California Workers' Compensation Institute

Research Update

Changes in Workers' Compensation Physician Reporting Under California's RBRVS Fee Schedule: Initial Results

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Executive Summary

In August 2014, a CWCI *Research Note*[1] presented benchmark data on the volume and the amounts paid for physician reports in California workers' compensation. That study, based on data from nearly 10 million medical report bills from accident year (AY) 2000 to 2013 claims, showed that the average number of medical reports per claim had grown steadily for more than a decade prior to the January 2014 adoption of the Resource-Based Relative Value Scale (RBRVS) fee schedule, fueled by increases in the number of evaluation and management (E/M) services per claim and in the number of physician reports per E/M service. The study further postulated that physician reporting would be directly impacted by two changes to the Official Medical Fee Schedule (OMFS) mandated by the 2012 workers' comp reform (SB 863):

- The incorporation of physician report fees into the underlying evaluation service fee, eliminating separate reimbursements for non-Primary Treating Physician reports except for consultation reports requested by the Administrative Director of the Division of Workers' Compensation (DWC), the Appeals Board or a Qualified Medical Evaluator in the context of a med-legal evaluation; and
- The elimination of separate reimbursements for non-face-to-face prolonged E/M services, including for a physician's review of medical records.

This analysis provides an initial look at California workers' compensation physician reporting in the wake of these reforms and recent changes in physician report billing codes by comparing data on physician reports from the first quarter of 2014 – the first three months after the changes took effect -- to first quarter data from each of the prior three years. The findings confirm post-reform reductions in both the average number of physician reports and in total report payments per claim. The study links the reduction in the average amount paid for all reports to the changes in the underlying E/M services that were introduced with the adoption of the RBRVS fee schedule rather than a decrease in the fee schedule amounts assigned to report codes. In addition, the preliminary data for 2014 indicate that the average number of reports per claim declined from 4.6 in 2013 to 3.3 reports in the first quarter of 2014, a 28 percent decline that likely reflects the elimination of separate reporting associated with consultations and prolonged services.

[1] Jones, S. *The Price of Progress: Progress Reports in the California Workers' Compensation System.* CWCI, 2014

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BACKGROUND

In California workers' compensation, maximum reasonable fees allowed for medical services provided to injured workers are established by the Official Medical Fee Schedule (OMFS), which is promulgated and periodically revised by the Administrative Director of the Division of Workers' Compensation.[2] Accurate, complete and timely medical reports are critical to effective claims handling, as they are the primary means of communication between treating physicians and claims adjusters who rely on the information to administer claim benefits.

SB 863, enacted by state lawmakers in 2012, mandated a transition to a new Official Medical Fee Schedule based on Medicare's Resource Based Relative Value Scale (RBRVS). The transition began in September 2013 when the state adopted the *Official Medical Fee Schedule for Physician and Non-Physician Practitioner Services – For Services Rendered On or After January 1, 2014.*[3] Among the changes in this schedule were new codes for medical billers to use when reporting physician report services for reimbursement. Prior to January 1, 2014, physicians who billed workers' compensation payers for report services included two codes for physician reporting services:

- Current Procedural Terminology (CPT) code 99080, defined as "Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form;" and

- California jurisdictional code 99081, defined as "Required Reports."

With the adoption of the new schedule, as of January 1, 2014, new California jurisdictional codes replaced CPT code 99080 for Special Reports, and California jurisdictional code WC002 replaced Required Report code 99081. The DWC also introduced codes to identify Primary Treating Physician's Permanent and Stationary Reports (WC003 and WC004), and created codes for special consultation reports (WC005 and WC007).

The payment methodology in the 2014 OMFS utilizes Medicare's Resource-Based Relative Value Scale, and two of the Medicare rules that were adopted affected Evaluation and Management (E/M) services:

1) Consultation services are now billed using CPT codes identifying a "New Patient" evaluation; and
2) Prolonged service code 99358, previously used to bill for separate reimbursement of a physician's non-face-to-face prolonged service time, was disallowed.

Both of these changes to E/M service billing and reimbursement rules impact report reimbursements.

[2] Title 8, California Code of Regulations sections 9789.10 et seq.
[3] Title 8, California Code of Regulations section 9789.12.1 filed with the Secretary of State September 24, 2013.

DATA & METHODOLOGY

The medical reporting data used in this study was drawn from CWCI's Industry Claims Information System (ICIS) database[4] and included medical bill data for Evaluation and Management (E/M) services and reporting services that were provided during the first quarter of 2011, 2012, 2013 and 2014. Data development constraints limited 2014 experience to the first quarter (Q1), which presents a 3-month snapshot of claim medical activity. In order to provide a valid comparison, the author limited the comparative data to Q1 experience for the four defined study years. The data were compiled from all ICIS claims with January 1, 2000 to March 31, 2014 injury dates.

The author extracted data from the ICIS database in order to examine multiple variables, including the volume and frequency with which reports are billed, as well as payment differentials. Filtering the data by service dates occurring during Q1 of 2011, 2012, 2013 and 2014, all records for professional outpatient E/M services (new patient, established patient and consultations) were extracted, as were records with the following reporting codes.

99080 - Special Reports
99081 - Required Reports
WC002 - Primary Treating Physician's Progress Report (PR-2 or narrative equivalent)
WC003 - Primary Treating Physician's Permanent and Stationary Report (Form PR-3)
WC004 - Primary Treating Physician's Permanent and Stationary Report (Form PR-4)
WC005 - Psych report requested by WCAB or AD, other than med-legal
WC007 - Consultation report requested by WCAB or AD (use modifier -32), or consultation report requested by QME or AME in context of med-legal evaluation (use modifier -30)

The services were grouped by claim, date of service, provider ID, E/M service and report code to link a report with an associated E/M service.

[4] ICIS is a proprietary database maintained by the California Workers' Compensation Institute that contains detailed information, including employer and employee characteristics, medical service information, and benefit and other administrative cost information on more than 4 million workplace injury claims with dates of injury between 1993 and 2014(ICIS V16A).

RESULTS

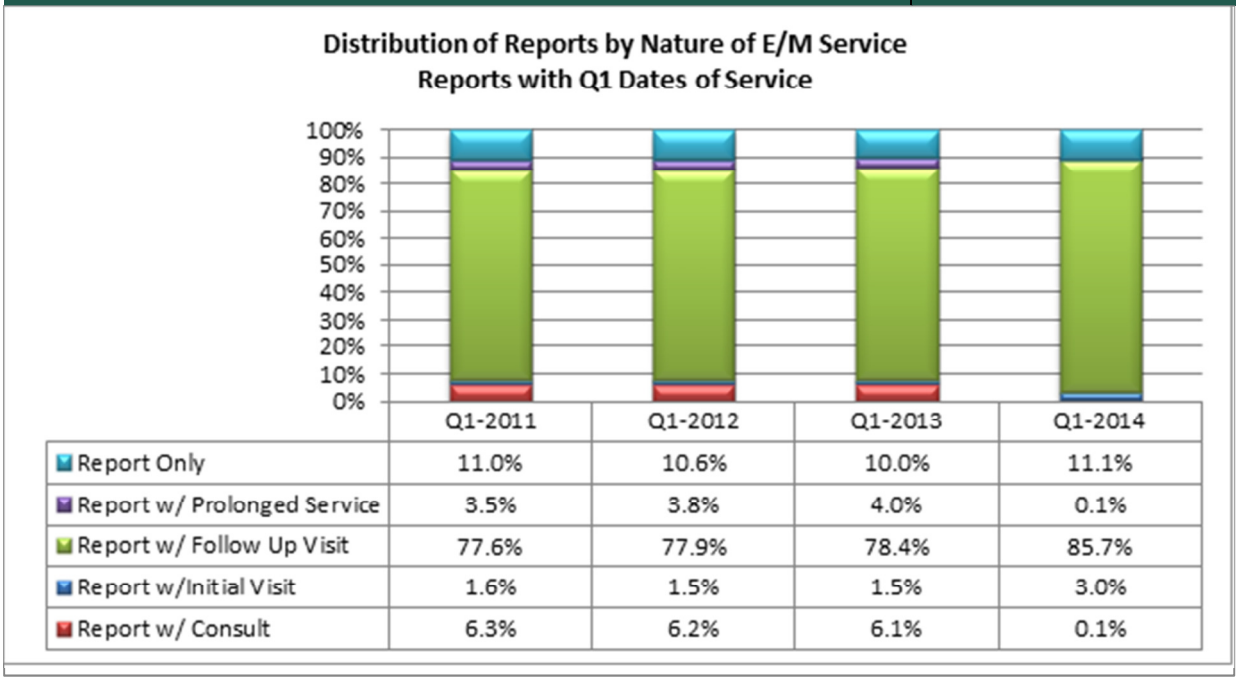
The Q1 data on the overall average paid per report for 2011 through 2014 suggest a general decline in the amounts reimbursed for reports (Exhibit 1), however a closer look shows that the decline in the average report cost resulted from changes in the underlying Evaluation and Management (E/M) services that were introduced with the adoption of the RBRVS fee schedule rather than a decrease in the fee schedule amounts assigned to report codes. Specifically, the reports that historically received the highest reimbursement were associated with E/M services that are no longer allowed under the OMFS. Effective for dates of service on or after January 1, 2014, consultation services must be billed using an initial office visit code, while Prolonged Services (99358) are bundled into the face-to-face E/M service.

Exhibit 1 – Average Paid Per Report Associated with E/M Service

	Avg Paid	Avg Paid w/Consult	Avg Paid w/Initial	Avg Paid w/Follow Up	Avg Paid w/Prolonged Svc (99358)	Avg Paid w/No Same-Day E/M
Q1-2011	$25.62	$97.06	$41.97	$17.92	$64.92	$23.94
Q1-2012	$24.28	$90.08	$55.00	$16.55	$60.67	$25.36
Q1-2013	$26.13	$94.08	$46.06	$17.79	$68.42	$27.06
Q1-2014	$16.53	$64.46	$47.31	$15.23	$49.35	$18.98

The majority of reports are progress reports associated with follow-up E/M services, as shown in Exhibit 2. Although reports associated with follow-up E/M services increased from 78 percent of all reports in Q1 2011, 2012 and 2013 to 86 percent in Q1 2014, the average number of follow-up office visits remained flat at two visits per claim during the same time frame.

Exhibit 2 – Distribution of Reports by Nature of E/M Service



	Q1-2011	Q1-2012	Q1-2013	Q1-2014
Report Only	11.0%	10.6%	10.0%	11.1%
Report w/ Prolonged Service	3.5%	3.8%	4.0%	0.1%
Report w/ Follow Up Visit	77.6%	77.9%	78.4%	85.7%
Report w/Initial Visit	1.6%	1.5%	1.5%	3.0%
Report w/ Consult	6.3%	6.2%	6.1%	0.1%

The Q1 data for 2011, 2012 and 2013 show that reports associated with consultation services and prolonged services that did not include direct face-to-face time with the patient accounted for a combined 10 percent of the total report volume (Exhibit 2). But the distribution shifted immediately after the RBRVS fee schedule took effect on January 1, 2014, as evidenced by the Q1 2014 data which show that reports associated with consultation and non-face-to-face prolonged services, which were the most expensive reports, fell to less than 1 percent of total report volume.

At the same time, initial E/M service reports rose from 1.5 percent to 3 percent of all physician reports. It is likely that the sudden growth in the number of initial E/M service reports reflects a shift in how services were coded, as services that would have been coded as consults prior to 2014 were coded as initial E/M services after the revised fee schedule took effect in 2014. This assumption will be subject to validation once the data is developed beyond these preliminary results from Q1 2014.

Exhibit 3 shows volume and payment information based on the types of reports submitted during Q1 2014. Unsurprisingly, the majority of physician reports paid during Q1 2014 were characterized as PTP Progress Reports (previously called Required Reports). The breakdown of data by report type corresponds with the data presented in Exhibit 2 associating reports with underlying E/M services.

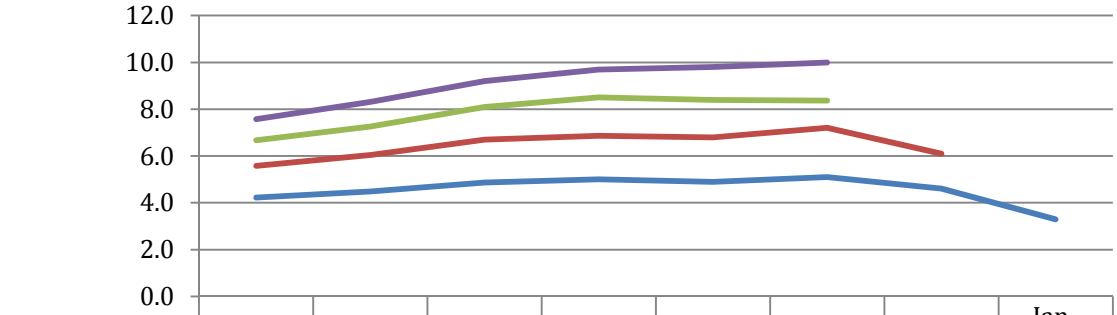
Exhibit 3 – Distribution of Q1 2014 Reports and Average Amount Paid

Code	Percent of Total Reports	Average Amount Paid
99080 Special Report	0.6%	$56.71
99081 Required Report	0.5%	$11.20
WC002 PR-2 Report	93.6%	$11.48
WC003 PR-3 Report	0.9%	$88.94
WC004 PR-4 Report	2.2%	$111.21
WC005 Psych Report[4]	0.2%	$80.25
WC007 Consultation[5]	2.0%	$98.27
Grand Total	100.0%	$16.53

[4] Psych report requested by WCAB or AD, other than med-legal
[5] Consultation report requested by WCAB or AD (modifier -32), or consultation report requested by QME or AME in context of med-legal evaluation (modifier -30)

The preliminary data for 2014 indicate that the average number of reports per claim declined 28 percent from 4.6 in 2013 to 3.3 in the first 3 months of 2014 (Exhibit 4). This decline in the average number of reports following the adoption of the RBRVS fee schedule likely reflects the elimination of separate reporting associated with consultations and prolonged services.

Exhibit 4 - Average Number of Reports in 1st Year Post Injury, AY 2007 to 2014 Indemnity Claims



	2007	2008	2009	2010	2011	2012	2013	Jan-June 2014
3 Months	4.2	4.5	4.9	5.0	4.9	5.1	4.6	3.3
6 Months	5.6	6.0	6.7	6.9	6.8	7.2	6.1	
9 Months	6.7	7.3	8.1	8.5	8.4	8.4		
12 Months	7.6	8.3	9.2	9.7	9.8	10.0		

Accident Year

Discussion

The reporting responsibilities of the primary treating physician (PTP) required by Labor Code 4061.5 are defined in California Code of Regulations §9785, and the regulatory changes that arose from recently enacted SB 863 did not alter these regulatory requirements. The changes in physician report submission and payment patterns that are emerging in the Q1 2014 data illustrate how payment rule changes implemented for a set of services impact payments for associated services.

Preliminary data for services paid during Q1 2014 show a decline in the number of reports per claim, but it is still too early to determine whether or not this initial trend continued as providers and payers gained more experience working within the parameters of the new Medicare-based RBRVS-based schedule. It can be stated with confidence that any changes in billing and payment patterns for E/M services will have a corresponding effect on report costs.

The data show that the overwhelming majority of reports paid during Q1 2014 were for reports required of the Primary Treating Physician (PTP), which underscores the importance of PTP reporting under §9785. The degree to which the change in reimbursements for other reports may materially affect the quality of information provided to the claims administrator will be subject to future analysis and discussion.

About the Author

Stacy L. Jones is a Senior Research Associate at the California Workers' Compensation Institute.

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California Workers' Compensation Institute

The California Workers' Compensation Institute, incorporated in 1964, is a private, nonprofit organization of insurers and self-insured employers conducting and communicating research and analyses to improve the California workers' compensation system. Institute members include insurers that collectively write more than 70 percent of California workers' compensation direct written premium, as well as many of the largest public and private self-insured employers in the state. Additional information about CWCI research and activities is available on the Institute's web site (http://www.cwci.org).