State of California
LABOR CODE
DIVISION 4. WORKERS' COMPENSATION AND INSURANCE
PART 4. COMPENSATION PROCEEDINGS
CHAPTER 1. JURISDICTION
§ 5307

5307.1. (a) (1) The administrative director, after public hearings, shall adopt and revise periodically an official medical fee schedule that shall establish reasonable maximum fees paid for medical services other than physician services, drugs and pharmacy services, health care facility fees, home health care, and all other treatment, care, services, and goods described in Section 4600 and provided pursuant to this section. Except for physician services, all fees shall be in accordance with the fee-related structure and rules of the relevant Medicare and Medi-Cal payment systems, provided that employer liability for medical treatment, including issues of reasonableness, necessity, frequency, and duration, shall be determined in accordance with Section 4600. Commencing January 1, 2004, and continuing until the time the administrative director has adopted an official medical fee schedule in accordance with the fee-related structure and rules of the relevant Medicare payment systems, except for the components listed in subdivision (j), maximum reasonable fees shall be 120 percent of the estimated aggregate fees prescribed in the relevant Medicare payment system for the same class of services before application of the inflation factors provided in subdivision (g), except that for pharmacy services and drugs that are not otherwise covered by a Medicare fee schedule payment for facility services, the maximum reasonable fees shall be 100 percent of fees prescribed in the relevant Medi-Cal payment system. Upon adoption by the administrative director of an official medical fee schedule pursuant to this section, the maximum reasonable fees paid shall not exceed 120 percent of estimated aggregate fees prescribed in the Medicare payment system for the same class of services before application of the inflation factors provided in subdivision (g). Pharmacy services and drugs shall be subject to the requirements of this section, whether furnished through a pharmacy or dispensed directly by the practitioner pursuant to subdivision (b) of Section 4024 of the Business and Professions Code.

(2) (A) The administrative director, after public hearings, shall adopt and review periodically an official medical fee schedule based on the resource-based relative value scale for physician services and nonphysician practitioner services, as defined by the administrative director, provided that all of the following apply:

(i) Employer liability for medical treatment, including issues of reasonableness, necessity, frequency, and duration, shall be determined in accordance with Section 4600.

(ii) The fee schedule is updated annually to reflect changes in procedure codes, relative weights, and the adjustment factor provided in subdivision (g).

(iii) The maximum reasonable fees paid shall not exceed 120 percent of estimated annualized aggregate fees prescribed in the Medicare payment system for physician services as it appeared on July 1, 2012, before application of the adjustment factor provided in subdivision (g). For purposes of calculating maximum reasonable fees, any service provided to injured workers that is not covered under the federal Medicare program shall be included at its rate of payment established by the administrative director pursuant to subdivision (d).

(iv) There shall be a four-year transition between the estimated aggregate maximum allowable amount under the official medical fee schedule for physician services prior to January 1, 2014, and the maximum allowable amount based on the resource-based relative value scale at 120 percent of the Medicare conversion factors as adjusted pursuant to this section.

(B) The official medical fee schedule shall include payment ground rules that differ from Medicare payment ground rules, including, as appropriate, payment of consultation codes and payment evaluation and management services provided during a global period of surgery.

(C) Commencing January 1, 2014, and continuing until the time the administrative director has adopted an official medical fee schedule in accordance with the resource-based relative value scale, the maximum reasonable fees for physician services and nonphysician practitioner services, including, but not limited to, physician assistant, nurse practitioner, and physical therapist services, shall be in accordance with the fee-related structure and rules of the Medicare payment system for physician services and nonphysician practitioner services, except that an average statewide geographic adjustment factor of 1.078 shall apply in lieu of Medicare's locality-specific geographic adjustment factors, and shall incorporate the following conversion factors:

(i) For dates of service in 2014, forty-nine dollars and five thousand three hundred thirteen ten thousandths cents ($49.5313) for surgery, fifty-six dollars and two thousand three hundred twenty-nine ten thousandths cents ($56.2329) for radiology, thirty dollars and six hundred forty-seven ten thousandths cents ($30.0647) for anesthesia, and thirty-seven dollars and one thousand seven hundred twelve ten thousandths cents ($37.1712) for all other before application of the adjustment factor provided in subdivision (g).

(ii) For dates of service in 2015, forty-six dollars and six thousand three hundred fifty-nine ten thousandths cents ($46.6359) for surgery, fifty-one dollars and one thousand thirty-six ten thousandths cents ($51.1036) for radiology, twenty-eight dollars and six thousand sixty-seven ten thousandths cents ($28.6067) for anesthesia, and thirty-eight dollars and three thousand nine hundred fifty-eight ten thousandths cents ($38.3958) for all other before application of the adjustment factor provided in subdivision (g).

(iii) For dates of service in 2016, forty-three dollars and seven thousand four hundred five ten thousandths cents ($43.7405) for surgery, forty-five dollars and nine thousand seven hundred forty-four ten thousandths cents ($45.9744) for radiology,

twenty-seven dollars and one thousand four hundred eighty-seven thousandths cents ($27.1487) for anesthesia, and thirty-nine dollars and six thousand two hundred five ten thousandths cents ($39.6205) for all other before application of the adjustment factor provided in subdivision (g).

(iv) For dates of service on or after January 1, 2017, 120 percent of the 2012 Medicare conversion factor as updated pursuant to subdivision (g).

(b) In order to comply with the standards specified in subdivision (f), the administrative director may adopt different conversion factors, diagnostic-related group weights, and other factors affecting payment amounts from those used in the Medicare payment system, provided estimated aggregate fees do not exceed 120 percent of the estimated aggregate fees paid for the same class of services in the relevant Medicare payment system.

(c) (1) Notwithstanding subdivisions (a) and (d), the maximum facility fee for services performed in a hospital outpatient department, shall not exceed 120 percent of the fee paid by Medicare for the same services performed in a hospital outpatient department, and the maximum facility fee for services performed in an ambulatory surgical center shall not exceed 80 percent of the fee paid by Medicare for the same services performed in a hospital outpatient department.

(2) The department shall study the feasibility of establishing a facility fee for services that are performed in an ambulatory surgical center and are not subject to a fee paid by Medicare for services performed in an outpatient department, set at 85 percent of the diagnostic-related group (DRG) fee paid by Medicare for the same services performed in a hospital inpatient department. The department shall report the finding to the Senate Labor Committee and Assembly Insurance Committee no later than July 1, 2013.

(d) If the administrative director determines that a medical treatment, facility use, product, or service is not covered by a Medicare payment system, the administrative director shall establish maximum fees for that item, provided that the maximum fee paid shall not exceed 120 percent of the fees paid by Medicare for services that require comparable resources. If the administrative director determines that a pharmacy service or drug is not covered by a Medi-Cal payment system, the administrative director shall establish maximum fees for that item. However, the maximum fee paid shall not exceed 100 percent of the fees paid by Medi-Cal for pharmacy services or drugs that require comparable resources.

(e) (1) Prior to the adoption by the administrative director of a medical fee schedule pursuant to this section, for any treatment, facility use, product, or service not covered by a Medicare payment system, including acupuncture services, the maximum reasonable fee paid shall not exceed the fee specified in the official medical fee schedule in effect on December 31, 2003, except as otherwise provided in this subdivision.

(2) Any compounded drug product shall be billed by the compounding pharmacy or dispensing physician at the ingredient level, with each ingredient identified using the applicable National Drug Code (NDC) of the ingredient and the corresponding quantity, and in accordance with regulations adopted by the California State Board

of Pharmacy. Ingredients with no NDC shall not be separately reimbursable. The ingredient-level reimbursement shall be equal to 100 percent of the reimbursement allowed by the Medi-Cal payment system and payment shall be based on the sum of the allowable fee for each ingredient plus a dispensing fee equal to the dispensing fee allowed by the Medi-Cal payment systems. If the compounded drug product is dispensed by a physician, the maximum reimbursement shall not exceed 300 percent of documented paid costs, but in no case more than twenty dollars ($20) above documented paid costs.

(3) For a dangerous drug dispensed by a physician that is a finished drug product approved by the federal Food and Drug Administration, the maximum reimbursement shall be according to the official medical fee schedule adopted by the administrative director.

(4) For a dangerous device dispensed by a physician, the reimbursement to the physician shall not exceed either of the following:

(A) The amount allowed for the device pursuant to the official medical fee schedule adopted by the administrative director.

(B) One hundred twenty percent of the documented paid cost, but not less than 100 percent of the documented paid cost plus the minimum dispensing fee allowed for dispensing prescription drugs pursuant to the official medical fee schedule adopted by the administrative director, and not more than 100 percent of the documented paid cost plus two hundred fifty dollars ($250).

(5) For any pharmacy goods dispensed by a physician not subject to paragraph (2), (3), or (4), the maximum reimbursement to a physician for pharmacy goods dispensed by the physician shall not exceed any of the following:

(A) The amount allowed for the pharmacy goods pursuant to the official medical fee schedule adopted by the administrative director or pursuant to paragraph (2), as applicable.

(B) One hundred twenty percent of the documented paid cost to the physician.

(C) One hundred percent of the documented paid cost to the physician plus two hundred fifty dollars ($250).

(6) For the purposes of this subdivision, the following definitions apply:

(A) “Administer” or “administered” has the meaning defined by Section 4016 of the Business and Professions Code.

(B) “Compounded drug product” means any drug product subject to Article 4.5 (commencing with Section 1735) of Division 17 of Title 16 of the California Code of Regulations or other regulation adopted by the State Board of Pharmacy to govern the practice of compounding.

(C) “Dispensed” means furnished to or for a patient as contemplated by Section 4024 of the Business and Professions Code and does not include “administered.”

(D) “Dangerous drug” and “dangerous device” have the meanings defined by Section 4022 of the Business and Professions Code.

(E) “Documented paid cost” means the unit price paid for the specific product or for each component used in the product as documented by invoices, proof of payment, and inventory records as applicable, or as documented in accordance with regulations

that may be adopted by the administrative director, net of rebates, discounts, and any other immediate or anticipated cost adjustments.

(F) "Pharmacy goods" has the same meaning as set forth in Section 139.3.

(7) To the extent that any provision of paragraphs (2) to (6), inclusive, is inconsistent with any provision of the official medical fee schedule adopted by the administrative director on or after January 1, 2012, the provision adopted by the administrative director shall govern.

(8) Notwithstanding paragraph (7), the provisions of this subdivision concerning physician-dispensed pharmacy goods shall not be superseded by any provision of the official medical fee schedule adopted by the administrative director unless the relevant official medical fee schedule provision is expressly applicable to physician-dispensed pharmacy goods.

(f) Within the limits provided by this section, the rates or fees established shall be adequate to ensure a reasonable standard of services and care for injured employees.

(g) (1) (A) Notwithstanding any other law, the official medical fee schedule shall be adjusted to conform to any relevant changes in the Medicare and Medi-Cal payment systems no later than 60 days after the effective date of those changes, subject to the following provisions:

(i) The annual inflation adjustment for facility fees for inpatient hospital services provided by acute care hospitals and for hospital outpatient services shall be determined solely by the estimated increase in the hospital market basket for the 12 months beginning October 1 of the preceding calendar year.

(ii) The annual update in the operating standardized amount and capital standard rate for inpatient hospital services provided by hospitals excluded from the Medicare prospective payment system for acute care hospitals and the conversion factor for hospital outpatient services shall be determined solely by the estimated increase in the hospital market basket for excluded hospitals for the 12 months beginning October 1 of the preceding calendar year.

(iii) The annual adjustment factor for physician services shall be based on the product of one plus the percentage change in the Medicare Economic Index and any relative value scale adjustment factor.

(B) The update factors contained in clauses (i) and (ii) of subparagraph (A) shall be applied beginning with the first update in the Medicare fee schedule payment amounts after December 31, 2003, and the adjustment factor in clause (iii) of subparagraph (A) shall be applied beginning with the first update in the Medicare fee schedule payment amounts after December 31, 2012.

(C) The maximum reasonable fees paid for pharmacy services and drugs shall not include any reductions in the relevant Medi-Cal payment system implemented pursuant to Section 14105.192 of the Welfare and Institutions Code.

(2) The administrative director shall determine the effective date of the changes, and shall issue an order, exempt from Sections 5307.3 and 5307.4 and the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), informing the public of the changes and their effective date. All orders issued pursuant to this

paragraph shall be published on the Internet Web site of the Division of Workers' Compensation.

(3) For the purposes of this subdivision, the following definitions apply:

(A) "Medicare Economic Index" means the input price index used by the federal Centers for Medicare and Medicaid Services to measure changes in the costs of a providing physician and other services paid under the resource-based relative value scale.

(B) "Hospital market basket" means the input price index used by the federal Centers for Medicare and Medicaid Services to measure changes in the costs of providing inpatient hospital services provided by acute care hospitals that are included in the Medicare prospective payment system.

(C) "Hospital market basket for excluded hospitals" means the input price index used by the federal Centers for Medicare and Medicaid Services to measure changes in the costs of providing inpatient services by hospitals that are excluded from the Medicare prospective payment system.

(D) "Relative value scale adjustment factor" means the annual factor applied by the federal Centers for Medicare and Medicaid Services to the Medicare conversion factor to make changes in relative value units for the physician fee schedule budget neutral.

(h) This section does not prohibit an employer or insurer from contracting with a medical provider for reimbursement rates different from those prescribed in the official medical fee schedule.

(i) Except as provided in Section 4626, the official medical fee schedule shall not apply to medical-legal expenses, as that term is defined by Section 4620.

(j) The following Medicare payment system components shall not become part of the official medical fee schedule until January 1, 2005:

(1) Inpatient skilled nursing facility care.

(2) Home health agency services.

(3) Inpatient services furnished by hospitals that are exempt from the prospective payment system for general acute care hospitals.

(4) Outpatient renal dialysis services.

(k) Except as revised by the administrative director, the official medical fee schedule rates for physician services in effect on December 31, 2012, shall remain in effect until January 1, 2014.

(*l*) Notwithstanding subdivision (a), any explicit reductions in the Medi-Cal fee schedule for pharmacy services and drugs to meet the budgetary targets provided in Section 14105.192 of the Welfare and Institutions Code shall not be reflected in the official medical fee schedule.

(m) On or before July 1, 2013, the administrative director shall adopt a regulation specifying an additional reimbursement for MS-DRGs Medicare Severity Diagnostic Related Groups (MS-DRGs) 028, 029, 030, 453, 454, 455, and 456 to ensure that the aggregate reimbursement is sufficient to cover costs, including the implantable medical

device, hardware, and instrumentation. This regulation shall be repealed as of January 1, 2014, unless extended by the administrative director.

(Amended by Stats. 2012, Ch. 363, Sec. 74. (SB 863) Effective January 1, 2013.)