PHYSICIAN FEE SCHEDULE PAYMENT GROUND RULES: A COMPARISON OF THE OMFS AND MEDICARE *

Ground Rule and/or Issue	Workers' Compensation	Medicare Policy Calendar Year 2013
OVERALL FEE SCHEDULE DESIGN		
Conversion factor	Separate conversion factors for: • Evaluation & Management • Medicine • Surgery • Radiology • Pathology • Anesthesia	Single conversion factor for all services other than anesthesia
Geographic practice cost index (GPCI)	Statewide fee schedule with no geographic adjustments	Geographic adjustments for eight localities
Site of service differential	Reimbursement is the same for all sites of service	Facility (hospital) and non-facility (office) differentials for the practice expense component of most services
Non-physician practitioners	No reduction for services provided by a non-physician practitioner is acting within the scope of their practice	• Nurse practitioner and physician assistant services paid at 85% of the Medicare allowed amount unless billed under incident-to rules(use modifiers to identify) unless billed under incident-to rules • Clinical social workers paid at 75% • Incident-to reimbursed at 100%
Hospital outpatient services (other than emergency and surgery services)	Paid under the OMFS for physician services	Paid under the Medicare prospective payment system for hospital outpatient services
CODING RULES		
Healthcare Common Procedure Coding System (HCPCS)	• OMFS uses o CPT 1997 revision (1994 for Physical Medicine) o NDC for pharmaceuticals o California only codes o By report • HCPCS Level II not recognized for physician services (however, HCPCS Level II used for DMEPOS fee schedule, dental service billing)	• Medicare uses HCPCS coding system o Level I: 2013 CPT codes o Level II: A system of letter and number codes assigned to services (mostly non-professional) services, medications, supplies and equipment • HCPCS codes updated quarterly and on an annual basis • CMS maintains a crosswalk between NDC codes and HCPCS drug codes

*(DWC and RAND acknowledge the work of Frank D. Navarro of the California Medical Association in creating a comparison chart that was used as the model for this document. This document is an outline for purposes of DWC Forum ground rules discussion; it is not a comprehensive summary of the workers' compensation or Medicare payment systems.)

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Modifiers	Uses 1997 CPT modifiers with some variation in description and modifiers unique to California Workers' Compensation * See OMFS for complete description of California workers' compensation modifiers	Medicare adopts current year AMA CPT modifiers and descriptions effective January 1 of each year
Bundled procedures	No specific rule with use of bundling edits varying by payer	Correct Coding Initiative has bundling edits
Unlisted service procedure	• Services may be determined by the value assigned to a comparable procedure (by report) • Must use unlisted procedure code	• Services may be determined by the value assigned to a comparable procedure or by report • Must use unlisted procedure code
EVALUATION AND MANAGEMENT AND RELATED SERVICES		
Consultations	Separate payment rates apply to consultations and consultative reports	• Medicare pays for consultations using the evaluation and management visit codes (99201-99215) • Medicare does make a separate payment for documentation of any kind, including consultative reports
New and established patient definition	• A new patient is either new to the physician or is an established patient with a new industrial injury or condition • If a physician is on call or covering for another physician, the patient's encounter would be the same as if the patient was treated by his/her own physician	• A new patient has not received any professional services within the past three (3) years from the physician or another physician of the same specialty who belongs to the same group practice • An establish patient has received professional services within the past three (3) years from the physician or another physician of the same specialty who belongs to the same group practice • If a physician is on call for or covering for another physician, the patient's encounter will be classified the same as if the physician had been available
Interpreter used by patient	• Reimbursement is 110% of the normal value of the service. • Use modifier -93 to report for billing purposes	Patient use of interpreters does not affect physician's payment
Venipuncture (routine)	Allows for the reimbursement of routine venipuncture or needle stick for collection of specimen	• 36415 Collection of venous blood by venipuncture is paid under the clinical laboratory fee schedule • 36416 Collection of capillary blood specimen (eg, finger, heel, ear stick) is bundled into the office visit payment

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Specimen handling	Allows for the reimbursement of transfer or conveyance of specimens from the physician's office to a laboratory	Medicare does not pay separately for the transfer or conveyance of specimens from the physician's office to a laboratory
ANESTHESIA		
Units	Billed in fifteen (15) minute increments	Billed in one (1) minute increments
Services performed by physician	• Covered separately when performed by surgeon • Use code 01995 (in CPT 1997 but not CPT 2013)	Not separately paid when performed by physician performing procedure and listed in Appendix G of CPT
Supervision	Combined payment for an anesthesiologist supervising a nurse anesthetist cannot exceed what would have been payable if only the anesthesiologist furnished the service	Specific rules/modifiers apply for supervision of concurrent procedures and for medical direction of nurse anesthetists
SURGERY		
Assistant surgeon	Paid at 20% of the allowed surgical fee	Paid at 16% of the allowed surgical fee
Non-physician surgical assistant	Paid at 10% of the allowed surgical fee	Physician assistants paid at 13.6 % (85% of 16%) of the allowed surgical fee
Co- surgeons	Procedure paid at 125% of the OMFS	Procedure paid at 125% of Medicare allowable surgical fee
Multiple or bilateral procedure reduction	• 100% for first procedure • 50% for the second procedure • 25% for the third procedure • The procedures are ranked from highest value to lowest. • If there are four or more procedures, a global fee should be charged by the physician and be supported by a report	• 100% for first procedure • 50% for the second thru fifth procedures. • The procedures are ranked from highest value to lowest. • Any procedures beyond the fifth require supporting documentation and *may* be paid upon carrier review
Arthroscopy	Special billing provision for multiple arthroscopic procedures performed on the same joint during the same surgery. • Payment is at 100% for the first procedure and 10% for the second and subsequent procedures. CPT codes covered by this provision are as follows: o Shoulder:29815, 29819, 29820, 29822, 29825 o Elbow: 29830, 29834, 29835, 29837 o Wrist: 29840, 29844 o Knee: 29870, 29872, 29874, 29875, 29877, 29884	• Payment 100% of Medicare allowable for 1st procedure in the same joint. • All other procedures considered bundled, unless modifier -59 is used to indicate different site, joint or compartment.

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	o Ankle: 29894, 29895, 29897 All other arthroscopic procedures not listed above fall under the multiple or bilateral formula.	
Endoscopy - multiple	Multiple surgery payment rules apply	• Special rules for payment of multiple endoscopies with the same base code. • Medicare will pay the full value of the higher valued endoscopy, plus the difference between the next highest endoscopy and the base endoscopy
Global surgical rule	Global surgery delineates the number of days allowed for pre and postoperative management 0-10-90 days • 0-days: Minor surgical or endoscopic procedure with "0" days postoperative care • 10-days: Minor surgical procedure with 10 days postoperative care 90-days: Major surgical procedure with 90 days postoperative and one day preoperative care	Global surgery delineates the number of days allowed for pre and postoperative management 0-10-90 days. • 0-days: Minor surgical or endoscopic procedure with "0" days postoperative care • 10-days: Minor surgical procedure with 10 days postoperative care • 90-days: Major surgical procedure with 90 days postoperative and one day preoperative care
Starred (*) procedure rule	• OMFS only rule • Allows separate reimbursement for associated pre and post-operative services Note: AMA discontinued Starred Procedure designations	• Payment for minor surgery codes generally includes the E/M services provided in order to perform the procedure on the day of surgery or service. • Codes are assigned "0" or "10" day global periods beginning the day following the procedure • Modifier -25 is allowed to by-pass rule if unrelated evaluation and management service is provided on same day
RADIOLOGY		
Multiple procedure discounting	• No payment reductions are applied when multiple services are furnished on the same day	• Multiple procedure payment reduction (MPPR) applies to advanced imaging (CT scans, MRI and ultrasound) furnished in the same session by a single physician or multiple physicians in the same practice regardless of imaging modality • Payment is reduced 25% for both the technical and professional components of the service
PHYSICAL MEDICINE		
Multiple procedure discounting	There are limits on how much can be billed on a single date of service and there is a multiple procedure formula for determining the billing amount.	• MPPR applies to the HCPCS codes contained on the list of "always therapy" services that are paid under the MPFS. The list of procedures is published as Addendum H of the

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	Modalities: • No more than two are paid on one date of service. Procedures**:** • Codes have an assigned time, and if not specified, the time is considered to be 30 minutes. Where not otherwise specified, time over the first 30 minutes is billed in15 minute increments and may be billed more than once in a single visit. • There is a 60- minute limitation without prior authorization; this limits the number of procedures to two in a single visit. Additional time codes do not count in the two-procedure limit. Combined Billing: • There is combined maximum of four procedures and/or modalities in a single visit. If one procedure is billed, then a maximum of four codes (including additional time codes) can be billed for one visit. For example, a physician can bill for two modalities and two procedures or two modalities, one procedure and two additional time codes. • When combining the modalities and procedures for billing, the physician must use the multiple billing formulas. **Payment formula** • **100%** for the first procedure/modality, • **75%** for the second, • **50%** for the third, and • **25%** for the fourth. • The procedures and/or modalities should be ranked using the highest value.	MPFS. • The MPPR applies to the practice expense (PE) payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures.It does not apply to add-on or bundled codes. • Full payment is made for the unit or procedure with the highest PE payment. Effective April 1, 2013 the remaining procedures/units will be reimbursed at 50% payment in all settings (as required by the Taxpayer Relief Act of 2012).
Patient assessments	• Physicians use E&M evaluation codes (95831-95852) • Therapists use codes 98770-98778 for their assessments, evaluations, and consultations • Values for physical medicine codes and acupuncture codes include routine follow-up assessment for E&M purposes. 2.4 RVUs are deducted when treatment and E&M/Physical Therapist Assessment codes are billed for the same visit, by the same medical provider. If the physical therapist has a separate facility or is not employed by the physician, then full value is paid for both treatment and E&M/Physical Therapist	• CPT 2013 has codes for physical therapy and occupational therapy evaluation and re-evaluation that apply to all qualified practitioners. • The RVUs for physical therapy do not include RVUs for patient assessments.

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	Assessment codes.	
Acupuncture	Acupuncture codes may be combined with physical medicine modalities and procedures or may be billed alone using this formula. Additional time codes are not included for these services.	Not a Medicare-covered service but RVUs are published as part of the annual fee schedule update
Chiropractic services	Chiropractic services are subject to the multiple procedure discounting.	Chiropractic services are extremely limited in Medicare and are not included in the "always therapy" codes and therefore not subject to the multiple procedure reduction.
Work hardening and conditioning		Not a Medicare-covered service and no RVUs are published as part of the annual fee schedule update
DRUGS, IMMUNIZATIONS, OTHER PHARMACEUTICALS AND SUPPLIES		
Supplies, materials, durable medical equipment (DME)	• Supplies and materials provided over and above those usually included with the service or procedure may be charged for separately • Paid at cost (purchase price plus sales tax) plus 20% of cost up to a maximum of cost plus $15.00. • Dispensed items separately reimbursed include cast and strapping materials, iontophoresis. electrodes, supplies for strains, reusable electrodes, canes, braces, slings, ace wraps, TENS electrodes, crutches, splints, back supports, hot or cold packs • Examples of supplies that are usually **not** separately reimbursable include applied hot or cold packs, eye patches injections or debridement trays, steristrips, needles, syringes, eye/ear trays, drapes, sterile gloves, eyewash or drops, creams (massage), florescein, ultrasound pads & gel, tissues, urine collection kits, gauze, cotton balls, sterile water, dressings (simple wound), head sheet, aspiration trays, tape for dressing • Dangerous device dispensed by a physician: reimbursement not to exceed either 1) the fee schedule amount, 2) 120% of documented paid cost but not less than 100% of documented paid cost plus the dispensing fee allowed for prescription drug dispensing and not more than 100% of documented paid cost plus $250	• With the exception of administration of injectable drugs and biologicals and casting materials, supplies used in a doctor office are not separately reimbursed under Medicare and are included in either the evaluation and management service or surgical procedure • Re-casting (as well as casting) supplies are separately paid • Medical supplies and equipment for home use are payable under the DMEPOS- same as OMFS

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Physician-dispensed drugs	• Medi-Cal fee schedule rate for NDC applies • For repackaged drugs whose NDC is not in the Medi-Cal database, the Medi-Cal rate for the underlying NDC applies • Reimbursement for compounded medications dispensed in a physician's office cannot exceed 300% of documented paid costs, but in no case exceed $20 above documented paid costs	Medicare does not reimburse for the dispensing of pharmaceuticals other than drugs and biologicals administered in the physician's office e.g. injectable and infusible drugs and therapeutics
Injectable Drugs	• Uses Medi-Cal Fee Schedule • If not covered by Medi-Cal Fee Schedule, injectable materials administered during therapeutic, diagnostic, or antibiotic injections are separately reimbursable at 110% of the average wholesale price (AWP) for brand or 140% of the average wholesale price (AWP) for generic • No dispensing fee is allowed	• Most drugs and biologicals reimbursed under the Medicare program are listed in the MPFS. Those that are not require copy of invoice submitted with bill. • Medicare uses Healthcare Common Procedure Coding System (HCPCS) Level II codes to describe drugs, vaccines, and supplies • Drugs and biologicals paid at averages sales price (ASP) methodology
Immunizations	• Immunizations provided under Medicine codes 90725-90749 and 90710-90711 are reimbursable • Cost of the vaccine plus a $15.00 injection fee • By report and invoice required	• Generally vaccines are not covered with the exception of Influenza, pneumococcal and hepatitis B vaccines • Vaccine rates are updated annually as part of the fee schedule update
REPORTS		
OMFS reimbursable reports	• The following reports are separately reimbursable. Where an office visit is involved, separate payment is made in addition to the office visit. o Primary Treating Physicians' Progress Reports - (PR2) – at least every 45-days or change in patient status o Final Treating Physician's Report of Disability Status (DWC Form RU-90) o Primary Treating Physician's Final Discharge Report o Primary Treating Physician's Permanent and Stationary ("P&S") Report • Separately paid using 99080 using the Medicine conversion factor at 6.5 RVUs for the first page and 4.0 RVUs for each additional page, up to a maximum of 6 pages except by	• Medicare does not separately pay for reports • Physicians may charge Medicare beneficiaries for the completion of forms i.e., life insurance applications, disability forms, DMV etc. at physician's usual and customary charge. • Physicians may charge Medicare beneficiaries for the completion of forms i.e., life insurance applications, disability forms, DMV, copies of medical records etc (but not CMS 1500 and/or UB claim forms)

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	mutual agreement by the provider and payor	
OMFS Non-reimbursable Reports	The OMFS does not pay separately for the following reports: • 1ST Occupational Illness or Injury • Initial Treatment Report and Plan • Treating Physicians Report of Disability Status (RU-90) where the physician has not been able to give an opinion regarding the employee's ability to return to pre-injury occupation. • Report by a secondary physician to the PTP, where the secondary physician also treats the patient	Medicare does not pay separately for reports
Duplicate reports	• When requested by a claims administrator duplicate reports are separately reimbursable at $10.00 for up to the 1st – 15 pages and at $0.25 for each additional page • Use CPT code 99087 to identify charge duplicate reports	Medicare does not pay separately for reports
Medical records	• Chart note requests are separately reimbursable at $10.00 for up to the first 15 pages. Pages in excess of 15 shall be reimbursable at $.025 per page. • Chart note requests shall be made only by the claims administrator and shall be in writing. • Use code 99086 to identify	Medicare does not pay for furnishing medical records