Section 9789.14.1(b)(3))
WC005	Not Reimbursable	Functional Improvement Report (Form FIR) (Section 9789.14.1(a)(2))
WC006	\$37.98 for first page \$23.37 each additional page. Maximum of six pages absent prior authorization mutual agreement (\$154.83)	Other Provider Report – Not Legally Mandated (Section 9789.14.1(b)(4))
WC007	\$37.98 for first page \$23.37 each additional page. Maximum of six pages absent prior authorization mutual agreement (\$154.83)	Consultation Reports (Section 9789.14.1(b)(5))
WC008	\$10.00 for up to the first 15 pages. \$0.25 for each additional page after the first 15 pages.	Chart Notes (Section 9789.14.1(c))
WC009	\$10.00 for up to the first 15 pages. \$0.25 for each additional page after the first 15 pages.	Duplicate Reports (Section 9789.14.1(d))
WC010	\$ 5.00 per x-ray	Duplication of X-Ray
WC011	\$10.00 per scan	Duplication of Scan
WC012	\$62.50 for each quarter hour or portion thereof spent by the treating physician	Medical Testimony (reimburse for all itemized reasonable and necessary time spent related to the testimony, including reasonable preparation and travel time, rounded to the nearest quarter hour. A minimum of one hour shall be reimbursed for a scheduled deposition, even if less than one hour is spent.)
WC013	No Fee Prescribed / Non Reimbursable absent prior authorization agreement	Missed Appointments. This code is designated for communication only. It does not imply that compensation is owed.

Discussion

The Division proposes to extend reimbursement for progress reports from primary treating physicians (PTPs) to all treating physicians. The Lewin Group in its reports did not consider the impact of this proposal and considered reports only as a “pass-through.” If all non-PTPs, in addition to PTPs, are paid for progress reports, the increase in costs will be both significant and unnecessary. Since such reports are not currently billed, it is difficult to estimate the extent of that additional increase.

Based on our analysis of progress reports with dates of service from January through June of 2009, progress reports represented 15.7% of Physician Fee Schedule codes and 2.7% of the total payments. The average number of physician providers on a claim is 4.3 (Table 2). Only one of them is the primary treating physician (PTP) at any given time; the other 3.3 are non-primary treating physicians (non-PTPs). If we assume that non-PTPs will submit progress reports at the same frequency as PTPs, 330% more progress reports will be reimbursed, and total physician payments will increase by 9.2% (Table 3). If we assume that non-PTPs will submit progress reports at half the PTP’s frequency, 165% more progress reports will be reimbursed, and total physician payments will increase by 4.6% (Table 4).

Table 2 – Average Number of Physicians Per Claim

	Average Number of Physicians per Claim
Medical Only Claims	2.1
Indemnity Claims	8.9
All Claims	4.3

Table 3 – Additional Progress Report Costs at 100% Frequency

	Number	Total Paid
99081 – PTP progress report	213,698	\$2,498,130
All other Physician FS codes	1,147,799	\$86,797,466
Total	1,361,497	\$89,219,768
99081 as % of Total	15.7%	2.7%
99081 – PTP progress report	213,698	\$2,498,130
99081 – 100% Est. non-PTP progress report	705,203	\$8,243,828
All other Physician FS codes	1,147,799	\$86,797,466
Total	2,066,700	\$97,539,423
99081 as new % of Total	44.5%	11.0%
% Change increases total Phys FS	51.8%	9.2%

Data based on sample of medical bill review data with DOS between Jan 2009 - June 2009
Estimated additional 99081 reimbursement assumes non-PTP reporting at same frequency as PTP

Table 4 – Additional Progress Report Costs at 50% Frequency

	Number	Total Paid
99081 – PTP progress report	213,698	\$2,498,130
All other Physician FS codes	1,147,799	\$86,797,466
Total	1,361,497	\$89,219,768
99081 as % of Total	15.7%	2.7%
99081 – PTP progress report	213,698	\$2,498,130
99081 – 50% Est. non-PTP progress report	352,602	\$4,121,914
All other Physician FS codes	1,147,799	\$86,797,466
Total	1,714,099	\$93,417,509
99081 as new % of Total	33.0%	7.1%
% Change increases total Phys FS	25.9%	4.6%

Data based on sample of medical bill review data with DOS between Jan 2009 - June 2009
Estimated additional 99081 reimbursement assumes non-PTP reporting at 50% of PTP’s frequency

The Institute believes that only the report of the PTP or the physician designated by the PTP must be separately reimbursed because Labor Code Section 4061.5 unambiguously requires “the treating physician primarily responsible for managing the care of the injured worker” (i.e., the primary treating physician) or a physician designated by that physician to render opinions on all medical issues necessary to determine eligibility for compensation. If there is more than one treating physician, Section 4061.5 requires the primary treating physician (PTP) to prepare a single report that incorporates the findings of the various treating physicians.

Here the Legislature crafted law that made the primary treating physician the gatekeeper for workers’ compensation medical care in California with the responsibility to draft and submit comprehensive reports to the claims administrator. If the Legislature intended to require secondary physicians (non-PTPs) to also render opinions on any and all medical issues necessary to determine eligibility for compensation and to prepare reports, it would not have assigned those responsibilities to the primary treating physician expressly in the statute.

These proposed changes, as well as changes proposed to sections 9785 and 9792.6, disregard that distinction, ignore the statute, and remove gatekeeping responsibilities from the PTP. The administrative director (AD) has no authority to limit or expand the scope of the statute by regulation. The proposed regulations, rather than implementing the requirements of the statute, which unambiguously establish the PTP as the gatekeeper for the injured worker’s medical care with the reporting responsibility, will cause confusion among treating physicians, treatment delays while contradictory procedures are sorted out, and unnecessary disputes over the recommended course of care.

Labor Code section 4603.2(b)(1) requires that any written authorization for services that may have been received by the physician to be submitted together with the itemized billing. Retaining the term “prior authorization” instead of “mutual agreement” will clarify that the written authorization should accompany the billing, facilitate faster payment, and avoid unnecessary confusion and disputes. The impact of this change was also not calculated by the Lewin Group’s analyses.

Recommendations

§ 9789.13.3 California-Specific Modifiers

If the administrative director accepts the recommendation to withdraw the requirement to pay for non-PTP progress reports, replace modifier -01 and clarify that it is a pre-requisite for payment.

If the administrative director does not accept the recommendation to withdraw the requirement to pay for non-PTP progress reports, replace modifiers -01 and -02 and clarify that they are pre-requisites for payment.

(a) The following modifiers are to be appended to the applicable CPT Code or California Specific code in addition to any applicable CPT modifier.

-01 Primary treating physician report/service:

This modifier shall be used to identify a required report issued or E&M service performed by the primary treating physician. This modifier shall be appended to each of the following codes and is required for payment, as appropriate: evaluation and management codes, report codes and prolonged service codes.

-02 Secondary treating physician report/service:

This modifier shall be used to identify a required report issued or E&M service performed by the secondary treating physician. This modifier shall be appended to each of the following codes and is required for payment, as appropriate: evaluation and management codes, report codes and prolonged service codes.

Discussion

If the administrative director withdraws the requirement to pay for non-PTP progress reports, modifier -01 will be necessary to identify and pay for PTP progress reports and services.

If the administrative director does not withdraw the requirement to pay for non-PTP progress reports, modifier -01 and -02 will be necessary to identify and pay for PTP and non-PTP progress reports.

As we have previously commented, modifiers included in the current fee schedule, except for those that affect reimbursement, remain largely unused and ignored. If the Division clarifies that these codes are not only required but are pre-requisites for payment, they will be included on medical billings.

Recommendations

§ 9789.13.7 “By Report” - Reimbursement for Unlisted Procedures / Procedures Lacking RBRVUs

(c) In some instances, the value of a By Report procedure may be determined using the value assigned to a comparable procedure and the relative. The comparable procedure should reflect the same amount of time, complexity, expertise, etc. as required for the procedure performed.

Discussion

The reimbursement amount for a By Report procedure can be appropriately determined by increasing or decreasing the fee for a comparable procedure, taking into account the factors such as time, complexity, expertise, etc.

Recommendations

§ 9789.14.1 Reimbursement for Reports, Duplicate Reports, Chart Notes

(a) Treatment Reports Not Separately Reimbursable.

The following treatment reports are not separately reimbursable as the appropriate fee is included within the underlying Evaluation and Management service, Physical Therapy Evaluation service or Occupational Therapy Evaluation service for an office visit:

- (1) Doctor's First Report of Occupational Illness or Injury (Form 5021) issued in accordance with section 9785(e). Use Code WC001;
- (2) Functional Improvement Report (DWC Form FIR) issued in accordance with section 9785(g)(2). Use Code WC005.

(3) Non-PTP Progress Report

(4) Documents submitted for the purpose of supporting medical bills or requests for authorization.

(b) Treatment Reports That Are Separately Reimbursable.

The following treatment reports are separately reimbursable. Where an office visit is included, the report charge is payable in addition to the underlying Evaluation and Management service for an office visit.

(1) Treating Physician's Progress Report (Form PR-2), by primary treating physician ~~or secondary treating physician~~, issued in accordance with section 9785(f), using DWC form PR-2, its narrative equivalent, or letter format where allowed by section 9785. Use Code WC002. Maximum reimbursement is \$11.69.

(2) Primary Treating Physician's Permanent and Stationary Report (Form PR-3) issued in accordance with section 9785(i). Use Code WC003. The physician may also report the appropriate *Current Procedural Terminology* Evaluation and Management code, if any, and, when appropriate, prolonged service codes. Maximum reimbursement is \$37.98 for first page, plus \$23.37, for each additional page. Maximum of six pages absent prior authorization mutual agreement. Maximum total reimbursement is \$154.83.

(3) Primary Treating Physician's Permanent and Stationary Report (Form PR-4) issued in accordance with section 9785(i). Use Code WC004. The physician may also report the appropriate *Current Procedural Terminology* Evaluation and Management code, if any, and, when appropriate, prolonged service codes. Maximum reimbursement is \$37.98 for first page, plus \$23.37, for each additional page. Maximum of seven pages absent prior authorization mutual agreement. Maximum total reimbursement is \$178.20.

(4) Provider Reports That Are Not Legally Mandated. 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 section 9785, except for documents submitted for the purpose of supporting medical bills or requests for authorization, the provider shall be separately reimbursed using code WC006. Maximum reimbursement is \$37.98 for first page, plus \$23.37, for each additional page. Maximum of six pages absent prior authorization mutual agreement. Maximum total reimbursement is \$154.83.

(5) Consultation Reports that are separately reimbursable. The following reports are separately reimbursable. Where an examination of the patient is performed, the report charge is payable in addition to the underlying Evaluation and Management visit code. Use Code WC007. Where there is no examination of the patient, see § 9789.13.5 subdivision (b) relating to use of "Prolonged Service Codes" by consultants.

(C) 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, however this does not include documents submitted for the purpose of supporting medical bills or requests for authorization.

Discussion

Clarification is needed that progress reports by non-PTPs (see previous comments) and documents submitted for the purpose of supporting medical billings or requests for authorization are also not separately reimbursable.

Labor Code section 4603.2(b)(1) requires that any written authorization for services that may have been received by the physician be submitted together with the itemized billing. Retaining the term "prior authorization" instead of "mutual agreement" will clarify that the written authorization should accompany the billing, facilitate faster payment, and avoid unnecessary confusion and disputes. The impact of this change also was not calculated by the Lewin Group's analyses.

Thank you for considering these comments. Please contact me for clarification or other assistance.

Sincerely,

Brenda Ramirez
CWCI Claims and Medical Director

BR/pm

cc: Carrie Nevans, DWC Acting Administrative Director
Susan Honor-Vangerov, J.D., DWC Medical Unit Manager
CWCI Claims Committee
CWCI Medical Care Committee
CWCI Return to Work Committee
CWCI Legal Committee
CWCI Regular Members
CWCI Associate Members