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: 1st 15-Day Comment -- RBRVS Physician Fee Schedule

Dear Ms. Gray:

These written comments on the additional modifications to regulations proposed for permanent adoption to implement Senate Bill 863 provisions regarding the conversion to a Resource-Based Relative Value Scale (RBRVS) based physician fee schedule are presented on behalf of members of the California Workers' Compensation Institute (the Institute). Institute members include insurers writing 70% of California's workers' compensation premium, and self-insured employers with $42B of annual payroll (24% 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 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.

Recommended revisions to the proposed regulations are indicated by highlighted underscore and ~~strikeout~~. Comments and discussion by the Institute are indented and identified by *italicized text*.

Introduction

The Institute continues to strongly support the Division's general approach to adopt an RBRVS-based Physician Fee Schedule that includes the minimal necessary exceptions to Medicare rules, and that transitions in four years to a schedule with one conversion factor for anesthesia services and one for all other services. The Institute supports the great majority of the proposed language in the fee schedule regulations and, as previously noted, appreciates the inclusion of useful tables. The RAND working report is an excellent resource with careful explanations and helpful alternative policy scenarios.

The Institute on behalf of its member companies particularly:

- Supports statewide locality GPCI values in lieu of multi-locality GPCIs and HPSAs

- Recommends limiting fee schedule factor changes to those that will not cause estimated aggregate fees to exceed 120% of the estimated aggregate fees allowed by Medicare for the same class of services as specified in Labor Code section 5307.1(b) and (f)

The Institute offers these general recommendations, followed by recommendations for specific modifications to the proposed regulations.

General Recommendations

Recommendation - GPCIs

Adopt the RAND-calculated statewide Geographic Practice Cost Index (GPCI) values that treat California as a statewide locality, as proposed, in lieu of the GPCIs for the nine California localities and the HPSAs. Alternatively, adopt the one statewide Geographic Adjustment Factor (GAF) value for anesthesia and the one for all other services in lieu of the GPCIs for the nine California localities and the HPSAs.

Discussion

The multiple GPCIs currently used for Medicare calculations discourage physicians and other practitioners from establishing practices in localities in which GPCIs result in lower reimbursement. This has created and exacerbated shortages of practices in those areas, including many rural areas. The GPCIs were intended to provide additional reimbursement to compensate providers in areas where costs are higher; however the current GPCI localities in California are illogical and are neither fair nor successful and they de-compensate where the population is sparse. If they are adopted for workers' compensation, we can expect them to create and exacerbate underserved areas. While HPSAs may provide some relief from this problem, addressing the disincentives that create and exacerbate this problem by treating California as a single locality with statewide GPCI values or single GAF values for workers' compensation is a better and more efficient solution than creating and exacerbating health professional shortage areas then compensating for them.

Adopting single-locality GPCIs or single GAF values will also eliminate the billing abuses that are associated with multiple-locality GPCIs (for example, when a provider reports an incorrect service location by entering a 3rd party biller zip code in the billing to increase reimbursement).

Recommendation – fee schedule cap
Adopt an RBRVS-based Physician Fee Schedule that shall be adjusted to conform to relevant Medicare changes within 60 days of their effective date; and adjusted by applying to the conversion factor an annual adjustment factor that is based on the percentage change in the Medicare Economic Indicator and any relative value scale adjustment factor, **provided that estimated aggregate fees shall not exceed 120 percent of estimated aggregate fees paid under the Medicare payment system for the same class of services**.

Discussion
The modification to the proposed Physician Fee Schedule regulations, and the corrected numbers in RAND's RBRVS report that issued with them, lower the increase in aggregate allowances expected during the transition period from $344 million to $250 million. While the news of a lower increase is welcome, the anticipated $250 million increase in aggregate physician and non-physician practitioner allowances during the transition period, and the additional $104.37 million plus compounded annual adjustments in every subsequent year, remain a concern since they were not factored into the reform saving calculations. See the attached CWCI Bulletin for additional detail.

To implement a fee schedule with the additional annual accelerators without a limit, will lead to increases in the Physician Fee Schedule allowances that threaten to overtake the total SB 863 net cost reductions of $520 million estimated by the Workers' Compensation Insurance Rating Bureau (WCIRB). If estimated aggregate allowable fees are not anchored to 120% of Medicare's, the acceleration of medical care costs is likely to continue unabated. The Institute does not believe that this was the result intended by the Legislature.

We note that Labor Code section 5307.1(a)(2)(A) prohibits the Administrative Director from adopting fees that would result in estimated annualized fees beyond the cap dictated in Labor Code section 5307.1(a)(2)(A)(iii), but the Administrative Director may adopt fees that result in estimated annualized fees below that cap, provided the maximum allowable amount is based on the RBRVS, and is adjusted by an annual adjustment factor that is based on the Medicare Economic Index and any relative value scale adjustment factor. The Institute believes the Administrative Director may adopt different conversion factors from those used by Medicare:

- as long as those factors do not result in aggregate payments that would exceed 120% of what Medicare would pay for the services (LC 5307.1(b)); and
- as long as, within those limits, the rates and fees established are adequate to ensure a reasonable standard of services and care for injured employees (LC 5307.1(f)).

As currently proposed in this regulation, the annual adjustment factors described in Labor Code section 5307.1(g) will soon escalate the conversion factors beyond the LC 5307.1(b) limit. Subdivision (g)(1)(A) begins with the phrase "Notwithstanding any other law," which could be read to be the paramount direction from the statute. But the language is "Notwithstanding any **other** law" and therefore subdivisions (b) and (g) must be read together to create an RBRVS-based fee schedule in which the estimated aggregate fees are within 120% of those under the Medicare fee schedule.

SB 863 was predicated upon a balance between benefit increases and cost reductions. A cap on estimated aggregate fees at 120% of Medicare's is not a stationary cap; annual revisions to Medicare conversion factors will still provide physicians with the benefit of Medicare fee schedule increases augmented by the 20% workers' compensation incentive, but it will restrain what would otherwise become a growing percentage in excess of Medicare.

Recommendation – ambulatory surgery centers and facility fees
Continue to restrict outpatient facility fee payments to only hospital emergency departments, hospital outpatient surgery departments and ambulatory surgery centers. Reimburse medical services that are appropriately provided in other outpatient settings, under the Physician Fee Schedule. Restrict payments to ambulatory surgery centers to surgeries on Medicare's ASC list of covered procedures.

Discussion
The setting for medical services must be reasonable and necessary, and above all, safe for injured employees. Limiting Ambulatory Surgery Center (ASC) payment to only those surgeries that Medicare has determined can be safely performed in in an ASC, but are not commonly performed in an office setting, furthers this goal. Paying under the Physician Fee Schedule for services that can be performed in a practitioner's office also supports that goal.

Recommendation – reports, California codes and BR codes
Include in the calculations for aggregate estimated fees the estimated payments for "proposed California specific codes," including those for reports, and By Report (BR) codes that will continue to receive separate payment.

If the Division decides not to bundle payments for P&S reports or consultation reports into the underlying service, reimburse those reports at a flat average fee.

If the Administrative Director decides to continue to make primary treating physician (PTP) progress reports and/or discharge reports separately reimbursable, clarify in the regulations that the fee is billable by and reimbursable to only the primary treating physician (PTP), as it is currently.

Delete the proposed California specific codes for services that are rarely used, that are part of another service, or that can be reported under another existing or proposed code.

Discussion
Medicare does not pay a separate fee for reports or for the other proposed California specific codes as it considers their reimbursement to be included in the reimbursement of their underlying services, such as evaluation and management services. We note that average reimbursement for evaluation and management services, which generally underlie the reports, are calculated to increase by 39.5% when fully implemented in 2017. If the Division decides to continue separate reimbursement for specified reports, their estimated payments should be included in the calculations of the estimated aggregate fees paid for the same class of services pursuant to Labor Code section 5307.1(b) and (c). Reports do fall within the "same class of services in the relevant Medicare payment system." In a 2010 analysis of progress reports with dates of service from January through June of 2009, the Institute found that progress reports represented 15.7% of Physician Fee Schedule codes and 2.7% of the total payments. Their inclusion is significant, and all the more so if their reimbursement is increased and is subject to annual adjustment as modified.

The Institute recommends paying a flat $69.00 fee for P&S reports and eligible consultation reports. The current per page methodology for calculating P&S reports and/or consultation reports is difficult to administer for both billers and reviewers, and it fuels disputes. In February 2013, 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 and found that the average payment for these reports was $68.80. The Institute believes that allowing an averaged flat fee is preferable because it will reduce administrative costs as well as disputes. The Institute recommends specific modifications in the section 9789.19 Update Table in the event the Administrative Director decides to retain a per-page payment methodology.

If the Administrative Director decides to continue to make primary treating physician (PTP) progress reports and/or discharge reports separately reimbursable, it is important to clarify in the regulations that the fee is billable by and reimbursable to only the primary treating physician (PTP), as it is currently. This will prevent unnecessary disputes over whether the fee is payable to other providers and will prevent significant additional fees.

As the Institute commented during Forum comments on the Lewin RBRVS report in 2010, if reimbursement for progress reports from primary treating physicians (PTPs) are extended to secondary treating physicians, total physician payments will rise significantly. In 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 was 4.3. Only one of them is the primary treating physician (PTP) at any given time; the others are non-primary treating physicians (non-PTPs). Assuming that non-PTPs submit progress reports at the same frequency as PTPs, we calculated that 330% more progress reports would be reimbursed and total physician payments would increase by 9.2%. If non-PTPs submit progress reports at half the frequency of PTPs, 165% more progress reports would be reimbursed and total physician payments would be expected to increase by 4.6%.

Because specific California codes are not necessary for services that are rarely used, that are part of another service, or that can be reported under an existing or proposed code, the Institute recommends deleting them; particularly proposed California codes WC008, WC009, WC010, and WC011.

Specific Recommendations

The Institute supports the great majority of the proposed regulations without change. The revisions that the Institute recommends for the proposed regulatory language are indicated by highlighted underscore and ~~strikeout~~. Comments and discussion by the Institute are indented and identified by *italicized text*.

§ 9789.12.2 Calculation of the Maximum Reasonable Fee - Services Other than Anesthesia

Except for fees determined pursuant to §9789.18.1 et seq., (Anesthesia), the base maximum reasonable fee for physician and non-physician professional medical practitioner services shall be the non-facility or facility fee calculated as follows:

(a) Non-facility site of service fee calculation:

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

Key: RVU = Relative Value Unit
GPCI~~GAF~~ = Geographic Practice Cost Index ~~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.

(b) Facility site of service fee calculation:

~~Facility Pricing Amount =~~
[(Work RVU * Statewide Work GPCI ~~GAF~~) +
(Facility PE RVU * Statewide PE GPCI ~~GAF~~) +
(MP RVU * Statewide MP GPCI ~~GAF~~)] * Conversion Factor = Base Maximum Fee

Key: RVU = Relative Value Unit
GPCI~~GAF~~ = Geographic Practice Cost Index ~~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.

The term "GPCI" is less confusing here than "GAF" in the context of Work/PE/MP multipliers for single-locality implementation. The term "GAF" instead of "GPCI" is good to indicate the single statewide anesthesia multiplier which is addressed in section 9789.18.1, and to easily differentiate it from the GPCIs. If the Administrative Director accepts this recommendation, conforming changes will be needed in the Update Table in section 9789.19.

§ 9789.12.3 Status Codes C, I, N and R

(d)(4) Maximum reasonable fee for procedures with status indicator code I, that do not meet the criteria of subdivisions (d)(1), (d)(2), or (d)(3) shall be determined as follows:

….

(B) If (d)(4)(A) is not applicable, use the RVUs listed in the federal 2012 Office of Workers' Compensation Program (OWCP) fee schedule. When the 2012 OWCP fee schedule lists total RVUs without separately providing RVUs for work, practice expense, or malpractice expense, the average statewide geographic adjustment factor shall be applied. See section 9789.19 for the location of the 2012 OWCP RVUs and average statewide geographic adjustment factor, by date of service;

….

Division representatives have said in the past that the Administrative Director may adopt a particular existing version of a fee schedule, but absent specific statutory authority such as the authority provided regarding Medicare and Medi-Cal schedules and rules, may not be able to adopt future versions that are not under the Division's direct control. If the Administrative Director is restrained from adopting future versions, the Institute suggests defining "OWCP fee schedule" to be the 2012 version of the OWCP fee schedule, or adding "2012" to OWCP fee schedule references in this section and in sections 9789.12.4, 9789.12.8, and 9789.12.19.

§ 9789.12.5 Conversion Factors

(b)(3) The conversion factors specified in subdivision (b)(2) shall be adjusted by the cumulative changes in MEI and the Relative Value Scale Adjustment Factor, if any, between 2012 and each transition year~~.~~, provided that these conversion factors do not cause estimated aggregate fees to exceed 120 percent of the estimated aggregate fees allowed for the same class of services in the relevant Medicare payment system. See section 9789.19 for annual and cumulative MEI, and Relative Value Scale Adjustment Factor, by date of service.

(c) For calendar year 2018, and annually thereafter, the Anesthesia conversion factor and the Other Services conversion factor in effect for the prior calendar year shall be updated by the Medicare Economic Index inflation rate and by the Relative Value Scale Adjustment Factor, if any~~.~~, provided that the adjusted conversion factor does not cause estimated aggregate fees to exceed 120 percent of the estimated aggregate fees allowed for the same class of services in the relevant Medicare payment system.

Labor Code section 5307.1(b) allows the Administrative Director to adopt different conversion factors from those used by Medicare, provided they will not cause estimated

aggregate fees to exceed 120 percent of the estimated aggregate fees paid under the Medicare fee schedule for the same class of services; and (within those limits) as long as the rates and fees established are adequate to ensure a reasonable standard of services and care for injured employees (LC5307.1(f)). As proposed, the schedule will exceed those limits. See the comments in the General Recommendations section for a fuller discussion.

Thank you for considering these recommendations and comments. Please contact me if additional clarification is needed.

Sincerely,

Brenda Ramirez
Claims & Medical Director

BR/pm
Attachment

cc: Christine Baker, DIR Director
Destie Overpeck, DWC Acting Administrative Director
Jackie Schauer, DIR Counsel
CWCI Claims Committee
CWCI Medical Care Committee
CWCI Regular Members
CWCI Associate Members
CWCI Legal Committee