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BULLETIN

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New CWCI research tracks changes in the utilization and reimbursement of physician and non-physician medical services governed by the California workers' compensation Official Medical Fee Schedule from 2013 to 2018 and documents the shifts that occurred in the distribution of these services and payments as the state transitioned to the Resource-Based Relative Value Scale (RBRVS) fee schedule mandated by the 2012 workers' compensation reform bill (SB 863).

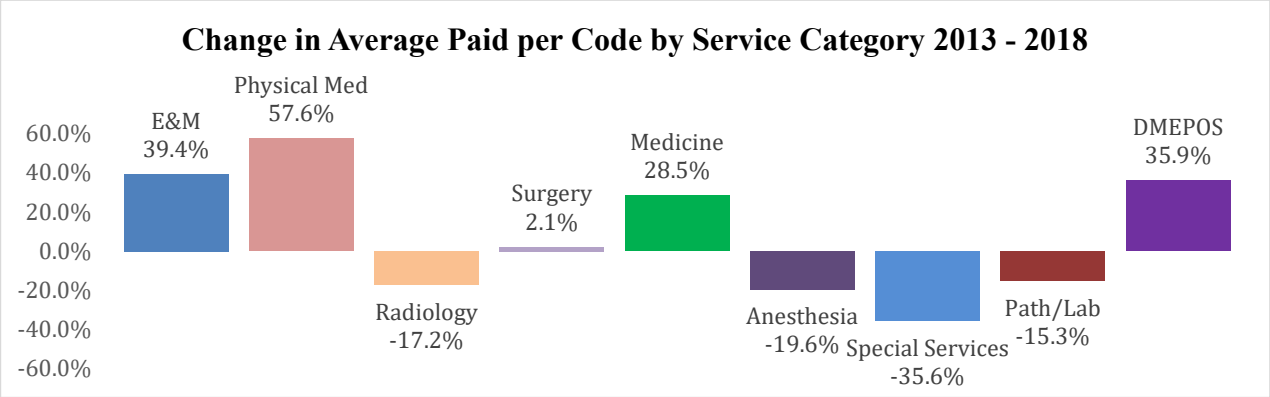
The study updates prior CWCI research using data from CWCI's Industry Research Information System (IRIS) database encompassing 35.9 million professional medical services provided to California injured workers in the first 10 months of calendar years 2013 through 2018 (the data was limited to the first 10 months of each year to account for the lag times between service dates, billing dates, and payment dates for those services). The author determined the distribution of medical services and payments across nine major service categories for each year beginning in 2013, the final year under the old fee schedule, then compared those results to the distributions from 2014 through 2017, the 4-year transition period to the new fee schedule, and 2018, the first year after the RBRVS schedule took full effect. Additional analyses tracked changes that occurred within each service category over the 6-year span of the study, including shifts in the mix of billing codes used and in the distribution of payments, as well as in the average amounts paid for subcategories of services.

Comparing the number of claims that received medical services covered by the fee schedule shows that overall claim volume declined by 5.2 percent from 2013 to 2018, which only partially explains the 28.4 percent drop in total service counts (identified by billing codes) and the 20.4 percent decline in aggregate payments over that 6-year span. Breaking out the results by service category shows that reductions in service counts ranged from a 17.2 percent drop in physical medicine services to a 71.8 percent drop in pathology and laboratory services, while the number of unique claims associated with each service category also declined across the board, ranging from a 4.4 percent drop in claims with physical medicine services to a 42.9 percent drop in claims with pathology and laboratory services. As was intended by the adoption of the RBRVS payment model, those declines, along with updates to the service codes and descriptions, led to a redistribution of the fee schedule reimbursements, with a smaller share paying for specialty services and an increased share paying for primary care. Over the 6-year study period, total payments for evaluation and management (E&M) and physical medicine services, which together account for most of the primary care delivered to injured workers (68.3 percent of professional services in 2018), increased by 9.3 percent and 30.6 percent respectively, while total payments for other services fell anywhere from 16.5 percent for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) to 76.1 percent for pathology and lab services.

Percent Change in Total Volume, Total Paid, and Unique Claims by Service Category, 2013 – 2018

Service Category	Code Volume	Total Paid	Unique Claims
Physical Medicine	-17.2%	30.6%	-4.4%
Evaluation & Management	-21.5%	9.3%	-4.7%
Special Services	-30.5%	-55.2%	-11.6%
Radiology	-27.0%	-39.6%	-9.1%
DMEPOS	-38.6%	-16.5%	-14.5%
Medicine	-57.1%	-44.9%	-33.2%
Pathology/Laboratory	-71.8%	-76.1%	-42.9%
Surgery	-42.9%	-41.7%	-26.1%
Anesthesia	-36.4%	-48.9%	-30.1%
All	-28.4%	-20.4%	-5.2%

Some of the variability between the changes in the volume of services in the nine service categories and the total reimbursements for each of the categories was due to the change in the average payment per service code. From 2013 to 2018 the average amount paid per service code increased 57.6 percent for physical medicine, 39.4 percent for E&M, 35.9 percent for DMEPOS, 28.5 percent for medicine services, and 2.1 percent for surgery, while average payments per code decreased 15.3 percent for pathology and laboratory services, 17.2 percent for radiology, and 19.6 percent for anesthesia**.** The biggest decline was in the special service category, where average payments fell 35.6 percent over the 6-year period**,** primarily due to lower report costs which reflect the RBRVS schedule's elimination of separate fees for consultation services and associated reports



The sharp increase in average payments for physical medicine services reflects the revised payment methodology used under the RBRVS fee schedule. The old fee schedule allowed reimbursement for up to four physical medicine services rendered by the same provider on the same day, but payments for these services were cascaded, with the highest valued service reimbursed at 100 percent of the scheduled amount and additional services reimbursed at 75 percent for the second service, 50 percent for the third service, and 25 percent of their scheduled amounts. In contrast, under the RBRVS schedule, only the practice expense portion of a physical medicine service is reduced under the multiple procedure rule, which resulted in higher average payments per service in this category.

The increase in average payments for E&M codes reflects the change in the mix of services within this category after the DWC followed Medicare's lead and discontinued the use of consultation codes in 2014 and instructed providers to bill referral services using appropriate level new patient or established patient (follow-up) visit codes, both of which accounted for an increasing share of the E&M codes in 2014 -- immediately after the consultation codes were discontinued. The 2014 OMFS also followed Medicare's lead by discontinuing payments for prolonged service codes, which plummeted from 10.4 percent of the E&M codes in 2013 to just 1.9 percent of the codes in 2014. Medicare changed its rules again in 2017 to allow separate payment for prolonged service codes without face-to-face contact, so in March 2017 the DWC adopted that change, as well as a redefinition of the description associated with one of the prolonged service codes that extended the length of service covered by that code from each 15 minutes to the first hour. In the wake of these changes, the prolonged services' share of the E&M services immediately doubled from 1.3 percent in 2016 to 2.6 percent in 2017, then continued to climb in 2018, rising to 3.1 percent. Once again, these shifts in the distribution of the E&M service subcategories led to a change in the mix of payments, as reimbursements for prolonged services more than doubled from 1.4 percent of the E&M payments in 2016 to 3.0 percent in 2017, and 3.5 percent in 2018.

To provide a more detailed look at how the utilization and reimbursement of workers' compensation medical services have changed from 2013 to 2018, the Institute has published a Research Update report, "**Trends in the Utilization and Reimbursement of California Workers' Compensation Professional Medical Services, 2013-2018"** that includes exhibits and analyses for the individual service categories. The report is available to CWCI members and subscribers under the Research tab at www.cwci.org, and is available for purchase by the public at www.cwci.org/store.html.

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