STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

FINAL STATEMENT OF REASONS

Subject Matter of Regulations: Workers' Compensation - Official Medical Fee Schedule: Physician Fee Schedule

TITLE 8, CALIFORNIA CODE OF REGULATIONS
Sections 9789.12.1 through 9789.19

AN IMPORTANT PROCEDURAL NOTE ABOUT THIS RULEMAKING:

The Physician Fee Schedule component of the Official Medical Fee Schedule "establish(es) or fix(es) rates, prices, or tariffs" within the meaning of Government Code section 11340.9(g) and is therefore not subject to Chapter 3.5 of the Administrative Procedure Act (commencing at Government Code section 11340) relating to administrative regulations and rulemaking.

This rulemaking proceeding to amend the Physician Fee Schedule is being conducted under the administrative director's rulemaking power under Labor Code sections 133, 4603.5, 5307.1 and 5307.3. This regulatory proceeding is subject to the procedural requirements of Labor Code sections 5307.1 and 5307.4.

CONSIDERATION OF RELEVANT MATTER PRESENTED

After Notice of the Proposed Rulemaking was published pursuant to Labor Code section 5307.4, a public hearing was held on July 17, 2013 at which interested persons could participate through the submission of written data, views, and arguments, including oral presentations. A notice of 15-day comment period issued on Aug. 2, 2013, and ending on Aug. 19, 2013, invited interested persons to submit written comments relative to the modifications to the proposed regulation or to the documents added to the rulemaking file. The Acting Administrative Director has subsequently considered all of the data, views, statements, and arguments presented or submitted.

The Acting Administrative Director of the Division of Workers' Compensation, pursuant to the authority vested in her, has adopted the following sections of Division 1, Chapter 4.5, Subchapter 1, of title 8, California Code of Regulations, relating to the Physician Fee Schedule component of the Official Medical Fee Schedule:

Section 9789.12.1	Physician Fee Schedule: Official Medical Fee Schedule for Physician and Non-Physician Practitioner Services – For Services Rendered On or After January 1, 2014 [Adopt]

Section 9789.12.2	Calculation of the Maximum Reasonable Fee - Services Other than Anesthesia [Adopt]
Section 9789.12.3	Status Codes C, I, N and R [Adopt]
Section 9789.12.4	"By Report" - Reimbursement for Unlisted Procedures / Procedures Lacking RBRVUs [Adopt]
Section 9789.12.5	Conversion Factors [Adopt]
Section 9789.12.6	Health Professional Shortage Area Bonus Payment: Primary Care; Mental Health [Adopt]
Section 9789.12.7	CMS' National Physician Fee Schedule Relative Value File / Relative Value Units (RVUs) [Adopt]
Section 9789.12.8	Status Codes [Adopt]
Section 9789.12.9	Professional Component (PC)/Technical Component (TC) Indicator [Adopt]
Section 9789.12.10	Coding; Current Procedural Terminology ©, Fourth Edition [Adopt]
Section 9789.12.11	Evaluation and Management: Coding – New Patient; Documentation [Adopt]
Section 9789.12.12	Consultation Services Coding – use of visit codes [Adopt]
Section 9789.12.13	Correct Coding Initiative [Adopt]
Section 9789.12.14	California Specific Codes [Adopt]
Section 9789.12.15	California Specific Modifier [Adopt]
Section 9789.13.1	Supplies [Adopt]
Section 9789.13.2	Physician-Administered Drugs, Biologicals, Vaccines, Blood Products [Adopt]
Section 9789.13.3	Physician-Dispensed Drugs [Adopt]
Section 9789.14	Reimbursement for Reports, Duplicate Reports, Chart Notes [Adopt]

Section 9789.15.1	Non-Physician Practitioner (NPP) – Payment Methodology [Adopt]
Section 9789.15.2	Non-Physician Practitioner (NPP) – "Incident To" Services [Adopt]
Section 9789.15.3	Qualified Non-physician Anesthetist Services [Adopt]
Section 9789.15.4	Physical Medicine / Chiropractic / Acupuncture Multiple Procedure Payment Reduction; Pre-Authorization for Specified Procedure/Modality Services [Adopt]
Section 9789.15.5	Ophthalmology Multiple Procedure Reduction [Adopt]
Section 9789.15.6	Diagnostic Cardiovascular Procedures – Multiple Procedure Reduction [Adopt]
Section 9789.16.1	Surgery – Global Fee [Adopt]
Section 9789.16.2	Surgery – Billing Requirements for Global Surgeries [Adopt]
Section 9789.16.3	Surgery – Global Fee – Miscellaneous Rules [Adopt]
Section 9789.16.4	Surgery – Global Fee; Exception: Circumstances Allowing E&M Code During the Global Period; Primary Treating Physician's Progress Report (PR-2) [Adopt]
Section 9789.16.5	Surgery – Multiple Surgeries and Endoscopies [Adopt]
Section 9789.16.6	Surgery – Bilateral Surgeries [Adopt]
Section 9789.16.7	Surgery – Co-surgeons and Team Surgeons [Adopt]
Section 9789.16.8	Surgery – Assistants-at-Surgery [Adopt]
Section 9789.17.1	Radiology Diagnostic Imaging Multiple Procedures [Adopt]
Section 9789.17.2	Radiology Consultations [Adopt]
Section 9789.18.1	Payment for Anesthesia Services - General Payment Rule [Adopt]
Section 9789.18.2	Anesthesia - Personally Performed Rate [Adopt]
Section 9789.18.3	Anesthesia - Medically Directed Rate [Adopt]
Section 9789.18.4	Anesthesia - Definition of Concurrent Medically Directed Anesthesia Procedures [Adopt]

Section 9789.18.5	Anesthesia - Medically Supervised Rate [Adopt]
Section 9789.18.6	Anesthesia - Multiple Anesthesia Procedures [Adopt]
Section 9789.18.7	Anesthesia - Medical and Surgical Services Furnished in Addition to Anesthesia Procedure [Adopt]
Section 9789.18.8	Anesthesia - Time and Calculation of Anesthesia Time Units [Adopt]
Section 9789.18.9	Anesthesia - Base Unit Reduction for Concurrent Medically Directed Procedures [Adopt]
Section 9789.18.10	Anesthesia - Monitored Anesthesia Care [Adopt]
Section 9789.18.11	Anesthesia Claims Modifiers [Adopt]
Section 9789.18.12	Anesthesia and Medical/Surgical Service Provided by the Same Physician [Adopt]
Section 9789.19	Update Table [Adopt]

UPDATE OF INITIAL STATEMENT OF REASONS AND INFORMATIVE DIGEST

The Acting Administrative Director incorporates the Initial Statement of Reasons prepared in this matter. The purposes and rationales for the regulations as set forth in the Initial Statement of Reasons continue to apply, unless otherwise noted in the Final Statement of Reasons.

The following sections of the proposed regulations were modified following the public hearing and were circulated for a 15-day comment period (From Aug. 2, 2013 to Aug. 19, 2013). The proposed regulation changes are summarized below.

THE FOLLOWING SECTIONS WERE AMENDED FOLLOWING THE PUBLIC HEARING AND CIRCULATED FOR A 15-DAY COMMENT PERIOD (Aug. 2, 2013 to Aug. 19, 2013)

Modifications to Section 9789.12.1 - Physician Fee Schedule: Official Medical Fee Schedule for Physician and Non-Physician Practitioner Services – For Services Rendered On or After January 1, 2014

Subdivision (b) was amended to add subsection (1) and add numbering. The following language was added as subsection (1): “except: (1) Evaluation and management codes are to be used only 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." The remaining existing text regulation was numbered as subsection (2) and the word, "However" was deleted.

Specific Purpose of Change: This change was required to clarify that evaluation and management codes are to be used only by physicians, and physician assistants and nurse practitioners, who are acting within the scope of their practice and are under the direction of a supervising physician.

Modifications to Section 9789.12.2 - Calculation of the Maximum Reasonable Fee - Services Other than Anesthesia

In this section and in many other sections of the regulations the term "provider" is deleted and the term "practitioner" is substituted for consistency and clarity. In addition, where appropriate the phrase "non-physician practitioner" is added for consistency and clarity.

Subdivision (a) The formula for calculating the base maximum reasonable fee for physician and non-physician professional medical practitioner services was amended to apply the average statewide geographic adjustment factors to the work RVUs, the practice expense RVUs, and to the malpractice RVUs, when the service is provided in a non-facility. The term "work" is added to the "key" describing the non-facility site of service fee calculation formula; the term "GAF" is added to the "key" defining "average statewide geographic adjustment factor". The term "GPCI" is deleted.

Subdivision (b) The formula for calculating the base maximum reasonable fee for physician and non-physician professional medical practitioner services was amended to apply the average statewide geographic adjustment factors to the work RVUs, the practice expense RVUs, and to the malpractice RVUs, when the service is provided in a facility. The term "work" is added to the "key" describing the facility site of service fee calculation formula; the term "GAF" is added to the "key" defining "average statewide geographic adjustment factor". The term "GPCI" is deleted.

Subdivision (e) was added to reference section 9789.19, by date of service, for the average statewide geographic adjustment factors.

Subdivision (e now f) was amended to change the numbering within the subdivision and make a non-substantive edit.

Specific Purpose of Changes: The majority of commenters for the 30-day comment period stated adopting an average statewide GAF will streamline the transition to RBRVS, reduce administrative burden and eliminate potential billing abuse. The changes made in this section are necessary to adopt an average statewide GAF. Substitution of the "GAF" in place of the term "GPCI" was necessary for clarity, as it represents a "factor" in the formula, whereas the geographic practice cost index could be confused with the Medicare 9-locality California GPCIs.

Modifications to Section 9789.12.3 - Status Codes C, I, N and R

Subdivision (b) was amended to clarify that when the OWCP fee schedule lists total RVUs for procedures with status indicator codes C,N, or R, without separately providing RVUs for work, practice expense, or malpractice expense, the average statewide geographic adjustment factor shall be applied.

Specific Purpose of Change: This subdivision was amended to conform the regulatory text to reflect adoption of average statewide GAF(s). This change clarified that when the 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.

Subdivision (d)(4) was amended to add a payment hierarchy for procedures with status indicator code I that do not meet the criteria of subdivisions (d)(1), (d)(2), or (d)(3). Payment would be determined according the following hierarchy: 1) use the RVUs listed in the CMS' National Physician Fee Schedule Relative Value File; 2) if there are no RVUs listed in the National Physician Fee Schedule Relative Value File, use the RVUs listed in the federal Office of Workers' Compensation Program (OWCP) fee schedule; 3) if there are no RVUs listed in the National Physician Fee Schedule Relative Value File and no RVUs listed in the OWCP, then the procedure is paid using a different OMFS fee schedule; or 4) if none of the above is applicable, the procedure is payable By Report. This subdivision was amended to state that when the 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.

Specific Purpose of Change: This subdivision clarified the payment hierarchy to be used when procedures with status indicator code I do not meet the criteria set forth in subdivisions (d)(1), (d)(2), or (d)(3). This subdivision was also amended to conform the regulatory text to reflect adoption of average statewide GAF(s). This change clarified that when the 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.

Modifications to Section 9789.12.5 – Conversion Factors

Subdivision (b) was amended to state the four year transition (2014 through 2017) shall be between the "OMFS Budget Neutral CF" (the estimated aggregate maximum allowable amount under the OMFS for physician services prior to January 1, 2014), and "120% RBRVS 2012 CF" (the maximum allowable amount based on the resource-based relative value scale at 120% of the Medicare conversion factor in effect in July 2012.) During the transition, the conversion factors for each year of the transition and the blend formulas, before adjustment, are listed. This subdivision was also amended to state the conversion factors shall be adjusted by the cumulative changes in MEI and the Relative Value Scale Adjustment Factor, if any, between 2012 and each transition year. Reference

was made to section 9789.19 for the annual and cumulative MEI, and Relative Value Scale Adjustment Factor, by date of service. This section was re-numbered.

Specific Purpose of Change: The changes to this subdivision clarified that the application of the four year transition is from the OMFS budget neutral conversion factor to 120% of RBRVS 2012 conversion factor. During the transition, the conversion factors would be adjusted by the cumulative increases in the annual MEI and the Relative Value Scale Adjustment Factor, if any, between 2012 and each transition year, as set forth in Labor Code section 5307.1.

Subdivision (c) was amended to state for calendar year 2018, and annually thereafter, the Anesthesia conversion factor and the Other Services conversion factor in effect in the prior calendar year shall be updated by the MEI and by the Relative Value Scale Adjustment Factor, if any.

Specific Purpose of Change: The changes to this subdivision was to clarify that the MEI and Relative Value Scale Adjustment factor, if any, would be applied to the anesthesia conversion factor and other services conversion factor in effect in the prior calendar year.

Modifications to Section 9789.12.8 – Status Codes

This section was amended to state that procedure codes with status code I are not valid for workers' compensation physician billing except as otherwise provided. The section was amended to include status code R, and specify that these procedures would be paid pursuant to section 9789.12.3.

Specific Purpose of Change: The changes to this subdivision clarified that procedure codes with status code I are not valid for workers' compensation billing except as other provided. The changes also clarified that procedures with status code R, if payable, are paid according to section 9789.12.3 since the "R" codes are restricted coverage under Medicare and often do not have listed Relative Value Units.

Modifications to Section 9789.12.11 – Evaluation and Management: Coding – New Patient; Documentation

Subdivision (b) was amended to state that the physicians and qualified non-physician practitioners must use either the 1995 or the 1997 documentation guidelines for evaluation and management services, but not a combination of the guidelines *for a patient encounter*. This subdivision was also amended to provide that if the physician's or qualified non-physician practitioner's documentation for a medically necessary service conforms to either one of the guidelines, the maximum reasonable fee shall be according to the documented level of service.

Specific Purpose of Change: The changes to this subdivision clarified the provider's use of either the 1995 documentation guidelines or the 1997 documentation guidelines, but not a combination of the guidelines are for a patient encounter. The changes also clarify

that if the provider's documentation conforms to either one of the guidelines, the maximum reasonable fee shall be paid according to the documented level of service.

Modifications to Section 9789.12.14 – California Specific Codes

This section was amended in conformity with section 9789.19 to state the California specific codes would be updated annually by the MEI.

Specific Purpose of Change: The changes to this subdivision clarified that the California specific codes would be updated annually in accordance with the Medicare Economic Index. This application of the MEI was included in the initial and revised modeling done by RAND.

Modifications to Section 97789.15.3 - Qualified Non-physician Anesthetist Services
Subdivision (a) was amended to replace "anesthesia assistants" with "certified anesthesiologist assistants".

Subdivision (b) was deleted.

The remaining subdivisions were re-numbered.

Specific Purpose of Change: The change to subdivision (a) was to clarify AAs are defined as certified anesthesiologist assistants. Comments from California Society of Anesthesiologists stated the prior term "anesthesia assistants" is undefined under federal law and lacks national recognition. Subdivision (b) was deleted as being unnecessary and confusing.

Modifications to Section 9789.16.2 – Surgery – Billing Requirements for Global Surgeries

Subdivision (c) was deleted.

Specific Purpose of Change: Subdivision (c) was deleted as being unnecessary and confusing, as the rules relating to Health Professional Shortage Area (HPSA) Payments are covered in section 9789.12.6.

Modifications to Section 9789.18.1 – Payment for Anesthesia Services – General Payment Rule

This section was amended to provide that the statewide anesthesia Geographic Adjustment Factor is to be applied as part of the formula for determining the payment rate for anesthesia services. In addition, the section was amended to provide that the statewide anesthesia GAF, by date of service, is set forth in section 9789.19.

Specific Purpose of Change: This subdivision was amended to conform the regulatory text to reflect adoption of average statewide GAF(s).

Modifications to Section 9789.19 – Update Table
And Specific Purpose of Changes

This section was amended as follows for the purpose described:

- Introductory language of subdivision (a) was re-ordered, and the applicable date was inserted, to improve clarity.
- California Specific Codes – Reference to WC006 was deleted, as this code is reserved and not currently used. Maximum reasonable fees were updated with the estimated 2014 MEI.
- CMS' Medicare National Physician Fee Schedule Relative Value File, "GPCI2013" – was deleted because California locality GPCI adjustments would no longer be applied. Instead, statewide Relative Value Unit component geographic adjustment factors (Work GAF, Practice Expense GAF, Malpractice GAF) would be applied.
- Conversion Factors – the 2014 conversion factors were revised to reflect RAND's revised analysis of the data, and the use of statewide RVU components' geographic adjustment factors.
- Listing of Current Procedural Terminology codes not to be used was amended to 1) list CPT codes 27215 – 27218 relating to pelvic fractures and to specify use of G0412-G0415 instead, and 2) list 97014 Electrical stimulation, unattended, and to specify use of G0283 instead, in accordance with Medicare payment rules.
- Medicare Economic Index was added to display the annual MEI, and the cumulative MEI.
- Relative Value Scale Adjustment Factor Adopted by CMS was added to the table.
- Statewide RVU Components' Geographic Adjustment Factors for other than anesthesia (Work, Practice Expense, and Malpractice expense) – was added.
- Statewide GAF for anesthesia was added.
- Statewide GAF (consolidated work, practice expense, malpractice expense) for use with OWCP RVU, where the OWCP lists a single consolidated RVU rather than components (work, PE, malpractice) was added.

UPDATE OF MATERIAL RELIED UPON

The following additional documents beyond those identified in the Initial Statement of Reasons were relied upon by the Acting Administrative Director and added to rulemaking file after close of the initial 30-day comment period. They were identified in the Notice of Modification to Text of Proposed Regulations and Notice of Addition of Documents to Rulemaking File for the 15-day comment period. These additional documents were available for 15 day public review and comment from August 2 through August 19, 2013.

Additional documents relied upon by the Acting Administrative Director and added to the rulemaking file and made available for public inspection and comment during the 15-day comment period (August 2 through August 19, 2013)

1. Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2013.
2. Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System*, June 2013.
3. *Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011* (CMS-1503-FC; 75 FR 73170; November 29, 2010)
4. Office of Inspector General, *Musculoskeletal Global Surgery Fees Often Did Not Reflect the Number of Evaluation and Management Services Provided*, A-05-09-0053, May 2012.
5. U.S. Government Accountability Office, *Medicare Physician Payments: Fees Could Better Reflect Efficiencies Achieved When Services are Provided Together*, GAO-09-647, July 31, 2009.
6. Whoriskey, Peter and Keating, Dan, *How a secretive panel uses data that distorts doctors' pay*, Washington Post, July 20, 2013.
7. Wynn, Barbara, Liu, Hangshen, Mulcahy, Andrew, Okeke, Edward, Iyer, Neema, and Painter, Lawrence, *Implementing a RB-RVS Fee Schedule for Physician Services: An Assessment of Policy Options for the California Workers' Compensation Program*, RAND, WR-993-1-DIR, July 2013, revised working paper.
8. Wynn, Barbara, Liu, Hangshen, Mulcahy, Andrew, Okeke, Edward, Iyer, Neema, and Painter, Lawrence, *Implementing a RB-RVS Fee Schedule for Physician Services: An Assessment of Policy Options for the California Workers' Compensation Program*, RAND, RR-395-DIR, August 2013.

LOCAL MANDATES DETERMINATION

- Local Mandate: None. The proposed regulations will not impose any new mandated programs or increased service levels on any local agency or school district.
- Cost to any local agency or school district that is required to be reimbursed under Part 7 (commencing with Section 17500) of Division 4 of the Government Code: None. The proposed amendments do not apply to any local agency or school district.
- Other nondiscretionary costs/savings imposed upon local agencies: None.

CONSIDERATION OF ALTERNATIVES

The Division considered all comments submitted during the public comment periods, and made modifications based on those comments to the regulations as initially proposed. The Acting Administrative Director has now determined that no alternatives proposed by the regulated public or otherwise considered by the Division of Workers' Compensation would be more effective in carrying out the purpose for which these regulations were proposed, nor would they be as effective as and less burdensome to affected private persons and businesses than the regulations that were adopted.