



Research Update

Trends in the Utilization and Reimbursement of California Workers' Compensation Professional Medical Services, 2013-2018

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Executive Summary

One of the key provisions in SB 863, the California workers' compensation reform bill signed into law by Gov. Brown in September 2012, was the replacement of the Official Medical Fee Schedule (OMFS) governing payments for physician and non-physician professional services. The legislation directed the Administrative Director of the Division of Workers' Compensation (DWC) to adopt a new fee schedule based on Medicare's Resource-Based Relative Value Scale (RBRVS). Although the DWC could adopt conversion and geographic factors affecting physician payments that differ from those used by Medicare, the legislation stipulated that the estimated aggregate fees could not exceed 120 percent of the estimated aggregate fees payable by Medicare for the same class of services. Once adopted, conversion to the new RBRVS-based fee schedule was mandated to take place over a four-year transition period.

This study analyzes the changes in payments and service mix since implementation of the RBRVS-based fee schedule by comparing provider payment data from 2013, the final year under the old fee schedule, to data for calendar years 2014 through 2017 – the four-year transition period to the new fee schedule, and 2018, the first year after the RBRVS schedule took full effect. Among the key findings:

- The top two fee schedule categories, Evaluation and Management (E&M), and Physical Medicine (including physical therapy, occupational therapy, chiropractic manipulation and acupuncture), accounted for 68.3 percent of all professional services in 2018.
- Between 2013 and 2018 payments for E&M increased from 23.5 percent to 32.2 percent of all OMFS reimbursements and payments for Physical Medicine services increased from 15.5 percent to 25.4 percent.
- The number of claims receiving medical services in the study population decreased by 5.2 percent over the six-year study period, however, the decline in the volume of physician services far exceeded the decline in claim volume, with reductions in paid service codes ranging from 17.2 percent for Physical Medicine to 71.8 percent for Pathology and Laboratory services.

- Total payments increased by 30.6 percent for Physical Medicine services and 9.3 percent for E&M services between 2013 and 2018 while total payments for all other categories decreased, ranging from a 16.5 percent drop in aggregate payments for Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS) to a 76.1 percent drop in the total paid for Pathology and Laboratory services.
- The average amount paid per service code increased for E&M (39.4 percent), Physical Medicine (57.6 percent), Surgery (2.1 percent), Medicine Section services (28.5 percent), and DMEPOS (35.9 percent). Average payments for Radiology, Anesthesia, Special Services, and Pathology and Laboratory decreased during the study period.

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 DWC adopted major changes to the schedule in 1995, including replacement of the 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, as well as new California workers' compensation codes and modifiers. The fee schedule changes adopted in 1999 remained in place until 2004.

In 2003, the California Legislature passed Senate Bill 228 (SB 228), which mandated that the DWC Administrative Director adopt new Medicare-based fee schedules for medical services excluding physician services. SB 228 resulted in the adoption of six new Medicare-based fee schedules, which became effective January 1, 2004:

- the Pathology and Clinical Laboratory Fee Schedule;
- the DMEPOS Fee Schedule;
- the Inpatient Hospital Fee Schedule;
- the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule;
- Ambulance Fee Schedule; and
- a new Medi-Cal-based Pharmaceuticals and Pharmacy Services Fee Schedule.

In addition to these Medicare-based fee schedules, SB 228 called for the effective physician fee schedule to remain in place, with five percent rate reductions, pending adoption of a new physician fee schedule or revision of the existing fee schedule by the Administrative Director. In

2008 and 2010, The Lewin Group, under contract with the DWC, produced two reports^{1,2} that evaluated the impact of adopting the Medicare Physician Fee Schedule as a basis for payment of services rendered by workers' compensation physicians (including 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).

In 2012 the California Legislature passed SB 863, which amended Labor Code section 5307.1 and directed the Administrative Director to adopt an official medical fee schedule based on Medicare's Resource-Based Relative Value Scale (RBRVS)³ for physician services and non-physician practitioner services. The RBRVS system calculates payment for services based on the resources needed to provide the services. There are three components of the resource costs: physician work, practice expense, and professional liability insurance. In addition to the relative value units for each of the resource costs, the payment formula also includes a geographic adjustment factor and a conversion factor to translate the combined units into dollar values.

The DWC contracted with RAND Corporation, RAND Center for Health and Safety in the Workplace to provide consultation and technical assistance on the implementation of the RBRVS-based system. RAND submitted a report⁴ detailing policy issues, options, and potential impacts of implementing an RBRVS-based system and related payment rules.

In order to maintain budget neutrality, SB 863 required that the transition to the RBRVS fee schedule take place over four years, beginning in January 2014. The four-year transition strategy involved annual adjustments to the conversion factors assigned to defined fee schedule sections (Surgery, Radiology, Anesthesia, and All Other) ending with a single conversion factor used for all services except anesthesia in March 2017. The annual updates to the fee schedule mandated by SB 863 must include changes in procedure codes⁵ and relative weights, in addition to the adjustment factors.

Geographic adjustments included in Medicare's RBRVS payment calculations are based on the ZIP code of the physician's practice location and are defined in its Geographic Practice Cost

¹ The Lewin Group. *Adopting 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).

² The Lewin Group. *Adopting the RBRVS Methodology to the California Workers' Compensation Physician Fee Schedule: Supplemental Report Prepared for California Division of Workers' Compensation*. March 3, 2010.

³ Medicare developed its RBRVS system in 1992 as a method to pay for services based on the resource costs need to provide the services. Those resource costs are defined by three components: physician work, practice expense and professional liability insurance.

⁴ Wynn, B. O., Hangsheng, L., Mulcahy, A., Okeke, E. N., Lyer, N., and Painter, S. RAND Corporation. *Implementing a Resource-Based Relative Value Scale Fee Schedule for Physician Services, An Assessment of Policy Options for the California Workers' Compensation Program*. June 2013 (rev. July 2013).

⁵ Medicare's Physician Fee Schedule is updated annually with new, deleted and revised American Medical Association Current Procedural Terminology (CPT) codes, as well as with changes to Healthcare Common Procedure Coding System (HCPCS) Level II codes used to bill Medicare and Medi-Cal.

Indices (GPCIs), but under the OMFS regulations adopted by the DWC in 2014, the geographic adjustments used in the California workers' compensation payment calculations were based on a single Average Statewide Geographic Adjustment Factor.⁶

Transition to the RBRVS schedule also necessitated changes to rules that govern how payments are calculated when multiple services are provided to an injured worker on the same date by the same service practitioner.

The OMFS (CCR §9789.12.1(c)) clarifies that “physicians and non-physician practitioners shall utilize other applicable parts of the OMFS” to determine payments for pharmaceuticals, pathology and clinical laboratory services, and durable medical equipment, orthotics, prosthetics and supplies.

Objective

This study measures changes in the number of claims that involved medical services in six major categories covered in the Physician and Non-Physician Practitioner Service sections of the OMFS, as well as DMEPOS and clinical lab services which are reimbursed based on the Medicare DMEPOS and Clinical Laboratory Fee Schedules, from 2013 (the final year under the old fee schedule) through the four-year transition period mandated by SB 863 (2014 through 2017), and ending with 2018, the first year that the RBRVS fee schedule was in full effect. The analysis also measures the percentage change in the total and average amounts paid per date of service for medical procedures and services covered in each of those sections during the same 6-year period.

Data and Methods

The data for this study was extracted from CWCI's Industry Research Information System (IRIS)⁷ database and encompasses services provided to California injured workers during the first 10 months of calendar years 2013 through 2018.⁸ The analysis utilizes data from the first 10 months of each year in order to account for the lag times between the service dates, the billing dates and the payment dates for those services. The data set includes medical service and payment details for 962,147 claims, 35.9 million medical services associated with those claims, and a total of \$2.7 billion in medical payments.

The author's core analysis is at the service year level and does not address medical utilization at specific claim development periods. An accident year analysis is not practical due to the four-year phase-in period for the RBRVS fee schedule. Furthermore, there are other factors that would adversely influence accident year-based outcomes, including Medicare rules that may be

⁶ Effective for services rendered on or after January 1, 2019, California Physician and Non-Physician Practitioner Fee Schedule regulations adopted Medicare's GPCIs in place of the Average Statewide Geographic Adjustment Factor.

⁷ IRIS is CWCI's proprietary database of California workers' compensation claims compiled from insurers representing approximately 60 percent of the insured market as well as self-insured employers.

⁸ Services paid as of 12/31/2018.

adopted for inclusion in the OMFS at different points in time, changes in standardized medical codes, medical dispute resolution, and increases in MPN utilization.

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 section of the fee schedule, these services were also separated out for analysis.

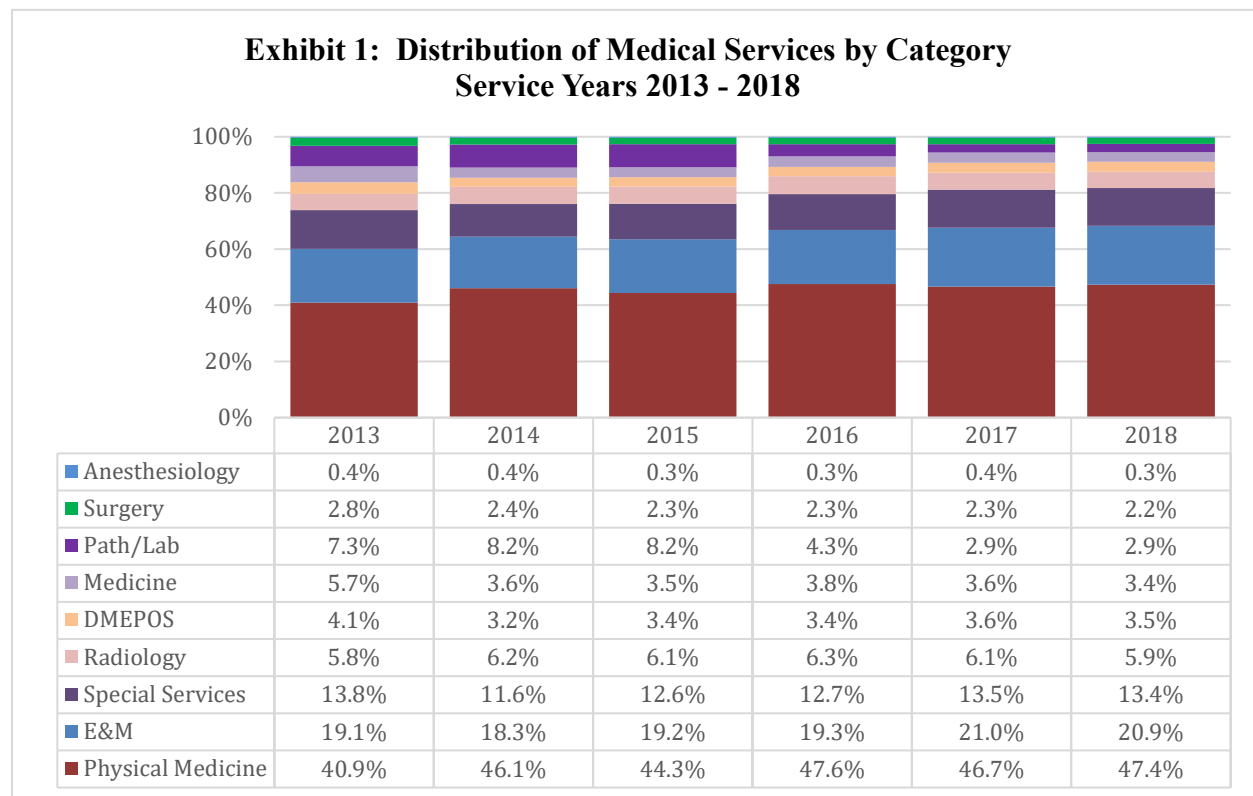
DMEPOS services were categorized based on the Center for Medicare and Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS) Level II categorizations.

The nine medical service categories defined for the comparative analysis are:

- Evaluation and Management (E&M)
- Radiology
- Surgery
- Medicine (including cardiovascular, nerve and muscle testing, psychiatric testing and psychotherapy)
- Physical Medicine (including physical therapy, chiropractic, and acupuncture services)
- Special Services
- Anesthesiology
- Pathology and Laboratory
- DMEPOS

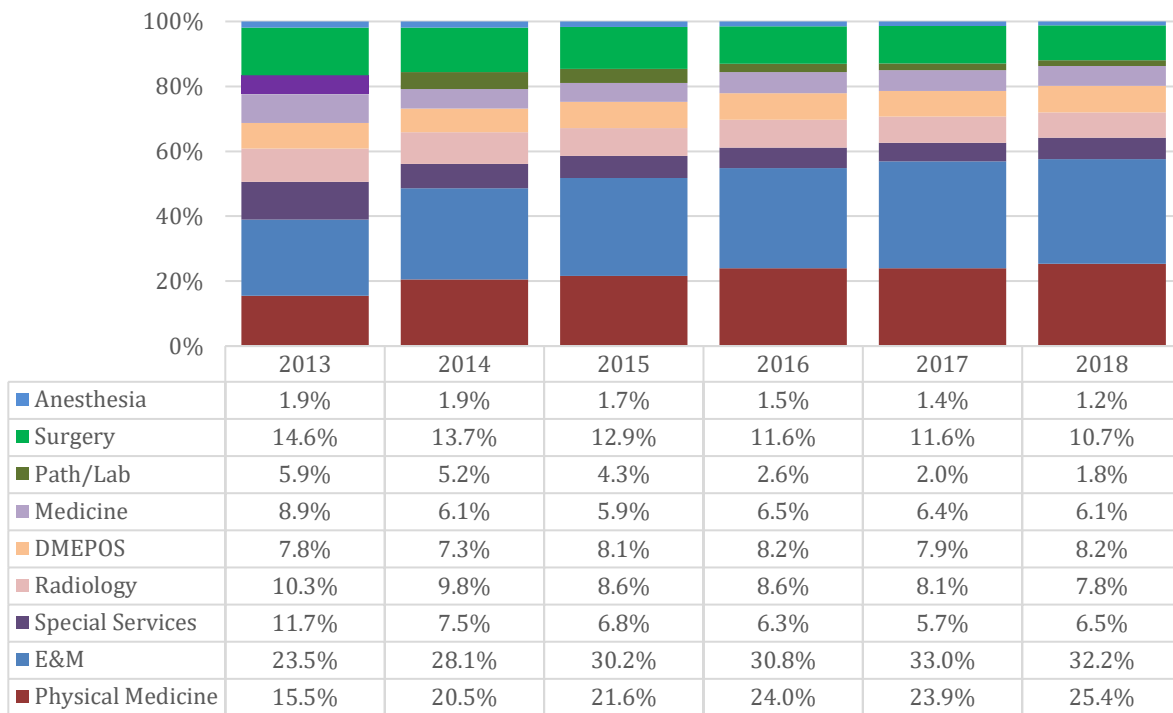
Results

The distribution of total medical services across the nine categories of services provided by physicians and non-physician practitioners shows relative consistency over the six-year study period. The greatest fluctuation, as shown in Exhibit 1, was in Physical Medicine services which increased by 6.5 percentage points from 40.9 percent of the services in 2013, the last year before the transition to the RBRVS fee schedule, to 47.4 percent of the services in 2018, the first year that the new fee schedule took full effect. At the same time, Pathology/Laboratory services' share of the medical services showed the sharpest decline after the RBRVS schedule took effect, decreasing from 7.3 percent of the services in 2013 to 2.9 percent in 2018.



As shown in Exhibit 2, from 2013 to 2018, the shifts in the distribution of the total payments among the nine service categories were far greater than the shifts in the distribution of services. The most significant increases were in Physical Medicine, which increased from 15.5 percent of the medical payments under the old schedule to 25.4 percent of the payments after the transition to the RBRVS schedule was completed, and in E&M services, which jumped from 23.5 percent to 32.2 percent of the medical payments. On the flip side, the most notable declines were in Special Services, which fell from 11.7 percent to 6.5 percent of the total medical payments over the 6-year span; Surgery, which fell from 14.6 percent to 10.7 percent; and Pathology/Laboratory services, which declined from 5.9 percent to 1.8 percent.

**Exhibit 2: Distribution of Total Payments by Service Category
Service Years 2013 - 2018**



Over the six-year span of the study, the volume of services (as measured by the count of service codes), and the number of unique claims receiving any service within the category, declined across all nine service categories (Exhibit 3). The total volume of services overall decreased by 28.4 percent from 2013 through 2018, though results varied significantly among the nine service categories, ranging from a 17.2 percent decline in Physical Medicine services to a 71.8 percent decline for Pathology/Laboratory services. The reductions in the volume of services exceeded the reductions in the number of claims, suggesting lower service utilization, an increase in bundled payments, or a combination of these two factors. This drop-off in the volume of services also coincided with the adoption of multiple procedure rules and National Correct Coding Initiative (NCCI) edits⁹ that placed new limits on the payment of multiple services within a category or subcategory rendered on the same date by the same provider, which were adopted along with the implementation of the RBRVS fee schedule.

⁹ 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.

**Exhibit 3: Percent Change in Service Counts & Claims w Service
2013 - 2018**

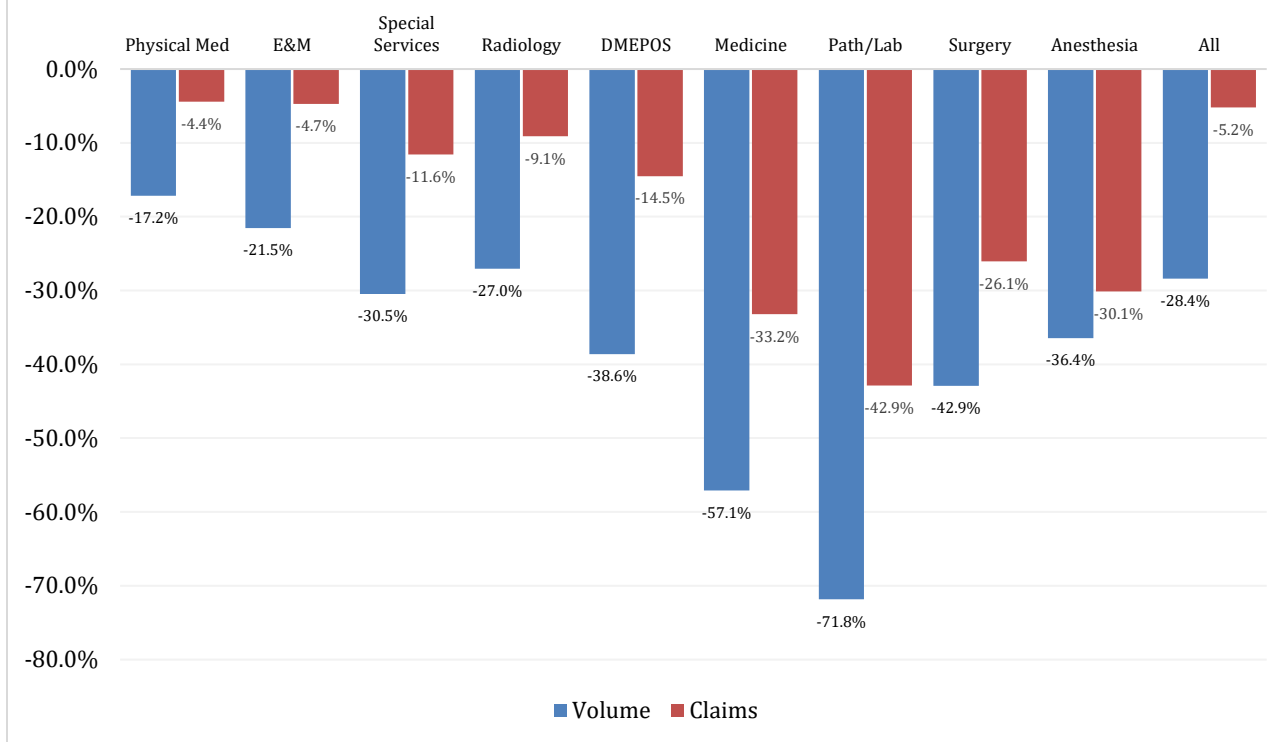


Exhibit 4 shows the change in total payments relative to the change in service code volume. The increases in total payments for primary care (E&M and Physical Medicine) over the six-year study period reflect the greater emphasis placed on these services by CMS and DWC. Although the volume of services decreased for all services during this period, total payments rose for both E&M (+ 9.3 percent) and Physical Medicine (+ 30.6 percent).

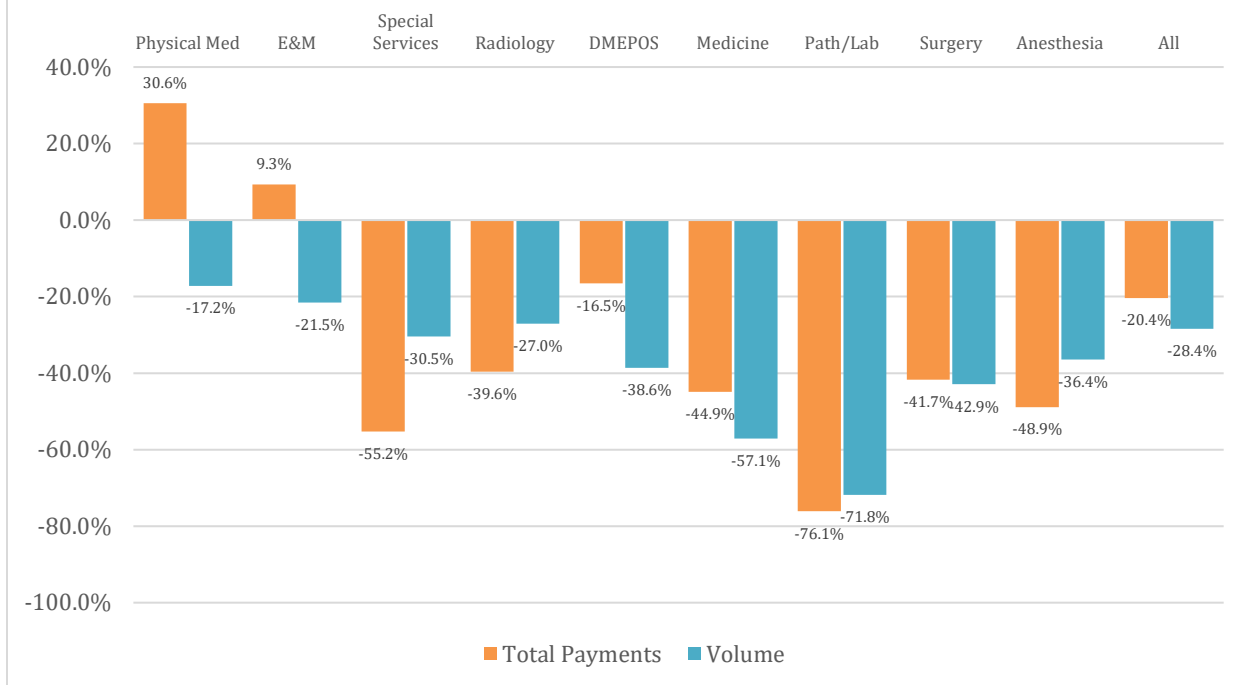
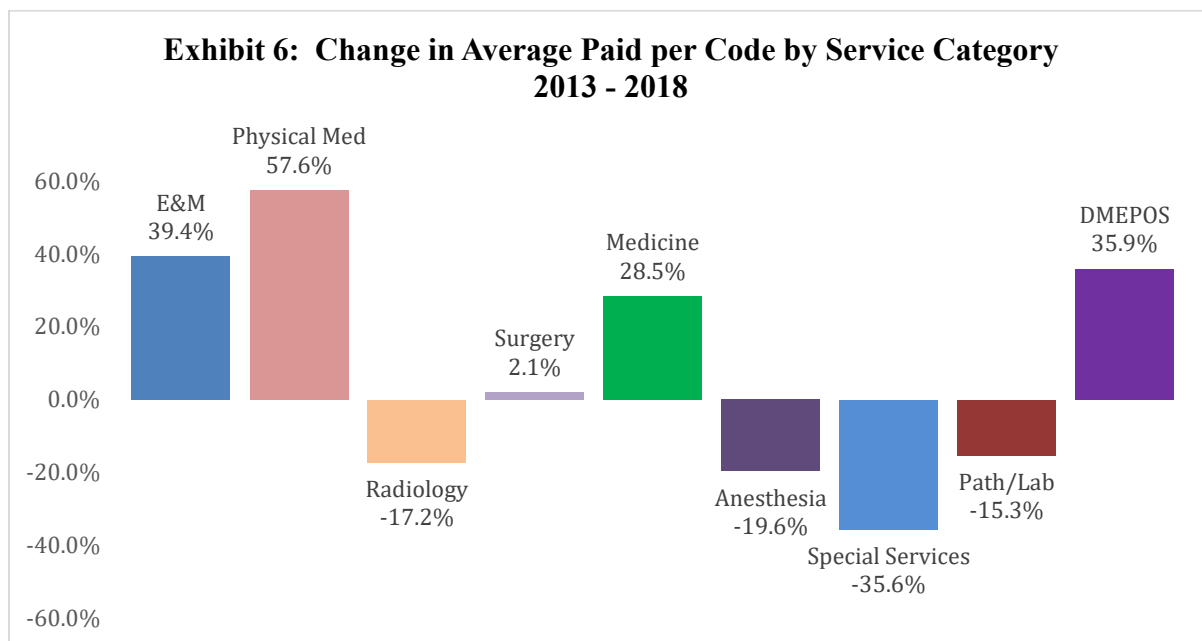
**Exhibit 4: Percent Change in Total Payments & Service Counts
2013 to 2018**

Exhibit 5 summarizes the relative changes in service code volume, total payments and unique claims associated with each service category. Except for E&M and Physical Medicine, total payments for all other service categories fell as the volume of services declined, with the percentage decreases in the volume and aggregate payments for Surgery services being very close (-42.9 percent and -41.7 percent respectively). Special Services experienced a greater divergence between the decline in volume and the decline in total payments, primarily due to the removal of reports associated with consultation services and the predominance of lower level progress reports (PR-2).

**Exhibit 5: Percent Change in Total Volume, Payments and Unique Claims
Service Years 2013 – 2018**

	Code Volume	Total Paid	Unique Claims
Physical Medicine	-17.2%	30.6%	-4.4%
E&M	-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%
Path/Lab	-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 code volume, the total paid, and the number of unique claims for each service category reflects the change in the average amount paid per code for each of the categories. As noted in Exhibit 6, the average amount paid per service code increased for E&M, Physical Medicine, Surgery, Medicine Section Services, and DMEPOS. The most significant change in the average amount paid per code was in Physical Medicine, as the payment methodology used under the RBRVS-based fee schedule when multiple Physical Medicine services are performed on the same day differs significantly from the payment cascade methodology¹⁰ that was used under the pre-2014 fee schedule.



SERVICE CATEGORY ANALYSES

The following sections provide detailed data on the changes in the average amounts paid and the distribution of payments and services within each of the 9 medical service categories for the final year under the old fee schedule, the four RBRVS fee schedule transition years, and the first full year of the new fee schedule.

¹⁰ Pre-2014, multiple physical medicine services rendered by the same practitioner on the same day were cascaded, with the highest valued service paid at 100% of its value, reducing additional services to 75%, 50% and 25% of their values. Under RBRVS only the practice expense portion of a service is reduced under the multiple procedure rule, resulting in higher per service payments.

Evaluation and Management

The E&M service category is dominated by codes associated with office visits, and as noted in Exhibit 7, between 2013 and 2018 the increases in the average amounts paid for these services ranged between 35.3 percent for Code 99212 and 66.1 percent for Code 99213.

Exhibit 7: Average Paid Amounts for Office Visit Codes (2013 – 2018)								
E&M Category	Code	2013	2014	2015	2016	2017	2018	Pct Change
Office/Outpatient Visit New Patient/Injury	99202	\$67.21	\$77.27	\$81.94	\$87.87	\$90.10	\$92.96	38.3%
	99203	\$97.90	\$112.81	\$118.54	\$126.08	\$130.68	\$134.01	36.9%
	99204	\$136.40	\$170.24	\$179.04	\$188.79	\$196.23	\$201.39	47.6%
	99205	\$170.85	\$210.69	\$220.57	\$228.94	\$240.35	\$241.41	41.3%
Office/Outpatient Visit Established Patient	99212	\$40.95	\$47.71	\$49.76	\$52.48	\$54.24	\$55.42	35.3%
	99213	\$54.57	\$77.16	\$80.53	\$85.25	\$88.55	\$90.64	66.1%
	99214	\$85.11	\$112.40	\$117.54	\$122.91	\$127.49	\$130.69	53.6%
	99215	\$120.83	\$145.93	\$151.99	\$155.46	\$166.84	\$168.49	39.4%
Office Consultation	99242	\$92.97					\$92.96*	0.0%
	99243	\$120.24					\$124.01*	11.5%
	99244	\$168.58					\$201.39*	19.5%
	99245	\$210.95					\$241.41*	14.4%

* Values for Initial Visit codes corresponding with level of service for discontinued Office Consultations.

Medicare ceased recognizing outpatient (99241 – 99245) and inpatient (99251 – 99255) consultation codes effective January 1, 2010, and increased the Relative Value Units (RVUs) for initial and established patient visit codes.¹¹ Stating that retention of consultation codes for workers' compensation would complicate timely fee schedule updates as visit codes would have to be adjusted to account for Medicare's increased RVUs, the DWC excluded these codes from the OMFS beginning in 2014.¹² After the consultation codes were discontinued, physicians were instructed to bill referral services using the appropriate level new patient or established patient visit codes.

The mix of E&M services changed as a direct result of the discontinuance of the consultation codes, with new patient referral services billed under initial office visit codes. The results of this change are evidenced in Exhibit 8, which compares the distribution of outpatient office visit subcategories based on their share of total E&M services.¹³ New patient office visit codes as a

¹¹ Centers for Medicare and Medicaid Services. *Revisions to Consultation Services Payment Policy*. MLN Matters Number: MM6740 Rev. <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6740.pdf>

¹² 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. § 9789.12.12. June 2013. https://www.dir.ca.gov/dwc/DWCPPropRegs/OMFS_PhysicianFeeSchedule/OMFSPhysicianFeeSchedule.htm

¹³ A detailed distribution of contributory codes is provided in Appendix 2a.

percent of E&M services increased by 5.6 percentage points in 2014, the first year following the discontinuance of the office consultation codes. Follow-up office visits for established patients represented the majority of the E&M services for each of the service years, but their share of the E&M services also jumped after the office consultation codes were discontinued, increasing nine percentage points to 77.2 percent of these services in 2014.

Exhibit 8: Service Subcategory as Percent of Total E&M by Count

	2013	2014	2015	2016	2017	2018
Office/Outpatient Visit New Patient/Injury	10.3%	15.9%	16.3%	16.7%	16.4%	16.6%
Office/Outpatient Visit Established Patient	68.2%	77.2%	76.8%	76.7%	75.2%	75.0%
Office Consultation	4.8%	0.0%	0.0%	0.0%	0.0%	0.0%
Prolonged Service	10.6%	1.9%	1.5%	1.3%	2.6%	3.1%
Total	93.9%	95.0%	94.6%	94.7%	94.2%	94.7%

In addition to Medicare rules impacting consultation services, the 2014 OMFS also followed Medicare payment rules¹⁴ by discontinuing payment for prolonged service codes. Beginning in 2017 Medicare rules changed, allowing separate payment for prolonged service codes without face-to-face contact. This change was included in the March 2017 updates to the California OMFS. Additionally, the prolonged service code 99358, effective March 2017, carried the description for the “first hour” of service instead of the “each 15 minutes” description in force in 2013.¹⁵ The elimination of the prolonged service code payments had an immediate impact on the mix of E&M services, as prolonged services’ share fell from 10.6 percent in 2013 to 1.9 percent in 2014, while office visits for established patients increased from 68.2 percent to 77.2 percent. A similar effect is reflected in the E&M payment distribution shown in Exhibit 9, as prolonged services declined from 10.3 percent of the E&M service reimbursements in 2013 to 1.9 percent in 2014. Following the reinstatement of prolonged service payments in 2017, 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. Similarly, prolonged service payments climbed from 1.4 percent of the E&M reimbursements in 2016 to 3.0 percent in 2017 and 3.5 percent in 2018.

Exhibit 9 provides the distribution of office visit subcategories based on their proportion of total E&M payments.¹⁶ Follow-up office visits accounted for the majority of payments in each study

¹⁴ Prior to CY 2017, prolonged services without face-to-face contact (99358 and 99359) were not separately payable and were included in the payment for the face-to-face evaluation and management service.

¹⁵ American Medical Association. *Current Procedural Terminology 2014*.

¹⁶ A detailed distribution of contributory codes is provided in Appendix 2b.

year, with a sharp increase (from 57.3 percent to 69.4 percent of the E&M payments) noted immediately after the OMFS changes in 2014, followed by a 5-year period of relative stability in which payments for follow-up visits ranged between 67.3 percent and 69.4 percent of E&M reimbursements.

Exhibit 9: Service Subcategory as Percent of Total E&M by Total Paid						
	2013	2014	2015	2016	2017	2018
Office/Outpatient Visit New Patient/Injury	13.6%	21.4%	21.6%	22.2%	21.5%	21.4%
Office/Outpatient Visit Established Patient	57.3%	69.4%	69.1%	69.1%	67.6%	67.3%
Office Consultation	9.1%	0.0%	0.0%	0.0%	0.0%	0.0%
Prolonged Service	10.3%	1.9%	1.6%	1.4%	3.0%	3.5%
Total	90.3%	92.8%	92.3%	92.7%	92.1%	92.2%

Physical Medicine

Service codes used for billing and payment of Physical Medicine services underwent several changes during the six-year study period, making a direct comparison at the code level more difficult. The billing codes included in the OMFS that was in effect during 2013 were from 1993, and many were obsolete and not directly comparable to the 2014 AMA CPT codes adopted under the new RBRVS-based fee schedule.

The Physical Medicine section encompasses physical and occupational therapy, chiropractic manipulation, and acupuncture. Physical therapy services fall into three basic categories: therapeutic procedures,¹⁷ modalities,¹⁸ and evaluations. One of the goals of the new fee schedule in 2014 was to encourage practitioners to provide more direct hands-on care (therapeutic procedures).

Exhibit 10, which compares the top 10 types of Physical Medicine treatment based on code volume for 2013 and 2018, shows a positive shift in that direction. As noted in the table, in 2013 the four most heavily used therapeutic procedures accounted for 44.5 percent of all Physical Medicine services, but by 2018, four of the top five codes were for therapeutic procedures and they accounted for 65.5 percent of all Physical Medicine services. The proportion of payments

¹⁷ Therapeutic procedures are defined by the AMA as “A manner of effecting change through the application of clinical skills and/or services that attempt to improve function.” *Current Procedural Terminology 2018*.

¹⁸ Modalities are defined by the AMA as “Any physical agent applied to produce therapeutic changes to biologic tissue; includes but not limited to thermal, acoustic, light, mechanical, or electric energy.” *Current Procedural Terminology 2018*.

associated with the top 10 most frequently billed codes shifted considerably as a result of various factors:

- lower valued modalities occurred less frequently;
- changes to code descriptions (30-minute codes revised to 15-minute codes);
- the multiple procedure cascade rule was discontinued and replaced with the Medicare multiple procedures rule; and
- the highest valued 2013 code (97250) was discontinued as a result of its obsolescence in CPT (deleted by AMA in 1999).

Exhibit 10: Top 10 Physical Medicine Codes (By Volume), 2013 vs. 2018

Top 10 by Volume - 2013				Top 10 by Volume - 2018			
Code	Treatment Type	% of PM Svcs	% of PM Payments	Code	Treatment Type	% of PM Svcs	% of PM Payments
97110	Therapeutic Procedure	20.3%	19.0%	97110	Therapeutic Procedure	31.2%	30.9%
97014	Modality	19.2%	5.9%	97140	Therapeutic Procedure	18.9%	13.4%
97250	Therapeutic Procedure	19.2%	26.3%	97530	Therapeutic Procedure	9.2%	11.5%
97026	Modality	6.3%	1.7%	G0283	Modality	8.1%	2.5%
97530	Therapeutic Procedure	2.5%	2.3%	97112	Therapeutic Procedure	6.2%	5.7%
97801	Acupuncture w/ Electric Stimulation	2.5%	5.6%	97814	Acupuncture w/ Electric Stimulation	2.3%	2.1%
97145	Therapeutic Procedure	2.5%	1.3%	97813	Acupuncture w/Electric Stimulation	2.1%	2.3%
97016	Modality	2.2%	0.5%	97035	Modality	2.1%	0.7%
98940	Chiropractic Manipulation	2.1%	2.1%	97026	Modality	2.0%	0.3%
97018	Modality	2.1%	0.6%	98940	Chiropractic Manipulation	1.6%	1.1%
Total		78.8%	65.3%			83.7%	70.5%

In addition to introducing newer codes in 2014, the AMA revised codes and service descriptions for initial evaluations and re-evaluations for physical therapy, occupational therapy and athletic training, effective 2017. This means that three different code sets, with inconsistent service descriptions, were used between 2013 and 2018 for evaluation services. Therefore, the author included all evaluations and re-evaluations in the evaluation services category for comparative purposes, rather than comparing costs and frequency at the code level.

As shown in Exhibit 11, average amounts paid for both initial and re-evaluation services increased during the six-year study period, while their share of total Physical Medicine payments

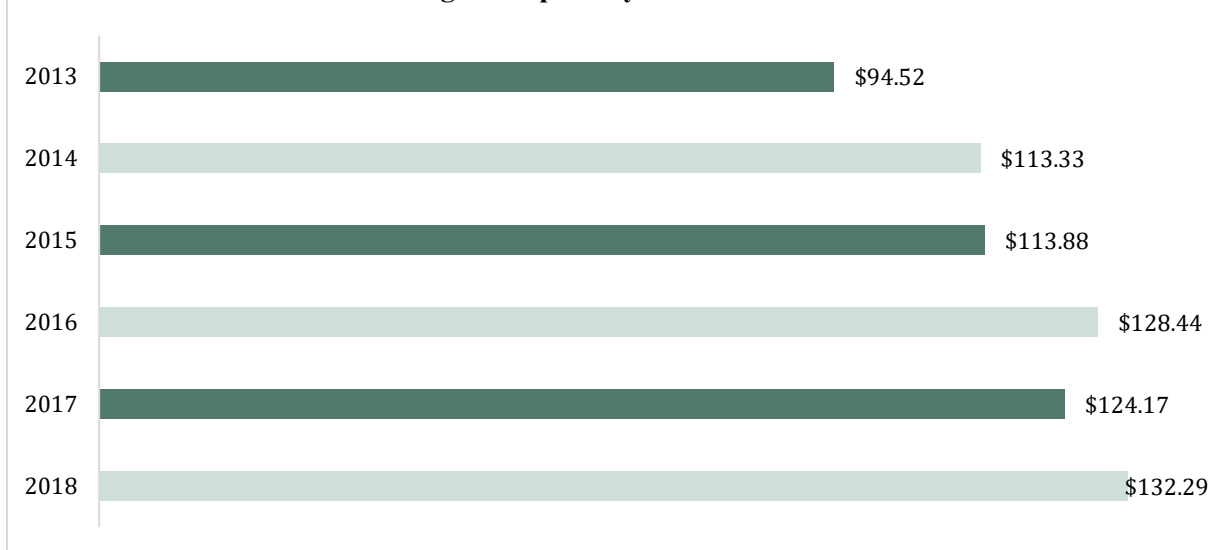
showed much smaller changes. Average payments for initial evaluations increased 48.0 percent from 2013 to 2018, while average payments for re-evaluations increased 62.1 percent. Physical therapy and occupational therapy evaluations' share of the Physical Medicine services dipped in 2017, then increased again in 2018, which may be related to the introduction of the revised CPT codes in 2017, which described different levels of service and provided a structure similar to the one used for evaluation codes in the E&M section. However, Medicare valued the different level services the same for reimbursement purposes.

Exhibit 11: Average Paid for Physical Therapy and Occupational Therapy Evaluations 2013 -2018

	Initial Evaluations		Re-evaluations	
Service Year	Average Paid	% of PM Payments	Average Paid	% of PM Payments
2013	\$74.93	4.8%	\$43.78	1.4%
2014	\$66.71	5.6%	\$40.32	1.4%
2015	\$66.24	5.6%	\$50.45	1.4%
2016	\$79.82	5.6%	\$48.95	1.4%
2017	\$99.65	3.1%	\$60.63	0.8%
2018	\$110.87	6.4%	\$70.98	1.6%
Pct Change	48.0%		62.1%	

OMFS rules for both pre-2014 and post-2014 Physical Medicine payments limit the number of payable services during a treatment session to one hour or four service codes, without pre-authorization for services exceeding these presumed reasonable limits.¹⁹ Billing for a Physical Medicine service session may consist of a single code or multiple codes. In order to compare service costs, the author combined all Physical Medicine codes for a single claim, rendered by the same provider on the same date of service. As shown in Exhibit 12, the total per session payment increased 40 percent from \$94.52 in 2013 to \$113.33 in 2014.

¹⁹ Title 8, California Code of Regulations. § 9789.15.4(b)(1)-(3). <https://www.dir.ca.gov/dwc/OMFS9904.htm#7>

Exhibit 12: Average Paid per Physical Medicine Service Session

An overview of the shifts in the distribution of Physical Medicine payments among the service subcategories between 2013 and 2018 is shown in Exhibit 13. The most notable shifts were the increased percentage of Physical Medicine dollars paying for physical therapy procedure codes, and the decreased share paying for physical therapy modalities.

Exhibit 13: Percentage Paid for Service Subcategories by Service Year

	Acupuncture	Chiropractic	PT Modality	PT Procedure	Evaluations	97799 *	Other
2013	6.7%	3.8%	9.7%	62.2%	6.2%	7.5%	3.9%
2014	6.2%	3.1%	7.9%	67.4%	7.0%	6.8%	1.7%
2015	6.5%	2.9%	6.2%	67.7%	7.0%	7.7%	2.0%
2016	7.1%	3.0%	5.6%	69.1%	7.0%	7.0%	1.2%
2017	7.3%	2.9%	5.4%	70.7%	3.9%	9.1%	0.6%
2018	6.9%	2.6%	4.7%	66.8%	8.0%	10.4%	0.6%

*97799 - Unlisted physical medicine/rehabilitation service or procedure

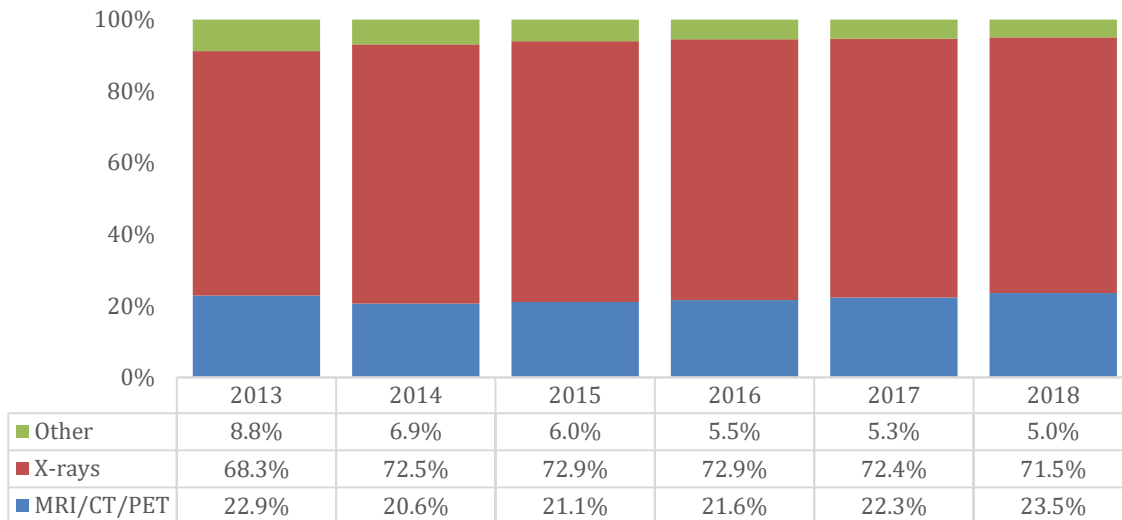
Diagnostic Imaging

To measure changes in the mix of Diagnostic Imaging (radiology) services over the six-year study period, as well as shifts in the payment distribution for those services, the author grouped these services into three subcategories (MRI/CT/PET, X-ray and Other²⁰). Though there was some fluctuation in the distribution of imaging services among these three subcategories, the overall distribution based on volume changed little over the six-year study period (Exhibit 14). X-rays consistently accounted for the majority of the diagnostic imaging services (ranging

²⁰ "Other" includes services such as bone scans, ultrasounds, imaging guidance for procedures, and radiation treatment.

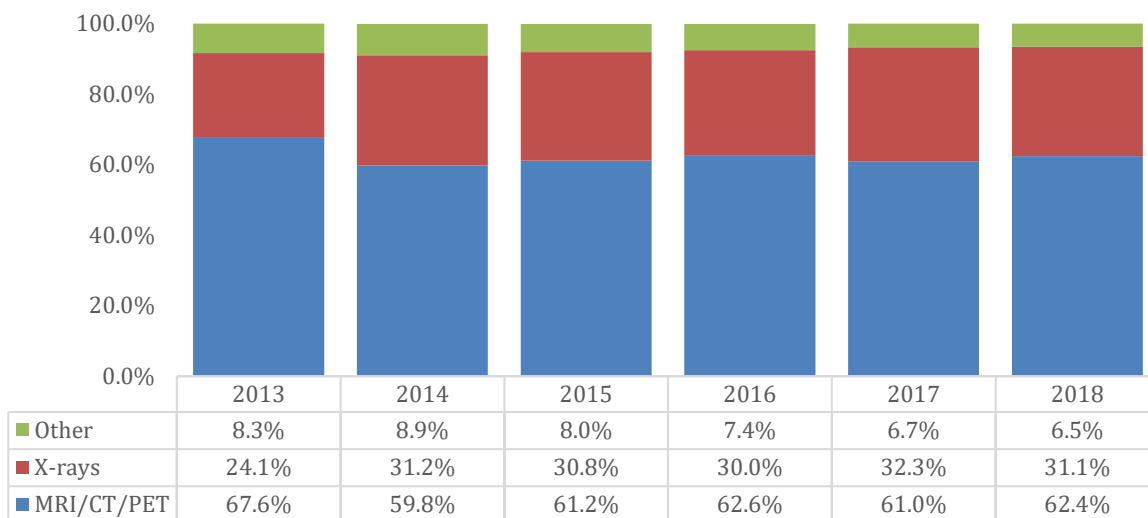
between 68.3 percent to 72.9 percent of all radiology services) while more advanced imaging services (MRI/CT/PET) ranged between 20.6 percent and most recently, 23.5 percent.

**Exhibit 14: Distribution of Diagnostic Imaging Subcategories
Based on Volume (2013 - 2018)**



Although X-rays accounted for more than two-thirds of all diagnostic imaging services throughout the study period, they accounted for less than one-third of total payments (Exhibit 15), as the average cost of an X-ray is considerably less than the average cost of a more advanced imaging service such as an MRI or CT scan.

**Exhibit 15: Distribution of Diagnostic Imaging Subcategories
Based on Total Payments (2013 - 2018)**



Surgery

The Surgery section encompasses an extremely broad range of services, including minor procedures such as the application of casts and straps, and simple wound repair, and major procedures such as cardiovascular surgery and joint replacements. Service code payments reflect not only the intensity of the service rendered, but also whether multiple services were performed during the same treatment session, and whether assistants were involved during a surgical event, both of which result in reduced payments.

Exhibit 16 compares the average amount paid for Surgery services at the service code level, as well as at the service event level across the 6-year span of the study. The service event data includes payments for all professional surgery services on the same date for the same injured worker (e.g., primary surgeon and assistant-at-surgery, bilateral and multiple procedures), but excludes related fees (e.g., facility fees, anesthesiology fees, and imaging fees).

Exhibit 16: Average Paid Amount for Surgery Service Codes by Service Year		
	Service Code	Service Event
2013	\$379.55	\$752.38
2014	\$403.78	\$708.77
2015	\$399.80	\$656.78
2016	\$378.26	\$611.61
2017	\$384.56	\$623.49
2018	\$387.64	\$619.92
Change 2013 - 2018	2.1%	-17.6%

The overall average paid per procedure remained relatively flat over the study period, with average Surgery services at the service code level increasing 2.1 percent from \$379.55 in 2013 to \$387.64 in 2018. In contrast, over this same period the average amount paid for professional services at the service event level decreased 17.6 percent, falling from \$752.38 in 2013 to \$619.92 in 2018.

To gain a better understanding of the mix of surgical services and the variation in payment amounts, the author grouped the surgical procedures into three categories (minor, major and other) using the global surgical package²¹ designations developed by CMS and included in the Medicare Physician Fee Schedule Relative Value tables. Service codes categorized as “other” include add-on codes which are billed in addition to a primary procedure, or “unlisted” codes which have not been assigned global service days in the Medicare table. Surgical events may involve multiple procedures within a defined category or across categories.

²¹ The global surgical package (aka global surgery), includes all necessary services normally provided by a surgeon, or a member of the surgeon’s group practice, before, during, and after a procedure. The three types of surgical packages (0-day, 10-day, 90-day) are based on the number of post-operative days included in payment for the surgical procedure. Centers for Medicare & Medicaid Services. Medicare Learning Network. *Global Surgery Booklet*. September 2018. <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/GlobalSurgery-ICN907166.pdf>

Exhibit 17 shows the average total amount paid for surgical services for each of the six service years based on the type of primary service (minor or major) and service combinations. A surgical event may be limited to a single minor or major service, multiple minor or major services, or a combination of service types. When a major procedure was identified with either a minor procedure or an “other” procedure, it was categorized under “major combination” to account for the dominance of major procedures.

Exhibit 17: Average Paid Amount by Procedure Types and Service Year							
Procedure Type	2013	2014	2015	2016	2017	2018	Change 2013 - 2018
Minor	\$127	\$166	\$164	\$156	\$157	\$154	21.0%
Major	\$2,128	\$1,604	\$1,673	\$1,609	\$1,613	\$1,646	-22.7%
Major Combination	\$3,905	\$3,549	\$3,307	\$3,026	\$2,946	\$2,920	-25.2%
Minor & Other	\$1,093	\$647	\$542	\$519	\$542	\$497	-54.5%
Other	\$896	\$531	\$418	\$400	\$671	\$416	-53.5%

Exhibit 18 shows the distribution of service year 2013 to 2018 surgical events by procedure type based on service volume and total paid for each category and category combination. Average payments are much higher for major surgical procedures than for minor surgical procedures, but minor procedures are much more prevalent, accounting for more than 70 percent of the Surgery procedures in each of the six years studied. Though minor procedures’ share of surgical services decreased by 3.1 percentage points from 2013 to 2018, “minor & other” procedures (those performed with add-on or unlisted procedures) increased by 3.4 percentage points during that period and their share of surgical payments increased from 2.2 percent to 22.5 percent.

Exhibit 18: Distributions of Surgical Events by Major vs Minor Procedure by Service Year							
Distribution by Volume							
Procedure Type	2013	2014	2015	2016	2017	2018	%-age Pt Change 2013 - 2018
Minor	75.5%	70.7%	72.6%	73.3%	72.2%	72.4%	-3.1%
Major	13.6%	15.1%	13.3%	12.9%	13.3%	13.3%	-0.3%
Major Combination	8.7%	8.8%	8.6%	8.7%	9.0%	9.0%	0.2%
Minor & Other	1.5%	5.1%	5.2%	4.8%	5.1%	4.9%	3.4%
Other	0.6%	0.4%	0.3%	0.4%	0.4%	0.3%	-0.3%
Distribution by Total Payments							
Minor	12.8%	16.6%	18.2%	18.7%	18.2%	14.5%	1.7%
Major	38.7%	34.2%	34.0%	34.0%	34.5%	28.7%	-10.1%
Major Combination	21.5%	44.3%	43.4%	43.0%	42.4%	34.2%	12.7%
Minor & Other	2.2%	4.6%	4.3%	4.1%	4.4%	22.5%	20.3%
Other	0.7%	0.3%	0.2%	0.2%	0.4%	0.2%	-0.6%

Exhibit 19 provides a more detailed distribution of the secondary services billed with minor procedures, reflecting the shift from unlisted secondary procedures to add-on procedures. Unlisted procedures are ill defined and do not have assigned fee schedule payment rates.

Inclusion of the updated service codes starting in 2014 limited the use of unlisted service codes and improved clarity for add-on service codes. As a result, the percentage of minor procedures performed with unlisted procedures fell from 16.6 percent in 2013 to 1.5 percent in 2014, and the percentage of minor procedures performed with add-on procedures increased from 83.4 percent to 98.5 percent. Since 2016, only 0.7 percent of minor procedures have been performed with unlisted procedures and 99.3 percent have been performed with add-on procedures.

Exhibit 19: Distributions of Minor Procedures Performed w/ Unlisted or Add-On Procedures by Service Year

Distribution by Volume						
Procedure Type	2013	2014	2015	2016	2017	2018
Minor + Unlisted	16.6%	1.5%	1.6%	0.7%	0.7%	0.7%
Minor + Add-on	83.4%	98.5%	98.4%	99.3%	99.3%	99.3%
Distribution by Payments						
Minor + Unlisted	17.3%	1.7%	2.0%	1.1%	2.0%	1.3%
Minor + Add-on	82.7%	98.3%	98.0%	98.9%	98.0%	98.7%
Average Payment Amount						
Minor + Unlisted	\$1,136.62	\$742.10	\$690.08	\$803.01	\$1,641.43	\$988.82
Minor + Add-on	\$1,084.29	\$645.11	\$539.26	\$516.82	\$534.58	\$493.89

In 2018, the top 10 minor surgery procedures accounted for 40.4 percent of all surgical services provided by a primary physician (excludes assistant-at-surgery), and 27.4 percent of the total paid for those services (Exhibit 20).

Exhibit 20: 2018 Top 10 Minor Procedures- Primary Surgeon Only

Code	Percent Volume	Percent Paid	Avg Paid	Short Description
20610	13.7%	6.6%	\$77.59	Arthrocentesis, aspiration and/or injection, major joint or bursa; without ultrasound guidance)
20550	5.4%	2.3%	\$68.10	Injection(s); single tendon sheath, or ligament
64483	3.5%	5.9%	\$269.93	Injection(s), transforaminal epidural; lumbar or sacral
12001	3.5%	2.5%	\$112.82	Simple repair of superficial wounds; 2.5 cm or less
20611	3.4%	2.4%	\$112.47	Arthrocentesis, aspiration and/or injection, major joint or bursa; with ultrasound guidance)
64415	2.5%	1.7%	\$105.28	Injection, anesthetic agent; brachial plexus
20605	2.4%	1.0%	\$64.54	Arthrocentesis, aspiration and/or injection, intermediate joint or bursa
20552	2.2%	1.0%	\$70.83	Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)
12002	2.1%	1.7%	\$126.42	Simple repair of superficial wounds; 2.6 cm to 7.5 cm
62323	1.7%	2.4%	\$221.30	Injection(s), interlaminar epidural or subarachnoid; lumbar or sacral
Total	40.4%	27.4%		

Eight of the top 10 minor procedures in 2018 were for the insertion of a needle for aspiration or drug delivery, and two were for superficial wound repair. Average payments ranged from \$64.54 for an intermediate joint (e.g., wrist, elbow, ankle) injection or aspiration to \$269.93 for a transforaminal lumbar or sacral epidural injection. The number one major surgery procedure in 2018 was arthroscopic rotator cuff repair, which accounted for 6.6 percent of the major procedures and 12.6 percent of major procedure payments (Exhibit 21).

Exhibit 21: 2018 Top 10 Major Procedures - Primary Surgeon Only				
Code	Percent Volume	Percent Paid	Avg Paid	Short Description
29827	6.6%	12.6%	\$1,872.73	Arthroscopy, shoulder
29823	5.2%	2.5%	\$469.65	Arthroscopy, shoulder
29881	5.0%	4.1%	\$806.76	Arthroscopy, knee
29824	4.7%	2.7%	\$566.07	Arthroscopy, shoulder
64721	3.9%	2.8%	\$722.52	Neuroplasty and/or transposition; carpal tunnel
29880	2.5%	2.2%	\$862.21	Arthroscopy, knee
20680	2.2%	1.5%	\$662.87	Removal of implant; deep (e.g., buried wire, pin, screw, rod or plate)
27447	2.0%	3.4%	\$1,711.19	Arthroplasty, knee
63047	1.8%	1.7%	\$976.18	Laminectomy, facetectomy and foraminotomy
26055	1.7%	0.9%	\$537.08	Tendon sheath incision (e.g., for trigger finger)
Total	35.6%	34.4%		

Medicine

As previously shown in Exhibit 3, the volume of Medicine section service codes decreased by 57 percent between 2013 and 2018. The Medicine section includes a wide range of medical services, including cardiovascular, psychiatric, ophthalmology, neurology and neuromuscular procedures. For comparison purposes the author focused on three primary service subcategories: cardiovascular; psychiatric and psychotherapy services; and neurology and neuromuscular procedures. All other services (ophthalmological, endocrinology, gastroenterology, and otorhinolaryngologic services) were grouped under “Other.” Declining volume in each service subcategory contributed to the 57 percent decrease in Medicine section services. Neurology and neuromuscular procedures showed the greatest decrease (-74.1 percent) and psychiatric and psychotherapy services experienced the lowest decrease (-41.1 percent) (Exhibit 22).

Exhibit 22: Change in Service Volume by Service Subcategory	
	Percent Change
Cardiovascular	-43.8%
Psych/Neuropsych	-41.1%
Neurology/Neuromuscular	-74.1%
Other	-55.4%
Total	-57.1%

As shown in Exhibit 23, the greatest shift in the proportional share of volume among the Medicine service subcategories during the study period were in psychiatric and psychotherapy services, which increased from 25.2 percent of the Medicine services in 2013 to 34.6 percent in 2018, and in neurology and neuromuscular services (primarily diagnostic testing), which decreased from 35.5 percent of the Medicine services to 21.4 percent over that same six-year span. Cardiovascular services experienced greater fluctuation over the study period but still increased from 11.5 percent to 15 percent of the Medicine Section services between 2013 and 2018. The aggregated remaining services accounted for less than one-third of the Medicine Section services each year, increasing from 27.8 percent of the services in 2013 to 28.9 percent in 2018.

Exhibit 23: Distribution of Medicine Services by Subcategory (volume)						
	2013	2014	2015	2016	2017	2018
Cardiovascular	11.5%	13.6%	12.7%	15.8%	13.5%	15.0%
Psych/Neuropsych	25.2%	31.5%	32.5%	30.7%	34.9%	34.6%
Neurology/Neuromuscular	35.5%	24.3%	24.5%	23.7%	22.7%	21.4%
Other	27.8%	30.5%	30.3%	29.8%	29.0%	28.9%
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Payments associated with the Medicine Section service subcategories followed a similar pattern. As shown in Exhibit 24, the biggest shift in the payment distribution was in neurology and neuromuscular procedures, which declined from 46.9 percent of all Medicine service reimbursements in 2013 to 30.6 percent in 2018.

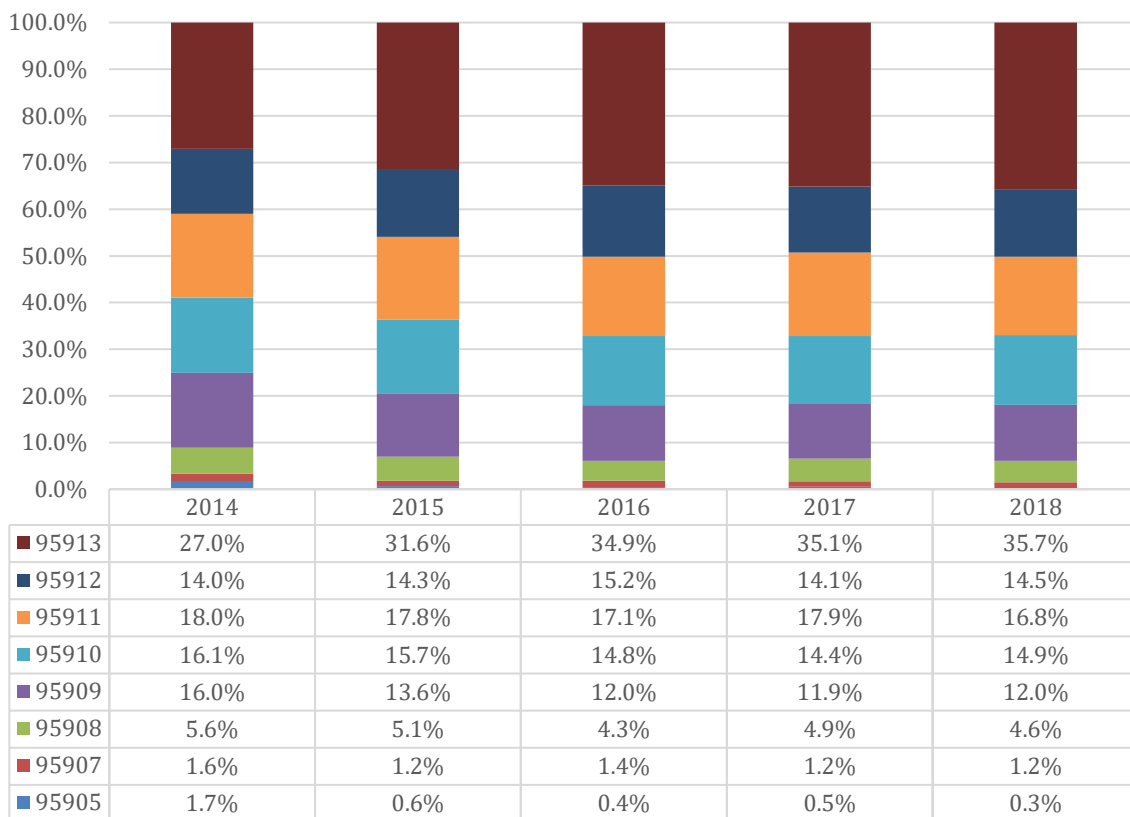
Exhibit 24: Distribution of Medicine Service Payments by Subcategory						
	2013	2014	2015	2016	2017	2018
Cardiovascular	11.5%	8.9%	7.8%	11.9%	13.6%	15.1%
Psych/Neuropsych	26.0%	35.4%	38.0%	35.8%	36.3%	35.5%
Neurology/Neuromuscular	46.9%	38.0%	36.3%	33.1%	31.7%	30.6%
Other	15.6%	17.8%	18.0%	19.2%	18.3%	18.8%
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

As noted earlier, the 2013 payment data reflects service codes from 1997, and beginning in 2014 the code sets were updated on an annual basis. Deletions, additions, and revisions to service codes make it difficult to make direct comparisons of average payments at the code level – coding for nerve conduction studies changed significantly with the newly adopted CPT codes in 2014, which expanded the number of codes from three to eight. Prior to adoption of the newer CPT codes, nerve conduction studies were billed and paid on a per study basis, and these studies were fairly evenly split between motor nerve studies (46.1 percent) and sensory nerve studies (53.9 percent). The average payment of \$161.69 in 2013 reflected the per study service description, compared to the higher average payment in 2014 of \$251.28, which reflected billing codes for multiple studies (Exhibit 25).

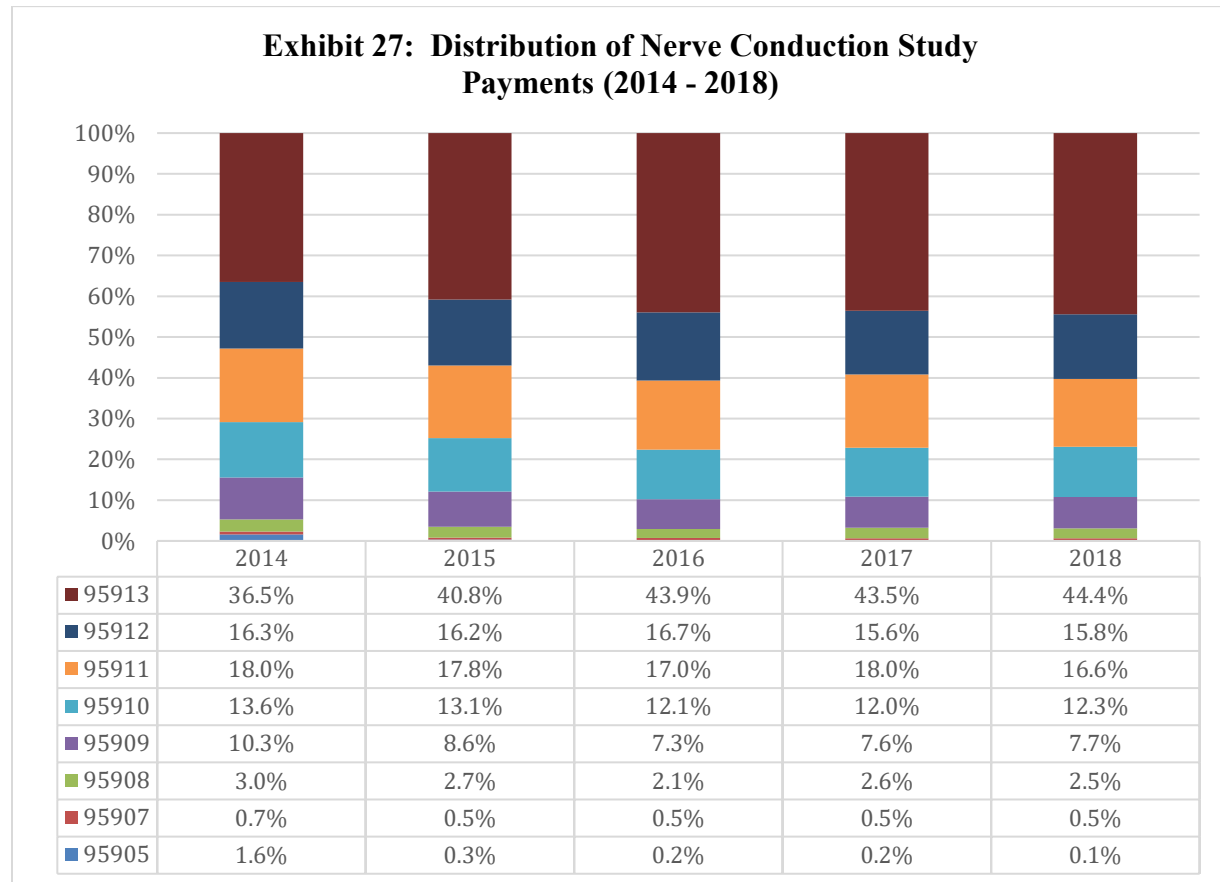
Exhibit 25: 2013, 2014 and 2018 Nerve Conduction Study Codes

Code	Brief Description	2013 Avg Paid	2014 Avg Paid	2018 Avg Paid
95900	NCS each nerve; motor, without F-wave study	\$117.35		
95903	NCS each nerve; motor, with F-wave study	\$207.95		
95904	NCS each nerve; sensory	\$144.46		
95905	NCS; using preconfigured electrode array(s), each limb		\$226.52	\$147.40
95907	NCS; 1-2 studies		\$113.79	\$128.56
95908	NCS; 3-4 studies		\$136.28	\$167.58
95909	NCS; 5-6 studies		\$160.98	\$200.20
95910	NCS; 7-8 studies		\$212.25	\$257.28
95911	NCS; 9-10 studies		\$251.64	\$308.93
95912	NCS; 11-12 studies		\$293.73	\$340.41
95913	NCS; 13 or more studies		\$339.25	\$388.96
Weighted Avg		\$161.69	\$251.28	\$312.15

The distribution of nerve conduction studies by code volume was remarkably consistent after the new coding structure took effect in 2014. The most notable shift was the increased proportion of charges for the highest-level code (Code 95913, used for 13 or more studies) which increased from 27.0 percent of the nerve conduction studies in 2014 to 35.7 percent in 2018 (Exhibit 26).

Exhibit 26: Distribution of Nerve Conduction Studies

Following the trend in the volume of nerve conduction studies, the distribution of payments associated with these services also experienced a year-over-year increase for the highest-level code (95913 for 13 or more studies). Exhibit 27 shows that payments for code 95913 increased from 36.5 percent of all nerve conduction reimbursements in 2014 to 44.4 percent in 2018.



Special Services

The Special Services section is an artifact of the pre-2014 OMFS and includes services specific to workers' compensation for reimbursement. Special services consist primarily of reports, which underwent coding changes related to the adoption of RBRVS-based payments. As was shown in Exhibit 5, between 2013 and 2018 the volume of Special Service codes and the total payments for those codes decreased by 30.5 percent and 55.2 percent respectively, while the number of unique claims with these services decreased by a much lower 11.6 percent. The removal of consultation services from the E&M section resulted in the elimination of payments for consultation reports, which were billed under code 99080 in 2013. Prior to the 2014 implementation of the new fee schedule, Special Report code 99080 was used to identify primary treating physician permanent and stationary reports, as well as consulting physician reports.

Beginning with the new OMFS in 2014, billing codes²² for reports were more clearly delineated, although the new fee schedule did not change the payment mechanism -- a flat fee for a primary treating physician's required progress reports (PR-2 reports), and a calculated fee for other reports.

As shown in Exhibit 28, the share of Special Service codes associated with PR-2 reports (paid at an average of \$11.71) increased from 67.9 percent in 2013 to 91.8 percent in 2018. With the more expensive consultation reports removed from the mix, the much lower cost required reports increased to nearly 92 percent of Special Services, which along with the declining number of claims involving these services, and the 30.5 percent decline in the volume of Special Service codes, helped fuel the 55.2 percent decline in total payments for this service category.

Exhibit 28: Average Paid and Distribution by Volume for the Top 10 Special Services 2013 and 2018							
2013	Avg Paid	% of Svcs	Description	2018	Avg Paid	% of Svcs	Description
99081	\$11.20	67.9%	Required reports	WC002	\$11.71	91.8%	Required report (PR-2)
99080	\$83.96	17.3%	Special reports	99199	\$717.01	3.2%	Unlisted special service or report
99070	\$69.45	8.9%	Supplies and materials	WC004	\$124.21	2.3%	P&S report (PR-4)
99199	\$1,682.21	1.8%	Unlisted special service or report	WC003	\$81.63	0.5%	P&S report (PR-3)
99071	\$7.43	1.5%	Educational supplies	99070	\$91.24	0.5%	Supplies and materials
Total		97.4%				98.3%	

The volume of charges for supplies and materials billed using code 99070 declined from 8.9 percent of the Special Service category codes in 2013 to 0.5 percent in 2018, reflecting the inclusion of bundled supplies in the underlying service codes. Separately reimbursable supplies are billed using HCPCS codes that identify the type of supply and these are paid under the DMEPOS fee schedule.

DMEPOS

A wide range of items fall under the DMEPOS fee schedule, including basic disposable supplies (e.g., replacement batteries and electrodes for TENS units), durable medical equipment (e.g., crutches, walkers and wheelchairs), and prosthetic and orthotic devices. Exhibit 29 compares the top 10 HCPCS codes for 2013 and 2018, based on volume, along with the average paid amount and the portion of DMEPOS payments associated with each ranked code.

²² Appendix 1 contains a complete list of pre-2014 and post-2014 report codes.

Exhibit 29: Top 10 DMEPOS Codes by Volume – 2013				
Code	Description	% of Codes	% of Payments	Avg Paid
A4556	Electrodes (e.g., apnea monitor), per pair	21.9%	11.0%	\$69.20
A4630	Replacement batteries, medically necessary, transcutaneous electrical stimulator, owned by patient	5.0%	2.3%	\$63.88
E1399	Durable medical equipment, miscellaneous	4.5%	9.5%	\$292.08
L3908	Wrist-hand orthosis (WHO), wrist extension control cock-up, nonmolded, prefabricated, off-the-shelf	4.1%	2.0%	\$67.01
A4558	Conductive gel or paste, for use with electrical device (e.g., TENS, NMES), per oz	3.7%	0.2%	\$8.59
E0215	Electric heat pad, moist	3.3%	1.6%	\$65.41
A4595	Electrical stimulator supplies, 2 lead, per month, (e.g., TENS, NMES)	3.0%	2.9%	\$131.97
A4557	Lead wires (e.g., apnea monitor), per pair	2.5%	0.5%	\$25.24
A9300	Exercise equipment	2.4%	0.5%	\$28.57
A9273	Cold or hot fluid bottle, ice cap or collar, heat and/or cold wrap, any type	2.3%	0.3%	\$19.67
Total		52.7%	30.9%	
Top 10 DMEPOS Codes by Volume – 2018				
Code	Description	% of Codes	% of Payments	Avg Paid
A9273	Cold or hot fluid bottle, ice cap or collar, heat and/or cold wrap, any type	10.3%	0.8%	\$13.89
E1399	Durable medical equipment, miscellaneous	6.1%	12.9%	\$392.07
A4556	Electrodes (e.g., apnea monitor), per pair	5.3%	2.8%	\$99.64
E0215	Electric heat pad, moist	4.8%	2.1%	\$79.27
L3908	Wrist-hand orthosis (WHO), wrist extension control cock-up, non-molded, prefabricated, off-the-shelf	4.6%	1.8%	\$74.79
A9300	Exercise equipment	4.3%	0.8%	\$36.59
A9999	Miscellaneous DME supply or accessory, not otherwise specified	2.4%	1.0%	\$78.91
A4558	Conductive gel or paste, for use with electrical device (e.g., TENS, NMES), per oz	2.2%	0.1%	\$11.41
L0625	Lumbar orthosis, flexible, provides lumbar support	1.8%	0.5%	\$50.48
E0218	Fluid circulating cold pad with pump, any type	1.8%	1.7%	\$178.43
Total		43.6%	24.6%	

In 2013 five of the top 10 DMEPOS codes were for supplies associated with electronic equipment, but in 2018 only two of the top 10 codes were associated with these disposable supplies. Though the proportion of DMEPOS codes used for TENS units showed little change between 2013 and 2018 (1.1 percent and 1.3 percent respectively), disposable supplies associated with TENS use decreased – five of the top 10 DMEPOS codes were associated with electrodes, batteries, and conductive material in 2013 and only two codes were in the top 10 in 2018.

The lack of apnea or cardiac monitor codes in the data suggests A4556 may have been used to bill electrodes for TENS units rather than for electrodes used with apnea or cardiac monitors. There is also Independent Bill Review (IBR) evidence that misapplication of this code may occur.²³ Medicare rules also require the use of A4595 for monthly TENS supplies instead of A4556 (electrodes), A4558 (conductive paste or gel), and A4630 (replacement batteries).²⁴

Two of the top 10 DMEPOS codes in the 2018 data (E1399 and A9999) were for unspecified services. These two codes represented 8.4 percent of DMEPOS items/services in 2018, which was up from 5.6 percent in 2013. Over that same 6-year span, total payments for these undefined codes increased from 10.2 percent to 13.9 percent of the all DMEPOS payments, primarily driven by increases in the average reimbursements for miscellaneous DME (E1399), which jumped 32.2 percent from \$292.08 in 2013 to \$392.07 in 2018.

Pathology and Laboratory

Services in the Pathology and Laboratory section are covered under two sections of the OMFS:

- (1) clinical laboratory services are paid at 120 percent of the rate in CMS' Clinical Diagnostic Laboratory Fee Schedule, and
- (2) professional services such as surgical pathology are reimbursed using the Medicare RBRVS Physician Fee Schedule tables and methodology.

As shown in Exhibit 30, most Pathology and Laboratory services fall under the Clinical Laboratory Fee Schedule, which has been used in California workers' compensation since 2004. Clinical laboratory tests for drug testing were the most prevalent services in the Pathology and Laboratory Service category throughout the six-year study period.

Exhibit 30: Fee Schedule Distribution for Pathology and Laboratory Services (Service Years 2013 - 2018)						
Percent Volume						
Fee Schedule	2013	2014	2015	2016	2017	2018
Physician	3.9%	3.2%	3.6%	6.8%	5.5%	3.2%
Clinical Laboratory	96.1%	96.8%	96.4%	93.2%	94.5%	96.8%
Percent Paid						
Physician	5.6%	5.7%	6.7%	13.7%	9.7%	6.9%
Clinical Laboratory	94.4%	94.3%	93.3%	86.3%	90.3%	93.1%

²³ Maximus IBR Case CB-13-0000091 upholds payment of A4595 instead of billed code A4556, A4630, and A4557 for TENS supplies. https://www.dir.ca.gov/dwc/IBR/IBR-Decisions/Decisions2013-2014/IBR2013_1-99/CB13-0000091.pdf

²⁴ Center for Medicare and Medicaid Services. *Local Coverage Determination (LCD): Transcutaneous Electrical Nerve Stimulators (TENS) (L33802)*. <https://med.noridianmedicare.com/documents/2230703/7218263/Transcutaneous+Electrical+Nerve+Stimulators+%28TENS%29%20LCD+and+PA/52e57b3b-fec4-4078-bcea-4ad556d06cef>

Over the past decade a series of changes to the codes used for these types of drug testing have been adopted by CMS and the AMA:

- In 2010, CMS began establishing new HCPCS for use in billing drug screening purposes, and CMS made additional code changes in 2011 to address abusive billing practices.²⁵
- In 2015, the AMA made significant changes to the coding structure for drugs of abuse testing used to detect the presence of one or more illegal drugs and/or prescribed medications in a patient's system, although Medicare did not adopt these changes for reimbursement purposes.

At the time of the 2015 AMA CPT code changes, CMS determined that it would need more time and public input to determine Medicare payments for drug testing under the new structure. In 2015 CMS created new HCPCS to replace deleted CPT codes and retained other 2014 HCPCS, basically maintaining a status quo for 2015.²⁶

CMS revised HCPCS again beginning in 2016, deleting codes and creating seven new codes (three G codes for presumptive testing and four G codes for definitive testing).²⁷ The new codes were intended as per day codes, meaning only one G code (G0477, G0478 or G0479) should be used for presumptive testing. CMS also limited definitive testing codes (G0480 – G0483) to once per day, depending on the number of drug classes included in the test. CMS continued to not recognize AMA CPT codes for payment of drug testing services.

A comparison of the distribution of the top 10 Pathological and Laboratory Services based on total payments for 2013 and 2018 is provided in Exhibit 31. Although the codes used to identify drug testing changed during this period, nine of the top 10 codes were for drug testing. In 2013, the top laboratory code was for testing for an unspecified substance, while the 2018 data show the top code was for testing for 22 or more drug classes.

Only twice during the six years studied did the top 10 Pathology and Laboratory Services include a service that fell outside the Clinical Laboratory Fee Schedule (87150 for culture typing in 2013, and 88305 for surgical pathology in 2018).

²⁵ Jones, S.L. The Utilization and Cost of Drug Testing in the California Workers' Compensation System. CWCI Report to the Industry. October 2015.

²⁶ Centers for Medicare and Medicaid Services. *Calendar Year (CY) 2015 Clinical Laboratory Fee Schedule (CLFS) Final Determinations*. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Laboratory_Public_Meetings.

²⁷ Centers for Medicare and Medicaid Services. *Calendar Year (CY) 2016 Clinical Laboratory Fee Schedule (CLFS) Final Determinations*. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Laboratory_Public_Meetings.

Exhibit 31: Distribution of Top 10 Pathology & Laboratory Services Based on Payments (2013 and 2018)			
2013	Avg Paid	% Paid	Description
82486	\$678.36	19.5%	Chromatography, qualitative
82491	\$724.42	11.5%	Chromatography, quantitative
83925	\$121.97	11.1%	Definitive Drug Testing – opioids
G0431	\$138.70	10.3%	Drug screen, qualitative; multiple drug classes
80101	\$215.66	4.3%	Drug screen, qualitative; single drug class method
80102	\$102.17	2.7%	Drug confirmation, each procedure
82542	\$156.95	2.1%	Column chromatography, includes mass spectrometry
G0434	\$31.02	1.5%	Drug screen, other than chromatographic; any number of drug classes
80154	\$64.51	1.5%	Therapeutic drug assay – benzodiazepines
87150	\$1,093.77	1.4%	Culture, typing
Top 10		65.9%	
2018	Avg Paid	% Paid	Description
G0483	\$277.32	39.5%	Drug test(s), definitive; 22 or more drug classes
80307	\$81.28	15.9%	Drug test(s), presumptive, any number of drug classes
G0482	\$202.24	4.5%	Drug test(s), definitive; 15-21 drug classes
G0481	\$169.64	3.5%	Drug test(s), definitive; 8-14 drug classes
88305	\$135.62	3.3%	Level IV - Surgical pathology
80299	\$290.55	2.3%	Quantitation of therapeutic drug, not elsewhere specified
80305	\$15.50	2.2%	Drug test(s), presumptive, any number of drug classes
80053	\$19.18	1.9%	Comprehensive metabolic panel
85025	\$12.60	1.7%	Blood count; complete (CBC)
G0480	\$107.68	1.6%	Drug test(s), definitive; 1-7 drug classes
Top 10		76.5%	

Exhibit 32 shows the proportion of clinical lab test services and payments from 2013 through 2018 that were used to monitor drugs of abuse²⁸ and those that were not. Drugs of abuse tests increased from just under half (49.5 percent) of all Clinical Lab Fee Schedule services in 2013 to 60.2 percent in 2015, but then dropped sharply to 23.5 percent of those services in 2017 before moving up to 29.1 percent in 2018. In terms of payments for Clinical Lab Fee Schedule services, reimbursements for tests to monitor drugs of abuse represented between 80.0 percent and 82.1 percent of all Clinical Laboratory Fee Schedule payments between 2013 and 2015, then declined to 73.1 percent in 2016, before edging up slightly to 74.6 percent in 2017 and 75.7 percent in 2018. Notably, the average amount paid for drugs of abuse testing declined from \$101.98 in

²⁸ Codes identified as related to drugs of abuse testing include drug screening, quantitative/definitive tests, and specimen validity testing (i.e., creatinine, specific gravity and pH tests) used to determine whether a urine sample has been adulterated or diluted.

2013 to \$57.72 in 2014 but have remained within a much narrower range since then, averaging between a low of \$56.95 and a high of \$66.13.

Exhibit 32: Drugs of Abuse Tests

Percent of Total Volume - Clinical Lab Fee Schedule Services						
Drug Testing	2013	2014	2015	2016	2017	2018
No	50.5%	45.4%	39.8%	63.3%	76.6%	70.9%
Yes	49.5%	54.6%	60.2%	36.7%	23.5%	29.1%
Percent of Total Clinical Lab Fee Schedule Services Payments						
Drug Testing	2013	2014	2015	2016	2017	2018
No	18.5%	20.0%	17.9%	26.9%	25.4%	24.3%
Yes	81.5%	80.0%	82.1%	73.1%	74.6%	75.7%
Average Paid						
Drug Testing	2013	2014	2015	2016	2017	2018
No	\$52.01	\$44.46	\$45.22	\$74.12	\$96.07	\$61.22
Yes	\$101.98	\$57.72	\$66.13	\$56.95	\$60.62	\$57.57
Combined Avg	\$56.93	\$45.69	\$49.07	\$71.10	\$91.18	\$60.76

Discussion

The California Official Medical Fee Schedule establishes payment rules based on statutory mandates for the following medical treatment categories:

- Physician and Non-Physician Practitioner Services
- Pathology and Laboratory Services
- Durable Medical Equipment, Prosthetics, Orthotics, Supplies Services
- Inpatient Hospital Services
- Outpatient Services (hospital and ambulatory surgery center)
- Ambulance Services

This study focused on the first three service categories, with special attention paid to the 2014 changes to the Physician and Non-Physician Practitioner Services as January 1, 2014 marked the beginning of the transition to the RBRVS-based fee schedule which utilizes the reimbursement methodology and value tables from Medicare's Physician Fee Schedule. Important goals of the new fee schedule included much needed updating of service codes and descriptions, and a mechanism to provide timely updates going forward; as well as adoption of a stable and easily updated reimbursement model tied to the cost of delivering services. SB 863 required a four-year transition period for full implementation of the RBRVS-based fee schedule, which was completed in March 2017.

Although the number of claims receiving medical services in the study population decreased by 5.2 percent over the six-year span of the study, the decreases in the volume of services across all

service categories far exceeded the decline in claim volume, ranging from a 17.2 percent drop in Physical Medicine services to a 71.8 percent drop in Pathology and Laboratory services.

An analysis of medical payment data for services rendered in the first 10 months of 2013, 2014, 2015, 2016, 2017 and 2018 confirms that as intended, payments for primary medical care services (e.g., Evaluation and Management and Physical Medicine) increased following the adoption of the RBRVS schedule while payments for Specialty Services (e.g., Surgery and Radiology) decreased.

The mix of services addressed under the Physician and Non-Physician Practitioner section of the OMFS remained relatively stable over the six-year study period, with Physical Medicine services showing the greatest proportional change, increasing from 40.9 percent of all services in 2013 to 47.4 percent of services in 2018, while E&M showed a more modest increase, climbing from 19.1 percent of the 2013 services to 20.9 percent in 2018. On the other hand, E&M reimbursements as a proportion of total physician and non-physician practitioner payments registered a much more significant increase, climbing from 23.5 percent in 2013 to 32.2 percent in 2018, while Physical Medicine reimbursements grew from 15.5 percent of the payments to 15.4 percent. This redistribution of payments toward E&M and Physical Medicine Services reflects the increased importance placed on primary care services, which represent the bulk of medical services provided to injured workers. E&M and Physical Medicine services combined to account for at least 60 percent of all physician and non-physician practitioner services in all six study years, and that proportion increased incrementally as the transition to the RBRVS fee schedule progressed, rising from 60 percent of the services in 2013 to 68.3 percent in 2018. At the same time, E&M and Physical Medicine payments as a proportion of all Physician and Non-Physician reimbursements increased from 39 percent in 2013 to 57.6 percent in 2018.

The RBRVS-based payment methodology now used in California workers' compensation is updated annually when the underlying relative value tables are updated for Medicare, and additional revisions may accompany these updates which can impact the volume and mix of services and OMFS payments. For example, prior to the adoption of the RBRVS-based fee schedule, prolonged service code 99358, which allows payment for a physician's time spent without face-to-face contact in association with an E&M visit, accounted for 9.5 percent of E&M services and 8.3 percent of the E&M payments. However, these services were not separately payable by Medicare until 2017, so from 2014 through 2016, while California was transitioning to the RBRVS fee schedule, payments for prolonged service code 99358 dropped to less than one percent of all E&M payments. However, after the schedule was updated in 2017 to reflect the Medicare change, payments for this prolonged service code increased to 2.3 percent of all E&M services and 2.6 percent of E&M reimbursements.

Changes to other sections of the fee schedule also have affected the mix of physician and non-physician services and the distribution of payments. As noted earlier, between 2013 and 2018, multiple changes were made to the fee schedule that impacted services in the Physical Medicine category. These changes included coding revisions as well as changes to payment calculations

for multiple services performed during the same session. The combination of revisions resulted in higher valuation of these services which, as was shown in Exhibit 12, pushed the average payment per Physical Medicine session up 40 percent between 2013 and 2018 (from \$94.52 to \$132.29). At the same time, an increased emphasis on functional improvement under the new schedule led to a shift in the mix of Physical Medicine services, with therapeutic procedures accounting for a greater share of the services and physical therapy modalities representing a smaller share. As shown in Exhibit 10, the top four therapeutic procedures as a proportion of all Physical Medicine services increased from 44.5 percent in 2013 to 65.5 percent in 2018.

The adoption of updated CPT codes in the Surgery section in 2014, along with the subsequent annual updates, have enabled services in this section to be more accurately described for payment purposes, and these changes account for some of the variation in Surgery services and average payments between 2013 and 2018. The most recent data show that needle insertions for injections or aspirations accounted for eight of the top 10 minor surgery services in 2018, with simple wound repairs accounting for the remaining two services, while shoulder and knee arthroscopies accounted for six of the top ten major surgery procedures in 2018.

Within the Medicine Section of the fee schedule, the biggest shifts in the mix of services and payments were in mental health services and neurological and neuromuscular diagnostic services. Although the volume of mental health services decreased 41.1 percent between 2013 and 2018 their share of Medicine Section service codes increased from 25.2 percent in 2013 to 34.6 percent in 2018, while payments for these services rose from 26.0 percent to 35.5 percent of the Medicine Section reimbursements. Conversely, neurologic and neuromuscular diagnostic services dropped from 35.5 percent to 21.4 percent of the Medicine Section services over the same period, while payments for these services dropped from 46.0 percent to 30.6 percent of the Medicine Section dollars. Again, the shifting mix of services and payments in this section reflect the changes to the CPT codes that resulted from the adoption of the Medicare updates in 2014 that required nerve conduction study codes to be billed and paid based on the number of studies involved rather than on a per-study basis. Following the adoption of this change in 2014, the distribution of nerve conduction services and associated payments showed great consistency, though as shown in Exhibit 25, there was a notable increase in the proportion of nerve conduction charges associated with the highest level code which is used to bill for 13 or more studies.

Discontinuance of consultation services and the associated reduction in consultation reports resulted in a change in the mix of Special Services, which consist primarily of physician reports. After separate payments for consultation reports were eliminated, the primary treating physician's required progress (PR-2) reports, which are the lowest per report service, increased from 67.9 percent of the Special Services in 2013 to 91.8 percent in 2018. The increase in proportional share of Special Services for the lowest per report service, contributed to the 55.2 percent decline in total payments for this service category.

The DMEPOS fee schedule has been in effect for California workers' compensation payments since 2004, but the implementation of Medicare relative value tables for payment calculations has likely influenced the decline in payments for the generic supply code 99070 since 2013. Although separately payable supplies fall under the DMEPOS fee schedule, and 8.9 percent of the Special Services in 2013 were billed under supply code 99070, that proportion dropped to 0.5 percent in 2018. Under the RBRVS-based fee schedule 99070 does not have a separate reimbursement value, making enforcement of the bundled service rule more consistent.

Disposable supplies associated with TENS units, accounted for a relatively high proportion of the DMEPOS items in 2013, with five of the top 10 codes related to TENS supplies; but TENS supplies accounted for only two of the top 10 codes in 2018. Unlisted miscellaneous DME (E1399) increased from 9.5 percent of DMEPOS payments in 2013 to 12.9 percent in 2018. The average amount paid for the unlisted DMEPOS service code increased 34.2 percent during the six-year study period.

Some pathology and laboratory services fall under the Physician and Non-Physician Practitioner section of the OMFS, but most of these services are reimbursed under the Clinical Laboratory section (in effect since 2004) and are paid at 120 percent of Medicare's Clinical Laboratory Fee Schedule values. Payments for Pathology and Laboratory services were dominated by drug testing in each of the study years, with drug testing services accounting for nine of the top 10 Pathology and Laboratory codes based on total payments in 2013, and eight of the top 10 codes in 2018. Furthermore, in 2018 a single code (G0483) used to describe a test that includes 22 or more drug classes accounted for 39.5 percent of the Pathology and Laboratory payments. In comparison, the highest utilized surgical pathology service accounted for just 3.3 percent of total payments in this service category.

The adoption of the RBRVS-based fee schedule, which includes annual updates to relative values, billing codes and inflation adjustments, has provided much needed improvement to the billing and payment process for medical services provided to California's injured workers. Services that are unique to workers' compensation (i.e., reports) are not as easily updated, however, so renewed assessment regarding adequate compensation is warranted. CWCI will continue to monitor payment trends under the OMFS, with the next analyses examining institutional (inpatient and outpatient hospital, and ambulatory surgery center) costs and trends.

Appendix 1

Pre-2014 Reports

99080 - Special Reports – Includes consulting physician reports, primary treating physician permanent and stationary reports, claims administrator requested reports.

99081 - Required Reports – Primary Treating Physician's Progress Reports. (PR-2 or narrative equivalent).

Post-2014 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)

Appendix 2a

Outpatient Office Visit Codes as Percent of Total E&M by Count & E&M Category													
Description	Code	Percent of Total E&M						Percent of E&M Category					
		2013	2014	2015	2016	2017	2018	2013	2014	2015	2016	2017	2018
Office/Outpatient Visit New Patient/Injury	99201	0.2%	0.4%	0.4%	0.3%	0.3%	0.4%	1.9%	2.5%	2.5%	1.8%	1.8%	2.4%
	99202	0.8%	1.4%	1.6%	1.5%	1.8%	2.1%	7.8%	8.8%	9.8%	9.0%	10.9%	12.7%
	99203	3.9%	5.3%	5.6%	5.9%	6.3%	6.8%	37.9%	33.3%	34.4%	35.5%	38.2%	41.0%
	99204	4.5%	6.5%	6.6%	6.9%	6.9%	6.1%	43.7%	40.9%	40.5%	41.6%	41.8%	36.7%
	99205	0.9%	2.3%	2.1%	2.0%	1.2%	1.2%	8.7%	14.5%	12.9%	12.0%	7.3%	7.2%
Subtotal		10.3%	15.9%	16.3%	16.6%	16.5%	16.6%	100.0%	100%	100%	100%	100%	100%
Office/Outpatient Visit Established Patient	99211	0.4%	0.5%	0.6%	0.4%	0.3%	0.3%	0.6%	0.6%	0.8%	0.5%	0.4%	0.4%
	99212	2.9%	3.8%	3.4%	3.1%	3.4%	3.6%	4.3%	4.9%	4.4%	4.0%	4.5%	4.8%
	99213	26.6%	31.4%	30.2%	29.7%	30.5%	32.3%	39.1%	40.6%	39.4%	38.7%	40.6%	43.0%
	99214	31.0%	34.3%	34.9%	36.2%	37.6%	35.8%	45.5%	44.4%	45.5%	47.2%	50.0%	47.7%
	99215	7.2%	7.3%	7.6%	7.3%	3.4%	3.1%	10.6%	9.4%	9.9%	9.5%	4.5%	4.1%
Subtotal		68.1%	77.3%	76.7%	76.7%	75.2%	75.1%	100%	100%	100%	100%	100%	100%
Office Consultation	99241	0.1%	0.0%	0.0%	0.0%	0.0%		2.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	99242	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	6.1%	0.0%	0.0%	0.0%	0.0%	0.0%
	99243	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	20.4%	0.0%	0.0%	0.0%	0.0%	0.0%
	99244	1.7%	0.0%	0.0%	0.0%	0.0%	0.0%	34.7%	0.0%	0.0%	0.0%	0.0%	0.0%
	99245	1.8%	0.0%	0.0%	0.0%	0.0%	0.0%	36.7%	0.0%	0.0%	0.0%	0.0%	0.0%
Subtotal		4.9%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Prolonged Service	99354	1.1%	1.5%	1.3%	1.1%	0.8%	0.7%	10.3%	83.3%	86.7%	84.6%	29.6%	23.3%
	99355	0.1%	0.1%	0.1%	0.1%	0.1%	0.0%	0.9%	5.6%	6.7%	7.7%	3.7%	0.0%
	99356	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	99357	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	99358	9.5%	0.2%	0.1%	0.1%	1.8%	2.3%	88.8%	11.1%	6.7%	7.7%	66.7%	76.7%
Subtotal		10.7%	1.8%	1.5%	1.3%	2.7%	3.0%	100%	100%	100%	100%	100%	100%
Total		93.9%	95.0%	94.6%	94.7%	94.2%	94.7%						

Appendix 2b

Outpatient Office Visit Codes as Percent of Total E&M Payments & E&M Category													
Percent of Total E&M by Total Paid								Percent of E&M Category					
Description	Code	2013	2014	2015	2016	2017	2018	2013	2014	2015	2016	2017	2018
Office/Outpatient Visit New Patient/Injury	99201	0.1%	0.2%	0.2%	0.1%	0.2%	0.2%	0.5%	0.8%	0.8%	0.6%	0.7%	0.9%
	99202	0.6%	1.0%	1.1%	1.1%	1.3%	1.6%	4.3%	4.6%	5.3%	5.1%	6.2%	7.5%
	99203	4.3%	5.5%	5.8%	6.2%	6.7%	7.4%	31.7%	25.6%	27.0%	28.1%	31.1%	34.5%
	99204	6.9%	10.3%	10.4%	10.8%	11.0%	9.9%	50.8%	48.0%	48.0%	48.7%	51.3%	46.4%
	99205	1.7%	4.5%	4.1%	3.9%	2.3%	2.3%	12.7%	21.0%	19.0%	17.5%	10.8%	10.7%
Subtotal		13.6%	21.4%	21.6%	22.2%	21.5%	21.4%	100.0%	100%	100%	100%	100%	100%
Office/Outpatient Visit Established Patient	99211	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.2%	0.1%	0.2%	0.1%	0.1%	0.1%
	99212	1.3%	1.7%	1.5%	1.4%	1.5%	1.6%	2.3%	2.4%	2.1%	2.0%	2.2%	2.4%
	99213	16.4%	22.3%	21.3%	21.1%	22.1%	23.6%	28.5%	32.2%	30.9%	30.6%	32.7%	35.2%
	99214	29.7%	35.5%	36.0%	37.1%	39.2%	37.8%	51.8%	51.2%	52.1%	53.7%	58.0%	56.1%
	99215	9.8%	9.8%	10.2%	9.4%	4.7%	4.2%	17.1%	14.1%	14.7%	13.7%	6.9%	6.2%
Subtotal		57.3%	69.4%	69.1%	69.1%	67.6%	67.3%	100.0%	100%	100%	100%	100%	100%
Office Consultation	99241	0.1%	0.0%	0.0%	0.0%	0.0%		0.7%	0.9%	2.0%	2.2%	0.6%	0.0%
	99242	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	3.3%	6.3%	2.6%	2.3%	15.4%	1.6%
	99243	1.3%	0.0%	0.0%	0.0%	0.0%	0.0%	14.7%	11.4%	18.1%	23.2%	25.0%	35.1%
	99244	3.2%	0.0%	0.0%	0.0%	0.0%	0.0%	34.7%	27.3%	29.3%	40.7%	33.1%	39.3%
	99245	4.2%	0.0%	0.0%	0.0%	0.0%	0.0%	46.6%	54.0%	48.0%	31.7%	25.9%	24.0%
Subtotal		9.1%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	100%	100%	100%	100%	100%
Prolonged Service	99354	1.8%	1.5%	1.3%	1.1%	0.9%	0.9%	17.8%	76.0%	77.0%	76.1%	30.7%	24.4%
	99355	0.1%	0.2%	0.2%	0.2%	0.1%	0.1%	0.8%	10.1%	13.3%	14.1%	3.8%	1.7%
	99356	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.5%	0.8%	0.5%	0.2%	0.2%
	99357	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.3%	0.0%	0.0%	0.0%
	99358	8.3%	0.3%	0.1%	0.1%	1.9%	2.6%	81.1%	13.1%	8.6%	9.2%	65.3%	73.7%
Subtotal		10.3%	1.9%	1.6%	1.4%	3.0%	3.5%	100%	100%	100%	100%	100%	100%
Total		90.3%	92.8%	92.3%	92.7%	92.1%	92.2%						

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- **Stacy Jones** is a Senior Research Associate at the CWCI.

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California Workers' Compensation Institute

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