California Workers' Compensation Institute
1111 Broadway Suite 2350, Oakland, CA 94607 • Tel: (510) 251-9470 • Fax: (510) 251-9485

April 5, 2010

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

Physician fee schedule proposed regulations Wversion version

Physician fee schedule draft conversion factor transition Wversion version

Adapting the RBRVS Methodology to the California Workers' Compensation Physician Fee Schedule: Supplemental report version

This Forum commentary on draft revisions to the Physicians Section of the Official Medical Fee Schedule (OMFS), conversion factor revision and the Lewin Group's Supplemental Report: *Adapting the RBRVS Methodology to the California Workers' Compensation Physician Fee Schedule* is presented on behalf of the California Workers' Compensation Institute's members. Institute members include insurers writing 87% of California's workers' compensation premium, and self-insured employers with $30B of annual payroll (20% of the state's total annual self-insured payroll).

Introduction

The California Workers' Compensation Institute (The Institute) supports the Division's approach to revising the Physician Section of the Official Medical Fee Schedule, including its plan to adopt a budget-neutral RBRVS schedule, retain the physical medicine cascade and to transition to a single conversion factor over a period of four years. The California Workers' Compensation Institute congratulates the Division of Workers' Compensation on the results of its hard work on this difficult project. The Institute's recommended modifications that are indicated by underline and ~~strikethrough~~, and *comments* follow.

The Institute recommends allowing at least three months between the adoption and date of service* implementation to allow for the re-programming, testing, training, and other operational preparation necessary for a major fee schedule change.

The Lewin Group in its reports did not consider the impact of increasing the allowance for progress reports from $11.69 to $37.98, nor did it consider the impact of extending reimbursement for progress reports from primary treating physicians to all physicians. It treated reports only as a "pass-through." If these changes are adopted, the revised schedule will not be cost neutral. Because the current frequency of PTP progress reports is so high, and because the frequency of paid progress reports from non-PTPs is also anticipated to be high, the impact will be significant and must be taken into account. The purpose of redesigning the progress report form was to facilitate efficient reporting of the information that physicians must already report. A secondary benefit to physicians was that the form would more effectively support the medical billing. The increase in reimbursement for the form is not necessary and perhaps is unintended. The Institute recommends removing it.

Draft OMFS Physician Section Regulations

Recommendations

§ 9789.12.1 Physician Fee Schedule: Official Medical Fee Schedule for Physician and Non-Physician Professional Provider Services – For Services Rendered On or After 10/1/2010*

(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 October 1, 2010*, 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 9789.18.1 ("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, which are to be used by the specified type of provider.

Discussion

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

Recommendations

§ 9789.12.2 Definitions

(h) "CPT " or "Current Procedural Terminology" is the book *Current Procedural Terminology, Standard Edition*, Fourth Edition, dated xxxxxxx, copyright by the American Medical Association.

(j) "Facility" means ~~that the~~ a site of service that receives or is eligible to receive a facility fee payment related to the procedure.

(l) "Non-Facility" means ~~that the~~ a site of service that does not allow for a facility fee payment related to the procedure.

Discussion

Each edition of the CPT book undergoes revisions periodically, therefore it is necessary to include an "as of" date in (h) and elsewhere in the regulation.

The language recommended for (j) and (h) is consistent with the language in other definitions.

Recommendations

§ 9789.12.3 Relative Value Units (RVUs)

For services rendered on or after October 1, 2010*, the Administrative Director incorporates by reference the specified portions of the 2010 National Physician Fee Schedule Relative Value File, revised 1/8/2010, entitled "PPRRVU10" and RVUPUF10.pdf which can be accessed at:
http://www.cms.hhs.gov/PhysicianFeeSched/PFSRVF/itemdetail.asp?filterType=dual,%20data&filterValue=2010&filterByDID=1&sortByDID=1&sortOrder=ascending&itemID=CMS1230197&intNumPerPage=10
The columns of the PPRRVU10 which are incorporated by reference include:

Column A	HCPCS (except the alpha-numeric codes)
Column B	Modifier
Column C	Description
Column D	Status Code (except G, I, N, R)
Column Q	Fully Implemented Non-Facility Total RVUs
Column S	Fully Implemented Facility Total RVUs
Column T	PC/TC Indicator
Column U	Global Days
Column V	Pre Operative
Column W	Intra Operative
Column X	Post Operative
Column Y	Multiple Procedure
Column Z	Bilateral Surgery

Column AA	Assistant Surgeon
Column AB	Co-Surgeon
Column AC	Team Surgeon
Column AD	Endoscopic Base Code
Column AH	Diagnostic Imaging Family Indicator

The codes of the PPRRVU10 that are incorporated by reference include: xx to xx
(add code intervals that are to be included in the Physician Section).

The portions of the RVUPUF10.pdf that are incorporated by reference include:
(add here the portions that are to be included in the Physician Section).

Discussion

Because the codes listed in PPRRVU10 include codes from other sections of the OMFS, such as the Ambulance Section, the regulation needs to indicate the code intervals included in the Physician Section.

RVUPUF10.pdf provides additional necessary and clarifying information, including information on CPT modifiers and status codes.

Recommendations

§ 9789.12.4 Conversion Factors

The conversion factor(s) for physician and non-physician professional medical services shall be as follows:

(a) Anesthesia services (codes listed in the anesthesia section of the CPT):

For services rendered on or after October 1, 2010*: $33.9815143289

(b) For medical treatment services other than anesthesia (codes listed, respectively, in the surgery, radiology, and all other sections of the CPT):

	Surgery	Radiology	All Other
For services rendered on or after October 1, 2010*	53.12508522	59.5335055	40.70478871
For services rendered on or after October 1, 2011*	49.9375801	53.5801549	42.50707112
For services rendered on or after October 1, 2012*	46.9413253	48.2221394	44.16981332
For services rendered on or after October 1, 2013*	45.14766194	45.1476619	45.14766194

Recommendations

§ 9789.12.5 Calculation of the Maximum Reasonable Fee - Services Other than Anesthesia

Except for fees determined in §9789.17.1 et seq., (Anesthesia), the base maximum reasonable fee for physician and non-physician professional medical provider services shall be the non-facility or facility fee calculated as follows:

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

For services rendered on or after October 1, 2010*:

Fully Implemented Non-Facility Total RVU (Column Q) * CF = Base Maximum Fee

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:

For services rendered on or after October 1, 2010*:

Fully Implemented Facility Total RVU (Column S) * CF = Base Maximum Fee

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.

(c)(1) "~~Total~~ Facility Total RVU" shall be used to calculate the fee for services furnished to a patient in the hospital (inpatient or outpatient), comprehensive inpatient rehabilitation facility, inpatient psychiatric facility, skilled nursing facility, community mental health center, or ambulatory surgical center.
(2)"~~Total~~ Non-Facility Total RVU" shall be used to calculate the fee for services furnished to a patient in the physician's or non-physician provider's office, the patient's home, or in a facility or institution other than those listed above as the site for use of "~~Total~~ Facility Total RVU."

Discussion

The modifications recommended for (c)(1) and (2) to make the term consist with (a) and (b) and in the CMS tables.

Recommendations

§ 9789.13.1 Coding; Current Procedural Terminology ©, Fourth Edition

(a) The coding, modifiers, guidelines, appendices and all other provisions of *Current Procedural Terminology* ©, Fourth Edition, dated xxxxxxx published by the American Medical Association are applicable to the bills submitted for physician and non-physician professional medical services, except that any regulation in the Physician Fee Schedule that conflicts with a provision in *CPT* will take precedence over the *CPT*.

For services rendered on or after October 1, 2010*, the Administrative Director incorporates by reference the American Medical Association's "Current Procedural Terminology," 4th Edition, Revised 2010.

(b) Copies of *Current Procedural Terminology* ©, Fourth Edition dated xxxxxxx may be purchased from the American Medical Association:

Order Department
American Medical Association
P.O. Box 930876
Atlanta, GA 31193-0876

Or over the internet at: www.amapress.com

Or American Medical Association's toll free order line: (800) 621-8335

Recommendations

§ 9789.13.2 California Specific Codes

Physicians shall use the "California Specific Codes" listed below. Maximum reasonable fees for services performed by providers within their scope of practice shall be no more than the fee listed below for the procedure.

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	**~~$37.98~~ $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 ($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**	**Primary Treating Physician's Permanent and Stationary Report (Form PR-4)**

	page. Maximum of seven pages absent prior authorization ($178.20)	**(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 ($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 ($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 agreement**	**Missed Appointments. This code is designated for communication only. It does not imply that compensation is owed.**

Discussion

The recommended modification in the WC002 “Reference to Fee (if any)” box, it is necessary to maintain the revenue neutral revision goal. The Lewin Group in its reports did not consider the impact of increasing the allowance for progress reports from $11.69 to $37.98, nor did it consider the impact of extending reimbursement for progress reports from primary treating physicians to all physicians. It treated reports only as a “pass-through. Because the current frequency of PTP progress reports is so high, and

because the frequency of paid progress reports from non-PTPs is also anticipated to be high, the impact is expected to be significant and needs to be taken into account. If the changes proposed in this table were adopted, the revised schedule will not be cost neutral.

	Number	Total Paid	Adjusted Paid	Difference
99081 – PTP progress report	213,698	$ 2,422,302	$ 8,116,250	$ 5,693,948
All other Physician FS codes	1,147,799	$ 86,797,466	$ 86,797,466	
Total	1,361,497	$ 89,219,768	$ 94,913,716	
99081 as % of Total	15.7%	2.7%	8.6%	
% change increases total Phys FS paid			6.4%	

Data based on sample of medical bill review data with DOS between Jan 2009 - June 2009
Adjusted Paid assumes 99081 reimbursement change from $11.69 to $37.98 per report

Based on a sample of medical bill review data from the ICIS data base, progress reports constitute 15.7% of Physician Fee Schedule codes with dates of service from January through June of 2009, and 2.7% of the total payments. Increasing the payment of those reports from $11.69 to $37.98 would increase the payments for progress reports to 8.6% of the total payments, increasing total payments under the physician fee schedule by 6.4%.

If all other physicians are also paid for progress reports, the increase would be significantly more. Since such reports are not currently billed, it is difficult to estimate the extent of that additional increase.

For the WC002 “Procedure” box recommended modification, see the Institute’s comments on subsections (a)(4) and (a)(9) of section 9785 regarding the statutory and operational need to limit the required progress reporting – the PR-2 or equivalent, to the primary treating physician.

Recommendations

§ 9789.13.3 California-Specific Modifiers

(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, 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, as appropriate: evaluation and management codes, report codes and prolonged service codes.~~

~~-03 **Non-physician provider report/service:**~~
~~This modifier shall be used to identify a required report issued by, or E&M service performed by, a non-physician professional provider.~~

~~-04 **Consultant Report/service:**~~
~~This modifier shall be used to identify a report issued by, or E&M service performed by, a Consultant. This modifier shall be appended to each of the following codes, as appropriate: evaluation and management codes, report codes and prolonged service codes.~~

~~-05 **Consultation Service During Medical-Legal Evaluation:**~~
~~This modifier shall be used to identify services or procedures performed by a consultant in the context of a medical-legal evaluation where those services are paid under the Physician Fee Schedule.~~

-83 **Surgical Assistant Services Provided by a Licensed Non-Physician Professional Provider**
This modifier shall be used to identify services performed by licensed non-physician professional providers acting within their scope of practice, and used in lieu of an assistant physician. Reimbursed at 10% of allowable surgical fee.

-93 **Interpreter Required at the Time of Examination:**
Where this modifier is applicable, the value of the evaluation and management service is modified by multiplying the normal value by 1.1. Prolonged service codes may not be used in combination with this modifier unless it is documented that the reason for the code is additional time required as a result of factors beyond the need for an interpreter.

Discussion

Although similar types of modifiers are included in the current fee schedule, except for those that affect reimbursement, they remain largely unused and ignored. Unless there is some consequence attached to their use, consider deleting unused codes as the situation is unlikely to change

Recommendations

§ 9789.13.4 Evaluation and Management Coding – New Patient

For purposes of workers' compensation billing, the CPT definitions of "new patient" and "established patient" are altered as follows:

(a) A "new patient" is one who is new to the physician or an established patient with a new industrial injury or illness. Only one new patient visit is reimbursable to a single physician or medical group per specialty for evaluation of the same patient relating to the same incident, injury or illness.
(b) An "established patient" is a patient who has been seen previously for the same industrial injury or illness by the physician or medical group.

Discussion

"Medical group" is needed in (b) for consistency with (a).

Recommendations

§ 9789.13.6 Correct Coding Initiative

For services rendered on or after October 1, 2010*, the Administrative Director incorporates by reference the National Correct Coding Initiative Edits - Physicians and the National Correct Coding Initiative Coding Policy Manual for Medicare Services, version 15.3, effective October 1, 2009.

Recommendations

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

(a) An unlisted procedure shall be billed using the appropriate unlisted procedure code from the CPT. The procedure shall be billed by report *(report not separately reimbursable)*, justifying that the service was reasonable and necessary to cure or relieve from the effects of the industrial injury or illness.

(c) In some instances, the value of a By Report procedure may be determined ~~using~~ based on the value assigned to a comparable procedure. The comparable procedure should reflect the same amount of time, complexity, expertise, etc. as required for the procedure performed or the differences considered when assigning a value.

Discussion

The modification to (a) will avoid disputes over whether the report is separately reimbursable.

The reimbursement amount for a By Report procedure can be determined by increasing or decreasing the fee for another procedure according to the differences in 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's 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 $37.98.

(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. 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 "Prolonged Service Codes", below.

(A) A report by a consulting physician, where consultation was requested on one or more medical issues by the treating physician, including a second medical opinion on the necessity or appropriateness of previously recommended medical treatment or a surgical procedure.

(B) A report by a consulting physician, where consultation was requested on one or more medical issues by a party, the Administrative Director, or the Workers' Compensation Appeals Board. Reports included under this section are those reports that are admissible and reimbursable in accordance with Labor Code section 4064(d).

(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.

~~(D) A report by a consulting physician where the claim does not meet the criteria of a "contested claim" as set forth in 8 CCR § 9793(b).~~ *(I think this is covered in (A) and (B).*

(E) A consultation code may not be billed when care or any part of care has been clearly transferred by the primary treating physician to another physician.

Discussion

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

(D) appears to be necessary because it is covered by (A) and (B).

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