California Workers' Compensation Institute
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VIA E-MAIL to dwcrules@dir.ca.gov

Maureen Gray, Regulations Coordinator
Department of Industrial Relations
Division of Workers' Compensation, Legal Unit
Post Office Box 420603
San Francisco, CA 94142

RE: Forum Comments -- Rules Differing from Medicare's for RBRVS Physician Fees

Dear Ms. Gray:

These Forum comments on Rules that must differ from Medicare's for an RBRVS-based Physician Section for California's Official Medical Fee Schedule (OMFS) are presented on behalf of members of the California Workers' Compensation Institute (the Institute). Institute members include insurers writing 80% 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).

Insurer members of the Institute include ACE, AIG, Alaska National Insurance Company, AmTrust North America, Chubb Group, CNA, CompWest Insurance Company, Crum & Forster, Employers, Everest National Insurance Company, Farmers Insurance Group, Fireman's Fund Insurance Company, The Hartford, Insurance Company of the West, Liberty Mutual Insurance, Pacific Compensation Insurance Company, Preferred Employers Insurance Company, Springfield Insurance Company, State Compensation Insurance Fund, State Farm Insurance Companies, Travelers, XL America, Zenith Insurance Company, and Zurich North America.

Self-insured employer members are Adventist Health, Agilent Technologies, City and County of San Francisco, City of Santa Ana, City of Santa Monica, City of Torrance, Contra Costa County Schools Insurance Group, Costco Wholesale, County of San Bernardino Risk Management, County of Santa Clara Risk Management, Dignity Health, Foster Farms, Grimmway Enterprises Inc., Kaiser Foundation Health Plan, Inc., Marriott International, Inc., Pacific Gas & Electric Company, Safeway, Inc., Schools Insurance Authority, Sempra Energy, Shasta County Risk Management, Southern California Edison, Sutter Health, University of California, and The Walt Disney Company.

Introduction
The Institute strongly supports the Division's general approach to adopt the Medicare ground rules, and recommends that ground rules differ from Medicare's only where absolutely necessary for services statutorily covered by workers' compensation but not by Medicare. It will be helpful to specify in regulation that Medicare ground rules apply unless differences are specified. Medicare ground rules will replace the great majority of existing ground rules in the Physician Section of the Official Medical Fee Schedule including, but not limited to, those in the Physical Medicine subsection.

In addition, the Institute offers the more specific recommendations that follow on Medicare ground rule differences.

Recommendation -- conversion factors
Transition over a period of four years to a single conversion factor for all services other than anesthesia, modifying the transitional and final conversion factors listed in Labor Code Section 5307.1(a)(2)(C) as necessary to ensure the fees will not exceed the 120% cap dictated in Labor Code Section 5307.1(a)(2)(A)(iii).

Discussion
The legislature has provided a template in Labor Code Section 5307.1(a)(2)(A)(iii) that the administrative director can follow and modify as necessary to meet the other requirements contained in Labor Code Section 5307.1.

Recommendation – geographic practice cost index (GPCI)
Consider adopting a single average California GPCI.

Discussion
A single GPCI will simplify medical billing and review, and will encourage workers' compensation participation by physicians and other practitioners in underserved and rural areas.

Recommendation – consult codes and E/M codes during global surgery periods
- Follow Medicare ground rules for coding consultation services under new and established evaluation and management codes
- Utilize the consult codes and RVUs for reporting and reimbursing the primary treating physician's P&S exam, including report
- Allow a PTP to bill separately for an E/M service (with modifier -24) for an office visit including report provided solely to conform to CCR Section 9785(f) requirements during his or her 10- or 90-day global surgical period.

Discussion

- Following recommendations by the CPT Editorial Panel, the Center for Medicare and Medicaid Services (CMS) mandated the use of new and established visit evaluation and management (E/M) codes in lieu of consultation codes. To avoid an increase or decrease in Medicare payments, CMS calculated the payments that had been made under consultation codes, and applied them instead to the new and established E/M codes by increasing those RVUs, as well as the RVUs for the global surgical codes that include E/M components[1]. Because payments stayed the same overall, it is reasonable to adopt the CMS ground rules for coding consultation services.

- This frees up consultation codes to be used instead by the primary treating physicians (PTPs) to identify and bill for permanent and stationary (P&S) exams including reports. The higher RVUs attributed to the consultation codes allow for additional report payment.

- If a PTP bills for a major surgical procedure, it is reasonable to specify in the ground rules that an E/M service performed solely to comply with CCR 9785(f) requirements may be billed separately during the global surgery 10- or 90-day period.

Recommendation – reports

- If the Division decides that separate reimbursement should continue for the PTP's progress and discharge reports, pay for these reports under 99080 at the current $11.69 fee.

- If the Division decides not to bundle payment for P&S reports or consultation reports into the underlying service, utilize 99080 with modifier -32 to reimburse the report at a flat $77.00 fee.

Discussion

Medicare considers reports to be bundled into the underlying services. If the Division decides to continue separate reimbursement for specified reports, the Institute suggests the Division use the new and established E/M codes for the underlying services and reimburse:

- PTP progress and/or discharge reports at the current $11.69 fee, but under CPT code 99080 instead of 99081. 99081 is a California code in the current OMFS, but it is not a CPT code.

- P&S reports and/or consultation reports at a flat $69.00 fee under CPT code 99080. If PTP progress or discharge reports are also to be paid separately, then modifier -32 should be appended to 99080 to identify P&S reports or consultation reports that should be paid at the higher rate. The current per page methodology for these reports is difficult to administer for both billers and reviewers and fuels disputes. The Institute analyzed the payment amounts for all 99080 reports in the Institute's ICIS database with dates of service between January 1, 2011 and June 30, 2012. The average payment was $68.80. The Institute believes that allowing this averaged flat fee is preferable because it will reduce administrative costs as well as disputes.

[1] www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se1010.pdf

Recommendation – reports
Allow payment for acupuncture services under the acupuncture CPT codes and RVUs.

Discussion
Unlike Medicare, acupuncture is a covered service in the California workers' compensation system. Acupuncture is included in the listing of allowed treatments in Labor Code Section 4600(a).

Thank you for considering this testimony. Please contact me if further clarification is needed.

Sincerely,

Brenda Ramirez
Claims & Medical Director

BR/pm

cc: Destie Overpeck, DWC Acting Administrative Director
CWCI Claims Committee
CWCI Medical Care Committee
CWCI Regular Members
CWCI Associate Members