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

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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: Written Testimony -- 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 supports 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 most of the proposed language in the fee schedule regulations and appreciates the inclusion of useful tables. The RAND working report is thorough, the methodology descriptions are careful and the alternative policy scenarios are helpful.

The primary recommendations by the Institute on behalf of its member companies are to:

- Adhere to Labor Code section 5307.1(b) which limits fee schedule factor changes to those that will not cause estimated aggregate fees to exceed the estimated aggregate fees allowed by Medicare for the same class of services
- Adopt a single California-wide GPCI instead of multiple GPCIs and HPSAs
- Maintain a single conversion factor for all services other than anesthesia.

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

General Recommendations

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 by Medicare for the same class of services**.

Discussion
The construction of the Physician Fee Schedule is a $344 million potential cost increase for the system. While the new fee schedule was not required to be cost neutral, such a large increase in physician and non-physician practitioner costs was not factored into the reform calculations and, if adopted as currently proposed, the RBRVS fee schedule will overwhelm the total projected net cost reductions.

The Administrative Director proposes a Physician Fee Schedule that transitions from the current schedule over a period of four years to an RBRVS-based schedule with one conversion factor for anesthesia and another for all other services. At the end of the transition, in 2017, those two conversion factors are proposed to be 120% of the 2012 Medicare conversion factor, modified by the annual adjustment factor described in Labor Code section 5307.1(g). This would create a schedule at the upper limit permitted by Labor Code section 5307.1(a)(2)(A), but above the upper limit imposed by Labor Code section 5307.1(b).

To implement a fee schedule with the additional annual accelerators as proposed in the regulations and addressed in the RAND working paper without a limit would lead to increases in

the Physician Fee Schedule allowances that by the end of the transition in 2017 threaten to eliminate most of the total estimated SB 863 net cost reductions of $540 million. If the fee schedule is not tied to the stated 120% of Medicare, the acceleration of medical care costs would continue unabated. The Institute does not believe that this was the result intended by the Legislature.

We note that the statute does not require the Administrative Director to set the schedule at this proposed upper level. 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.

Labor Code section 5307.1(b) allows the Administrative Director to adopt different conversion factors, as long as those factors do not result in aggregate payments that would exceed 120 percent of what Medicare would pay for the services. As proposed, the schedule will exceed that limit. The annual adjustment factors described in Labor Code section 5307.1(g) rapidly escalate the conversion factors beyond the 120 percent of Medicare 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.

A fee schedule based on section 5307.1(a)(2)(A) that ignores the strictures of subdivision 5307.1(b) will lead to an uncontrolled acceleration of fees. According to RAND's impact analysis in Chapter 5 of its working paper "*Implementing a RB-RVS Fee Schedule for Physician Services*," total allowable fees are estimated to be 19.6% higher in 2017 than in 2013; and total allowable fees under the proposed schedule are estimated to increase during the transition period by $344 million, which is 64% of the net estimate of cost reductions for the total reform package. SB 863 was predicated upon a balance between benefit increases and cost reductions. The legislative intent underlying the RBRVS fee schedule is to impose an overall cap of 120% of Medicare. This is not a stationary cap on fees; annual revisions to Medicare conversion factors will still provide physicians with the benefit of the inflation factors that are built into the Medicare fee schedule and augmented by the 20% workers' compensation incentive, but it will restrain what would otherwise become a growing percentage in excess of Medicare.

Recommendation – single conversion factor
Maintain one single conversion factor for anesthesia and another single conversion factor for all other services.

Discussion
The Institute strongly supports the adoption of a single conversion factor for all services other than anesthesia, and transitioning over a period of four years to the single conversion factor. Some have warned that physicians and other practitioners, and particularly physician specialists, will refuse to treat injured employees in California if an RBRVS fee schedule is calibrated at an average 120 percent of Medicare allowances. This warning, which is sometimes based on self-reported survey information, is routinely raised when fee schedule revisions are proposed; however the threatened

refusal to treat has not come to pass before, and is not expected to do so this time. We note that the 2013 MedPAC Report (see attached) on physician and other health care providers examines the availability of Medicare providers and concludes that "Overall, beneficiary access to physicians and other health professional services is stable and similar to access for privately insured individuals ages 50 to 64." Since physicians are accessible to treat patients under an RBRVS fee schedule for 100% of the Medicare treatment allowances, we are confident that they will continue to treat workers' compensation patients at allowances that will average 20% more than the Medicare allowances.

Recommendation - GPCIs
Adopt a single, RAND calculated Geographic Practice Cost Index (GPCI).

Discussion
The multiple GPCIs currently used for Medicare calculations provide lower reimbursements for services in certain areas. These lower reimbursements discourage physicians and other practitioners from establishing practices in those areas, and encourage them to practice where higher GPCIs provide higher reimbursement. This has created and exacerbates shortages of such practices in lower GPCI areas, including many rural areas. The GPCIs are intended to provide additional reimbursement to compensate providers in areas where costs are higher; however the current GPCI areas 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 establishing a single state-wide GPCI for workers' compensation is a better solution and is more efficient than creating or exacerbating health professional shortage areas then compensating for them.

Adopting a single GPCI will also eliminate the billing abuse associated with multiple GPCIs (for example, when a provider reports an incorrect service location by entering a 3rd party biller zip code on the form to increase reimbursement).

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 payment for P&S reports or consultation reports into the underlying service, reimburse the reports at a flat average fee.

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 as it considers their reimbursement to be included in the reimbursement of their underlying services, such as evaluation and management services. If the Division decides to continue separate reimbursement for specified reports, their estimated payments should be included (they are currently excluded) 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). 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. Reports are within the "*same class of services in the relevant Medicare payment system"* specified in (b) that *"may not exceed 120 percent of the estimated aggregate fees*

paid for the same class of services in the relevant Medicare payment system." With respect to (d), reports are covered by a *"Medicare payment system"* and even if they were not considered covered, *"the maximum fee paid shall not exceed 120 percent of the fees paid by Medicare for services that require comparable resources,"* and comparable resources are not separately paid by Medicare. We also note that average reimbursement for evaluation and management services, which generally underlie the reports, are calculated to increase by 49 percent when fully implemented in 2017.

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.

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%.

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 commencing on page 14 in the event the Administrative Director decides to retain a per-page payment methodology.

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 proposed California codes WC008, WC009, WC010, and WC011.

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.

Specific Recommendations

The Institute supports the majority of the proposed regulations without change, and finds the RAND working paper helpful. They are well researched, carefully considered, and well written.

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*.

§ 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

(a) Maximum reasonable fees for physician and non-physician practitioner medical treatment provided pursuant to Labor Code section 4600, which is rendered on or after January 1, 2014, shall be no more than the amount determined by the Official Medical Fee Schedule for Physician and Non-Physician Practitioners, consisting of the regulations set forth in Sections 9789.12.1 through 9789.19 ("Physician Fee Schedule.") Maximum fees for services rendered prior to January 1, 2014 shall be determined in accordance with the fee schedule in effect at the time the service was rendered. 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 except to the extent that contracted fees are predicated on Physician Fee Schedule allowances.

The Institute recommends this change to clarify that contract fees are not precluded from being based on Physician Fee Schedule allowances.

(b) Maximum fees for services of a physician or non-physician practitioner 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. ~~However,~~ Osteopathic Manipulation Codes (98925-98929) are to be used only by licensed Doctors of Osteopathy and Medical Doctors.

Maximum fees in an RBRVS-based fee schedule sometimes differ by type of provider.

§ 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 provider services shall be the non-facility or facility fee calculated as follows:

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

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

Key: RVU = Relative Value Unit
GPCI = Geographic Practice Cost Index
PE = Practice Expense
MP = Malpractice Expense

The California state-wide Geographic Practice Cost Index (GPCI) Schedule is 1.082 and shall be used in calculations of maximum reasonable fees.

The multiple GPCIs currently used for Medicare calculations provide lower reimbursements for services in certain areas. These lower reimbursements discourage physicians and other practitioners from establishing practices in those areas, and encourage them to practice where higher GPCIs provide higher reimbursement. This has created and exacerbates shortages of such practices in lower GPCI areas, including many rural areas. The GPCIs are intended to provide additional reimbursement to compensate in areas where costs are higher; however the current GPCI areas in California are illogical and do not fairly or successfully accomplish this. In addition they de-compensate where the population is sparse. If they are adopted for workers' compensation, we can expect them to create and exacerbate provider shortages. While HPSAs may provide some relief for this problem, addressing the disincentives that create and exacerbate this problem by establishing a single state-wide GPCI for workers' compensation would be more efficient than creating or exacerbating health professional shortage areas then compensating for them.

Adopting a single GPCI will also eliminate certain common billing abuses associated with multiple GPCIs, such as reporting an incorrect service location by entering a 3rd party biller zip code on the form to increase reimbursement.

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.

§ 9789.12.5 Conversion Factors

(b) (1) Commencing January 1, 2014, there shall be a four-year transition between: "OMFS Budget Neutral CF": the estimated aggregate maximum allowable amount under the official medical fee schedule for physician services prior to January 1, 2014, and "120% RBRVS CF Adjusted": the maximum allowable amount based on the resource-based relative value scale at 120 percent of the Medicare conversion factor in effect in July 2012, as adjusted by the Medicare Economic Index annual adjustment factors, and any annual Relative Value Scale Adjustment Factors, 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.

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

This recommended change is to ensure that adjustments to the conversion factors and other factors affecting payment amounts do not result in estimated aggregate fees that exceed 120 percent of estimated aggregate fees paid by Medicare for the same class of services, as required

by Labor Code section 5307.1(b). See the comments on the conversion factor in the General Recommendations section for a full explanation on these points.

§ 9789.12.6 Health Professional Shortage Area Bonus Payment: Primary Care; Mental Health

(a) Physicians who provide professional services in a Health Professional Shortage Area (HPSA) are eligible for a 10 percent bonus payment. Eligibility for receiving the 10 percent bonus payment is based on whether the specific location at which the service is furnished is within an area that is designated as a HPSA by the Health Resources and Services Administration (HRSA), within the United States Department of Health & Human Services.

Physicians, including psychiatrists, furnishing services in a primary medical care HPSA are eligible to receive bonus payments. In addition, psychiatrists furnishing services in mental health HPSAs are eligible to receive bonus payments.

It is not enough for the physician merely to have his/her office or primary service location in a HPSA, nor must the injured worker reside in a HPSA. Eligibility for the bonus is determined by where the service is actually provided (place of service). For example, a physician providing a service in his/her office, the patient's home, or in a hospital qualifies for the incentive payment as long as the specific location of the service is within an area designated as a HPSA. On the other hand, a physician may have an office in a HPSA but go outside the office (and the designated HPSA area) to provide the service. In this case, the physician would not be eligible for the incentive payment.

(b) Only services provided in areas that are designated as of December 31 of the prior year are eligible for the HPSA bonus payment. Physicians providing services in areas that were designated as of December 31 of the prior year but not on the automated file shall use the AQ modifier. Only services provided in areas that were designated as of December 31 of the prior year but not on the automated file may use the modifier. Services provided in areas that are designated during the year will not be eligible for the HPSA bonus payment until the following year, provided they are still designated on December 31. Services provided in areas that are de-designated during the year will continue to be eligible for the HPSA bonus through the end of the calendar year.

(c) The claims administrator shall automatically pay bonuses for services rendered in ZIP Code areas that fully fall within a designated primary care or mental health full county HPSA; are considered to fully fall in the county based on a determination of dominance made by the United States Postal Service (USPS); or are fully within a partial county HPSA area.

(d) Should a ZIP Code fall within both a primary care and mental health HPSA, only one bonus will be paid on the service. Bonuses for mental health HPSAs will only be paid when performed by the provider specialty of 26 – psychiatry.

(e) For services rendered in ZIP Code areas that do not fall within a designated full county HPSA; are not considered to fall within the county based on a determination of dominance made

by the USPS; or are partially within a partial county HPSA, physicians must submit an AQ modifier to receive payment.

To determine whether a modifier is needed, physicians must review the information provided on the CMS web site or the HRSA web site for HPSA designations to determine if the location where they render services is within a HPSA bonus area. Physicians may also base the determinations on letters of designations received from HRSA. They must be prepared to provide these letters as documentation upon the request of the claims administrator.

For services rendered in ZIP Code areas that cannot automatically receive the bonus, it will be necessary to know the census tract of the area to determine if a bonus should be paid and a modifier submitted. Census tract data can be retrieved by visiting the U.S. Census Bureau Web site at www.Census.gov or the Federal Financial Institutions Examination Council (FFIEC) Web site at www.ffiec.gov/geocode/default.htm . Instructions on how to use these Web sites can be found on the CMS Web site at http://new.cms.hhs.gov/HPSAPSAPhysicianBonuses .

(f) The claims administrator shall pay the 10% bonus together with the payment for the service performed in the HPSA designated area. The HPSA bonus pertains only to physician's professional services. Should a service be billed that has both a professional and technical component, only the professional component will receive the bonus payment.

(g) See section 9789.19, by date of service, for:
(1) The links for the Primary Care HPSA zip code file and the Mental Health HPSA zip code file listing zip codes that will automatically receive the HPSA bonus;
(2) The HRSA web link to determine if a particular address is in a Primary Care HPSA and/or a Mental Health HPSA;
(3) The HRSA web link to find Primary Care HPSA and Mental Health HPSA by State & County.

If the Administrative Director adopts one state-wide GPCI as recommended, the Institute recommends deleting this section. Adopting a single GPCI for workers' compensation services is a better and less complex alternative than HPSAs to address the problem of health care professional shortage areas in California. The multiple GPCIs currently used for Medicare calculations provide lower reimbursements for services in certain areas. These lower reimbursements discourage physicians and other practitioners from establishing practices in those areas, and encourage them to practice where higher GPCIs provide higher reimbursement. This has created and exacerbates shortages of such practices in lower GPCI areas, including many rural areas (see also the discussion on page 7 regarding a California state-wide GPCI). HPSAs provide some relief for this problem, however addressing the disincentives that create and exacerbate this problem by establishing a single state-wide GPCI is a better and less administratively burdensome solution than compensating for disincentives caused by the multiple GPCIs.

§ 9789.12.11 Evaluation and Management: Coding – New Patient; Documentation

(b) To properly document and determine the appropriate level of evaluation and management service, providers must use either one of the following guidelines but not a combination of the two guidelines:

(1) The "1995 Documentation Guidelines for Evaluation & Management Services," *or*

(2) The "1997 Documentation Guidelines for Evaluation and Management Services."

Both guidelines are incorporated by reference and are available on Medicare's website, or will be made available upon request to the Administrative Director.

The 1995 version is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf

The 1997 version is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf.

> *The Institute recommends that the Administrative Director adopt and require the use of either the 1995 or the 1997 Guidelines rather than both guidelines. If the Director does not accept the recommendation to adopt only one, we recommend requiring the provider to document for each evaluation and management billing the Guideline utilized.*

§ 9789.12.12 Consultation Services Coding – use of visit codes

> *Medicare increased general E/M service reimbursement in exchange for the reimbursement previously allowed under consultation codes. The Institute supports the application of the Medicare consultation coding policy.*

§ 9789.12.13 Correct Coding Initiative

> *The Institute supports the application of NCCI edits to workers' compensation bills except where payment ground rules differ from Medicare ground rules.*

§ 9789.12.14 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 in section 9789.19, by date of service.

CA Code	Procedure
WC001	Doctor's First Report of Occupational Illness or Injury (Form 5021) (Section 9789.14(a)(1))
WC002	Primary Treating Physician's Progress Report (PR-2 or narrative equivalent submitted by the Primary Treating Physician in accordance with § 9785) (Section 9789.14(b)(1))
WC003	Primary Treating Physician's Permanent and Stationary Report (Form PR-3) (Section 9789.14(b)(2))
WC004	Primary Treating Physician's Permanent and Stationary Report (Form PR-4) (Section 9789.14(b)(3))
~~WC005~~	~~Psychiatric Report requested by the WCAB or the Administrative Director, other than medical-legal report. Use modifier -32 (Section 9789.14(b)(4))~~
WC006	[Reserved]
WC007	Consultation Reports Requested by the Workers' Compensation Appeals Board or the Administrative Director (Use modifier -32) Consultation Reports requested by the QME or AME in the context of a medical-legal evaluation (Section 9789.14(b)(5)). (Use modifier -30)
~~WC008~~	~~Chart Notes (Section 9789.14(c))~~
~~WC009~~	~~Duplicate Reports (Section 9789.14(d))~~
~~WC010~~	~~Duplication of X-Ray~~
~~WC011~~	~~Duplication of Scan~~
WC012	Missed Appointments. This code is designated for communication only. It does not imply that compensation is owed.

Clarify that proposed California WC002 may be reported by and paid only to the primary treating physician.

Delete the proposed California code WC005 that is intended to separately reimburse Psychiatric Reports requested by the WCAB or the Administrative Director, other than medical-legal reports.

Delete the proposed California codes intended to separately reimburse chart notes (WC008), duplicate reports (WC009), duplication of X-Ray (WC010) and duplication of scan (WC011).

Only progress reports by the primary treating physician (PTP) have been separately reimbursable under the OMFS because the PTP is responsible for managing the employee's care and for reporting to the claims administrator pursuant to Labor Code section 4061.5. If the separate reimbursement is to continue for this report even though Medicare reimbursements for all reports are included in the underlying services, the regulation needs to clarify that WC002 is to be reported by and paid to only the PTP. If this is not clear, it will generate disputes, and if interpreted to apply more broadly medical costs will rise significantly.

Psychiatric Reports requested by the WCAB or the Administrative Director, other than medical-legal reports can be reported under proposed California code WC007 with modifier -32. A separate code is not necessary.

Proposed California codes WC008, WC009, WC010, and WC011 codes are not necessary. They have been rarely used in WC while available and reimbursements for notes, reports and duplicate records such as X-rays and scans are bundled into the underlying services under the Medicare schedule and are not separately reimbursed. See the frequency data in Table 1.

Table 1: Services provided in 2011 that are subject to Physican FS

Physician FS Code	Description	Percentage of Output Codes	Percentage of Output Payments
76175	Duplication of X-ray	0.001%	0.000%
76176	Duplication of scan	0.008%	0.001%
99086	Reproduction of chart notes	0.028%	0.002%
99087	Reproduction of duplicate reports	0.061%	0.003%
	Sub-total:	0.099%	0.006%
Source: CWCI ICIS Database (v14B)			

§ 9789.14 Reimbursement for Reports, Duplicate Reports, Chart Notes

This section governs reimbursement of all reports other than those which are payable under the medical-legal fee schedule, found at section 9793 et seq.

(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) Consultation Reports, except as specified in subdivision (b)(5).

(3) Report by a secondary physician to the primary treating physician.

(4) Physician's Return-to-Work & Voucher Report (DWC-AD 10133.36) issued in accordance with section 9785 subdivision (i) (reimbursement is bundled into payment for PR-3 or PR-4).

(b) Treatment Reports That Are Separately Reimbursable.

The following treatment reports are separately reimbursable.

(1) Primary Treating Physician's Progress Report (Form PR-2), issued by the primary treating physician 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.

(2) Primary Treating Physician's Permanent and Stationary Report (Form PR-3) issued in accordance with section 9785(h). Use Code WC003.

(3) Primary Treating Physician's Permanent and Stationary Report (Form PR-4) issued in accordance with section 9785(h). Use Code WC004.

~~(4) Psychiatric Report Requested by the WCAB or the Administrative Director, other than a medical-legal report. Use Code WC005, modifier -32.~~

(~~5~~4) Consultation Reports that are separately reimbursable. The following reports are separately reimbursable.
(A) Consultation reports requested by the Workers' Compensation Appeals Board or the Administrative Director. Use WC007, modifier -32.
(B) Consultation reports requested by the Qualified Medical Evaluator ("QME") or Agreed Medical Evaluator ("AME") in the context of a medical-legal evaluation. Use WC007, modifier -30.

~~**(c)** Chart Notes. Requests for chart notes shall be in writing and shall be separately reimbursable. Chart note requests shall be made only by the claims administrator. Use Code WC008 to bill for requested chart notes "By Report".~~

~~**(d)** Duplicate Reports. A primary treating physician has fulfilled his or her reporting duties by sending one copy of a required report to the claims administrator or to a person designated by the claims administrator to be the recipient of the required report. Requests for duplicate reports related to billings shall be made only by the claims administrator and shall be in writing. Duplicate reports are separately reimbursable. Use Code WC009 to bill for duplicate reports "By Report".~~

See the discussion on reports, California codes and BR codes on page 5 in the General Recommendations, and the comments on pages 11 and 12 regarding the specific recommended changes to section 9789.12.14.

§ 9789.19 Update Table

(a) The following documents are incorporated by reference and will be made available upon request to the Administrative Director.

Document	Services Rendered On or After 1/1/2014
Anesthesia Base Units by CPT Code	2013anesBASEfin
California-Specific Codes	WC001 – Not reimbursable WC002 - $11.78 WC003 - $38.25 for first page $23.54 each additional page. Maximum of six pages absent ~~mutual agreement~~ prior authorization ($155.95) *The Institute recommends restoring the term "prior authorization" instead of "mutual agreement" here and elsewhere in these regulations. Labor Code section 4603.2(b)(1) requires that any written authorization for services that may have been received by the physician to be submitted together with the itemized billing. Retaining the term "prior authorization" instead of "mutual agreement" will clarify that the written authorization should accompany the billing, facilitate faster payment, and avoid unnecessary confusion and disputes.* WC004 - $38.25 for first page $23.54 each additional page. Maximum of ~~seven~~ six pages absent ~~mutual agreement~~ prior authorization ($~~179.49~~ 155.95) *The Institute objects to raising the current reimbursement from $155.95 for six pages. $155.95 is already generous for completing the form. Since reimbursement for reports and forms is already included in the Medicare reimbursement of the underlying service, there is a strong argument to be made for deleting the separate reimbursement altogether. The 20% workers' compensation incentive over Medicare is intended to cover any additional resources inherent in providing workers' compensation services. In addition, by 2017, fees for*

	evaluation services, which are the underlying services for these reports, are proposed to increase by 49%. It is therefore not necessary to raise the reimbursement for filling out the form to $179.49. ~~WC005 - $38.25 for first page, $23.54 each additional page. Maximum of six pages absent mutual agreement ($155.95)~~ *We have recommended the deletion of WC005 because this report can be reported under WC007.* ~~WC006 - $38.25 for first page~~ ~~$23.54 each additional page. Maximum of six pages absent mutual agreement ($155.95)~~ *WC006 is "reserved" and therefore should not have an assigned value* WC007 - $38.25 for first page $23.54 each additional page. Maximum of six pages absent ~~mutual agreement~~ prior authorization ($155.95) ~~WC008 - $10.07 for up to the first 15 pages. $0.25 for each additional page after the first 15 pages.~~ ~~WC009 - $10.07 for up to the first 15 pages. $0.25 for each additional page after the first 15 pages.~~ ~~WC010 - $5.04 per x-ray~~ ~~WC011 - $10.07 per scan~~ *We recommend the deletion of proposed California codes WC008, WC009, WC010, and WC011 as they are for services that have been rarely billed and paid, and each of these services is considered part of its underlying service.* WC012 - No Fee Prescribed / Non Reimbursable absent ~~agreement~~ prior authorization
CCI Edits: Medically Unlikely Edits	http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html in the document "Practitioner Services MUE Table – Updated 4/1/2013."
CCI Edits: National Correct Coding Initiative Policy Manual for Medicare Services	NCCI Policy Manual for Medicare Services - Effective January 1, 2013 [ZIP, 696KB]
CCI Edits: Physician CCI Edits	Physician CCI Edits v19.1 effective April 1, 2013 (659,304 records). The last row contains edit column 1 = 39599 and column 2 = 49570 Physician CCI Edits v19.0 effective April 1, 2013 (576,593 records). The first row contains edit column 1 = 40490 and column 2 = C8950

CMS' Medicare National Physician Fee Schedule Relative Value File [Zip], excluding ANES2013 file • RVUPUF13 (Excluding Attachment A) • PPRRVU13.V0215_04162013 • OPPSCAP • GPCI2013 • 13LOCCO	RVU13C
CMS Pub 100-04 Medicare Claims Processing: Casting and Splint Supplies	Transmittal 2565 (Change Request 8051)
Conversion Factors	Anesthesia Conversion Factor: $32.645 Surgery Conversion Factor: $52.478 Radiology Conversion Factor: $50.101 Other Services Conversion Factor: $35.94
Current Procedural Terminology (CPT®)	CPT 2014 https://commerce.ama-assn.org/store/
Current Procedural Terminology CPT codes that shall not be used	Do not use CPT codes: 76140 (see §9789.21) 80100 through 80104 (see clinical lab fee schedule, § 9789.50) 90889 (See §9789.14. Use codeWC0057 code) *See comment on WC005 above.* 99075 (see Medical-Legal fee schedule, §9795) 99080 (see §9789.14) 99241 through 99245 (see §9789.12.12) 99251 through 99255 (see §9789.12.12) 99455 and 99456.
Diagnostic Cardiovascular Procedure CPT codes subject to the MPPR	RVU13C, PPRRVU13_V0503, Number "6" in Column labeled "Multiple Procedure (Modifier 51); PPRRVU13_V0503
Diagnostic Imaging Family Indicator Description	National Physician Fee Schedule Relative Value File Calendar Year 2013 http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU13C.html RVUPUF13 (Word document)
Diagnostic Imaging Family Indicator for Procedure	http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU13C.html PPRRVU13_V0503, column AB, labeled, "Diagnostic Imaging Family Indicator".

DWC Pharmaceutical Fee Schedule	http://www.dir.ca.gov/dwc/OMFS9904.htm#8
Federal Office of Workers' Compensation Program (OWCP) fee schedule RVUs	2012 OWCP Fee Schedule, "CPT, HCPCS, ADA & OWCP codes with RVU and conversion factors" fs12_code_rvu_cf.xls
Health Professional Shortage Area zip code data files	2013 Primary Care HPSA [ZIP, 102KB] 2013 Mental Health HPSA [ZIP, 246KB]
Health Resources and Services Administration: HPSA shortage area query (By State & County) (By Address)	 http://hpsafind.hrsa.gov/ http://datawarehouse.hrsa.gov/geoHPSAAdvisor/GeographicHPSAAdvisor.aspx
Incident To Codes	RVU13C, PPRRVU13_V0503, with PC/TC indicator number "5"; PPRRVU13_V0503
Medi-Cal Rates - DHCS	http://files.medi-cal.ca.gov/pubsdoco/Rates/rates_download.asp
Ophthalmology Procedure CPT codes subject to the MPPR	RVU13C, PPRRVU13_V0503, Number "7" in Column labeled "Multiple Procedure (Modifier 51); PPRRVU13_V0503
Physical Therapy Multiple Procedure Payment Reduction: "Always Therapy" Codes; and Acupuncture and Chiropractic Codes	RVU13C, PPRRVU13_V0503, Number "5" in Column labeled "Multiple Procedure; PPRRVU13_V0503 In addition, CPT codes: 97810, 97811, 97813, 97814, 98940, 98941, 98942, 98943
Physician Time	CY 2013 PFS Physician Time [ZIP, 473KB]
Radiology Diagnostic Imaging Multiple Procedures	http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU13C.html PPRRVU13_V0503, number "4" in column S, labeled, "Mult Proc".
The 1995 Documentation Guidelines for Evaluation & Management Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf
The 1997 Documentation Guidelines for Evaluation and Management Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf.

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

Sincerely,

Brenda Ramirez
Claims & Medical Director

BR/pm

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