A REPORT TO THE INDUSTRY

Impact of the RBRVS Fee Schedule on California Workers' Comp Physician & Non-Physician Practitioner Service Payments

By Stacy L. Jones, M.A.

California Workers' Compensation Institute

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California Workers' Compensation Institute

1333 Broadway, Suite 510, Oakland, CA 94612 | 510-251-9470 | www.cwci.org

EXECUTIVE SUMMARY

In September 2012, Governor Brown signed a comprehensive workers' compensation reform bill (SB 863) that included a number of provisions affecting workers' compensation medical costs. Among the key provisions was the mandate that starting in 2014 and continuing with a 4-year phase-in, the sections of the Official Medical Fee Schedule (OMFS) governing fees paid to physicians and non-physician practioners be replaced with a new fee schedule based on Medicare's Resource-Based Relative Value Scale (RBRVS). The expectation was that the adoption of the RBRVS-based fee schedule would be budget neutral in terms of the overall cost of workers' compensation medical care, as it would merely shift where the medical dollars flow, with reduced payments going to specialists (such as surgeons and radiologists), while increased amounts would be paid to primary care physicians who provide the bulk of the treatment to injured workers. This study analyzes the initial outcomes under the RBRVS fee schedule by comparing provider payment data from 2013, the final year under the old fee schedule, to data from 2014 and 2015 – the first two years of the transition to the new schedule. Among the key findings:

- From 2013 to 2015, total payments for services covered under the Official Medical Fee Schedule for Physician and Non-Physician Practitioner Services decreased by 14.3 percent, and the corresponding volume of services decreased by 17.7 percent.
- The change in the total amount paid for each of the eight defined service categories varied between a decrease of 44.9 percent for medicine services to an increase of 12.7 percent for physical medicine services.
- The volume of services provided within each of the eight medical service categories declined – ranging from an 11.4 percent reduction in radiology services to a 49.5 percent reduction in medicine services.
- Overall, the average amount paid for individual service codes increased 4.2 percent.
- The change in the average amount paid per service code for each service category ranged from a 26.3 percent reduction for radiology services to a 28.1 percent increase for physical medicine services.
- Consistent with the legislative intent, the total amount paid for ancillary diagnostic services (e.g. MRIs, nerve conduction studies, etc.) declined, while the total amount paid for primary care services (e.g. evaluation and management) under the categories of evaluation and management and physical medicine increased.

BACKGROUND

The California workers' compensation physician fee schedule was originally adopted in 1965 and was based on a relative value scale developed by the California Medical Association (CMA) in 1956 and last revised in 1974. The Division of Workers' Compensation (DWC) adopted major changes to the schedule in 1995, including replacement of California Relative Value Scale (CRVS) codes with 1994 Current Procedural Terminology (CPT) codes defined by the American Medical Association (AMA) in 1993 and the partial replacement of the relative value scale with values based on a commercial vendor's (Medicode, Inc.) database of physician charges. The fee schedule was subsequently updated in 1996 and 1999 to incorporate code modifications, new California codes and modifiers. The update process was prolonged, inefficient and inadequate in addressing new medical treatment and diagnostic services. In point, the 1999 revision still used the AMA CPT codes from the 1993 and 1996 version years.

Acknowledging the inadequacies in the update process, the California Industrial Medical Council (IMC)[1] commissioned a study by the UCLA Center for Health Policy Research to evaluate alternatives to the California Relative Value Scale (CRVS).[2] The authors of that study recommended that the IMC undertake an impact analysis that would model payments based on the Medicare Resource-Based Relative Value Scale (RBRVS) for high-volume services delivered to California injured workers. The IMC contracted with The Lewin Group to perform an impact analysis and an initial analysis was completed in October 2002.[3]

In 2003, the California Legislature passed Senate Bill 228 (SB 228), which mandated that the DWC Administrative Director adopt new fee schedules for pharmaceuticals, inpatient hospital services, hospital outpatient departments and ambulatory surgery center services, and revise the physician fee schedule to reduce fees by 5 percent. SB 228 also gave the Administrative Director the authority to adopt an Official Medical Fee Schedule (OMFS) for physician services, noting that it need not be based on the Medicare physician fee schedule. The Administrative Director subsequently adopted revised values for ten Evaluation and Management codes that increased payments for physician office visits and consultations by an average of 23 percent. In 2008 and 2010, The Lewin Group produced two additional reports[4,5] that evaluated the impact of adopting the Medicare RBRVS physician fee schedule as a basis for payment of services rendered by workers' compensation physicians (MDs, DOs, psychologists, acupuncturists, optometrists, dentists, podiatrists and chiropractors) and non-physicians (including physical therapists, occupational therapists, nurse practitioners, physician assistants and certified registered nurse anesthetists).

1. The IMC was a state-appointed advisory board with a mandate to provide policymaking, rulemaking and regulatory authority for the medical component of the workers' compensation program. The functions of the IMC were transferred to the Administrative Director with the enactment of SB 228 in 2003 and the new entity was renamed the Division of Workers' Compensation – Medical Unit in January 2005.
2. Kominski, G.F., Pourat, N. and Black, J.T. *The Use of Relative Value Scales for Reimbursement in State Workers' Compensation Programs: A Report to the Industrial Medical Council California Department of Industrial Relations.* UCLA Center for Health Policy Research. August 1999.
3. The Lewin Group. *California Workers' Compensation RBRVS Study: Prepared for Industrial Medical Council Department of Industrial Relations.* October 8, 2002.
4. The Lewin Group. *Adapting the RBRVS Methodology to the California Workers' Compensation Physician Fee Schedule: First Report Prepared for California Division of Workers' Compensation.* May 5, 2008 (rev. December 19, 2008).
5. The Lewin Group. *Adapting the RBRVS Methodology to the California Workers' Compensation Physician Fee Schedule: Supplemental Report Prepared for California Division of Workers' Compensation.* March 3, 2010.

In 2012 the California Legislature passed and Governor Brown signed Senate Bill 863 (SB 863), which amended Labor Code section 5307.1 and directed the Administrative Director to adopt a new OMFS based on Medicare's Resource-Based Relative Value Scale for physician services and non-physician practitioner services. Medicare had developed its RBRVS system in 1992 as a method to pay for services based on the resource costs needed to provide the services. Those resource costs are defined by three components: physician work, practice expense and professional liability insurance, and the Medicare RBRVS payment calculations also take into account geographical differences in costs. The physician work component is updated annually based on recommendations from a committee involving the American Medical Association (AMA) and national medical specialty societies. The AMA/Specialty Society Relative Values Scale Update Committee (RUC) makes recommendations to the Centers for Medicare and Medicaid Services (CMS) on the resources required to provide a medical service for new or revised Current Procedural Terminology (CPT) codes.

SB 863 allowed the DWC to adopt conversion factors and other factors affecting physician payments that are different from those used by Medicare, but only if the estimated aggregate fees did not exceed 120 percent of the estimated aggregate fees payable by Medicare for the same class of services. In order to maintain budget neutrality, the statute required that the transition to the RBRVS fee schedule take place over four years, beginning in January 2014. Under the regulations adopted by the state, the annual adjustments to the conversion factors assigned to specific fee schedule sections (surgery, radiology, anesthesia and all other) will end in January 2017, at which time a single conversion factor will be used for all services except anesthesia. The annual update to the fee schedule mandated under SB863 also must include changes in procedure codes and relative weights in addition to the changes in the adjustment factors.

The geographic adjustments called for in Medicare's RBRVS payment calculations are based on the ZIP code of the physician's practice and are defined in its Geographic Practice Cost Indices (GPCIs), but under the OMFS regulations adopted for California workers' compensation, geographic adjustments used in the payment calculations are based on a state-specific index (the Average Statewide Geographic Adjustment Factor).

The transition from the old charge-based relative value scale to the RBRVS also necessitated changes to rules that govern how a payment is calculated when multiple services are provided to an injured worker on the same date by the same service practitioner.

OBJECTIVE OF THIS ANALYSIS

This analysis measures the percentage change in the total amount paid and in the average amount paid for medical procedures and services covered in the Physician and Non-Physician Practitioner Service sections of the Official Medical Fee Schedule during the first two years of California's transition to the RBRVS fee schedule mandated by SB 863. The analysis also measures changes in the number of claims that involved medical services in eight major OMFS service categories during that same time frame, and changes in the total volume of services and in the average amounts paid per date of service for each of those specific service categories.

DATA & METHODOLOGY

The data for this study was extracted from CWCI's Industry Research Information System (IRIS)[6] database and encompasses a total of 11.4 million medical services provided to California injured workers during the first ten months of calendar years 2013, 2014 and 2015. Payments for those services totaled $844.7 million. The analysis focuses on data from the first ten months of each calendar year in order to account for time lags in billing for services rendered and payment issuing for those services. To the extent that payments may be delayed beyond 60 days from the date of service the values for the total paid and the total volume for 2015 services may be slightly understated.

Although the AMA has specified medical service categories, for comparative purposes, the IRIS data used in this study was grouped into the service categories as defined under the 1999 version of the OMFS. The service categories defined by the AMA and California OMFS broadly matched, but the workers' compensation fee schedule separated out "special services," which include physician reports. Since some physical medicine services have payment calculation rules that differ significantly from other services that are included in the Medicine category, these services also were separated out for analysis. The eight medical service categories defined for the comparative analysis are:

- Radiology
- Surgery
- Evaluation and Management
- Medicine (including cardiovascular, nerve and muscle testing, psychiatric testing and psychotherapy, physician-administered drugs and biologicals and ophthalmology services)
- Physical Medicine (including physical therapy, chiropractic, osteopathic, and acupuncture services)
- Special Services
- Anesthesiology and Pathology

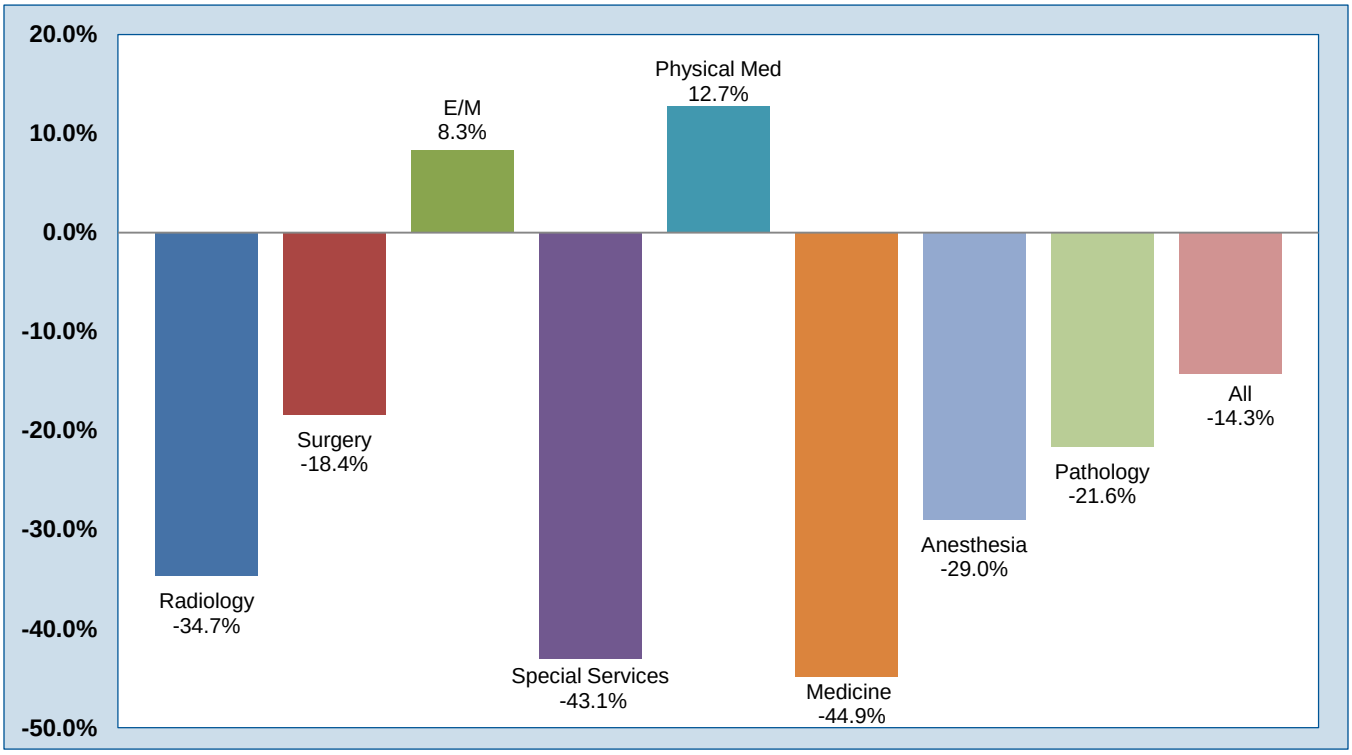
In addition to the aggregated payment and volume values for each service category the data was further analyzed at the claim and service code level. The claim, date of service and provider were identified for each service code in the defined service categories, allowing for calculation of the average paid per date of service by service category, and for each service code category the average paid amounts were weighted to account for utilization differences that may have resulted from factors other than the implementation of RBRVS.

6. IRIS is CWCI's proprietary database containing data on employee and employer characteristics, medical service data, benefits and administrative costs on approximately 5 million California workers' compensation claims.

RESULTS

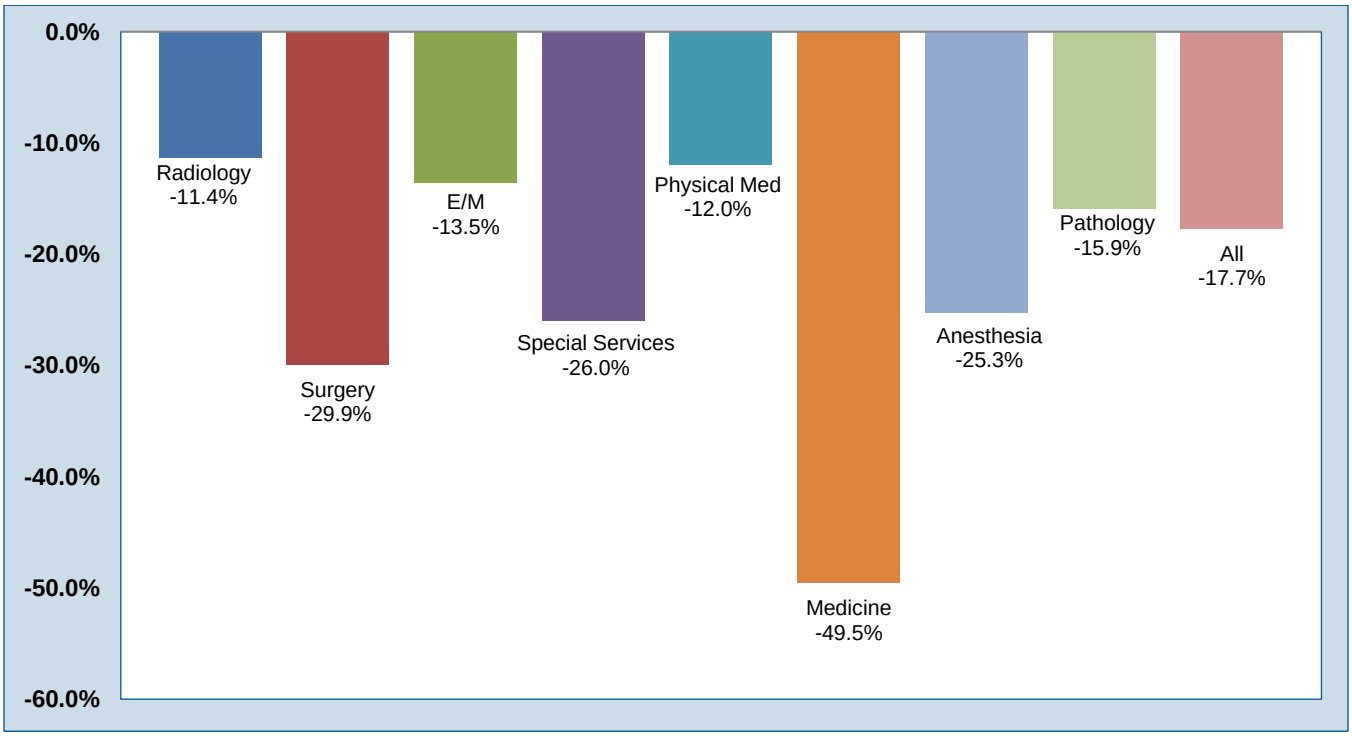
From 2013 to 2015, the total amount paid for services covered under the Official Medical Fee Schedule for Physician and Non-Physician Practitioner Services decreased by 14.3 percent, and the corresponding volume of services decreased by 17.7 percent, though the volume of claims with services declined only 3.3 percent during the same time period (Exhibit 3). Exhibit 1 shows that across the eight medical service categories the percentage change in the total amount paid ranged from a 44.9 percent decrease in medicine services to an increase of 12.7 percent for physical medicine.

Exhibit 1: Change in Total Paid by Category – Service Years 2013 to 2015



Changes in the total amount paid for each medical service category are a factor of the total volume of services provided and the amount paid for each service based on the fee schedule values. The change in service volume for each service category is shown in Exhibit 2, which once again reveals significant variation between the different service categories – ranging from a decrease of 11.4 percent in radiology services to a decrease of 49.5 percent in medicine services.

Exhibit 2: Change in Service Volume by Category – Service Years 2013 to 2015



To determine the underlying causes for the decreases in volume for each of the medical service categories the author identified the number of injured workers receiving the services by extracting the unique claim identifiers associated with services in each service year. Exhibit 3 shows the percent change in the volume of unique claims with services in each category from service year 2013 to service year 2015.

Exhibit 3: Percent Change in Unique Claims by Service Category – Service Years 2013 to 2015

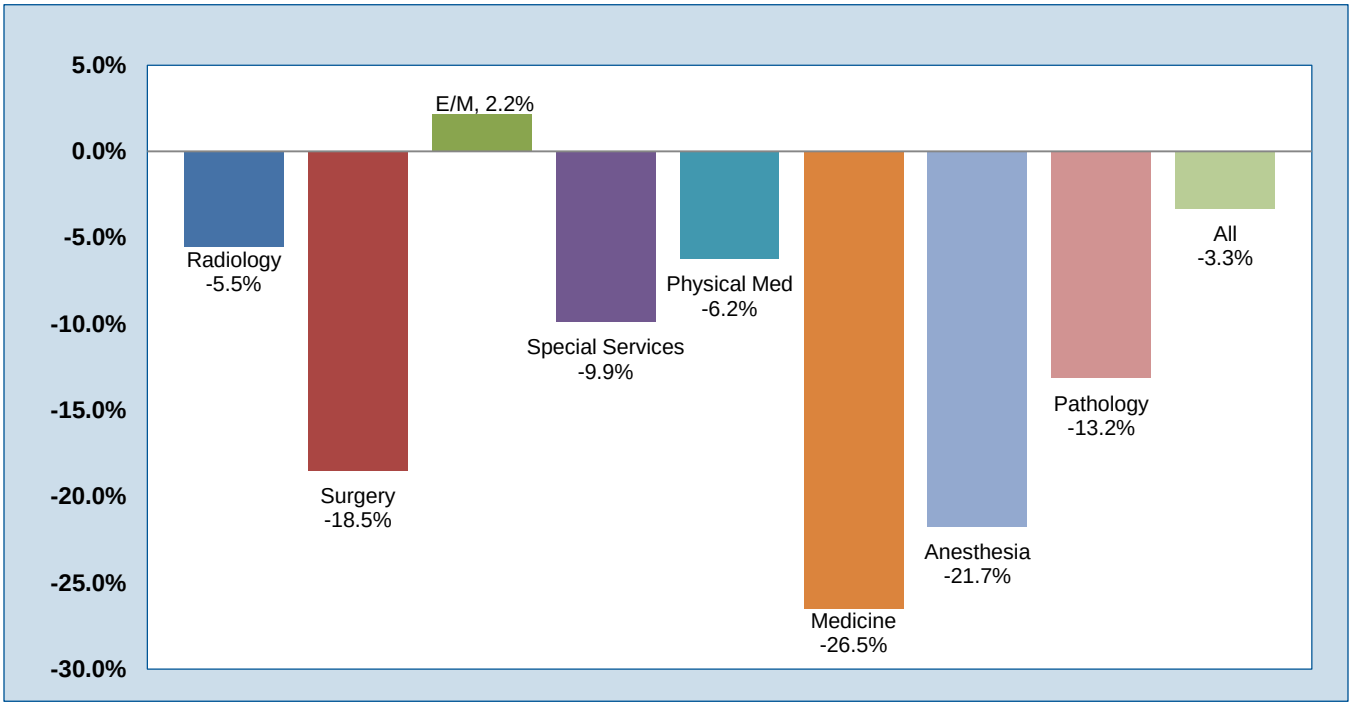


Exhibit 4 provides comparative data for changes in service code volume, total amounts paid and number of unique claims for each service category from service year 2013 to service year 2015. Combining the unique claim identifiers across all categories for each service year shows an overall reduction of 3.3 percent in the number of unique claim records associated with professional services provided by physicians and non-physicians from 2013 to 2015. This reduction, however, was far less than the 17.7 percent decrease noted in the total volume of service codes and the 14.3 percent decrease in the total amount paid for services.

Exhibit 4: Percent Change in Total Volume, Payments and Claims, Service Years 2013 to 2015

	Total Paid	Code Volume	Unique Claims
Radiology	-34.7%	-11.4%	-5.5%
Surgery	-18.4%	-29.9%	-18.5%
Evaluation & Management	-8.3%	13.5%	2.2%
Special Services	-43.1%	-26.0%	-9.9%
Physical Medicine	-12.7%	12.0%	-6.2%
Medicine	-44.9%	-49.5%	-26.5%
Anesthesiology	-29.0%	-25.3%	-21.7%
Pathology	-21.6%	-15.9%	-13.2%
Combined Change	**-14.3%**	**-17.7%**	**-3.3%**

Changes that resulted from implementation of the new fee schedule in 2014 are evident when comparing the decreases in the number of services with the total amounts paid for each service category. Exhibit 5 shows the weighted average[7] amounts paid per service code in 2013, 2014, and 2015 for each of the eight service categories, as well as the overall average service payment. Although the volume of services decreased for each service category between 2013 and 2015, the average amount paid for service codes in the category increased for some categories – most notably for evaluation and management and for physical medicine services.

Exhibit 5: Weighted Average Paid by Service Code by Category and Service Year

	2013	2014	2015	% Change
Radiology	$161.49	$132.52	$119.03	-26.3%
Surgery	$343.71	$362.62	$400.39	16.5%
E/M	$94.56	$112.65	$118.46	25.3%
Special Services	$72.55	$47.74	$55.82	-23.1%
Physical Medicine	$27.75	$31.75	$35.54	28.1%
Medicine	$109.87	$116.64	$120.00	9.2%
Anesthesiology	$377.37	$375.88	$358.79	-4.9%
Pathology	$76.08	$61.55	$70.89	-6.8%
Overall Average	**$74.10**	**$71.60**	**$77.20**	**4.2%**

7. Weighted averages were calculated using the average amount paid for each service code (e.g. 99215) and the relative number of services within a service category.

Exhibit 6 shows the percent change in the average amount paid for services within each service category between service years 2013 and 2015, with increases in surgery (16.5 percent), evaluation and management (25.3 percent), physical medicine (28.1 percent) and medicine (9.2 percent). Radiology (-27.7 percent), special services (-23.1 percent), anesthesiology (-4.9 percent) and pathology (-6.8 percent) all experienced a decrease in the average amount paid for services. Overall, there was an increase of 4.2 percent in the average amount paid for all individual service codes.

Exhibit 6: Change in Average Paid per Code by Service Category – Service Years 2013 to 2015

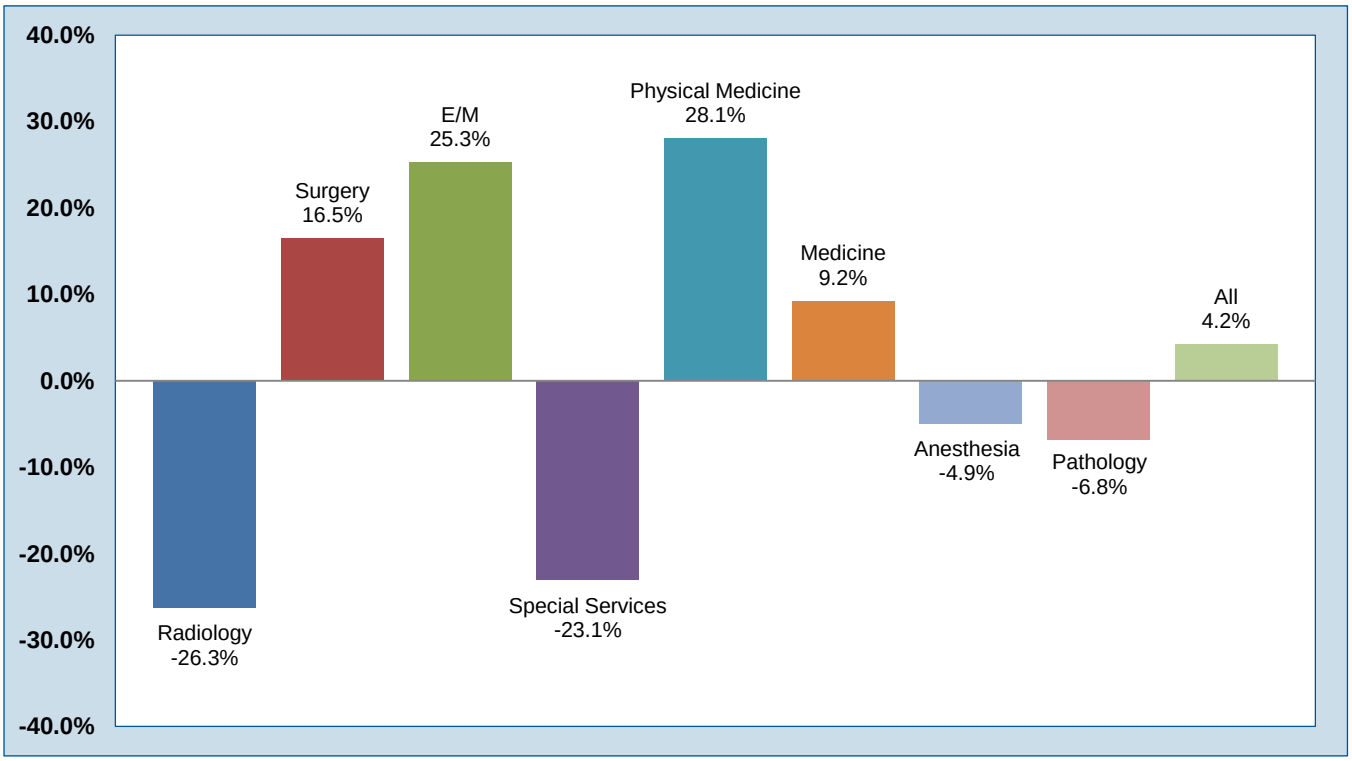
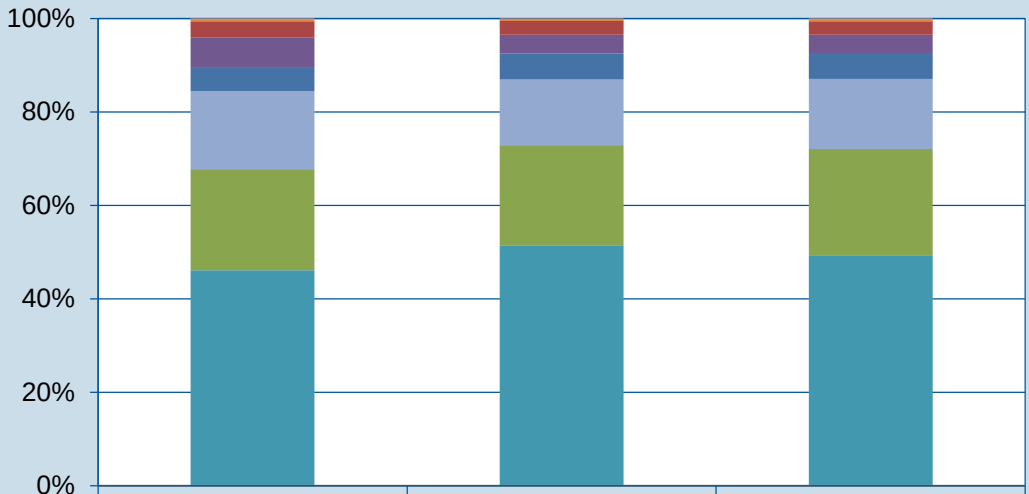


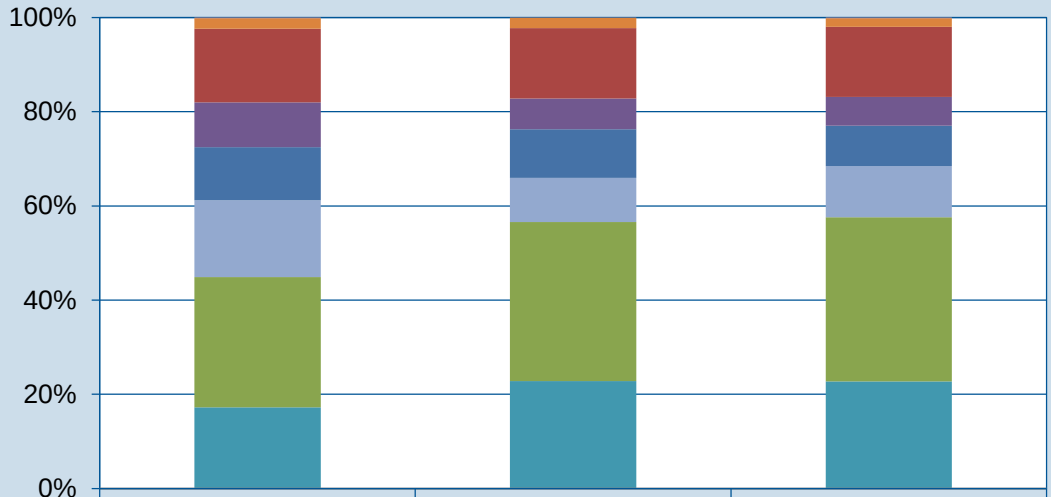
Exhibit 7 shows the distribution of total medical services across the eight service categories for service year 2013, the last year before the transition to the RBRVS fee schedule began, and for service years 2014 and 2015, the first two years of the transition to the new schedule. Exhibit 8 shows the distribution of medical payments across the eight service categories over the same three years, illustrating the shifts in total paid amounts that occurred as the RBRVS schedule began to take effect. As was expected when SB 863 was enacted, beginning in 2014, a smaller share of the workers' compensation medical dollar paid for services that are typically provided by specialists and ancillary diagnostic services, while a larger share paid for services provided by primary treating physicians and physical medicine providers.

Exhibit 7: Distribution of Medical Services by Category - Service Years 2013 to 2015



	2013	2014	2015
Pathology	0.2%	0.1%	0.2%
Anesthesiology	0.4%	0.4%	0.4%
Surgery	3.4%	3.0%	2.9%
Medicine	6.4%	4.0%	3.9%
Radiology	5.1%	5.6%	5.5%
Special Services	16.7%	14.0%	15.0%
Evaluation/Management	21.6%	21.5%	22.7%
Physical Medicine	46.1%	51.5%	49.3%

Exhibit 8: Distribution of Total Paid by Medical Service Category – Service Years 2013 to 2015



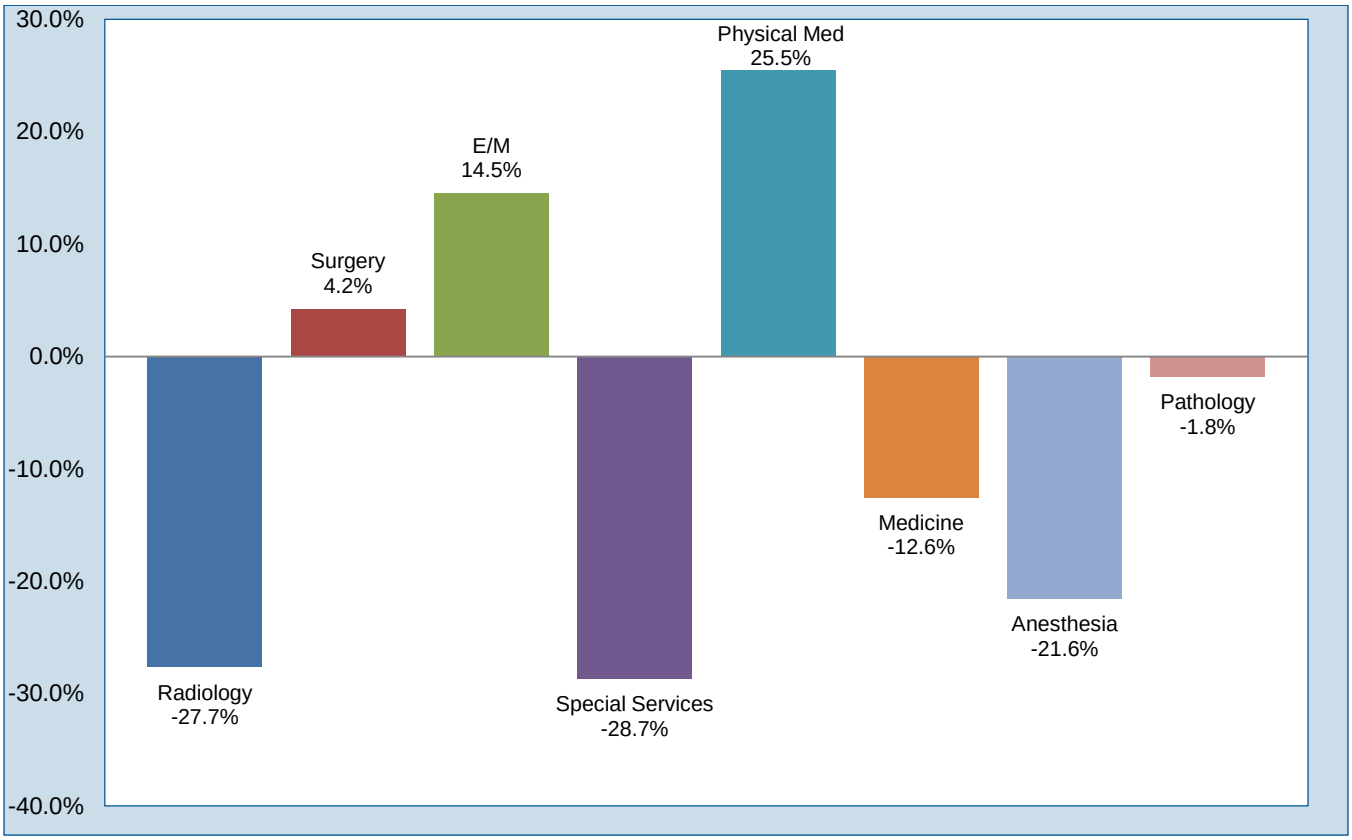
	2013	2014	2015
Pathology	0.2%	0.1%	0.2%
Anesthesiology	2.2%	2.2%	1.8%
Surgery	15.6%	14.9%	14.9%
Medicine	9.5%	6.5%	6.1%
Radiology	11.2%	10.3%	8.6%
Special Services	16.3%	9.3%	10.8%
Evaluation/Management	27.6%	33.8%	34.9%
Physical Medicine	17.3%	22.8%	22.7%

The shifts in the relative volume and payments among the eight service categories were influenced by changes in the rules governing payment of multiple services within the category or subcategory when provided on the same date of service by the same provider. There are two primary mechanisms whereby payments may be reduced as a result of multiple services within a category being provided during the same service session – multiple procedure rules and National Correct Coding Initiative (NCCI) edits.[8] Under California's pre-RBRVS OMFS, multiple procedure rules were used to calculate payments for physical therapy and surgery services, but beginning in January 2014, the new RBRVS fee schedule revised these rules and added new multiple procedure rules for a subset of radiology services.

8. Established by the Centers for Medicare and Medicaid Services (CMS), the NCCI edits include two types of edits: Procedure to Procedure (PTP) edits and Medically Unlikely Edits (MUEs). PTP edits prevent inappropriate payment of services that should not be reported together and MUEs prevent payment for an inappropriate number/quantity of the same service on a single day.

Due to data limitations the author was unable to determine the specific impact of multiple procedure rules and NCCI edits for specific services, however Exhibits 6 and 9 illustrate the combined effect on payments for surgery services. Exhibit 6 shows that the average amount paid for surgery codes increased 16.5 percent between service years 2013 and 2015, while Exhibit 9 shows that the average paid for a surgical event (defined as surgery services for the same injured worker on the same day by the same provider) increased by only 4.2 percent. The fact that the amount paid for a surgical session increased at a lower rate than the average payment for individual services shows the impact of the multiple procedure rules and NCCI edits.

Exhibit 9: Change in Average Paid per Date of Service per Service Category - Service Years 2013 to 2015



RBRVS Outcomes by Service Category

To provide a more detailed look at the changes that occurred in the utilization and cost of various types of medical services during the initial transition to the RBRVS Fee Schedule, the author identified the top services in each of the eight fee schedule categories for service years 2013, 2014 and 2015 based on both the amount paid and the volume of services; and noted the changes in the payment and service distributions, the rankings of the top 10 services and the average amounts paid.

The following sections of the report present the results broken out separately for each fee schedule service category. For reference, descriptions of the services associated with high frequency/payment codes in each category are noted in sidebars within each section and changes in the fee schedule values for specific codes are noted where applicable.

Evaluation and Management (E/M) Services

The new RBRVS-based OMFS eliminated separate reimbursement for consultation services, which are now billed using CPT codes identifying a "new patient" evaluation; and limited the instances in which reports derived from consultation services are reimbursable. In explaining the rationale behind this regulatory change, the DWC Administrative Director noted that due to inconsistent and improper use of consultation codes Medicare had eliminated separate payments for consultation services, but had redistributed the reimbursement values, resulting in "approximately a 6 percent increase in the new and established office visits,"[9] which made this change "budget neutral."

E/M Codes from the Top 10 Lists for 2013, 2014 or 2015 with Descriptions

Office/Outpatient Visit New Patient/Injury	
99202	presenting problem(s) low to moderate severity - typical time 20 minutes w/patient and/or family
99203	presenting problem(s) moderate severity - typical time 30 minutes w/patient and/or family
99204	presenting problem(s) moderate to high severity - typical time 45 minutes w/patient and/or family
99205	presenting problem(s) moderate to high severity - typical time 60 minutes w/patient and/or family
Office/Outpatient Visit Established Patient	
99212	presenting problem(s) self-limited or minor - typical time 10 minutes w/patient and/or family
99213	presenting problem(s) low to moderate severity - typical time 15 minutes w/patient and/or family
99214	presenting problem(s) moderate to high severity - typical time 25 minutes w/patient and/or family
99215	presenting problem(s) moderate to high severity - typical time 40 minutes w/patient and/or family
Office Consultation	
99244	presenting problem(s) moderate to high severity - typical time 60 minutes w/patient and/or family
99245	presenting problem(s) moderate to high severity - typical time 80 minutes w/patient and/or family
Emergency Department Visit	
99283	presenting problem(s) of moderate severity
99284	presenting problem(s) of high severity, but do not pose an immediate threat to life or physiologic function
Prolonged Services	
99354	Prolonged E/M or psychotherapy service(s)… requiring direct patient contact beyond usual service; 1st hour
99358	Prolonged E/M service before and/or after direct (face-to-face) patient care (eg review of extensive patient records); each 15 minutes
Other	
99499	Unlisted E/M service

9. State of California Department of Industrial Relations, Division of Workers' Compensation. Initial Statement of Reasons. Subject Matter of Regulations: Official Medical Fee Schedule Physician Fee Schedule Services Rendered on or after January 1, 2014. June 2013.

Prior to removal of consultation codes (99241 – 99245) from the OMFS in 2014, the two highest level consultation codes were among the top ten E/M services for total payments (Exhibit 10) and total volume (Exhibit 11) in 2013. When the new patient/injury codes (99201 – 99205) replaced the consultation codes, there was a shift in the volume of new patient/injury codes, with code 99205 entering the list of the top ten E/M services in 2014. As shown in Exhibits 10 and 11, follow-up office visits (99211 – 99215) consistently ranked as the leading E/M services in terms of both payments and volume during 2013, 2014 and 2015.

Exhibit 10: Top 10 E/M Codes by Total Amount Paid

		Percent of E&M Payments			E&M Top 10 Payment Rank			E&M Average Paid per Code		
E&M Category	Code	2013	2014	2015	2013	2014	2015	2013	2014	2015
Office/Outpatient Visit New Patient/Injury	99203	3.3%	4.5%	4.9%	8	6	5	$97.37	$111.58	$117.26
	99204	6.0%	9.1%	9.4%	5	4	4	$137.60	$169.69	$177.67
	99205		4.7%	4.2%		5	6		$209.75	$218.64
Office/Outpatient Visit Established Patient	99212			1.4%			10			$49.79
	99213	12.6%	18.0%	18.0%	2	2	2	$55.03	$$77.12	$80.47
	99214	29.9%	35.8%	36.0%	1	1	1	$85.64	$111.64	$116.68
	99215	12.2%	12.2%	11.7%	3	3	3	$122.89	$145.40	$150.46
Office Consultation	99244	2.7%			10			$167.01		
	99245	4.4%			6			$211.58		
Emergency Department Visit	99283	2.7%	2.5%	2.8%	9	7	7	$156.80	$156.52	$182.52
	99284		1.8%	2.0%		9	9		$222.77	$267.42
Prolonged Services	99354		1.6%			10			$107.10	
	99358	8.4%			4			$80.36		
Other	99499	3.3%	2.3%	2.4%	7	8	8	$992.30	$1,018.35	$1,048.02

Exhibit 11: Top 10 E/M Codes by Volume

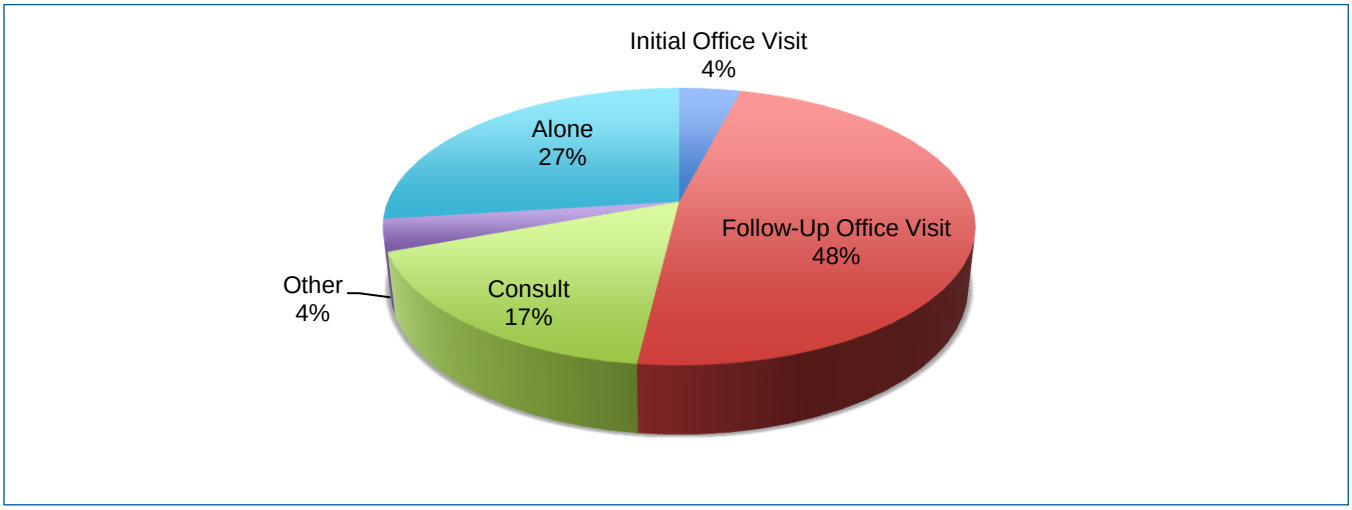
		Percent of E&M Service			E&M Top 10 Volume Rank		
E&M Category	Code	2013	2014	2015	2013	2014	2015
Office/Outpatient Visit New Patient/Injury	99202		1.6%	1.6%		9	9
	99203	3.2%	4.6%	5.0%	6	5	5
	99204	4.1%	6.0%	6.3%	5	4	4
	99205		2.3%	2.3%		7	7
Office/Outpatient Visit Established Patient	99212	2.8%	3.8%	3.3%	7	6	6
	99213	21.6%	26.3%	26.5%	2	2	2
	99214	33.0%	36.0%	36.5%	1	1	1
	99215	9.4%	9.5%	9.2%	4	3	3
Office Consultation	99244	1.5%			10		
	99245	1.9%			8		
Emergency Department Visit	99283	1.6%	1.8%	1.8%	9	8	8
Prolonged Services	99354		1.4%	1.4%		10	10
	99358	9.9%			3		

The relative values established under the RBRVS system are based on the cost of providing the service, and services that are identified as bundled into a primary service are not separately payable. Prolonged service codes (99358 and 99359) that are used to identify services provided either immediately before or after direct patient care are identified by Medicare as bundled services and the payment value for the services is included in the primary office visit service.

The shifts that occurred in the rankings of the top ten evaluation and management service codes based on volume and total paid amounts following the elimination of the separate payment for prolonged service code 99358 can be seen in Exhibits 10 and 11. In 2013, code 99358, which is defined as "prolonged evaluation and management service before and/or after direct patient care; first hour,"[10] accounted for 9.9 percent of all E/M services and 8.4 percent of E/M payments, ranking third behind follow-up office visits (OV) in terms of volume, and ranking fourth behind follow-up office visits in terms of E/M payments. As noted in Exhibit 10, the average amount paid for prolonged service code 99358 in 2013 was $80.36.

Analysis of 2013 data for the subpopulation of E/M service events that included prolonged service code 99358 on the same date of service by the same provider showed that these events were associated with another E/M service 73 percent of the time and were billed without another E/M service on the same date 27 percent of the time (Exhibit 12).

Exhibit 12: Distribution of Prolonged Service Codes 99358 w/ & w/o Associated E/M Services - Service Year 2013



10. American Medical Association. Current Procedural Terminology. 2014.

Exhibit 13 shows the calculated payment values for the primary E/M service codes, with the values for the corresponding level of service for new patient/injury codes substituted for the consultation code values (e.g. the value for 99205 is used for 99245 for the RBRVS years (2014 and 2015). Using this substitution logic, the replacement values for these services show the largest decreases under the RBRVS fee schedule have been for the lowest level consultation services (codes 99242 and 99241). The 2013 payment data shows that together these two codes represented less than 0.5 percent of total E/M code volume and payments, so the relatively large decrease associated with these two consultation codes has had little impact on the total amount paid under the new fee schedule.

The highest volume services also experienced the largest increases in payment values under the new fee schedule with code 99214, ranking first in volume, increasing by 39.71 percent in 2014 and an additional 6.22 percent under the March 2015 fee schedule update, for a total 2-year increase of 48.41 percent. The payment values for the second most utilized service code (99213) increased by a total of 57.76 percent under the March 2015 fee schedule update. Together, these service codes have consistently represented over 50 percent of total E/M services.

Exhibit 13: Evaluation and Management Code Payment Values

CPT Code	2007 - 2013 OMFS	2014 OMFS	March 2015 OMFS	2014 Change	2014 – 2015 Change	Total Change
99205	$186.73	$237.67	$252.73	27.28%	6.33%	35.34%
99204	$146.12	$191.11	$201.77	30.79%	5.58%	38.09%
99203	$103.86	$125.39	$133.40	20.73%	6.39%	28.44%
99202	$70.19	$86.95	$92.65	23.88%	6.55%	31.99%
99201	$39.90	$50.88	$54.59	27.52%	7.30%	36.83%
99215	$129.41	$167.15	$178.59	29.16%	6.84%	38.00%
99214	$89.57	$125.14	$132.93	39.71%	6.22%	48.41%
99213	$56.93	$84.99	$89.81	49.29%	5.68%	57.76%
99212	$42.02	$51.32	$54.59	22.13%	6.38%	29.93%
99211	$23.81	$23.90	$25.18	0.38%	5.37%	5.76%
99245	$238.79	$237.67	$252.73	-0.47%	6.33%	5.84%
99244	$184.86	$191.11	$201.77	3.38%	5.58%	9.15%
99243	$131.62	$125.39	$133.40	-4.73%	6.39%	1.35%
99242	$104.98	$86.95	$92.65	-17.17%	6.55%	-11.75%
99241	$79.14	$50.88	$54.59	-35.71%	7.30%	-31.02%
Average				**14.41%**	**6.32%**	**21.61%**

Surgery

The payment calculation rules for surgical services under the pre-2014 OMFS included a multiple procedure rule that paid for the highest valued procedure at 100 percent of its value, 50 percent of the value for the next highest valued procedure and 25 percent of the value for additional procedures. The multiple procedure rule under the RBRVS-based fee schedule continues to pay the highest valued procedure at 100 percent and all additional procedures at 50 percent of their calculated values. The revised multiple procedure rule allows for greater reimbursement when multiple procedures are performed during the same surgical session and they are not disallowed based on the CMS NCCI "Procedure to Procedure" or "Medically Unlikely Edits."

As was shown in Exhibits 1 and 2, the total paid amount and total volume of surgical services decreased in 2014, with payments decreasing by 18.4 percent and volume decreasing by 29.9 percent. The average amount paid for a surgical event, defined as surgery procedure(s) for the same injured worker, by the same physician on the same date of service, increased by 4.2 percent (Exhibit 9). The average payment per individual service code increased by 16.5 percent for services provided during 2015 (Exhibits 5 and 6).

There was a wide range of variability in the revised payment amounts for surgical services under the old fee schedule and the new fee schedule. Service code 29826, which is an arthroscopic shoulder decompression procedure, showed the greatest decrease in the fee schedule value under the 2014 fee schedule – an 80.4 percent reduction, which was primarily a result of the code descriptor change made by the AMA in 2012, whereby the code became an add-on code instead of a stand-alone code. By definition add-on codes are always paid in addition to a primary procedure instead of being characterized as a primary procedure, and as such, are paid at a reduced amount.

Surgery Codes Found in the Top 10 Lists for 2013, 2014 or 2015 with Descriptions	
12001	Simple repair of superficial wounds; 2.5 cm or less
12002	Simple repair of superficial wounds; 2.6 cm to 7.7 cm
20550	Injection(s); single tendon sheath, or ligament
20605	Drain/inject intermediate joint/bursa
20610	Drain/inject major joint/bursa
22845	Insert instrumentation; 2 to 3 vertebral segments
22851	Apply spine device (e.g. cage(s))
27447	Total knee arthroplasty
29125	Apply short arm splint
29823	Arthroscopy, shoulder, surgical; debridement, extensive
29824*	Arthroscopy, shoulder; distal claviculectomy (Mumford procedure)
29826	Arthroscopy, shoulder; decompression
29827	Arthroscopy, shoulder; with rotator cuff repair
29880	Arthroscopy, knee; with meniscectomy (medial AND lateral)
29881	Arthroscopy, knee; with meniscectomy (medial OR lateral)
62278	Lumbar epidural, single [replaced by 62311 in 2000 CPT]
62311*	Injection spine, lumbar/sacral
63047	Lumbar laminectomy, single vertebral segment
63685	Insertion or replacement of spinal neurostimulator
64415	Nerve block injection, brachial plexus
64443**	Facet joint injection, add'l level (replaced by 64476 in 2000 CPT)
64450	Nerve block injection, other peripheral nerve
64483*	Transforaminal epidural injection, lumbar or sacral, single level
64484*	Transforaminal epidural injection, lumbar or sacral, add'l level
64721	Carpal tunnel surgery
* Denotes new code under RBRVS	
** Denotes deleted code under RBRVS	

Under the new fee schedule the highest ranking surgical service by volume (20610 - arthrocentesis, aspiration and/or injection, major joint or bursa; without ultrasound guidance[11]) increased from a value of $45.90 under the old fee schedule to $100.80 when performed in an office setting and $76.42 when performed in a facility setting. The data shows that the average amount paid for this procedure rendered during 2013 was $43.87 and the average paid for a 2015 service date was $85.83 (Exhibit 14).

Exhibit 14: Top 10 Surgery Codes by Volume

Code	Percent of Service			Top 10 Rank			Average Paid per Code		
	2013	2014	2015	2013	2014	2015	2013	2014	2015
20610	9.8%	10.9%	10.0%	1	1	1	$43.87	$86.65	$85.83
20550	9.6%	6.9%	6.6%	2	2	2	$33.56	$67.31	$65.55
62278*	2.3%			3			$184.20		
29826	2.1%	2.2%	2.1%	4	5	5	$815.68	$340.64	$219.79
20605	1.9%	2.2%	1.7%	5	6	6	$44.38	$70.76	$71.67
12001	1.7%	2.2%	2.2%	6	4	4	$64.40	$106.87	$103.89
29125	1.5%			7			$45.87		
64443	1.5%			8			$68.76		
64450	1.3%			9			$54.45		
29823	1.3%			10			$983.92		
64483		2.5%	3.3%		3	3		$278.41	$318.71
62311		1.6%	1.7%		7	7		$191.80	$263.78
29881		1.4%	1.5%		8	8		$717.24	$833.90
64484		1.4%			9			$114.39	
12002		1.3%	1.4%		10	10		$133.52	$127.06
64415			1.4%			9			$107.10
Total	**33.1%**	**32.7%**	**31.9%**						

* Replaced by Code 62311 in 2000 CPT

Prior to implementation of the RBRVS-based fee schedule the physician was paid the same amount for a procedure regardless of where it was performed; under the new fee schedule the physician may receive a decreased payment if the procedure is performed in a hospital or ambulatory surgery center because the practice expense portion of the payment calculation is lower.

11. American Medical Association. Current Procedural Terminology. 2014.

As shown in Exhibit 15, in terms of the total amount paid, the number one surgical procedure code in 2014 and 2015 was code 29827 (arthroscopy, rotator cuff repair). This code was added by the AMA in 2003 and did not have a defined value under the pre-2014 OMFS. Carpal tunnel surgery (code 64721) exemplifies services showing greater consistency in the percent of surgical procedure payments, as it accounted for 2.3 percent of the surgery payments in 2013, 2.4 percent in 2014 and 2.1 percent in 2015. Similarly, the utilization of the carpal tunnel surgery code was stable, accounting for 1.2 percent of all surgery codes in 2013, 2014 and 2015. The average amount paid for code 64721 was also relatively flat, increasing only 2.7 percent from 2013 to 2015.

Exhibit 15: Top 10 Surgery Codes by Total Amount Paid

Code	Percent of Paid			Top 10 Rank			Average Paid per Code		
	2013	2014	2015	2013	2014	2015	2013	2014	2015
29826	5.0%	2.0%		1	5		$815.68	$340.64	
29823	3.7%	1.8%	2.0%	2	7	7	$983.92	$677.31	$808.95
29881	3.5%	2.8%	3.1%	3	2	3	$1,019.79	$717.24	
64721	2.3%	2.4%	2.1%	4	4	6	$721.90	$734.66	$741.35
29880	2.2%	1.5%	1.7%	5	10	8	$1,124.31	$778.20	$860.64
63047	2.2%			6			$1,408.11		
22851	1.7%			7			$553.66		
29827	1.7%	4.4%	5.0%	8	1	1	$2,695.55	$1,626.18	$1,661.80
27447	1.6%	1.7%	1.4%	9	9	9	$1,444.83	$1,339.06	$1,345.71
22845	1.6%			10			$1,259.98		
20610	2.6%	2.6%	2.1%		3	5		$86.65	$85.83
64483		2.0%	2.7%		6	4		$278.41	$318.71
29824		1.7%	3.1%		8	2		$648.17	$1,027.93
63685			1.3%			10			$4,566.90
Total	**28.1%**	**22.9%**	**24.6%**						

Radiology

As was noted in Exhibit 2, the total volume of radiology services in 2013 and 2014 remained relatively static; increasing just 1.4 percent, but in 2015, the second year of the transition to the RBRVS fee schedule, the volume of radiology services decreased by 12.6 percent, resulting in a net 2-year decrease of 11.4 percent from 2013 to 2015.

The corresponding decrease in the total amount paid for radiology services was a more significant 34.7 percent from 2013 to 2015, as was shown in Exhibit 1. The primary factor in the sharper decrease in radiology payments is the reduced fee schedule values under the RBRVS-based fee schedule.

Radiology Codes Found in the Top 10 Lists for 2013, 2014 or 2015 with Descriptions	
70450	CT, head or brain; w/o contrast
72100	X-Ray, spine, lumbosacral; 2 or 3 views
72110	X-Ray, spine, lumbosacral; minimum of 4 views
72141	MRI, spinal canal & contents, cervical; w/o contrast
72146	MRI, thoracic spine; w/o contrast
72148	MRI, lumbar spine; w/o contrast
72158	MRI, lumbar spine, w/o contrast, followed by contrast and further sequences
73030	X-Ray, shoulder; complete, minimum of 2 views
73110	X-Ray, wrist; complete, minimum of 3 views
73130	X-Ray, hand; minimum of 3 views
73218	MRI, upper extremity, other than joint; w/o contrast
73221	MRI, any joint of upper extremity; w/o contrast
73222	MRI, any joint of upper extremity; w/contrast
73562	X-Ray, knee; 3 views
73610	X-Ray, ankle; complete, minimum of 3 views
73630	X-Ray, foot; complete, minimum of 3 views
73718*	MRI, lower extremity other than joint; w/o contrast
73721	MRI, any joint of lower extremity; w/o contrast
76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection)
* Denotes new code under RBRVS	

Exhibit 16 shows the top four radiology codes based on total payments were those for MRIs of the upper extremity, lumbar spine, lower extremity and neck (all without contrast). Together these four codes represented 51.8 percent of all radiology payments in 2013, but that proportion fell to 41.2 percent in 2014 and 41.4 percent in 2015 as the fee schedule values decreased by 38.1 percent, 35.8 percent, 35.1 percent and 36.4 percent respectively for these four MRI codes under the RBRVS fee schedule.[12]

Exhibit 16: Top 10 Radiology Codes by Total Amount Paid

Code	Percent of Paid			Top 10 Rank			Average Paid per Code		
	2013	2014	2015	2013	2014	2015	2013	2014	2015
73221	17.0%	12.4%	12.6%	1	1	1	$623.01	$404.29	$359.81
72148	14.6%	12.2%	12.2%	2	2	2	$532.49	$356.02	$316.55
73721	12.1%	10.6%	10.6%	3	3	3	$566.48	$403.49	$364.66
72141	8.0%	6.0%	6.0%	4	4	4	$558.96	$341.33	$307.56
76942	2.0%	2.0%		5	10		$144.72	$105.41	
73030	2.0%	2.4%	2.5%	6	5	5	$53.86	$52.00	$47.07
72158	2.0%			7			$763.92		
70450	1.7%			8			$275.57		
72146	1.7%			9			$571.01		
72110	1.6%	2.0%	2.1%	10	8	9	$64.90	$72.90	$69.15
73110		2.1%	2.2%		6	7		$62.94	$57.53
73222	2.0%	2.3%			7	6		$589.37	$576.41
72100		2.0%	2.1%		9	8		$51.43	$48.35
73718			1.7%			10			$553.66
Total	**64.7%**	**54.1%**	**52.0%**						

12. RBRVS fee schedule values were calculated using the conversion factor and geographic adjustment factor in effect beginning March 1, 2015; the relative values were from the Medicare RVU14D table.

From 2013 through 2015 x-rays of the shoulder (73030) and x-rays of the lumbar spine (72100) continued to be the most heavily utilized radiology services (Exhibit 17). Notably, as the transition to the RBRVS fee schedule began in 2014 and 2015, MRIs of the lumbar spine (72148) rose to the number three spot in terms of volume, moving ahead of wrist x-rays (73110).

Exhibit 17: Top 10 Radiology Codes by Volume

Code	Percent of Service			Top 10 Rank			Average Paid per Code		
	2013	2014	2015	2013	2014	2015	$316.55	2014	2015
73030	6.0%	6.1%	6.3%	1	1	1	$53.86	$52.00	$47.07
72100	5.1%	5.2%	5.2%	2	2	2	$46.03	$51.43	$48.35
73110	4.4%	4.5%	4.5%	3	4	4	$48.35	$62.94	$57.53
72148	4.4%	4.6%	4.6%	4	3	3	$532.49	$356.02	$316.55
73221	4.4%	4.1%	4.2%	5	5	5	$623.01	$404.29	$359.81
72110	3.9%	3.7%	3.5%	6	7	7	$64.90	$72.90	$69.15
73130	3.7%	3.8%	4.0%	7	6	6	$42.25	$52.43	$47.70
73721	3.4%	3.5%	3.5%	8	8	8	$566.48	$364.66	$364.66
73610	3.0%	3.2%	3.4%	9	9	9	$40.97	$51.68	$47.18
73562	2.9%		3.2%	10		10	$48.49		$55.60
73630		3.2%			10			$55.60	
Total	**41.3%**	**41.8%**	**42.4%**						

The RBRVS fee schedule introduced a new multiple procedure rule into the calculation of payments when more than one related service is performed on the same date. This rule applies primarily to MRI and CT scan services, but it is unusual for an individual to have multiple MRIs or multiple CT scans on the same date of service, so the overall impact of the rule is insignificant. The data shows that the average paid per claim per date of service decreased by 27.7 percent from 2013 to 2015, while the average paid per individual code also changed by 27.7 percent, further confirming the limited impact of the multiple procedure rule.[13]

13. The average number of services per claim per date of service remained unchanged at 1.7.

Pathology and Laboratory

Services that fall under the pathology section of the OMFS represented between 0.1 percent and 0.2 percent of the total services and total payments for service years 2013, 2014 and 2015 (Exhibits 7 and 8). The author limited analysis of CPT codes that are included in the Pathology and Laboratory section of the AMA's CPT manual to those services that are paid under the physicians' and non-physicians' OMFS. As a result, clinical laboratory codes, which are paid under the pathology and clinical laboratory section of the OMFS pursuant to California Code of Regulations (CCR) §9789.40 rather than under the physician's and non-physician's fee schedule, were excluded from the analysis of the RBRVS fee schedule implementation.

Pathology Codes Found in the Top 10 List for 2013, 2014 or 2015 with Descriptions	
80500	Lab pathology consultation; limited
80502	Lab pathology consultation; comprehensive
81355*	Vkorc1 gene analysis
81400*	Molecular pathology; level 1
81401*	Molecular pathology; level 2
81402*	Molecular pathology; level 3
81408*	Molecular pathology; level 9
81479*	Unlisted molecular pathology
85060	Blood smear interpretation
86580*	Tb intradermal test
88182	Cell marker study
88300	Surgical path gross
88302	Surgical pathology; level 2
88304	Surgical pathology; level 3
88305	Surgical pathology; level 4
88307	Surgical pathology; level 5
88311	Decalcify tissue
88312	Special stains group 1
88313	Special stains group 2
88342	Immunohistochemistry antibody slide
G0452*	Molecular pathology; interpretation
* Denotes new code under RBRVS	

As shown in the sidebar, the pathology codes found in the top 10 lists based on utilization, total amount paid, or both, included a number of new CPT codes that were added under the RBRVS-based OMFS. With the exception of code 86580, which is a skin test for tuberculosis, the new codes represent genetic testing. These codes (81355 and 81400 – 81408) were created by the AMA in 2012 and were revised in 2013; code 81479 was added by the AMA in 2013. Although these genetic testing services are now included in the new fee schedule utilizing Medicare relative values, their codes have not yet been assigned values by Medicare, so when used in California workers' compensation they continue to be paid "By Report" under the OMFS.

Exhibit 18 shows the top ten paid physician pathology service codes, which together accounted for 87.6 percent of the total paid for pathology in 2013, 84.6 percent in 2014 and 86.3 percent in 2015. Exhibit 19 shows these codes represented 89.7 percent of all pathology services used in 2013, and that level of utilization showed only a marginal increase following the adoption of the RBRVS fee schedule, rising to 89.9 percent in 2014 and 2015.

Exhibit 18: Top 10 Pathology Codes by Total Amount Paid

Code	Percent of Paid			Top 10 Rank			Average Paid per Code		
	2013	2014	2015	2013	2014	2015	2013	2014	2015
80500	27.0%	17.7%	14.3%	1	2	3	$49.47	$24.05	$27.22
88305	17.5%	16.8%	16.0%	2	3	2	$110.97	$81.67	$79.19
88182	15.6%			3			$1,635.10		
81479	9.1%	18.9%	29.7%	4	1	1	$1,071.78	$748.51	$353.03
88304	8.0%	5.0%	6.8%	5	6	4	$41.63	$28.95	$35.65
81355	2.5%	3.4%	2.7%	6	8	7	$185.71	$206.19	$370.91
80502	2.2%			7			$65.15		
88311	2.0%	2.0%		8	10		$16.23	$16.31	
81402	1.9%			9			$625.24		
81401	1.7%	7.9%	5.8%	10	4	5	$229.40	$335.92	$420.71
88342		6.5%			5			$413.76	
G0452		3.5%			7			$59.51	
88312		2.9%	2.7%		9	8		$107.22	$116.39
81408			3.6%			6			$395.71
88307			2.4%			9			$185.33
81400			2.2%			10			$367.24
Total	**87.6%**	**84.6%**	**86.3%**						

Exhibit 19: Top 10 Pathology Codes by Volume

Code	Percent of Service			Top 10 Rank			Average Paid per Code		
	2013	2014	2015	2013	2014	2015	2013	2014	2015
80500	41.6%	45.4%	37.4%	1	1	1	$49.47	$24.05	$27.22
88304	14.5%	10.7%	13.5%	2	3	3	$41.63	$28.95	$35.65
88305	12.0%	12.6%	14.4%	3	2	2	$110.97	$81.67	$79.19
88311	9.5%	7.6%	8.3%	4	4	4	$16.23	$16.31	$16.92
88300	3.8%	3.9%	4.6%	5	5	6	$16.02	$8.02	$10.35
80502	2.6%			6			$65.15		
88312	1.9%	1.7%	1.6%	7	7	8	$48.75	$107.22	$116.39
88313	1.6%		1.1%	8		9	$43.38		$65.33
86580	1.1%			9			$11.39		
G0452	1.1%	3.6%		10	6		$36.86	$59.51	
81479		1.6%	6.0%		8	5		$748.51	$353.03
81401		1.4%	1.0%		9	10		$335.92	$420.71
85060		1.4%			10			$24.03	
88302			2.1%			7			$23.95
Total	**89.7%**	**89.9%**	**89.9%**						

Physical Medicine

Prior to implementation of the RBRVS-based OMFS, physical therapy, chiropractic and osteopathic manipulation and acupuncture services were included in rules governing calculation of individual services and multiple services provided to an injured worker on the same date by the same service provider. The regulatory requirements under CCR §9789.5.4 revised the multiple procedure rules under the new OMFS, but maintained the same limitations on time (60 minutes) and number of codes (maximum of four).

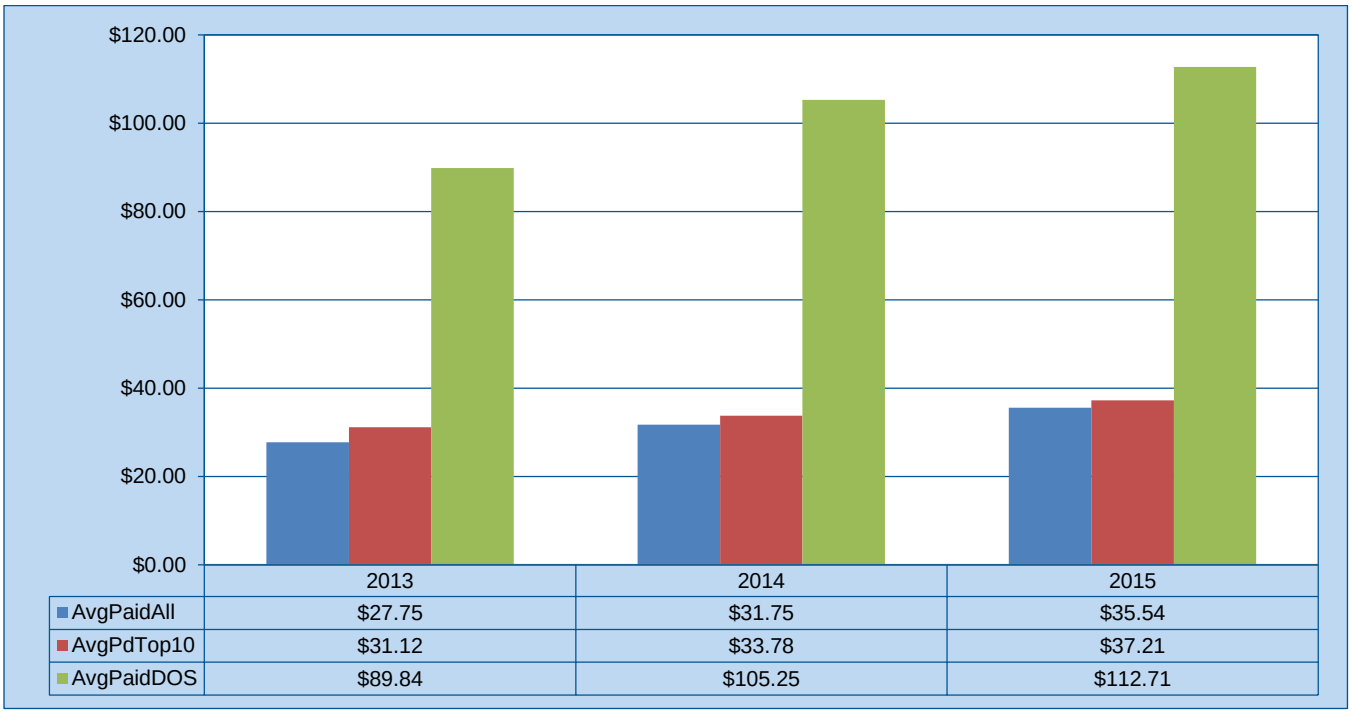
Multiple procedure reduction rules continue to be applied when more than one service is provided on the same date by the same provider, but the method for calculating the reduced rates is now limited to the practice expense portion of the calculated value.

Exhibits 1 and 2 showed that while there was a 12 percent decrease in the total volume of physical medicine services from 2013 to 2015, the total amount paid for these services increased by 12.7 percent over that same period.

Physical Medicine Codes Found in the Top 10 Lists for 2013, 2014 or 2015 with Description	
97110	Therapeutic exercises
97001*	Patient evaluation by physical therapist
97014**	Electric stimulation therapy
97016	Vasopneumatic device therapy
97018	Paraffin bath therapy
97026	Infrared therapy
97035	Ultrasound therapy
97112	Neuromuscular reeducation
97140	Manual therapy 1/> regions
97145**	Additional 15 minutes
97250**	Myofacial/soft tissue mobilization
97530	Therapeutic activities
97801**	Electro Acupuncture
97813*	Acupuncture w/stimulation 15 min
97814*	Acupuncture w/o electric stimulation 15 min
98940	Chiropractic manipulation 1-2 regions
G0283*	Electrical stimulation other than wound
* Denotes new code under RBRVS	
** Denotes deleted code under RBRVS	

Exhibit 20 shows the breakdown of average payments for the individual physical medicine service codes, as well as the average amount paid per date of service (DOS) by the same service provider for an individual injured worker. The average amount paid per date of service, which often includes multiple physical medicine procedures and/or modalities, increased by 25 percent between 2013 and 2015.

Exhibit 20: Average Amounts Paid for Physical Therapy Service Codes and Service Dates Service Years 2013 to 2015



	2013	2014	2015
AvgPaidAll	$27.75	$31.75	$35.54
AvgPdTop10	$31.12	$33.78	$37.21
AvgPaidDOS	$89.84	$105.25	$112.71

Exhibit 21 lists the top ten physical medicine service codes based on utilization for service years 2013, 2014 and 2015, and notes the proportion of the total physical medicine volume and payments represented by these codes. For services provided during 2013, the top ten codes combined accounted for 78.2 percent of all physical medicine service codes, but under the RBRVS fee schedule that proportion increased to 82.1 percent in 2014 and 83.1 percent in 2015.

Exhibit 21: Top 10 Physical Medicine Codes by Volume

Code	Percent of Service			Top 10 Rank			Average Paid per Code		
	2013	2014	2015	2013	2014	2015	2013	2014	2015
97110	20.4%	30.9%	31.4%	1	1	1	$25.59	$34.40	$38.54
97014	18.9%			2			$8.41		
97250	18.9%			3			$37.44		
97026	6.1%	3.3%	2.5%	4	6	6	$7.74	$4.60	$4.77
97801	2.6%			5			$60.51		
97530	2.5%	6.3%	7.5%	6	4	4	$25.18	$37.32	$41.44
97145	2.4%			7			$14.88		
98940	2.3%	2.0%		8	9		$26.87	$25.99	
97016	2.1%			9			$6.56		
97018	2.0%			10			$7.32		
97140		18.5%	19.0%		2	2		$26.47	$28.09
G0283		10.7%	9.0%		3	3		$10.80	$11.24
97112		3.7%	4.8%		5	5		$32.54	$33.93
97035		2.5%	2.4%		7	7		$11.14	$11.17
97813		2.3%	2.3%		8	8		$39.39	$40.79
97001		1.9%	2.1%		10	10		$78.23	$80.83
97814			2.2%			9			$32.72
Total	**78.2%**	**82.1%**	**83.1%**						

The top ten physical medicine service codes based on the total amount paid together accounted for 75.8 percent of all physical medicine payments in 2013, but as shown in Exhibit 22, following the adoption of the RBRVS fee schedule that proportion increased to 82.4 percent in 2014 and to 83.9 percent during 2015 as utilization of these codes increased as well, climbing from 67.7 percent of the physical medicine codes in 2013 to 77.9 percent in 2014 and to 80.2 percent in 2015.

Exhibit 22: Top 10 Physical Medicine Codes by Paid

Code	Percent of Paid			Top 10 Rank			Average Paid per Code		
	2013	2014	2015	2013	2014	2015	2013	2014	2015
97250	25.5%			1			$37.44		
97110	18.8%	33.5%	34.0%	2	1	1	$25.59	$34.40	$38.54
97799	7.9%	7.6%	7.7%	3	3	4	$802.29	$815.98	$1,012.03
97801	5.7%			4			$60.51		
97014	5.7%			5			$8.41		
97620	2.8%			6			$58.15		
97670	2.7%			7			$725.65		
97530	2.2%	7.4%	8.7%	8	4	3	$25.18	$37.32	$41.44
97545	2.2%			9			$162.59		
98940	2.2%			10			$26.87		
97140		15.4%	15.0%		2	2		$26.47	$28.09
97001		4.8%	4.8%		5	5		$78.23	$80.83
97112		3.8%	4.6%		6	6		$32.54	$33.93
G0283		3.6%	2.8%		7	7		$10.80	$11.24
97813		2.8%	2.7%		8	8		$39.39	$40.79
97814		1.8%	2.0%		9	9		$30.59	$32.72
97113		1.8%			10			$53.14	
97535			1.6%			10			$34.07
Total	**75.8%**	**82.4%**	**83.9%**						

Exhibits 21 and 22 show that during 2013, 2014 and 2015 the top ten physical medicine services provided included a mix of physical therapy treatment and modality services, chiropractic manipulation and acupuncture. In service year 2013, before the transition to the RBRVS fee schedule began, myofascial release/soft tissue mobilization (CPT 97250) was the top paid physical medicine code (representing 25.5 percent of total physical medicine payments). This code had been deleted in 1999 and replaced with code 97140, but because the California workers' compensation OMFS used physical medicine CPT codes from 1997, CPT 97250 continued to be in use until the 2014 fee schedule change. Once the new schedule was adopted, however, CPT 97250 was retired, and therapeutic exercises (CPT 97110) became the number one physical medicine service in terms of volume and total amount paid.

Acupuncture is an area of physical medicine that shows the effect of changes in coding descriptions and payment rules. Under the RBRVS fee schedule, the average payment per acupuncture service code decreased 38.2 percent, but the average payment per date of service increased 10.1 percent (Exhibit 23). This apparent discrepancy is a result of changes in the CPT codes and the descriptions used for the primary acupuncture services provided. Under the old OMFS schedule the codes for acupuncture by manual stimulation and electro acupuncture were not time based, and therefore were only billable once per treatment session. The RBRVS fee schedule based these acupuncture CPT codes on 15-minute time increments, so depending on the level of direct patient interaction, multiple codes per treatment session can now be billed. Thus, the 75.2 percent increase in the volume of acupuncture services noted in Exhibit 23 does not reflect more treatment, but instead is merely a product of the new coding structure.

Exhibit 23: Acupuncture Services Change in Values from 2013 to 2015

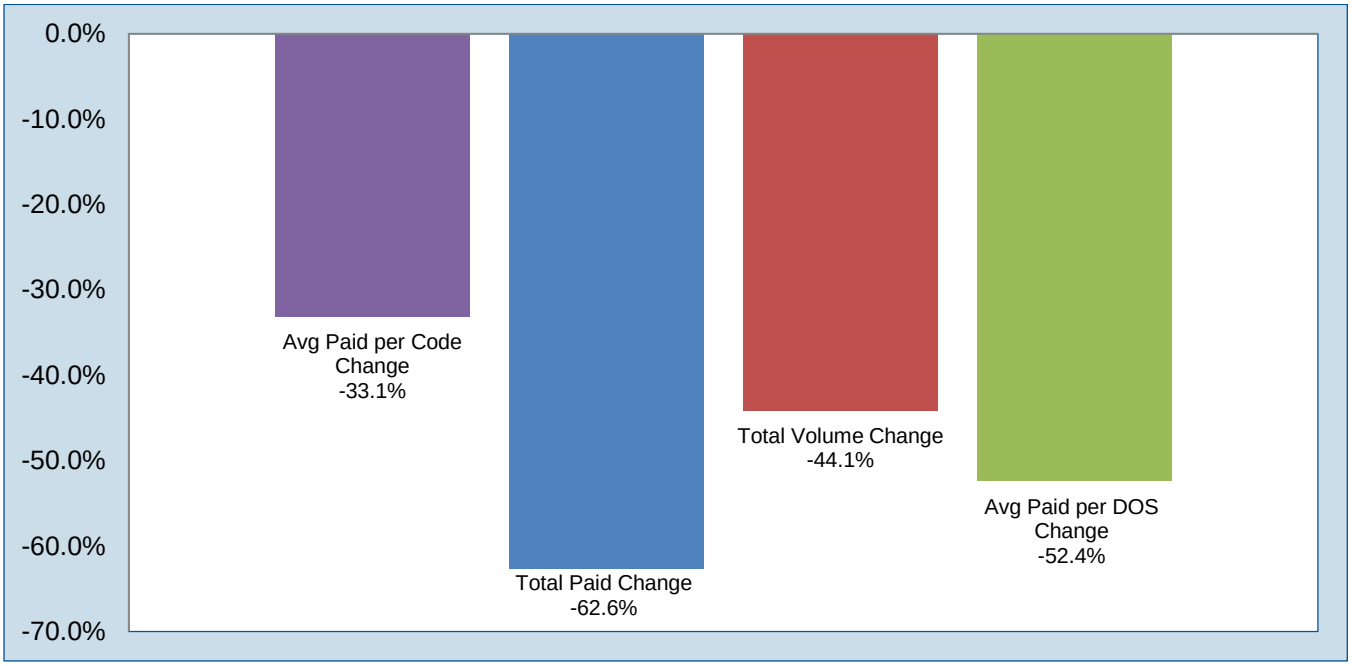
	2013	2014	2015	Percent Change
Total Paid	$3,643,404	$3,975,854	$3,943,052	8.2%
Total Volume	62,909	115,794	110,214	75.2%
Average Paid per Code	$57.92	$34.34	$35.78	-38.2%
Average Paid per DOS	$71.06	$69.54	$78.22	10.1%

Medicine

The medicine section includes an array of diagnostic and clinical treatment services such as cardiovascular testing and treatment, neurology and neuromuscular procedures, psychiatric diagnostic procedures and psychotherapy, ophthalmological services, noninvasive vascular services and injections. As was shown in Exhibits 1 and 2, from service year 2013 to service year 2015, the total paid amount for all medicine services and the total volume of medicine services decreased by almost the same degree (-44.9 percent for the total amount paid and -49.5 percent for the total volume). There was greater variability, however, when subcategories of medicine section services were analyzed separately.

Cardiovascular diagnostic and treatment services experienced a decrease in both the volume of paid services and the average amount paid for individual service codes, and when multiple services were provided on the same date by the same service provider. Exhibit 24 shows that the 62.6 percent decrease in the total amount paid for cardiovascular services between service year 2013 and service year 2015 was the result of a 44.1 percent reduction in the volume of services combined with a 33.1 percent decline in the average amount paid for individual service codes.

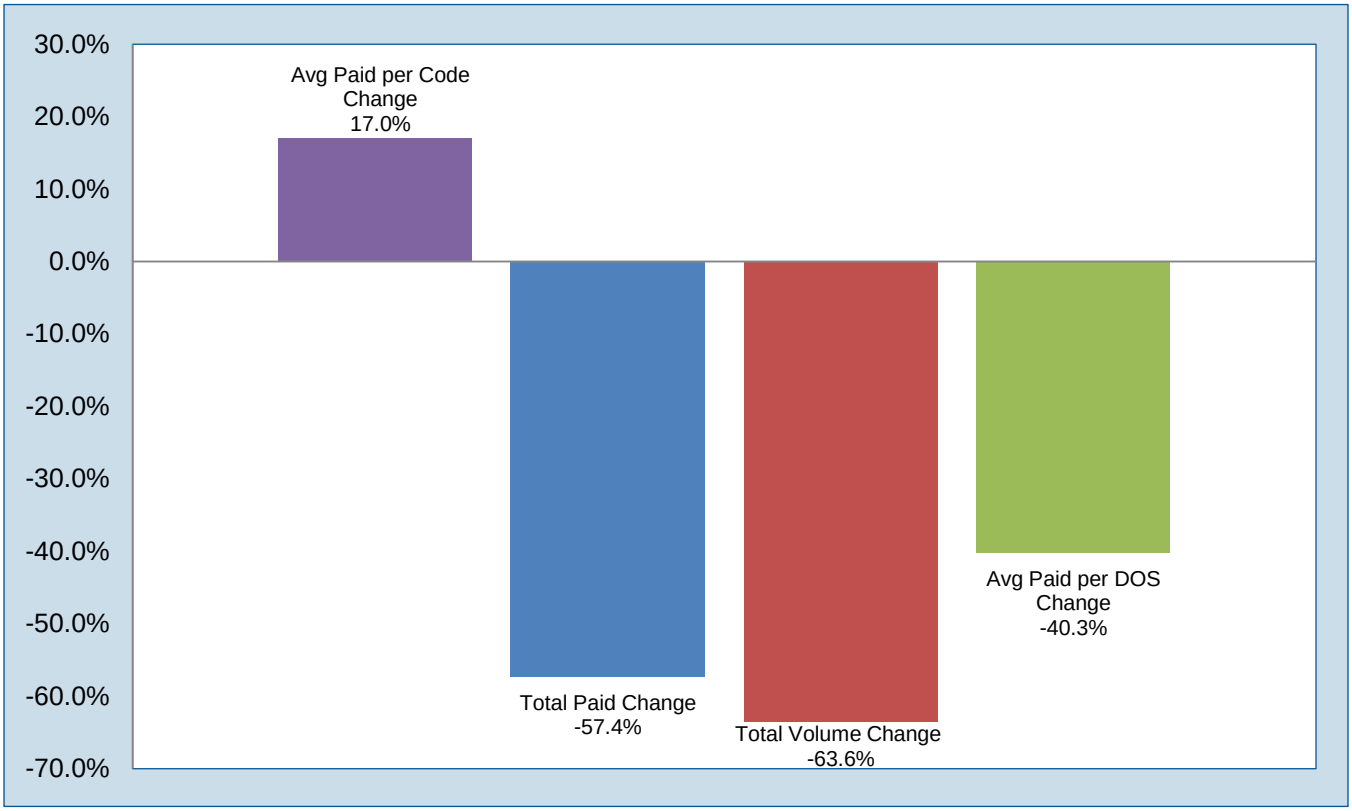
Exhibit 24: Change in Values for Cardiovascular Services – Service Years 2013 to 2015



In contrast to cardiovascular services, the total amount paid and the total volume of neurology and neuromuscular services (e.g. muscle and range of motion testing, nerve conduction tests, electromyography, etc.) decreased between 2013 and 2015, even though the average paid amount for the associated service codes increased by 17 percent (Exhibit 25). As shown in Exhibit 25, the average payment for neurology and neuromuscular services billed for an injured worker by the same provider on the same date of service decreased by 40.3 percent.[14] There may be multiple causes for the decline in the number of service codes per date of service, including a coding change implemented by the AMA in 2013 that impacted the coding of nerve conduction studies. Prior to the AMA's 2013 changes, the service units for nerve conduction studies (codes 95900, 95903, and 95904) were defined by each nerve tested. In 2013, codes 95900, 95903, and 95904 were deleted and replaced by seven new codes (95907-95913) with service units defined by the number of nerve conduction studies performed.

Exhibit 25: Change in Values for Neurology & Neuromuscular Services

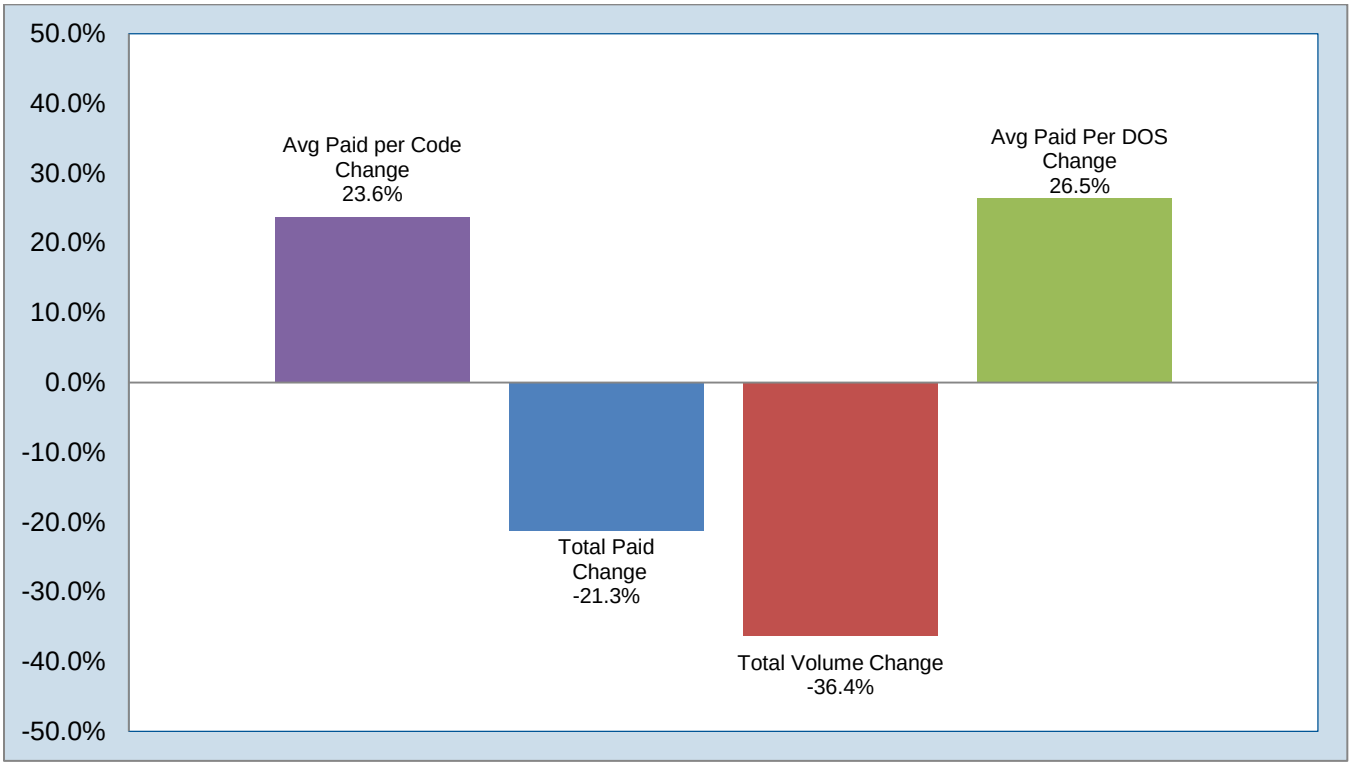
Service Years 2013 to 2015



14. Over this same period, the average number of service codes paid per date of service declined from 3.8 in 2013 to 1.9 in 2015.

Another subcategory of Medicine section services where utilization and the total amount paid changed following the adoption of the RBRVS fee schedule was psychiatric diagnostic procedures and psychotherapy services. Both the volume and the aggregate payments for these services declined between 2013 and 2015, though the decrease in the total amount paid for these services was mitigated somewhat by a 23.6 percent increase in the average amount paid per service code and a 26.5 percent increase in the average payment when multiple services were provided on the same date (Exhibit 26).[15]

Exhibit 26: Change in Values for Psychiatric Diagnostic and Psychotherapy Services Service Years 2013 to 2015



15. The average number of service codes per date of service remained consistent at 1.2 for service dates in 2013.

Special Services

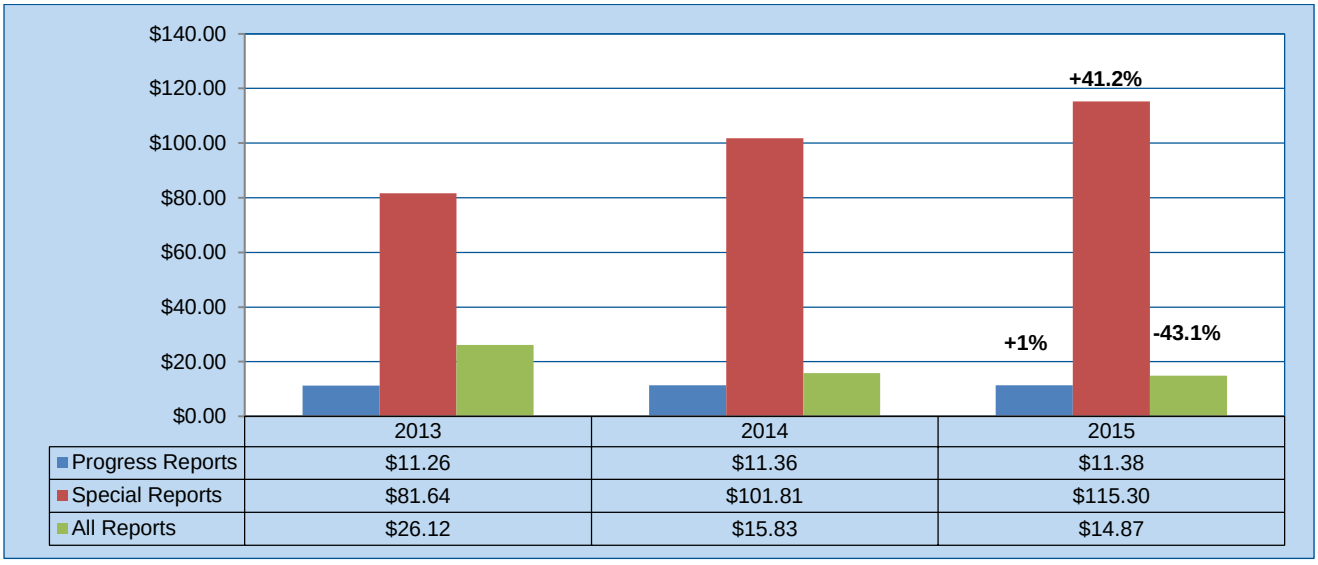
The special services section of the pre-2014 OMFS included services that were specific to workers' compensation for reimbursement and that were typically identified using codes created for services rendered to injured workers. The most significant services under this section are physician reports, followed by code 99199 defined as "unlisted special service, procedure or report," and code 99070 for "supplies and materials…"[16] Exhibit 27 shows that in 2013, reports, unlisted services and supplies/materials combined to account for 96 percent of all services in this fee schedule section, and that proportion edged up to 98 percent in 2015, though the percentage of special service payments accounted for by these three components held steady at 97.3 percent in 2013, 2014 and 2015.

Exhibit 27: Reports as a Percent of Total Special Service Category

Percent of Total Special Services Volume				Percent of Total Special Services Paid		
	2013	2014	2015	2013	2014	2015
Reports	87.1%	93.7%	95.3%	31.4%	31.0%	25.3%
Unlisted Service	2.0%	2.4%	1.8%	60.5%	57.7%	68.9%
Supplies/Materials	6.9%	1.6%	0.9%	5.4%	8.6%	3.1%
Total	96.0%	97.7%	98.0%	97.3%	97.3%	97.3%

As noted in prior CWCI studies on physician reporting in California workers' compensation,[17] [18] physician reports fall into two basic categories: progress reports and special reports. Exhibit 28 shows that the average amount paid for progress reports (99081 or WC002) remained stable from service year 2013 to service year 2015, while the average amount paid for special reports (99080, WC003, WC004, WC005, WC007) increased by 41.2 percent and the average paid for all reports declined by 43.1 percent (all averages were weight adjusted).

Exhibit 28: Average Paid per Physician Report by Report Type – Service Years 2013 to 2015



	2013	2014	2015
Progress Reports	$11.26	$11.36	$11.38
Special Reports	$81.64	$101.81	$115.30
All Reports	$26.12	$15.83	$14.87

16. American Medical Association. Current Procedural Terminology. 2014.
17. Jones, S. The Price of Progress: Progress Reports in the California Workers' Compensation System. CWCI, 2014.
18. Jones, S. Changes in Workers' Compensation Physician Reporting Under California's RBRVS Fee Schedule: Initial Results. CWCI, January 2015.

Although the average amount paid for special reports increased in 2014 and 2015, special reports as a percent of special services declined sharply under the RBRVS fee schedule. Exhibit 29 shows that special report code 99080 accounted for 18.4 percent of all special services in 2013, but in 2014 code 99080 and the new special report codes WC003, WC004, WC005 (which was not on the top 10 list) and WC007 together accounted for 4.5 percent of all special services, and that proportion declined to 3.2 percent in 2015.

Exhibit 29: Top 10 Special Services Codes by Volume

Code	Percent of Special Services			Top-10 Rank			Average Paid per Code		
	2013	2014	2015	2013	2014	2015	2013	2014	2015
99081	68.7%			1			$11.26		
99080	18.4%	0.2%		2	10		$81.64	$126.33	
99070	6.9%	1.6%	0.9%	3	4	4	$56.68	$251.13	$197.08
99199	2.0%	2.4%	1.8%	4	2	3	$2,160.91	$1,125.88	$2,115.95
99071	1.5%			5			$7.70		
99049	0.5%			6			$93.20		
99050	0.4%			7			$21.27		
99087	0.2%			8			$9.71		
99025	0.2%			9			$21.36		
99058	0.1%			10			$27.29		
WC002		89.3%	92.2%		1	1		$11.36	$11.38
WC004		2.3%	2.1%		3	2		$111.89	$121.42
WC007		1.0%	0.4%		5	7		$92.77	$94.95
WC003		0.9%	0.7%		6	6		$87.35	$91.85
WC012		0.5%	0.9%		7	5		$93.73	$83.91
WC008		0.5%	0.3%		8	9		$8.37	$9.68
99144		0.3%	0.3%		9	8		$106.32	$95.84
98969			0.1%			10			$127.48
Total	**98.9%**	**99.2%**	**99.6%**						

A similar reduction was noted in special report payments (Exhibit 30), as total reimbursements for special reports fell from 20.7 percent of all special service payments in 2013 (code 99080) to 9.7 percent of all special service payments in 2014 and to 6.6 percent in 2015.

Exhibit 30: Top 10 Special Services Codes by Paid

Code	Percent of Paid			Top-10 Rank			Average Paid per Code		
	2013	2014	2015	2013	2014	2015	2013	2014	2015
99199	60.5%	57.7%	68.9%	1	1	1	$2,160.91	$1,125.88	$2,115.95
99080	20.7%	0.6%	0.3%	2	9	9	$81.64	$126.33	$375.75
99081	10.7%			3			$11.26		
99070	5.4%	8.6%	3.1%	4	3	4	$56.68	$251.13	$197.08
99049	0.7%			5			$93.20		
99060	0.4%			6			$498.11		
99090	0.3%			7			$222.59		
99135	0.2%			8			$169.79		
99183	0.2%			9			$233.20		
99071	0.2%			10			$7.70		
WC002		21.3%	18.8%		2	2		$11.36	$11.38
WC004		5.3%	4.5%		4	3		$111.89	$121.42
WC007		2.0%	0.7%		5	7		$92.77	$94.95
WC003		1.6%	1.1%		6	6		$87.35	$91.85
WC012		1.1%	1.3%		7	5		$93.73	$83.91
99144		0.8%	0.6%		8	8		$106.32	$95.84
WC005		0.2%			10			$76.97	
98969			0.2%			10			$127.48
Total	**99.3%**	**99.1%**	**99.4%**						

Data limitations do not allow for identification of the types of services and/or items that are billed and paid using non-specific codes, such as 99199 and 99070. Prior to implementation of the RBRVS-based fee schedule the code for supplies and materials (99070) was payable as a By Report code, meaning the reimbursement was based on documentation.[19]

Under the RBRVS reimbursement rules code 99070 is identified as a bundled code, which means that the payment for the supplies or materials are included in the service to which they are incident. Supplies and materials that are dispensed to the injured worker are reimbursed under the OMFS Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS) Fee Schedule, and as such, were not included in this analysis of the RBRVS-based fee schedule.

19. The 1999 CA OMFS described code 99070 as "Supplies and materials (except spectacles) provided by the *health care provider over* and above those usually included with the office visit or other services rendered (must be *identified and quantified;* list drugs, trays, supplies or materials provided).

DISCUSSION

This analysis, which compares California workers' compensation medical payment data for services rendered from January through October of 2013, 2014 and 2015, finds that in the first two years under the new RBRVS-based fee schedule for physician and non-physician services, the total volume of OMFS-covered medical services provided to injured workers declined by 17.7 percent (Exhibit 2), and that the corresponding total payments for those services declined by 14.3 percent (Exhibit 1). Furthermore, the data show significant variability between service categories (e.g. surgery, evaluation and management, physical medicine, radiology, etc.) and within service categories (e.g. neurology and neuromuscular vs cardiovascular within the medicine category).

An important mandate of SB 863 was that the new physician fee schedule had to be implemented over a four-year time period in order to maintain budget neutrality. The data in this study includes payments that were based on the first two years of the implemented changes to conversion factors used to calculate final fee schedule payments. As noted, at the two-year mark, the overall volume of services covered was down 17.7 percent from the 2013 level, with reductions ranging from 11.4 percent to 49.5 among the different service categories. Likewise, while the total amount paid for all services under the schedule was down 14.3 percent, changes in the total amounts paid among the various categories of services ranged from a 44.9 percent decline for the medicine section to a 12.7 percent increase for the physical medicine section. The number of unique claims associated with each service category showed similar variability, though the variations fell within a narrower range (-26.5 percent to +2.2 percent), resulting in a decline of 3.3 percent in the overall number of unique claims for all services (Exhibit 4).

In addition to the variability in the volume of services, the total paid amounts and volume of claims, the change in the average amount paid per service also varied significantly by service category. Exhibit 5 shows that there was an overall increase of 4.2 percent in the average amount paid per service code, with results among the various service categories ranging from a 26.3 percent reduction in radiology services to a 28.1 percent increase in physical medicine services. The low end of this range represents the change in the average amount paid for special services, primarily due to lower report costs which reflect the elimination of separate payments for reports associated with consultation services. The high end of the range represents the intended increase of payments for primary care physicians billing for the evaluation and management services, which account for the largest share of injured worker care.

The provision of timely and effective treatment for California injured workers requires access to primary care physicians and the increase in payment values for basic services such as evaluation and management and physical therapy reflect this. In March 2015, the state reduced the conversion factors used to calculate payments for anesthesiology, surgery and radiology by 6.8 percent, 6.6 percent and 5.5 percent respectively, while implementing a 5.1 percent increase in the conversion factor for "other services," which include evaluation and management and physical medicine. The most recent changes in January and April of 2016 further reduced the conversion factors for anesthesiology, surgery and radiology, producing total net decreases of 14.8 percent, 12.9 percent and 10.7 percent respectively for those service categories compared to the 2014 levels. Meanwhile, an

additional increase in the conversion factor for "other services" in 2016 produced a total increase of 10.6 percent in the conversion factor for those services over the 2014 level.

The final four-year adjustment will be made in 2017, at which time the conversion factor will be the same for all service sections except anesthesiology. This means that overall, payers and providers can expect to see increases in payments for evaluation and management and physical medicine services, and decreases in anesthesiology, surgery and radiology. In the future, fee schedule values for specific services and procedures within the various service categories will continue to vary based on adjustments made to the relative values by CMS and on the deletion, revision and addition of new codes.

Under the charge-based fee schedule that was in effect for physician and non-physician services prior to 2014 there was no mechanism to assign relative values and conversion factors that adequately addressed cost differentials for services provided – a shortfall made worse by the use of aging, and in some instances obsolete, service codes and the absence of codes for newer technologies and techniques. While the new RBRVS-based schedule for physician and non-physician services does not provide a defined payment value for all services (e.g. genetic testing services now have codes under the OMFS, but they do not have assigned relative values) the services provided to injured workers in California are now better defined and the amounts paid are more reflective of the relative cost of providing the services.

About the Author

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

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1333 Broadway, Suite 510
Oakland, CA 94612
www.cwci.org

(510) 251-9470

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