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# Implementing a Resource-Based Relative Value Scale Fee Schedule for Physician Services

An Assessment of Policy Options for the  
California Workers' Compensation Program

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## Preface

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California Senate Bill 863 requires that the administrative director (AD) of the Division of Workers' Compensation implement a resource-based relative value scale (RBRVS) fee schedule to establish maximum allowable amounts for physician and other practitioner services under the California workers' compensation system. The Department of Industrial Relations asked the RAND Corporation to provide technical assistance in implementing the fee schedule. This report replaces earlier working papers.<sup>1</sup> It models the transition policies and impact of implementing the RBRVS fee schedule according to the policies in the AD's notice of modification to text of proposed regulations (first 15-day comment period) issued on August 2, 2013. The report should be of interest to the California provider and payer communities and to policymakers in California and in other states that are considering implementing a resource-based physician fee schedule for medical services provided to injured workers.

### RAND Center for Health and Safety in the Workplace

The RAND Center for Health and Safety in the Workplace is dedicated to reducing workplace injuries and illnesses. The center provides objective, innovative, cross-cutting research to improve understanding of the complex network of issues that affect occupational safety, health, and workers' compensation. Its vision is to become the nation's leader in improving workers' health and safety policy. Program research is supported by government agencies, foundations, and the private sector.

The center is housed in the RAND Safety and Justice Program, which addresses all aspects of public safety and the criminal justice system, including violence, policing, corrections, courts and criminal law, substance abuse, occupational safety, and public integrity. The center also draws on the expertise in RAND Health, one of the most trusted sources of objective health policy research in the world.

Questions or comments about this report should be sent to the project leader, Barbara Wynn (Barbara\_Wynn@rand.org). For more information on the RAND Center for Health and Safety in the Workplace, see <http://www.rand.org/jie/centers/workplace-health-safety.html> or contact the director (chsw@rand.org).

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<sup>1</sup> This report replaces earlier working papers (Wynn, Liu, et al., 2013a; Wynn, Liu, et al., 2013b). Wynn, Liu, et al. (2013b) used separate GAFs for each Medicare locality as proposed in the initial notice of proposed rulemaking issued June 17, 2013 (DWC, 2013a). The August 2, 2013, notice proposes to use a single statewide locality to determine payment (DWC, 2013c). Accordingly, this report uses a single statewide locality to model payments.



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# Summary

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## Background

The California Division of Workers' Compensation (DWC) maintains an Official Medical Fee Schedule (OMFS) for medical services provided under California's workers' compensation (WC) program. The OMFS establishes the maximum allowable amount (MAA) for services unless the payer and provider contract for a different payment amount. The OMFS for physician services applies to all services performed by physicians and other practitioners. Because the last major revision occurred in 1999, the procedure codes are outdated. Further, the MAAs are based on historical charges, which tend to undervalue evaluation and management (E&M) services relative to procedures and do not reflect changes in practice patterns and new medical technology.

Senate Bill (SB) 863 requires that the administrative director (AD) of DWC implement a resource-based relative value scale (RBRVS) fee schedule to establish MAAs for physician and other practitioner services. As amended by SB 863, Labor Code §5307.1(a)(2) requires a four-year transition from the estimated aggregate MAAs under the OMFS for physician services prior to January 1, 2014, to the MAAs based on the RBRVS. The MAAs are not to exceed 120 percent of estimated annualized aggregate fees prescribed in the Medicare payment system for physician services. The fee schedule is to be updated annually to reflect changes in procedure codes, relative values, and inflation and is to include, as appropriate, payment ground rules that differ from Medicare payment ground rules.

The RBRVS fee schedule, which is maintained by the Centers for Medicare & Medicaid Services (CMS), has three basic elements:

- relative value units (RVUs) for each medical service based on the resources associated with the physician's work (the time and skill required for the procedure), practice expenses (PEs) (the staff time and costs of maintaining an office), and malpractice expenses. For some services, the RVUs for PEs vary based on whether the service is performed in the physician's office or at a facility. The RVUs compare the resources required for one service with those required for other services. Relative to the current OMFS, the RBRVS tends to provide lower relative values for procedures and higher relative values for E&M services. The RBRVS bundles values for reports and most supplies into the RVUs for the primary procedure.
- a conversion factor (CF) that converts the RVUs into a payment amount for the service. The CF determines overall fee-schedule payment levels. The Medicare program uses a single CF for all services except anesthesia. Anesthesia is priced under a different scale (using base units and time units) and has a separate CF.

- a geographic adjustment factor (GAF) that adjusts for geographic differences in the costs of maintaining a physician practice. There are adjustment factors for nine geographic areas or payment localities in California.

Until the AD adopts an RBRVS fee schedule, §5307.1(a)(2) provides as a default that an RBRVS fee schedule for physician and nonphysician practitioner services will be effective January 1, 2014, in accordance with the fee-related structure and rules of the Medicare payment system. Under the default provision, initial CFs for anesthesia, surgery, radiology, and all other services transition to a single CF effective January 1, 2017, for all services other than anesthesia. A statewide GAF is applied to the CF in lieu of Medicare locality-specific factors.

## Impact Analysis

### *Data and Methods*

We used 2011 WC information system (WCIS) medical data to model how implementing the RBRVS over a four-year transition period could affect MAAs for services furnished by physicians and nonphysician practitioners. Consistently with the policies that DWC proposes to implement, our impact analysis assumes that the fee schedule would follow Medicare ground rules with two important exceptions: (1) a single statewide locality will be used in lieu of Medicare’s nine payment localities to determine MAAs and (2) a few WC-required services and reports will continue to be paid separately under the RBRVS. For certain issues, we separately analyzed the impact of alternative policies.

Following the framework for the transition specified in §5307.1(a)(2), we computed separate CFs for anesthesia, surgery, radiology, and all other services based on current OMFS allowances and assessed the impact by comparing estimated total aggregate allowances under the OMFS with estimated allowances under the RBRVS during 2014–2017.

### *Transition Conversion Factors*

We computed “budget-neutral” conversion factors for anesthesia, surgery, radiology, and all other services combined that would result in estimated aggregate allowances under the RBRVS that equal estimated aggregate allowances under the OMFS. Under the transition framework established in §5307.1(a)(2), the RBRVS is to be phased in over a four-year period by transitioning from multiple CFs in 2014 to a single CF for all services other than anesthesia (which continues to have its own CF) in 2017. The 2014 CFs are based on 75 percent of the budget-neutral CFs and 25 percent of 1.2 times the Medicare 2012 CF. The 2017 single CF for all services other than anesthesia is based on 1.2 times the Medicare 2012 CF. The CFs will be further adjusted for inflation and geographic location. The inflation adjustment is based on the cumulative increase in the Medicare Economic Index (MEI) between 2012 and the payment year.

The geographic adjustment is based on separate statewide geographic adjustments for work, PE, and malpractice RVUs.

Table S.1 provides the CF that we used for each year of the transition to model the impact of the RBRVS. The amounts shown are appropriate blend of the revised budget-neutral CFs and 1.2 times the Medicare CF before the inflation and GAFs are applied.

**Table S.1 Revised Transition Conversion Factor Before Adjustments for Inflation and Geographic Location**

Type of Service	RAND Budget-Neutral CF	120% 2012 Medicare <sup>a</sup>	2014 75/25 Blend	2015 50/50 Blend	2016 25/75 Blend	2017 120% Medicare
Anesthesia	34.5903	25.6896	32.3651	30.1400	27.9148	25.6896
Surgery	55.6849	40.8451	51.9750	48.2650	44.5551	40.8451
Radiology	52.9434	40.8451	49.9188	46.8943	43.8697	40.8451
All other services	34.4566	40.8451	36.0537	37.6509	39.2480	40.8451

<sup>a</sup> The Medicare 2012 CFs for anesthesia and all other services are \$21.408 and \$34.042, respectively.

### *Impact, by Type of Service*

Table S.2 summarizes the impact on California WC MAAs during the transition (2014–2017) by type of service. Over the four-year period, total allowable fees are estimated to increase 11.9 percent. The increase represents the combined effect of estimated inflation (which increases the rates 8 percent over the period) and the transition from current OMFS payment levels at 116 percent of Medicare to 120 percent of Medicare in 2017. For anesthesia, allowable fees decline 19.6 percent over the transition. There are also declines in surgery (–20.1 percent) and radiology (–15.9 percent). Within the “all other services” category, there are significant increases for medicine (17.3 percent)<sup>2</sup> and E&M (39.5 percent). In contrast, there are significant reductions in pathology (–29.0 percent). Because pathology is grouped with other services that have low OMFS payments relative to Medicare payments, the transition policy does not work as intended for pathology services. The reduction is greatest in the first year (–41.1 percent) and lessens over the transition as the CF increases.

Services are assigned in Table S.2 consistently with how they are classified in the 2013 CPT codebook. For example, reports and supplies are classified as “medicine” so that the changes in ground rules for bundling these services under the RBRVS are included in the medicine rather than E&M service category. As a result, the percentage change in allowances for specialties that predominantly furnish E&M services (see Table S.3) is lower than the increase for E&M

<sup>2</sup> Medicine (Current Procedural Terminology [CPT] 90281–99199, 99500–99607) includes noninvasive or minimally invasive services, such as drug infusions and injections, physical medicine, psychiatric and neurologic medicine, reports, supplies, and other special services, and excludes E&M services.

services, and the percentage change for physical medicine specialties is higher than the increase for the medicine category. Because surgeons furnish a substantial amount of E&M services in addition to surgical services, the percentage change in allowances for the surgical specialties in 2017 is -8.7 percent, compared with the -20.1-percent change for surgery.

**Table S.2 Impact of Resource-Based Relative Value Scale Implementation on Maximum Allowable Amounts, by Type of Service and Transition Year**

Type of Service	OMFS		RBRVS 2014		RBRVS 2015		RBRVS 2016		RBRVS 2017	
	Total MAAs (\$ millions)	Percentage of Total	Total MAAs (\$ millions)	Change (%)						
Anesthesia	24.81	2.8	23.64	-4.7	22.36	-9.8	21.19	-14.6	19.95	-19.6
Surgery	164.89	18.8	156.98	-4.8	148.31	-10.1	140.27	-14.9	131.78	-20.1
Radiology	104.35	11.9	100.76	-3.4	96.22	-7.8	92.13	-11.7	87.80	-15.9
Pathology	1.80	0.2	1.06	-41.0	1.13	-37.5	1.20	-33.3	1.28	-29.0
Medicine	315.01	35.9	310.95	-1.3	328.31	4.2	348.52	10.6	369.48	17.3
E&M	266.01	30.3	308.10	15.8	326.85	22.9	348.50	31.0	370.96	39.5
Total	876.88	100	901.50	2.8	923.18	5.3	951.82	8.5	981.25	11.9

NOTE: Because of rounding, totals might not sum precisely. Change percentages are dollar-weighted averages.

**Table S.3 Impact of Resource-Based Relative Value Scale Implementation on Maximum Allowable Amounts, by Provider Specialty and Transition Year**

Provider Specialty	OMFS		RBRVS 2014		RBRVS 2015		RBRVS 2016		RBRVS 2017	
	Total MAAs (\$ millions)	Percentage of Total	Total MAAs (\$ millions)	Change (%)						
Practice groups										
Multispecialty	44.99	5.1	49.61	10.3	51.20	13.8	53.20	18.2	55.27	22.8
Single specialty	2.52	0.3	2.48	-1.8	2.51	-0.4	2.57	1.7	2.62	3.8
Individual providers										
Family medicine or general practice	190.82	21.8	195.56	2.5	200.56	5.1	207.09	8.5	213.80	12.0
Surgery	133.51	15.2	121.76	-8.8	121.29	-9.2	121.61	-8.9	121.87	-8.7
PT	62.76	7.2	86.82	38.3	91.74	46.2	97.46	55.3	103.38	64.7
Radiology	56.62	6.5	48.95	-13.5	46.98	-17.0	45.24	-20.1	43.40	-23.3
Physical medicine and rehabilitation	45.33	5.2	57.75	27.4	61.03	34.6	64.84	43.0	68.79	51.7
Occupational medicine	35.89	4.1	41.11	14.5	42.62	18.8	44.48	23.9	46.39	29.2
Chiropractic	34.38	3.9	35.28	2.6	37.29	8.5	39.63	15.3	42.05	22.3
Anesthesiology	26.63	3.0	24.62	-7.5	23.86	-10.4	23.23	-12.8	22.55	-15.3
Internal medicine	19.77	2.3	18.94	-4.2	19.39	-2.0	19.99	1.1	20.60	4.2
Acupuncture	11.82	1.3	10.84	-8.3	11.46	-3.1	12.17	3.0	12.91	9.2
Neurology	11.15	1.3	7.53	-32.5	7.88	-29.4	8.29	-25.6	8.73	-21.8
Occupational therapy <sup>a</sup>	7.96	0.9	11.24	41.2	11.90	49.5	12.67	59.2	13.46	69.1
Emergency medicine	7.44	0.8	8.14	9.3	8.43	13.3	8.79	18.1	9.16	23.1
Psychiatry	6.43	0.7	5.54	-13.9	5.85	-9.0	6.22	-3.3	6.60	2.6
Podiatry	4.55	0.5	5.36	17.7	5.40	18.7	5.49	20.5	5.57	22.3
Pathology	1.25	0.1	1.00	-20.5	1.05	-16.5	1.10	-11.8	1.16	-6.9

Provider Specialty	OMFS		RBRVS 2014		RBRVS 2015		RBRVS 2016		RBRVS 2017	
	Total MAAs (\$ millions)	Percentage of Total	Total MAAs (\$ millions)	Change (%)						
Other	173.03	19.7	168.98	-2.3	172.72	-0.2	177.76	2.7	182.93	5.7
Total	876.88	100.0	901.50	2.8	923.18	5.3	951.82	5.6	981.25	11.9

<sup>a</sup> Includes speech-language therapy and hearing providers.

NOTE: Because of rounding, totals might not sum precisely. PT = physical therapy. Change percentages are dollar-weighted averages.

## *Alternative Policies*

In addition to modeling the impact of implementing the RBRVS based on Medicare ground rules, we examined alternative policies that might be considered for managing WC medical-provider fees. In this section is a summary of key findings from this analysis. To the extent that an alternative policy would increase aggregate allowances, an offsetting adjustment would be required so that estimated aggregate allowances do not exceed 120 percent of Medicare allowances.

### Geographic Adjustment Factors

The OMFS uses a single statewide fee schedule with no adjustment for geographic differences in the costs of maintaining an office. Medicare has different GAFs for eight urban areas (e.g., Los Angeles, San Francisco, Oakland/Berkeley) and a “rest-of-state” locality made up of 14 urban counties (including San Diego, Monterey, and Sacramento) and all rural counties. In states that have adopted a single payment locality, Medicare establishes separate statewide geographic practice cost index (GPCI) values for each component of the RVUs. The separate values adjust for price differences in the RVU components across services while providing the same payment across the state for a given service. Our baseline impact analysis used a single payment locality with separate statewide GPCIs for work (1.0370), PE (1.1585), and malpractice (0.5877) for all services other than anesthesia and a statewide GAF for anesthesia. We used the statewide GAF for anesthesia because the RVU components do not differ across procedures. We also examined the impact of using either Medicare’s nine payment localities or a single statewide GAF for all services other than anesthesia. Using the 2011 WCIS data, the statewide GAF was 1.0799 for all other services. The effect of using the statewide GPCI values is to redistribute allowances to the urban and rural counties that are classified in a rest-of-state locality (Table S.4). A single statewide GAF has a similar locality effect, but it would also redistribute allowances from services with relatively high PEs, such as radiology services and services provided in office settings, to services that are performed in facility settings. For example, the average geographic adjustment for radiology services is 1.1274 using the statewide GPCI values and 1.1265 using the nine-locality structure, compared with 1.0799 using a single statewide GAF. Differences in the mix of services across localities account for the locality differences in total RBRVS allowances between the statewide GPCI values and statewide GAF seen in Table S.4.

**Table S.4 Comparison of 2014 Total Allowances Under the Official Medical Fee Schedule and Resource-Based Relative Value Scale Using Nine Payment Localities, Statewide Locality Geographic Practice Cost Index, and Single Statewide Geographic Adjustment Factor, by Locality**

Medicare Locality	Total OMFS Allowances		RBRVS Total Allowances (including BR)		
	Statewide GAF		9 Payment Localities and HPSA Bonus Payments	Statewide GPCI and HPSA Bonus Payments <sup>a</sup>	Single Statewide GAF <sup>b</sup>
	Total Allowances (\$ millions)	Percentage of Total Allowances	Percentage Change from OMFS Total Allowances		
Marin/Napa/Solano	12.55	1.4	6.7	3.0	3.1
San Francisco	20.16	2.3	10.8	1.7	2.7
San Mateo	11.18	1.3	12.6	3.5	3.7
Oakland/Berkeley	56.68	6.5	6.0	1.5	1.7
Santa Clara	29.43	3.4	13.2	4.5	4.6
Ventura	16.25	1.9	2.2	0.8	0.7
Los Angeles	301.16	34.3	0.3	0.4	0.2
Anaheim/Santa Ana	90.31	10.3	-1.2	-4.1	-4.2
Rest of California	278.03	31.7	3.2	7.4	7.3
Unknown	61.14	7.0	4.9	5.0	3.9
Total	876.88	100	2.8	2.8	2.8

<sup>a</sup> The statewide GPCI values are as follows: work = 1.0370, PE = 1.1585, and malpractice expense = 0.5877. The statewide GAF was used for anesthesia.

<sup>b</sup> The statewide GAFs used in the modeling are as follows: anesthesia = 1.0212, and all other services = 1.0799.

NOTE: Change percentages are weighted averages.

### Nonphysician Practitioners

The OMFS does not differentiate between physicians and nonphysician practitioners acting within their scope of practice and sets the MAAs for similar services at the same amount. Unless their services are billed “incident to” a physician’s service, Medicare pays services furnished by nurse practitioners (NPs) and physician assistants (PAs) at 85 percent of the allowed amount for physician services. Medicare pays clinical social workers at 75 percent of the allowed amount. Our baseline impact follows the Medicare policies, but we also modeled the impact of setting the allowances at 100 percent of the amounts paid to physicians. Paying nonphysician practitioners based on 100 percent of the amounts payable to physicians would increase total RBRVS aggregate allowances 0.4 percent.

### Alternative Conversion Factors

We calculated two alternative CFs that grouped pathology with other services that are projected to have reductions in allowances under the RBRVS. One combined pathology with radiology, and the second combined surgery, radiology, and pathology into a single grouping.

Because physician pathology services represent only 0.2 percent of OMFS allowances, a change in the transition CF for these services has little impact on the CFs for other services but increases the first-year payments for pathology 41–44 percent relative to combining pathology with E&M and medicine.

#### Bundling Payment for Supplies and Reports

The OMFS establishes separate allowances for certain reports and supplies. Medicare bundles payment for reports and supplies into the payment for E&M and other services. Our impact analysis generally follows Medicare’s rules and bundles supplies and most reports, including consultation reports. We assumed that certain WC-required reports that are separately reimbursable would continue to be paid separately. Because these reports are not Medicare-covered reports, separate payment for these reports does not require an adjustment to remain within 120 percent of Medicare allowances.

#### Consultations

The OMFS has separate, higher allowances for consultations, while Medicare does not. In 2010, Medicare stopped recognizing CPT codes for consultation services and instead pays for consultations using the E&M visit codes. To make the change budget neutral, CMS increased the compensation for E&M visits (CMS, 2009a). Following the Medicare ground rules (using the E&M visit codes and bundling consultation reports), estimated RBRVS allowances are 57 percent of current OMFS allowances for consultations and reports. Allowances for consultations are 27 percent higher using RVUs for the consultation codes instead of the RVUs for the E&M visit codes. Using the consultation RVUs would increase E&M allowances 1.98 percent and total aggregate allowances by 0.78 percent beginning in 2017, when the RBRVS is fully implemented.

#### Global Periods

Under both the OMFS and the Medicare fee schedule, a single global surgical fee covers a package of services that includes the surgical procedure itself, immediate pre- and postsurgical services, and E&M services routinely delivered after the surgery in a fixed period of time. Surgical procedures are assigned a global period length of zero, ten, or 90 days. The global period definitions used by the OMFS and the RBRVS are nearly identical. Postsurgical E&M visits account for a considerable proportion of the total time and work associated with surgical procedures in the RBRVS, but there is some concern regarding whether the global billing rules provide sufficient recognition of work-related components of follow-up care. Because both Medicare and WC use global periods, data are not available to determine whether WC patients require more follow-up visits and what the impact would be of eliminating the global periods. However, WC patients have a shorter length of stay than Medicare patients for surgical

admissions and are younger and healthier than Medicare patients. As a result, they are likely to require fewer follow-up visits for *medical* reasons.

### Physical Medicine

The OMFS has a complex set of rules concerning payment for physical medicine codes, including discounting of multiple procedures furnished during the same encounter and limits on the number of procedures or time billed during the encounter. When more than one unit of therapy services is furnished during the same encounter, Medicare pays 100 percent for the service with the highest allowance and discounts the PE component of the remaining units by 50 percent. The baseline impact analysis follows Medicare's rules for discounting the PE component and applies the discounting to chiropractic and acupuncture codes, as well as therapy services. By including only bills for which payment was made, the impact analysis implicitly assumes that current limits on the number of procedures and time billed during an encounter will continue.

### Physician-Administered Vaccines and Drugs

The OMFS contains outdated allowances for physician-administered vaccines and drugs that are injected or infused during an E&M visit or other procedure. Our baseline impact analysis includes the physician-administration codes but does not include drug ingredient costs. Currently, the OMFS uses the Medi-Cal fee schedule for outpatient prescription drugs. Either the Medicare or Medi-Cal fee schedule would provide a vehicle to establish reasonable allowances for drug ingredient costs that would be updated on a regular basis. The Medi-Cal fee schedule for physician-administered drugs (PADs) would provide broader coverage for vaccines than the Medicare fee schedule.

### Site-of-Service Differentials

The OMFS sets the same allowance for all sites of service. (Separate facility fees are allowed for hospital inpatient services, hospital emergency rooms, and operating rooms (ORs) for ambulatory surgery, but otherwise there are no differences in payment across different care settings.) The PE component of the Medicare fee schedule distinguishes between services that are furnished in nonfacility settings (i.e., physician offices) and facility settings (e.g., hospitals and ambulatory surgery centers [ASCs], for which Medicare makes a separate payment for the costs of the facility services). We do not include services furnished by ASCs or hospitals that are currently paid under the OMFS for physician services in our baseline impact analysis. Medicare ground rules would pay for any nonsurgical services provided to hospital outpatients under its prospective payment system for hospital outpatient services. Hospital outpatient services account for about 2.2 percent of OMFS payments. Paying for these services under the RBRVS would result in a 6.5-percent reduction in allowances, while paying for these services at 1.2 times the Medicare rate for hospital outpatient services would increase allowances 73 percent. Only a

small volume of nonsurgical services is furnished by ASCs. Under Medicare, these services would be paid under the RBRVS fee schedule.

## Acknowledgments

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## Abbreviations

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AAOS	American Association of Orthopaedic Surgeons
AD	administrative director
AHRQ	Agency for Healthcare Research and Quality
AMA	American Medical Association
AMP	average manufacturer price
ASA	American Society of Anesthesiologists
ASC	ambulatory surgery center
ASP	average sales price
AWP	average wholesale price
BR	by report
CF	conversion factor
CMS	Centers for Medicare & Medicaid Services
CPT®	Current Procedural Terminology
CRNA	certified registered nurse anesthetist
CRVS	California Relative Value Scale
CT	computerized tomography
CWCI	California Workers' Compensation Institute
CY	calendar year
DF	discounting factor
DME	durable medical equipment
DMEPOS	durable medical equipment, prosthetics, orthotics, and supplies
DWC	California Division of Workers' Compensation
ECG	electrocardiogram
ED	emergency department
E&M	evaluation and management
final PR-2	Primary Treating Physician's Final Discharge Report
Form 5021	Doctor's First Report of Occupational Illness or Injury
FROI	first report of injury
FUL	federal upper limit
GAF	geographic adjustment factor
GPCI	geographic practice cost index
HCPCS	Healthcare Common Procedure Coding System
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HMO	health maintenance organization

HOPD	hospital outpatient department
HPI	history of present illness
HPSA	health-professional shortage area
HRSA	Health Resources and Services Administration
IOM	Institute of Medicine
IT	information technology
IV	intravenous
MAA	maximum allowable amount
MAIC	maximum allowable ingredient cost
MCO	managed-care organization
MedPAC	Medicare Payment Advisory Commission
MEI	Medicare Economic Index
MP	malpractice expense
MPFS	Medicare Physician Fee Schedule
MPPR	multiple-procedure payment reduction
MRI	magnetic resonance imaging
MUE	medically unlikely edit
NCCI	National Correct Coding Initiative
NCQA	National Committee for Quality Assurance
NDC	National Drug Code
NOC	not otherwise classified
NP	nurse practitioner
NQF	National Quality Forum
OMFS	Official Medical Fee Schedule
OPPS	outpatient prospective payment system
OR	operating room
OWCP	Office of Workers' Compensation Programs
P4P	pay for performance
P4R	pay for reporting
PA	physician assistant
PAD	physician-administered drug
PC	professional component
PE	practice expense
PFSH	past, family, and social history
PR-2	Primary Treating Physician's Progress Report
PR-3	Primary Treating Physician's Permanent and Stationary Report
RBRVS	resource-based relative value scale

ROS	review of systems
RVU	relative value unit
SB	Senate bill
TC	technical component
UB	uniform bill
W	work
WAC	wholesale acquisition cost
WC	workers' compensation
WCAB	Workers' Compensation Appeals Board
WCIRB	Workers' Compensation Insurance Rating Bureau of California
WCIS	workers' compensation information system
WCRI	Workers' Compensation Research Institute



## Chapter One. Introduction

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California Senate Bill (SB) 863 (DeLeón) requires that the administrative director (AD) of the California Division of Workers' Compensation (DWC) implement a resource-based relative value scale (RBRVS) fee schedule to establish maximum allowable amounts (MAAs) for physician and other practitioner services under the California workers' compensation (WC) system. This report summarizes the results from our modeling of the impact of the proposed policies and selected alternative policies.

### Description of the Official Medical Fee Schedule and Its Shortcomings

DWC maintains an Official Medical Fee Schedule (OMFS) for medical services provided under California's WC program. The OMFS establishes the MAA for services unless the payer and provider contract for a different payment amount. The OMFS for physician services applies to all services performed by physicians and other practitioners regardless of type of facility in which the services are performed.<sup>3</sup> The OMFS primarily uses 1997 Common Procedural Terminology (CPT) codes to describe medical services. CPT codes from 1994 are used for anesthesia services and physical medicine, and there are a few WC-specific codes or definitions.<sup>4</sup>

The fee schedule consists of two components:

- relative value units (RVUs) for each procedure. The relative value scale is based on the California Relative Value Scale (CRVS), which was developed by the California Medical Association in 1956 and adopted by DWC in 1965. The CRVS was last revised in 1974 and used historical physician charges to develop its relative values for services. The American Society of Anesthesiologists (ASA) 1993 *Relative Value Guide* is used for anesthesia services.
- a dollar conversion factor (CF) that converts the RVUs into an allowance. Separate CFs apply to each type of service defined by CPT codebook section: evaluation and management (E&M), anesthesiology, surgery, radiology, pathology (and laboratory), and medicine. The CFs have not been updated regularly.

The general formula for determining the MAA is  $\text{maximum fee} + RVU \times CF$ . Under current law, the AD has the authority to revise the physician fee schedule no less than biennially. However, the last major revision was completed in April 1999. SB 228 (2003) reduced

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<sup>3</sup> Separate facility fees are allowed for hospital inpatient services, hospital emergency room, and operating suites for ambulatory surgery, but otherwise there are no differences in allowances across different care settings.

<sup>4</sup> The CPT code set is maintained and copyrighted by the American Medical Association (AMA). The code set is designated under the Health Insurance Portability and Accountability Act (HIPAA) as the national coding standard for physician and other health care professional services.

allowances for services that exceed the Medicare fee schedule 5 percent (but not below Medicare rates) and froze allowances until the AD establishes a new fee schedule for physician and practitioner services. Administratively, the OMFS allowances for some E&M codes were increased to no less than Medicare fee-schedule levels in 2007.

There are three major shortcomings in the current fee schedule. First, the OMFS uses outdated procedure codes to describe medical services. This poses an administrative burden on providers, who must maintain a separate coding system for WC patients. Also, because the OMFS does not include codes for new technology that has been developed since 1997, fee disputes between providers and payers are likely to occur over these typically high-cost services. Second, the relative values in the current fee schedule are based on historical charges, which tended to undervalue E&M services relative to procedures. Overvaluing a service provides an incentive for unnecessary utilization, while undervaluing a service could raise access issues. In contrast, an RBRVS reflects the resources (costs) required to furnish services and provides neutral incentives for providing services. Third, the current fee schedule does not provide for regular updates for changes in coding, practice patterns, and inflation. These problems have led to efforts to adopt a fee schedule based on the Medicare physician fee schedule (MPFS) in the past decade.

## A Brief Description of the Resource-Based Relative Value Scale

The MPFS was implemented in January 1992 and incorporates an RBRVS that values services according to the relative resources required to furnish them. The fee schedule is maintained by the Centers for Medicare & Medicaid Services (CMS) and is updated annually through a rulemaking process to take into account changes in the coding system, practice patterns, and inflation. The RBRVS fee schedule has three basic elements:

- RVUs for each medical service based on the resources associated with the physician's work (the time and skill required for the procedure), practice expenses (PEs) (the staff time and costs of maintaining an office), and malpractice expenses. For most procedures, the RVUs for PEs vary according to whether the procedure is performed in the physician's office or at a facility. The RVUs compare the resources required for one service with those required for other services. Compared with the current OMFS, the RBRVS tends to provide lower relative values for procedures and higher relative values for E&M services.
- a CF that converts the RVUs into a Medicare payment amount for the procedure. The CF determines overall fee-schedule payment levels. The Medicare program uses a single CF for all services except anesthesia. Anesthesia is priced under a different scale (using base units and time units) and has a separate CF.
- a geographic adjustment factor (GAF) that adjusts for geographic differences in the costs of maintaining a physician practice. Separate geographic practice cost indexes (GPCIs) are applied to the RVUs for the three components constituting the service: physician

work, malpractice expense, and PE. There are adjustment factors for nine geographic areas or localities in California.

## History of the Resource-Based Relative Value Scale in California

For more than a decade, DWC has considered replacing the current OMFS with a fee schedule based on the RBRVS. SB 228 (2003) postponed an effort initiated in 2001 to revise the fee schedule. The SB 228 provisions specified that the existing physician fee schedule would remain in place (except that fees would be reduced by 5 percent but not below the Medicare payment amount) until the AD adopted a physician fee schedule no earlier than January 1, 2006. As amended by SB 228, §5307.1 of the Labor Code did not specify the type of fee schedule that the AD should adopt but required that the schedule be revised no less frequently than biennially. Most other components of the OMFS (other than pharmaceuticals) are based on Medicare fee schedules and are limited in the aggregate to 120 percent of the amounts that would be payable under Medicare for comparable services.

The last effort to adopt an RBRVS fee schedule was initiated with a pre-rulemaking proposal to issue draft regulations in March 2010 and a revised draft proposal in July 2010 that responded to comments on the March proposal. Major issues were the adequacy of the overall payment levels (which are among the lowest of state WC programs) and the redistribution of payments across specialties. The March draft proposed to transition from multiple CFs to a single CF with total expenditures “budget neutral” to estimated expenditures under the OMFS. The July draft increased the total level of funding used to determine the CF, proposed higher CFs for surgery and radiology than for other services, and left the question of a transition to a single CF to future rulemaking. The pre-rulemaking proposals were supported by impact analysis prepared by The Lewin Group (Welch, El-Gamil, et al., 2008; Welch, Koenig, and Schuster, 2010).

SB 863 was enacted on September 18, 2012. The legislation made wide-ranging changes to California’s WC system, one of which was to require the AD to adopt and periodically review an OMFS based on the RBRVS for physician and nonphysician practitioner services. As amended by SB 863, Labor Code §5307.1(a)(2) requires that the AD adopt an RBRVS-based fee schedule for physician and other practitioner services with a four-year transition from the estimated aggregate maximum allowable amounts (MAAs) under the OMFS for physician services prior to January 1, 2014, to MAAs based on the RBRVS. The MAAs are not to exceed 120 percent of estimated annualized aggregate fees prescribed in the Medicare payment system for physician services. The fee schedule is to be updated annually to reflect changes in procedure codes, relative values, and inflation and is to include, as appropriate, payment ground rules that differ from Medicare payment ground rules.<sup>5</sup>

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<sup>5</sup> As discussed in greater detail in Chapter Three, the limit applies in the aggregate to the amounts that would be paid by Medicare by the 2012 Medicare CF updated for inflation by the MEI and any budget-neutrality adjustment for

Until the AD has adopted an RBRVS fee schedule, §5307.1(a)(2) provides as a default that an RBRVS fee schedule for physician and nonphysician practitioner services in accordance with the fee-related structure and rules of the Medicare payment system for physician and nonphysician practitioner services will be effective January 1, 2014. Under the default provision, initial CFs for anesthesia, surgery, radiology, and all other services transition to a single CF effective January 1, 2017, for all services other than anesthesia. A statewide GAF is applied to the CF in lieu of Medicare locality-specific factors.

## Overview of Our Analysis

Our modeling had two basic objectives: (1) determine budget-neutral CFs that will apply during the transition to the RBRVS fee schedule and (2) assess the impact that the transition to RBRVS could have on MAAs for services furnished to WC patients. The results from the first objective have implications for the level of aggregate spending during the transition period. They do not affect aggregate spending beginning in 2017, when the MAA will be determined solely by a CF based on 120 percent of Medicare updated for inflation. The results from the second objective do not affect aggregate spending levels; rather, they estimate what changes in aggregate spending levels will occur relative to the current OMFS MAA.

Generally, our baseline impact analysis in Chapter Five reflects the differences in the allowances under current OMFS rules and Medicare rules.<sup>6</sup> For certain issues, we separately analyzed the impact of alternative policies and discuss the results of that analysis in Chapters Six and Seven. In this section, we summarize our approach.

### *Coding System*

The OMFS primarily uses 1997 CPT codes (1994 for physical medicine) to describe physician and other practitioner services, National Drug Code (NDC) numbers to bill for physician-administered pharmaceuticals, and some California-specific codes. Medicare uses the Healthcare Common Procedure Coding System (HCPCS). Level I is current CPT codes, and level II is alphanumeric codes assigned to services (mostly nonprofessional), medications, supplies, and equipment. For the impact analysis, we cross-walked the OMFS procedure codes into their 2013 CPT code equivalents (see “Cross-Walking to 2013 Codes” in Chapter Three). We also cross-walked NDC numbers into Medicare’s J-codes for pharmaceuticals to analyze alternative drug pricing policies in Chapter Seven. We did not assign services to the alphanumeric codes because in general the AD proposes to adopt only CPT codes for professional services.

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changes in the RVUs. The actual CFs used by the Medicare program after 2012, which are affected by a sustainable growth-rate adjustment and federal budget decisions, are not used in applying the limitation.

<sup>6</sup> Appendix A contains a detailed comparison of the two fee schedules.

### ***Conversion Factors***

The OMFS has separate CFs for E&M services, medicine, surgery, radiology, pathology, and anesthesia. Medicare uses a single CF for all services other than anesthesia, which has its own CF. The default option in §5307.1(a)(2) provides for separate CFs for anesthesia, surgery, radiology, and all other services combined that transition over four years to a single CF for all services other than anesthesia. We used the structure of the default-option transition but recalculated budget-neutral CFs for the OMFS portion of the transition CFs.

### ***Geographic Adjustment Factors***

The OMFS uses a single statewide fee schedule with no adjustment for geographic differences in the costs of maintaining an office. Medicare uses nine localities to adjust for geographic differences. Our baseline impact analysis uses statewide GPCI factors for the three components of the fee schedule: work, PE, and malpractice insurance.<sup>7</sup> We examine the impact of using alternative GAFs in Chapter Six.

### ***Nonphysician Practitioners***

The OMFS does not differentiate between physicians and nonphysician practitioners acting within their scope of practice and sets the MAAs for similar services at the same amount. Unless their services are billed “incident to” a physician’s service, Medicare pays services furnished by nurse practitioners (NPs) and physician assistants (PAs) at 85 percent of the allowed amount for physician services. Medicare pays clinical social workers at 75 percent of the allowed amount. Our baseline impact analysis follows the Medicare policies, but we also examine in Chapter Six the impact of setting the allowances at 100 percent of the amounts paid to physicians.

### ***Site-of-Service Differentials***

The OMFS sets the same allowance for all sites of service. (Separate facility fees are allowed for hospital inpatient services, hospital emergency room, and operating rooms (ORs) for ambulatory surgery, but otherwise there are no differences in payment across different care settings.) The PE component of the Medicare fee schedule distinguishes between services that are furnished in nonfacility settings (i.e., physician offices) and facility settings (e.g., hospitals and ambulatory surgery centers [ASCs]) where Medicare makes a separate payment for the costs of the facility services. In our baseline impact analysis, we did not include facility services furnished by ASCs or hospitals that are currently paid under the OMFS for physician services.

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<sup>7</sup> This analysis is consistent with the notice of first 15-day comment period issued by the AD on August 2, 2013, that modified the text of regulations proposed on June 17, 2013. The impact analysis in the earlier working papers was based on the initial notice of proposed rulemaking, which adopted the Medicare locality structure. Based on public comment, the proposed modification is to adopt a single statewide locality.

Instead, we separately examine, in Chapter Seven, the impact of alternative policies to pay for these services.

### *Consultations*

The OMFS has separate higher allowances for consultations than for E&M visits. In 2010, Medicare stopped recognizing CPT codes for consultation services and instead pays for consultations using the E&M visit codes. To make the change budget neutral, CMS increased the fees for E&M visits (CMS, 2009a). Our baseline impact analysis follows the Medicare pricing rules, but we examine in Chapter Six the impact of using the consultation-code RVUs.

### *Bundling Payment for Supplies and Reports*

The OMFS establishes separate allowances for certain reports and supplies. Medicare bundles payment for reports and most supplies into the payment for E&M services. Our impact analysis generally follows Medicare's bundling rules and bundles most supplies and reports, including consultation reports. We assumed that certain WC-required reports that are separately reimbursable would continue to be paid separately. Because these reports are not Medicare-covered reports, separate payment for these reports does not require an adjustment to remain within 120 percent of Medicare allowances.

### *Physical Medicine*

The OMFS has a complex set of rules concerning payment for physical medicine codes, including discounting of multiple procedures furnished during the same encounter and limits on the number of procedures or time billed during the encounter. When more than one unit of therapy services is furnished during the same encounter, Medicare pays 100 percent for the service with the highest allowance and discounts the PE component of the remaining units by 50 percent. The baseline impact analysis follows Medicare's discounting rules and applies the discounting to chiropractic and acupuncture codes, as well as therapy services. By including only bills for which payment was made, the impact analysis implicitly assumes that current limits on the number of procedures and time billed during an encounter will continue.<sup>8</sup>

### *Physician-Administered Vaccines and Drugs*

The OMFS contains outdated allowances for physician-administered vaccines and drugs that are injected or infused during an E&M visit or other procedure. Our baseline impact analysis includes the physician-administration codes but does not include drug ingredient costs. However, in Chapter Seven, we examine alternative policies for paying for the drug ingredient costs.

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<sup>8</sup> Medicare also has an annual per-beneficiary limit on aggregate payments for therapy services. Because this is a coverage rather than fee-schedule limitation, we did not apply the limitation to WC therapy services.

## Organization of This Report

The remainder of this report is organized as follows:

- Chapter Two describes the data used in the analysis.
- Chapter Three discusses our methodology for conducting the impact analysis.
- Chapter Four contains descriptive results.
- Chapter Five presents impact results from the baseline model.
- Chapter Six discusses alternative ground rules, including results from alternative policy simulations.
- Chapter Seven discusses other fee-schedule issues that are not directly related to how prices are set under the RBRVS.
- Appendix A compares the OMFS and Medicare ground rules for physician services.
- Appendix B contains the crosswalk from OMFS codes to 2013 CPT codes.
- Appendix C summarizes how WC-specific codes were handled in the impact analysis.
- Appendix D contains an analysis of alternative pricing policies for the ingredient costs of physician-dispensed drugs.



## Chapter Two. Data

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### Workers' Compensation Information System Data

The primary data source for the impact analysis is the WC information system (WCIS) database maintained by DWC. The WCIS uses electronic data interchange to collect comprehensive information from claim administrators<sup>9</sup> to help the Department of Industrial Relations oversee the state's WC system. Historically, the data were collected in paper form, but, starting in 2000, electronic transmission of first reports of injury (FROIs) were required. In 2006, the WCIS was expanded to include medical transmissions. Data are transmitted to DWC within 90 calendar days of the bill payment or the date of final determination that payment for billed medical services would be denied. By law, claim administrators with at least 150 total claims per year are required to report medical data for all services provided on or after September 22, 2006.

We chose the WCIS as our primary data source because it is the most complete and representative data set available to us. Even though the WCIS contains the best data available, it has limitations. One limitation is that not all claims are reported into the system;<sup>10</sup> among reported claims, there is further underreporting of medical data.<sup>11</sup> Because the WCIS does not include all claims with medical expenditures, representativeness is a potential issue. If the distribution of services in the available data diverges from the "true" distribution (for all claims), this has implications for our policy simulations. Given the absence of a gold-standard data set with which we can compare the WCIS, we adopted several different approaches to assess the representativeness of the 2011 WCIS medical claim data. First, we compared the distribution of the nature of worker injury based on the FROI<sup>12</sup> with the distribution for the claims with medical data (Table 2.1). If the distributions are similar, this suggests that, at a minimum, the medical claim data are representative of all claims with an FROI.

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<sup>9</sup> A claim administrator is an insurer, a self-insured self-administered employer, or a third-party administrator.

<sup>10</sup> According to DWC, there is thought to be about 20 percent underreporting.

<sup>11</sup> About 21 percent of FROI claims have no medical claim data. When we exclude denied claims, the percentage of claims without medical data decreases to 14 percent.

<sup>12</sup> These figures were obtained from DWC tables (California Department of Industrial Relations, 2013b).

**Table 2.1 Nature of Injury in 2011: All Claims with First Report of Injury Versus Only Claims with Medical Data**

<b>Code</b>	<b>Nature of Injury</b>	<b>All Claims (FROI) (%)</b>	<b>Claims with Medical Data (%)</b>
52	Strain	30.7	37.6
49	Sprain	10.7	11.0
10	Contusion	11.4	9.3
59	All other specific injuries, NOC	8.3	7.5
40	Laceration	10.6	6.6
80	All other cumulative injuries, NOC	3.5	5.2
28	Fracture	2.6	3.8
37	Inflammation	2.8	3.1
90	Multiple physical injuries only	3.1	3.1
43	Puncture	3.4	2.0
78	Carpal tunnel syndrome	0.7	1.4
77	Mental stress	1.7	1.3
25	Foreign body	2.2	1.3
04	Burn	1.5	0.9
16	Dislocation	0.3	0.8
13	Crushing	0.8	0.7
34	Hernia	0.6	0.6
91	Multiple injuries, including both physical and psychological	0.3	0.4
07	Concussion	0.3	0.3
01	No physical injury	0.8	0.3
71	All other occupational disease injury, NOC	0.4	0.3
68	Dermatitis	0.6	0.3
36	Infection	0.5	0.3
	All others	2.1	2.0
	Total	100.0	100.0

NOTE: NOC = not otherwise classified.

Second, we compared the distribution of payments by physician specialty in the WCIS with the distribution of payments reported by the Workers' Compensation Insurance Rating Bureau of California (WCIRB). The WCIRB includes only insurer claims, while the WCIS includes both insurer and self-insured claims. To increase comparability between the two data sets, we included only WCIS insurer data and reclassified the specialty designations to be consistent with the WCIRB to the extent feasible. However, important distinctions remain. The WCIRB data categorize services according to the provider who received the payment. For example, payments for physician-dispensed pharmaceuticals, supplies, and equipment are included in the WCIRB

physician payments but are not captured in our WCIS physician file; instead, our file includes only items that are physician-administered during an encounter. If we are willing to assume that the WCIRB represents the universe of insurer claims, i.e., that it captures most claims not reported to the WCIS, and the distribution of specialty payments are similar between the WCIS and the WCIRB, this increases our confidence that our claims are representative of all claims in California (Table 2.2).

**Table 2.2 Percentage of Payments by Physician Specialty, Workers' Compensation Information System and Workers' Compensation Insurance Rating Bureau of California**

Specialty	WCIS	WCIRB
General and family practice	22.4	20.5
Surgery <sup>a</sup>	14.9	13.8
Physical therapy	7.4	9.1
Physical medicine and rehabilitation	5.7	4.8
Occupational medicine	4.2	2.3
Chiropractic provider	3.9	4.7
Anesthesiology	3.3	2.9
Radiology	3.1	5.4
Psychology	2.0	1.8
Internal medicine <sup>b</sup>	2.0	1.3
Acupuncture	1.3	1.1
Neurology	1.3	1.2
Emergency medicine	0.9	0.9
Psychiatry	0.7	1.6
Podiatry	0.5	0.4
Pathology	0.4	0.8
Marriage, family, or child counselor	0.1	0.1
Ophthalmology	0.1	0.1
Dentistry	0.1	1.0
Dermatology	0.1	0.1
Optometry	0.0	0.1
Clinical social work	0.0	0.0
All other providers <sup>c</sup>	25.5	26.0
Total	100	100

<sup>a</sup> We aggregated the following specialties in the WCIRB table to create the surgery category: orthopedic surgery, general surgery, hand surgery, plastic surgery, and neurosurgery.

<sup>b</sup> In the WCIRB, we included osteopathy in the internal-medicine category to make it comparable to the WCIS.

<sup>c</sup> Specialties that we could not match in both data sets were folded into this "all other" category. In the WCIRB table, 15 percent of payments were to unknown or unclassified specialties.

Overall, the evidence in Tables 2.1 and 2.2 suggests that the WCIS data can be assumed to be broadly representative of all WC claims in California.

A second limitation is that the WCIS is a relatively new database, so many of the steps required to create the analytic file had not been previously undertaken. This meant that we needed to undertake some exploratory analysis and data-cleaning activities to develop the analytic file. We used the paid amounts as a tool to develop algorithms to address data inconsistencies. These included algorithms to separate ASC facility fees from professional fees, identify professional components (PCs) and technical components (TCs) of diagnostic tests that had not been reported with the appropriate payment modifiers, identify payments that had been reported in dollars only rather than dollars and cents, and address inconsistencies in reporting volume for services defined in time increments. We anticipate that, in the future, additional “front-end” edits will eliminate some of these activities.

Our final WCIS analysis file contains line items for professional services furnished by physicians and other practitioners in 2011. It excludes services that are payable under other fee schedules, such as the fee schedules for diagnostic clinical laboratory tests and for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). It excludes physician-dispensed pharmaceuticals and the ingredient costs for physician-administered drugs and vaccines. It includes 50 percent of the payments for supplies billed under CPT 99070 (special supplies and materials provided by the physician or other qualified health professional). Handling of the supply costs is challenging because information of the types of supplies billed under CPT 99070 is lacking, so assumptions must be made concerning whether the supplies would be (1) bundled under the RBRVS, (2) be paid separately because the billed items are either physician-dispensed drugs or medical supplies or items excepted from the RBRVS bundling rule that DWC proposes to pay separately using HCPCS alphanumeric codes, or (3) determined nonallowable because they should be bundled with OMFS facility allowances. We found that, of the \$13 million billed under CPT 99070, only 58 percent was billed when any other service was furnished on the same date (by the same or different provider) and only 25 percent was on the same bill as another service. We decided to treat only 50 percent of the CPT 99070 paid amounts as allowances that would be bundled under the RBRVS. We eliminated the other 50 percent from the analysis file on the assumption that it would either be paid separately using alphanumeric codes or should be bundled with OMFS facility allowances. Until the OMFS ground rules are harmonized with the other parts of the OMFS fee schedule, there are likely to be inconsistencies in how physician-furnished supplies are billed.

Our analysis file includes professional services billed by hospitals but excludes other services that are currently payable under the OMFS for physician services when they are furnished by a hospital or ASC. We retained invalid OMFS codes that were valid 2013 CPT codes because it is likely that some providers are billing and being paid using more-recent codes than those used by

the current OMFS. We excluded the remaining services that had missing codes or other invalid OMFS codes.

## Additional Data Sources

Data on 2013 Medicare RVUs are publicly available on the CMS website (CMS, 2013a, 2013b). The zipped file contains a Microsoft Word document with an overview of the pricing methodology, an Excel spreadsheet with RVUs and Medicare status indicators, and a separate file with GPCI locality values for the three components of the Medicare fee schedule: work, PE, and malpractice. For data on 2013 anesthesia base units, we used another publicly available CMS data set (CMS, undated). To model bonus payments for services provided in health-professional shortage areas (HPSAs), we used information on 2013 HPSA designations in California available on the CMS website (CMS, 2012d, 2012e). The Texas Department of Insurance Division of Workers' Compensation provided us with a line-item distribution of CPT 2011 codes for services provided under the Texas WC program. We used this distribution to estimate how OMFS codes that cross-walk to multiple CPT codes will be distributed under the RBRVS.<sup>13</sup> For codes without a Medicare-assigned RVU (MPFS status codes C, I, N, and R), we used a supplementary file containing RVUs assigned under the Federal Workers' Compensation Program (U.S. Department of Labor, undated [a]). The most recent year available was for services provided on or after July 1, 2012.

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<sup>13</sup> A public-use data file is available (Texas Department of Insurance, 2013a).



## Chapter Three. Analytical Approach

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This chapter describes our methods for cross-walking the OMFS code and related service volume and payments to CPT 2013 codes, estimating payments under the OMFS and the RBRVS, and calculating budget-neutral conversion factors.

### Cross-Walking to 2013 Codes

To model the impact of moving from the current OMFS to the RBRVS fee schedule, we needed to reconcile CPT codes in both fee schedules. As we have discussed, the OMFS codes are based primarily on the 1997 CPT codes (1994 codes for physical medicine), some of which have been deleted, modified, or otherwise updated. We therefore needed to “cross-walk” the outdated OMFS CPT codes to their CPT 2013 equivalents. There were also some California-specific OMFS codes that were not in either the 1997 or 2013 CPT codebooks or that were in the 2013 CPT codebook but had different code descriptions. In addition, we found that some providers were using more-recent CPT codes that did not have OMFS RVUs but did have 2013 CPT RVUs. We discuss how we handled these in a separate section.

We built on an earlier crosswalk developed by The Lewin Group for its earlier impact analysis that assigned OMFS codes to their 2010 CPT equivalents (Welch, El-Gamil, et al., 2008; Welch, Koenig, and Schuster, 2010). Since 2010, other CPT codes used by the OMFS have been revised, and some of The Lewin Group replacement codes have themselves changed. In general, revised codes fell into one of two groups: (1) codes that were deleted (with or without replacement) (for example, code A is deleted and replaced with codes B and C) or (2) codes that were revised without being deleted (for example, code A was revised and code B was added—in other words, code A is now split into codes A and B).

We used Appendix B of the CPT codebooks to identify codes that underwent revisions. For codes that were deleted, replacements were usually specified within the text of the CPT codebook. Where the replacements were not clearly specified and the OMFS codes had significant volume, we used our clinical judgment to identify the most suitable replacement.<sup>14</sup> Identifying codes that were revised without being deleted was more challenging, and we often had to resort to manually comparing code descriptions between codebooks. The final crosswalk is contained in Appendix B.

In total, 983 OMFS codes were revised between 1997 and 2013. The Lewin Group originally cross-walked 538 of these codes. We cross-walked the remaining 445 OMFS codes and updated

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<sup>14</sup> We did this for ten codes: 01995, 76375, 90745, 90841, 93875, 99025, 99052, 99054, 99185, and 99186.

42 of The Lewin Group replacement codes that had been revised. In total, 91 OMFS codes were deleted without replacement, 429 OMFS codes were deleted and replaced with a single code, 343 codes were deleted and replaced with multiple codes, and 120 codes were revised without being deleted.

To carry out the impact analysis, we had to also cross-walk the service volume for modified OMFS (“old”) codes to their 2013 replacements (“new” codes). Where the billed code and the paid code were not identical (because of changes made during bill review), we cross-walked the paid-code service volume to the 2013 replacement code. In the simple case of a code that was deleted and replaced by another code, we simply assigned the service volume for the old code to its replacement. For example, old CPT 29815 was replaced by new CPT 29805 in our crosswalk. If the service volume for CPT 29815 was 500, we assigned CPT 29805 a volume of 500. For cases in which a single OMFS code was split into multiple codes, we had to determine how to apportion the service volume for the old code across the new codes. We discuss our approach below.

We obtained 2011 utilization data<sup>15</sup> from the Texas WC program. We used the observed distribution of service volume in the Texas data to create weights that allowed us to replicate this distribution in the WCIS data when assigning service volume from old OMFS codes to new CPT codes. For example, CPT 64443 was replaced by CPT 64494 and CPT 64495. Service volumes for these two CPT codes in the Texas utilization file were 1,969 and 623, respectively. The distribution weights are therefore equal to 0.76 and 0.24. In other words, we assigned 76 percent of the volume for CPT 64443 to CPT 64494 and the remaining 24 percent to CPT 64495. For codes that were revised after 2011 and therefore did not appear in the Texas file, we turned to a CMS utilization file. CMS releases a crosswalk to provide guidance on the expected distribution of Medicare service volume from old to new CPT codes when codes are revised (CMS, 2012f). We used the CMS 2011-to-2013 crosswalk to fill in the gaps left by the Texas WC data.

Of the 463 OMFS codes that we cross-walked to multiple CPT codes,<sup>16</sup> service volume for 271 codes (58.5 percent) was redistributed using weights constructed from the Texas WC file, and volume for 119 codes (25.7 percent) was redistributed using weights constructed from the CMS file. For the remaining 73 codes (15.8 percent), we either had missing service volume data for at least one of the new CPT codes<sup>17</sup> or all the replacement codes had zero volume; we therefore redistributed the service volume for these OMFS codes equally across the new CPT codes.

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<sup>15</sup> This was the latest year available.

<sup>16</sup> This includes expanded codes.

<sup>17</sup> The majority of these were codes not paid under the MPFS. With missing data for at least one of the codes, it was not possible to construct the weights.

## Pricing Under the Official Medical Fee Schedule

The OMFS establishes the MAA for services under California's WC program. The fee schedule consists of two main components: (1) RVUs for each procedure code and (2) a CF. Separate CFs apply to codes assigned to the different sections of the CPT codebook: E&M services, anesthesia, surgery, radiology, pathology, and medicine. The general formula used in determining the MAA is  $RVU \times CF \times DF$ , where  $DF$  is a discounting factor equal to  $1 - \delta$ , where  $\delta$  is a reduction percentage required by SB 228 (2003). In most cases,  $\delta = 0.05$ .<sup>18</sup> We modified this payment formula in certain situations, following DWC ground rules. These modifications are summarized in Table 3.1.

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<sup>18</sup> SB 228 (2003) reduced OMFS payments 5 percent but not below Medicare fee-schedule amounts in 2004 and 2005. These reductions remain in effect.

**Table 3.1 Modifications Based on California Division of Workers' Compensation Ground Rules**

Category	Pricing Rules
Surgical procedures	For multiple procedures furnished on the same day, the procedure with the highest allowance was valued at 100%, the next highest at 50%, and additional procedures at 25%.
Bilateral surgical procedures	Bilateral procedures were valued at 100% for the first procedure and 50% for the second.
Co-surgeons	A procedure with co-surgeons was valued at 125% of the standard amount.
E&M	E&M visits requiring an interpreter (modifier 93) were valued at 110% of the standard amount.
Diagnostic tests with PCs and TCs	Modifiers for PCs and TCs are not reliably reported. We developed a pricing algorithm that compared paid amounts with the allowances for the technical, professional, and complete service and took into account other factors to identify PCs and TCs for which a modifier was missing.
Laboratory tests	We treated any pathology or laboratory code that is payable under the MPFS as a physician service. Codes that were misclassified in the OMFS as clinical diagnostic laboratory tests were reclassified and valued at 95% of the allowance applicable prior to 2004.
PT, acupuncture, and chiropractic manipulative treatment	The procedure with the highest allowed amount was valued at 100%, the second-highest at 75%, the third-highest at 50%, and the fourth-highest at 25%. Additional procedures were valued using the actual paid amount. Services with no payments that exceeded limits on the number of minutes or number of procedures that are payable during an encounter were excluded.
Arthroscopic procedures	The procedure with the highest allowed amount was valued at 100%, while additional procedures were valued at 10%.
Assistants at surgery	Procedures requiring a physician to assist the surgeon were valued at 20% of the standard amount, while procedures with nonphysician assistant surgeons were valued at 10%.
Microsurgery	Spinal procedures (code 61712) were valued at 25% of the allowed amount for the primary procedure. Nerve dissection or repair (code 64830) was valued at 50% of the allowed amount for the primary procedure.
BR services	Some services under the OMFS are priced on a case-by-case basis according to a report submitted by the provider. These BR services include unlisted procedure codes, unusual services, and CPT 99070 for supplies. Because there is no standard pricing for these services, they were valued at the paid amounts.

NOTE: PT = physical therapy.

## Baseline Pricing Under the Resource-Based Relative Value Scale

Most procedures under the MPFS are assigned three relative values: work (W), practice expense (PE), and malpractice expense (MP).<sup>19</sup> Each of these three values is multiplied by a related statewide GPCI value, and the resulting value is multiplied by a CF to convert it into a dollar amount. Medicare has not established RVUs for all the codes that are covered under the

<sup>19</sup> Anesthesia services are handled differently, and we discuss this in a separate section.

WC system. We discuss how we handle pricing for these codes separately. In general, the formula used in calculating payments is

$$CF \times \sum_i (RVU \times GPCI)_i,$$

where  $i$  takes on three values denoting W, PE, and MP. (For the baseline analysis, we assumed a statewide locality and calculated statewide GPCI values for each component.) We adjusted this basic formula in certain situations to conform to Medicare’s ground rules. See Table 3.2.

**Table 3.2 Pricing Based on Medicare Ground Rules**

Category	Pricing Rules
Surgical procedures	For multiple procedures furnished on the same day, the procedure with the highest RVU was valued at 100% and additional procedures were valued at 50%.
Bilateral surgical procedures	Bilateral procedures were valued at 100% for the first procedure and 50% for the second.
Radiology	The discount policy applies separately to the PC (the highest-value code was valued at 100%, while additional codes were valued at 75%) and the TC (the highest-value code was valued at 100%, while additional codes were valued at 50%).
PT	The unit or procedure with the highest PE RVU was valued at 100%, while the PE for additional units or procedures was valued at 50%. Full payment is made for W and MP.
Diagnostic cardiovascular procedures	The discount applies to the only to the TC of the procedure. The code with the highest TC RVU was valued at 100%, while additional procedures were valued at 75%.
Ophthalmology	The discount applies to the only to the TC of the procedure. The code with the highest TC RVU was valued at 100%, while additional procedures were valued at 80%.
Global surgical period adjustments	If the surgeon does not furnish care throughout the global period, only a percentage of the fee is payable. Depending on the modifier reported, we applied the relevant portion of the payment. For example, if modifier 56 were reported, we applied only the preoperative portion of the RVU.
Assistants at surgery	Assistant surgeon services were valued at 16%.
Nonphysician practitioners	Services provided by a PA or NP were valued at 85%, while services provided by a clinical social worker were valued at 75%.
Endoscopic procedures	The highest-value endoscopy was valued at 100%. For the endoscopy procedure with the next-highest amount, Medicare pays the marginal difference above the payment amount for the base endoscopy.

***Pricing 2013 Current Procedural Terminology Codes with No Medicare Relative Value Units***

There are several reasons that procedure codes for physician and other practitioner services may not have assigned RVU values under the Medicare fee schedule. The reason applicable to a given code is identified through its status code, which indicates whether the CPT code is included in the fee schedule and, if it is covered, whether it is separately payable (see Table 3.3).

The codes that always have RVUs are status codes A and T. Noncovered services are designated by status code N. Some of these services, including chiropractic and acupuncture codes, have RVUs assigned to them that have been established by the AMA. CMS publishes the RVUs as a courtesy in Addendum B of the annual fee-schedule update. Status code I services are not valid for Medicare purposes because Medicare uses another code for the reporting and payment of the services. Some status code I services have RVUs assigned to them, but most do not.

**Table 3.3 Definition of Status Codes in the Medicare National Payment File for Physician Services**

Status Code	Definition	RVU?
A	Active codes	Yes
B	Bundled codes	Some
C	Contractor-priced codes	No
I	Priced under a different code under Medicare	Some
J	Anesthesia	Yes <sup>a</sup>
N	Noncovered service	Some
R	Restricted coverage	No
T	Injection codes payable only when another service is not provided	Yes

<sup>a</sup> Have base-unit RVUs.

We used different approaches to value services described by the different status codes that do not have RVUs that are used by the Medicare RBRVS.

### Bundled Services

Most status code B services are bundled into the payment for the primary procedure. Except with respect to certain WC-required reports that are separately reimbursable under the OMFS, we assumed that Medicare bundling policies would be followed under the RBRVS.

With respect to reports, DWC proposes to adopt the following policies:

- Reports billed under CPT 99080 in conjunction with a medical consultation for a primary treating physician would be bundled, but WC-required consultation reports performed in the context of medical-legal evaluations (OMFS modifier = 30) or other mandated consultations (OMFS modifier = 32) would be paid separately. Primary Treating Physician’s Permanent and Stationary Report [PR-3] would also be paid separately.
- Reports billed under CPT 99081 would continue to be paid separately under the RBRVS. These WC-required reports are the Primary Treating Physician’s Progress Reports [PR-2s] and Final Discharge Report [final PR-2].

For purposes of the impact analysis, we priced the reports that would remain separately payable under CPT 99080 at the OMFS-paid amounts for those reports. We priced the reports billed under CPT 99081 at the OMFS-allowed amounts. We were unable to model the nuances of the policies for WC-related reports in the proposed rule because we were unable to determine the

type of report billed under CPT 99080 (i.e., whether a line item was a PR-3 or a consultation report requested by the Workers' Compensation Appeals Board). We assumed that reports billed within 30 days of a consultation visit would be bundled under the RBRVS and that the remaining reports would be separately payable. The latter reports represented 19 percent of payments under CPT 99080. Because these are WC-related reports that are not Medicare-covered services, the 120-percent limitation on aggregate fees is not affected by the separate payments for the reports. This assumption affects the impact analysis but does not affect the budget-neutral CFs.

As noted in Chapter Two, we included only 50 percent of the payments for supplies and materials billed BR under CPT 99070 in our analysis file. In modeling the impact, we assumed that these supplies would be bundled under the RBRVS.<sup>20</sup> This assumption affects both the estimated budget-neutral CF for the "all other services" category and the impacts.

### Status Codes C, N, and R

Status code C services are priced by the contractor on a case-by-case basis and are analogous to BR services under the OMFS. Status code N services are noncovered services. Status code R services have restricted coverage, and, to the extent that they are covered, payment is often determined by the Medicare contractor. The work hardening codes (CPT 97545 and CPT 97546) are two high-volume WC services that are assigned status code R in the MPFS. The typical Medicare contractor policy is that work hardening programs are not covered because they are not medically necessary (and therefore no prices are established), but most WC fee schedules have established prices for the codes. We considered several options for valuing these and other services with status code C, N, or R:

1. Adopt MPFS RVUs applicable to comparable services.
2. Adopt RVUs or dollar amounts based on rates paid by other payers.
3. Continue current OMFS price or BR status.

In evaluating the options for specific codes, we weighed the following considerations:

- *ease of administration*: Assigning RVUs to codes that are currently valued using BR documentation would reduce the burden on claim administrators. Rather than perusing

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<sup>20</sup> Medicare ground rules provide limited exceptions to the general bundling policy for supplies that are provided in conjunction with a patient care service. Namely, injectable drugs, biologicals, casting materials, and implants used during an office-based procedure are separately payable using HCPCS alphanumeric codes. In addition, when furnished to patients in settings in which a TC is payable, separate payments may be made for contrast material used during intrathecal radiologic procedures, pharmacologic stressing agents used in connection with nuclear medicine and cardiovascular stress-testing procedures, and radionuclides used in connection nuclear medicine procedures. These supplies cannot be identified directly because of the general nature of the CPT 99070 code. Of the \$2.9 million for line items that were billed in conjunction with a medical or surgical service, 7.6 percent was billed in conjunction with casting procedures, radiologic procedures requiring contrast media, and nuclear medicine procedures. Because we had already excluded 50 percent of supply billings from the analysis file, we did not make a further adjustment for these items. The effect is to overstate slightly understate the MAAs for specialties that furnish the excepted supplies, such as radiologists.

large amounts of paperwork, claim administrators can simply pay providers based on appropriate units.

- *standardized payments*: Payment codes assigned a value would be standardized based on relative resources required to perform the service rather than the judgment of claim administrators. This ensures objective and fair payment while reducing the potential for payment disputes.
- *automatic updates*: Codes with assigned RVUs allow for easier and automatic updates by adjusting the CFs for inflation. Assigned dollar values could also be updated using the same inflation factors.
- *equitable relative to OMFS allowance for other services*: Assigning appropriate RVUs to these codes allows providers to be paid for services at a level comparable to other services, creating more-equitable allowances for services furnished.

Other state WC programs that have adopted the RBRVS have different approaches to pricing the codes that have not been assigned RVUs. Several states, such as Oregon and Ohio, have developed state-specific codes that are paid at a specified maximum allowable payment amount or, in the case of certain Ohio state-specific service codes, BR. For CPT codes that are not valued by CMS, Maryland Workers' Compensation Commission releases maximum reimbursement amounts annually on its website that increase concurrent with the Medicare Economic Index (MEI) and multiplier. For services without a negotiated or contracted amount, the Texas Department of Insurance Division of Workers' Compensation payment is the lower of its maximum reimbursement amount, the provider's usual and customary charge, or a "fair and reasonable" amount.

After consultation with DWC, we used the federal Office of Workers' Compensation Programs (OWCP) fee schedule to assign RVUs to the status code C, R, and N services that do not have RVUs under the RBRVS. The OWCP reviews states' WC fee schedules and establishes prices based on the midrange of state fee-schedule amounts. There are several advantages to using this fee schedule. First, the values are updated annually and are available in a public-use file on the OWCP website (U.S. Department of Labor, undated [b]). Second, the fee schedule uses RVUs and CFs for the codes rather than dollar amounts. Relativity can be maintained across codes by adjusting the CFs.<sup>21</sup> Third, the fee schedule is used in California to pay for services to injured workers under the Federal Employees' Compensation Act. WC payers will BR-price 2013 CPT codes that do not have RVUs in either the Medicare or OWCP fee schedules. For the impact analysis, we assumed that the BR-allowed amounts under the RBRVS would be the same as OMFS-paid amounts and updated the paid amounts for inflation by the estimated increase in the MEI.

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<sup>21</sup> The codes that are not on the MPFS have a 1.25 CF. Using a 1.20 CF will maintain relativity with other services under the RBRVS.

## Status Code I

Status code I services are not valid for Medicare purposes because Medicare uses another code to report and pay for the services. Some status code I services, such as the consultation codes, have RVUs assigned to them, but most do not. If Medicare uses another CPT code to price the service, we used the RVUs for the other code to price status code I procedures, e.g., the E&M visit codes instead of the consultation codes. However, if Medicare uses an HCPCS alphanumeric code to price the service, we did not use the RVUs because, in general, DWC proposes to adopt the current CPT codes for purposes of the RBRVS for professional services. (Alphanumeric codes will be used to bill for physician-administered drug ingredients and vaccines, casting and splint supplies, and contrast media and radionuclides that are separately payable under the RBRVS.) Examples of these codes are CPT codes describing nonphysician services furnished in the patient's home (CPT 99500–99602) that are also described by HCPCS alphanumeric codes. For these codes, we used the RVUs published in Addendum B when available. Otherwise, we priced using the RVUs assigned by the federal OWCP and assumed BR pricing when RVUs are not assigned by the OWCP.<sup>22</sup>

### *Pricing Official Medical Fee Schedule Codes with No 2013 Current Procedural Terminology Counterpart*

In consultation with DWC staff, we assigned OMFS codes that we were unable to cross-walk to 2013 CPT codes into two categories for purposes of pricing under the RBRVS (Appendix C). The first category included codes that are likely to continue to be paid under the RBRVS either as an unlisted code (e.g., 97680 job site visit or assessment) or as a listed code, which could be either a continuation of the OMFS-specific code or an assigned 2013 CPT/modifier combination. These codes describe services that are mostly special services and reports, such as CPT 99081 (required reports). We priced these codes in the impact analysis at the OMFS-paid amounts and updated them for inflation throughout the transition. We assumed that other OMFS codes with no 2013 CPT counterpart would not be payable under the RBRVS. Generally, these are low-volume codes that no longer exist or have been revised so that the 2013 code describes a different service.

### *Transition Conversion Factors*

Labor Code §5307.1(a)(2) specifies transition CFs that are to be effective until the AD issues regulations implementing an RBRVS fee schedule. The default CFs are based on the budget-neutral CFs estimated by The Lewin Group with the PT cascade (multiple-procedure discounting

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<sup>22</sup> The OMFS does not recognize the CPT codes for disability examinations (CPT 99455 and 99456). Instead, allowances are established through the E&M visit codes with a -17 modifier or the medical-legal procedure codes. Consistent with this policy, we did not assign OWCP RVUs to any services that were billed as CPT 99455 or 99456.

that values the code with the highest allowed amount at 100 percent, the second highest at 75 percent, the third highest at 50 percent, and the fourth highest at 25 percent) and adjusted to remove the estimated statewide GAF of 1.078 (Welch, Koenig, and Schuster, 2010). Separate CFs are specified for anesthesia, surgery, radiology, and all other services (Table 3.4). The CFs transition from multiple CFs in 2014 based on 75 percent of the budget-neutral CFs and 25 percent of the Medicare 2012 CF times 1.2 to a single CF for all services other than anesthesia (which continues to have its own CF) based on the Medicare 2012 CF times 1.2 in 2017. The CFs in Table 3.4 are the factors specified in the labor code and have not been adjusted for inflation and geographic location.

**Table 3.4 Default Transition Conversion Factors Specified in Labor Code Section 5307.1(a)(2), in Dollars**

Type of Service	2014 75% OMFS CF + 25% Medicare 2012 CF × 1.2	2015 50% OMFS CF + 50% Medicare 2012 CF × 1.2	2016 25% OMFS CF + 75% Medicare 2012 CF × 1.2	2017 100% Medicare 2012 CF × 1.2
Surgery	49.53	46.63	43.74	40.85
Radiology	56.23	51.10	45.97	40.85
Anesthesia	30.06	28.61	27.15	25.69
All other services	37.17	38.40	39.62	40.85

NOTE: SB 863 specified CFs that are to be used along with a 1.078 statewide GAF and updated for inflation if the AD does not implement a fee schedule by January 1, 2014.

We computed revised budget-neutral CFs for all services that are paid under the OMFS and will be payable using RVUs under the RBRVS fee schedule. The budget-neutrality calculation is based only on the services that will be priced with RVUs under the RBRVS. It excludes services that are priced as BR under the RBRVS. Our modeling uses the estimated allowances and service volumes for each CPT code after cross-walking services to their 2013 CPT equivalents and does not account for any behavioral changes that might occur under the RBRVS.

We calculated separate budget-neutral CFs for anesthesia, surgery, radiology, and all other services:

$$CF = \frac{\sum_i \text{OMFS MAA}_s}{\sum_i (RVU \times GPCI)_i}$$

The numerator is the sum of the allowed OMFS amounts for the services that will be paid using RVUs under the RBRVS, including the allowed amounts for services that will be bundled into payment for the primary services. For example, the numerator for the “all other services” category includes the OMFS allowances for consultations and other E&M services, supplies, and 81 percent of the estimated reports billed under CPT 99080. It does not include the remaining 19 percent of OMFS allowances for CPT 99080 or the allowances for CPT 99081 because we

treat these as BR amounts that will continue to be paid under the OMFS. The denominator is the sum of the geographically adjusted RVUs for the services included in the numerator after pricing rules regarding multiple-procedure discounting are applied. To be consistent with the proposed rule as modified by the notice of first 15-day comment period, we assumed a statewide locality with separate statewide GPCI values for each fee-schedule component for all services other than anesthesia in lieu of the statewide GAF specified as the default option. We calculated a separate statewide GAF for anesthesia services. After applying the geographic adjustments, the RVUs are further adjusted for HPSA bonus payments.

We found that the default CFs in Labor Code §5307.1(g) are no longer budget neutral to the OMFS MAAs. This is not unexpected given the differences in the data and methodologies used in The Lewin Group report and our analysis and the changes that have been made in the MPFS in the intervening years. The Lewin Group used data furnished by the California Workers' Compensation Institute (CWCI) from a sample of insurers and self-insured employers. The sample had estimated OMFS allowances (including by-report [BR] services) totaling \$210 million in 2006 (Welch, Koenig, and Schuster, 2010). Our WCIS analysis file has estimated OMFS allowances totaling \$798.5 million for physician and practitioner services furnished in 2011. Further, the sample used by The Lewin Group did not include certain information needed to model payments under the RBRVS, such as whether a professional service was provided in a facility or office setting and whether a claim was for services furnished by a hospital to outpatients (Welch, El-Gamil, et al., 2008). The WCIS includes this information. In consultation with DWC staff, we substituted our estimates of the budget-neutral OMFS CFs for the default CFs and determined revised transition CFs for 2014–2017. By using the revised budget-neutral CFs, the impact of the fee-schedule changes are more evenly distributed over the transition years.

We updated the CFs for inflation using the estimated cumulative increase in the MEI (Table 3.5). Labor Code §5307.1(g) requires that the CF be updated annually by two factors: the estimated increase in the MEI and the adjustment factor that CMS applies to the CF to maintain budget neutrality for any changes made in the RVUs. We applied an update factor for 2013 that incorporates the actual adjustments that CMS used in setting the Medicare 2013 CF. The update factors for 2014–2017 in our impact analysis are estimates based on the projected increase in the MEI only because the budget-neutrality adjustment requires knowing the estimated effect of the actual changes in the RVUs (which could increase, decrease, or have no effect on estimated expenditures). The actual OMFS update factors beginning in 2014 will be determined in the annual OMFS update process based on the actual MEI and budget-neutrality factors that Medicare uses in its annual update to the MPFS. As noted earlier, the OMFS update factors will include only the MEI and budget-neutrality adjustment factors and will not reflect Medicare adjustments for the sustainable growth rate or other budgetary adjustments. If the Medicare update factors continue to be less than the full MEI increase, the OMFS CF will, over time, become an increasingly higher multiple of the actual Medicare CF.

**Table 3.5 Estimated Increases in the Medicare Economic Index 2012–2017**

Year	Annual Increase	Cumulative Increase
2012	NA	1.0000
2013 <sup>a</sup>	1.007	1.0073
2014	1.011	1.0184
2015	1.016	1.0347
2016	1.023	1.0585
2017	1.023	1.0828

SOURCE: IHS Global Insight, undated.

<sup>a</sup> For 2013, the 1.008 estimated increase in the MEI is multiplied by the 0.99932 budget-neutrality factor that CMS applied to the 2013 CF to make changes in the RVUs budget neutral. This adjustment is required by Labor Code §5307.1(g).

## Pricing Anesthesia Services

### *Official Medical Fee Schedule Pricing*

Most anesthesia services are billed with base values and time values, and, because the scale is different, there is a separate CF. Under the OMFS, the time value is computed by allowing 1.0 unit for each 15 minutes of anesthesia time for the first four hours and 1.0 unit for each ten minutes thereafter. Five minutes or more is considered a significant portion of the time unit. Additional units are added to the values for certain patient status codes and qualifying conditions. For example, CPT code 00670 is anesthesia for extensive spine and spinal-cord procedures and is assigned 13 base units. A procedure taking 125 minutes for a patient with severe systemic disease (patient status code = 3) would be priced as follows:

base value = 13 units

$$\text{time value} = 9 \left( \begin{array}{l} \frac{120}{15} = 8; 125 - 120 = 5 \text{ minutes,} \\ \text{which is the minimum number of minutes to count as a unit} \end{array} \right)$$

patient status code = 1 unit

total units = 23

maximum allowance =  $0.95 \times \$34.50 \times 23 \text{ units} = \$753.83$ .

We were unable to model OMFS allowances using the WCIS data. The WCIS reporting instructions are unclear regarding how the anesthesia units should be reported. We found wide variation in the number of units reported for a given procedure code, and we could not determine reliably whether the values are reported in units or minutes and whether the units are time units only or also include base units or the additional units allowed under the patient status codes. As a result, our impact analysis assumes that the total OMFS payments are the allowed amounts.

### *Resource-Based Relative Value Scale Pricing*

Appendix A has a detailed comparison between the ground rules for the two anesthesia fee schedules. The most important difference is in the CFs. Other important differences are that (1) patient status and qualifying codes count as additional units under the OMFS but are bundled under the RBRVS and (2) the RBRVS requires reporting time in minutes, which are divided by 15 and rounded to the nearest 0.1 unit by the payer. The unit interval remains the same regardless of procedure length. Across all procedures, the time values will be lower under the RBRVS because the units are more precise. For example, a 35-minute procedure counts as three units under the OMFS (because five or more minutes is considered significant) and 2.3 units under the RBRVS because the five minutes equates to 0.3 units. They will also be one-third lower for each hour that a procedure takes beyond four hours. The Lewin Group estimated that the differences in base units and time units increased a budget-neutral CF by 3.7 percent (Welch, El-Gamil, et al., 2008).

The unreliability of the reported units precluded a direct estimation of allowances under the RBRVS. Instead, we estimated a percentage change in total allowances by accounting for the differences between the OMFS and RBRVS ground rules. We used The Lewin Group estimate to increase the OMFS portion of the transition CFs 3.7 percent to account for differences in how anesthesia time will be reported and another 3.65 percent to account for the bundling of patient status and qualifying-circumstance codes based on our analysis of the WCIS data.



## Chapter Four. Descriptive Results

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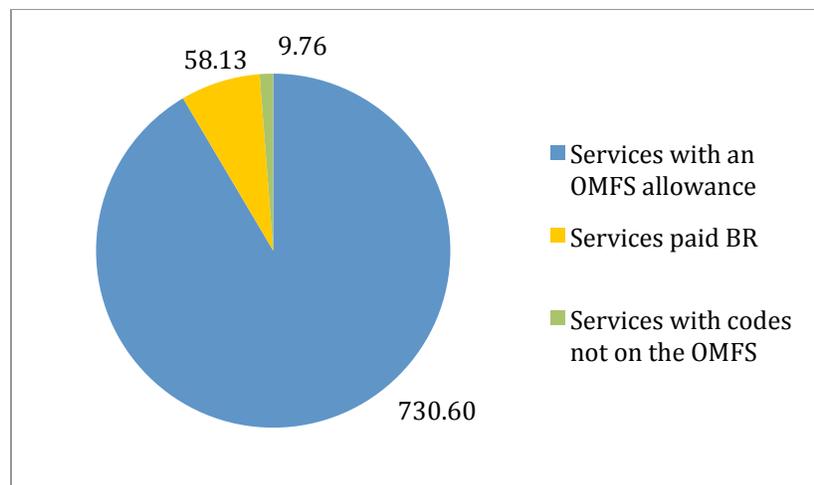
In this chapter, we provide summary descriptions of services and payments under the OMFS and how they would be priced under the RBRVS. The baseline impact analysis is presented in Chapter Five.

### Services and Payments Under the Official Medical Fee Schedule

#### *Distribution of Total Payments, by Type of Payment*

Our analysis file included 14 million services (exclusive of anesthesia services) provided by physicians and other practitioners in 2011 that have paid amounts greater than \$0. Total payments for these and anesthesia services were \$798.5 million (Figure 4.1). Services with RVUs in the OMFS for physician services account for 91.5 percent of payments, including \$1.3 million billed by hospitals for professional services. Another 7.3 percent were priced as pass-throughs (BR). The remaining payments were for services with codes that are not on the OMFS. We retained invalid OMFS codes that were valid 2013 CPT codes in our analysis file because it is likely that some providers are billing and being paid using more-recent codes than those used by the current OMFS.

**Figure 4.1 Distribution of Official Medical Fee Schedule Payments for Physician and Other Practitioner Services, by Type of Payment: 2011 Paid Amounts, in Millions of Dollars**

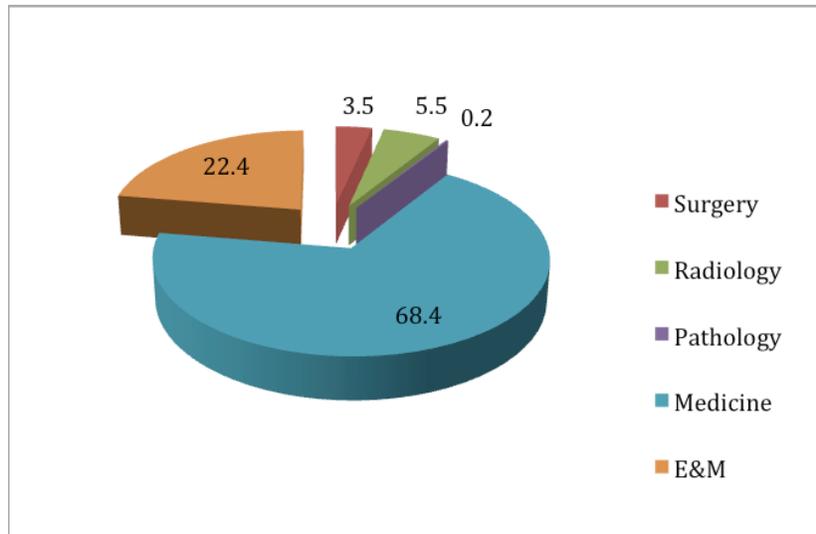


#### *Distribution of Services and Payments, by Type of Service*

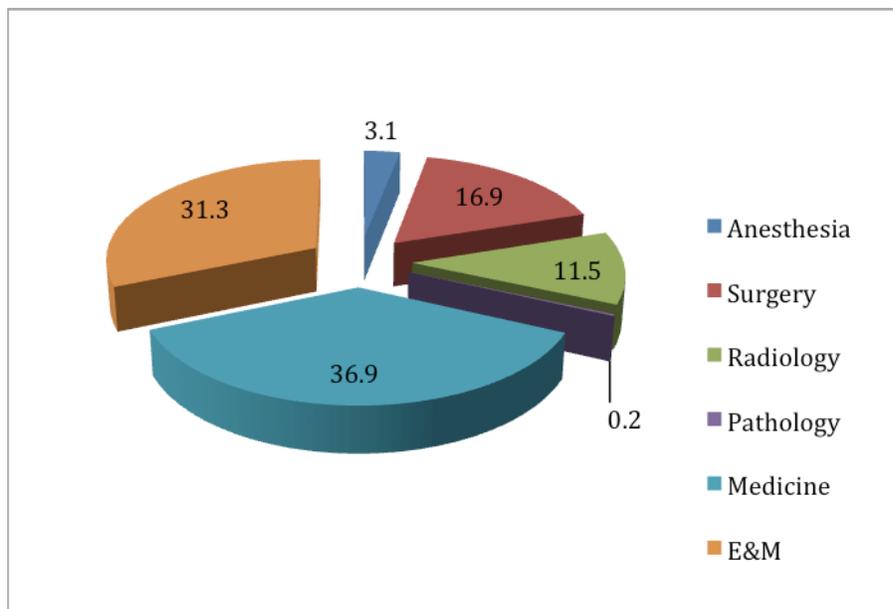
Figure 4.2 shows the distribution of total units of service across the type of service categories used in the OMFS, exclusive of anesthesia services. We have excluded anesthesia because the

units are not reported on a per-service basis. Medicine accounts for 68 percent of the units of service. This category contains a wide range of services, including physical medicine, services provided by medical specialties exclusive of E&M and surgical procedures, and special services, such as reports and supplies. Medicine also accounts for the highest proportion of OMFS payments (Figure 4.3).

**Figure 4.2 Distribution of Services, by Official Medical Fee Schedule Type of Service: Percentage of Total Units of Service, Excluding Anesthesia**



**Figure 4.3 Distribution of Total Official Medical Fee Schedule Paid Amounts, by Type of Service Category: Percentage of Total 2011 Official Medical Fee Schedule Payments**



During the RBRVS transition period, separate CFs will be used for surgery (16.9 percent of OMFS payments), radiology (11.5 percent), and anesthesia (3.1 percent). The “all other services” CF will apply to medicine, E&M, and pathology, which together account for 68.5 percent of total OMFS payments.

*Distribution of Official Medical Fee Schedule Payments, by Provider Specialty*

The OMFS payments shown in Table 4.1 are for all professional services provided by a physician or other practitioner. In addition to services that are specific to their specialty, most physicians provide other services. As a result, there is no one-to-one correspondence between payments by type of service and payments by specialty. For example, the chiropractic-manipulation codes account for 0.9 percent of total OMFS payments, but services for which chiropractors will be paid under the RBRVS account for 3.9 percent of payments. The two specialty groups that account for the highest percentage of OMFS payments are generalists in family medicine and internal medicine (24.0 percent) and surgeons (14.7 percent). Physical therapists account for 7.3 percent of payments.

**Table 4.1 Official Medical Fee Schedule 2011 Paid Amounts, by Provider Specialty, in Millions of Dollars and Percentage**

Provider Specialty		Total Payment	
		Amount (\$)	Percentage
Practice groups	Multispecialty groups	42.6	5.3
	Single-specialty groups	1.8	0.2
Individual providers	Family medicine or general practice	174.0	21.8
	Surgery	117.3	14.7
	PT	58.3	7.3
	Radiology	49.0	6.1
	Physical medicine and rehabilitation	43.2	5.4
	Occupational medicine	33.1	4.1
	Chiropractic providers	30.9	3.9
	Anesthesiology	25.8	3.2
	Internal medicine	17.9	2.2
	Acupuncture	10.8	1.4
	Neurology	10.3	1.3
	Occupational therapy <sup>a</sup>	7.7	1.0
	Emergency medicine	7.0	0.9
	Psychiatry	5.9	0.7
	Podiatry	4.1	0.5
Pathology	1.2	0.1	
Other <sup>b</sup>		157.6	19.7
Total		798.5	100.0

<sup>a</sup> Includes speech, language, and hearing service providers.

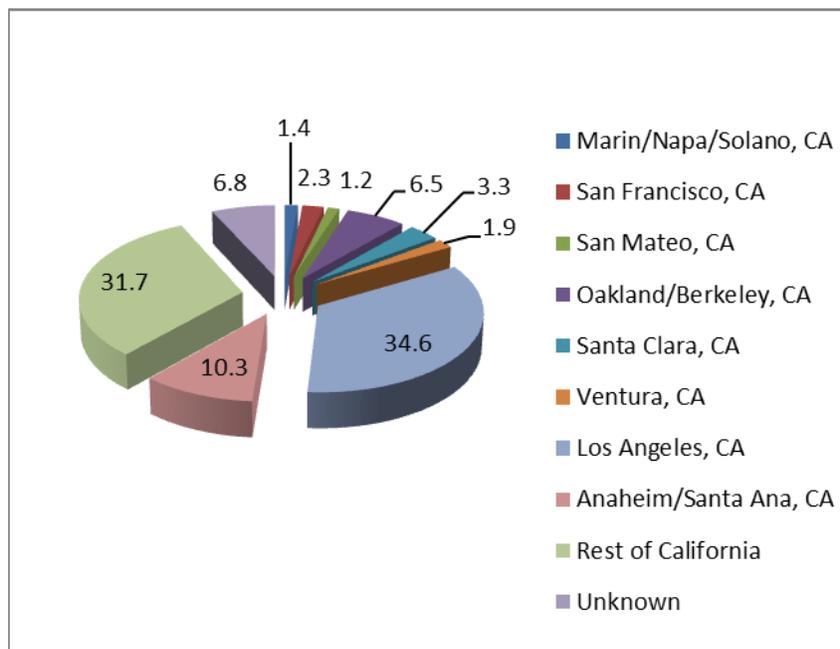
<sup>b</sup> Includes unspecified specialists or missing specialty codes (53%), various types of ambulatory clinics (6%), professional services billed by hospitals (6%), orthotists (5%), and pharmacy and durable medical equipment (DME) suppliers (2%).

NOTE: Because of rounding, totals might not sum precisely.

### *Distribution of Official Medical Fee Schedule Payments, by Medicare Payment Locality*

In Figure 4.4, payments are classified according to the Medicare payment locality in which the services were provided. Los Angeles County accounts for more than one-third of total OMFS payments. Nearly one-third of payments are also made for services provided in the “rest-of-California” locality, which is made up of any urban area that is not designated as a separate payment locality and rural areas. We were unable to determine the payment locality for 6.9 percent of payment. We did not include these services in our calculation of the statewide GPCI values but assigned those values to them in the impact analysis.

**Figure 4.4 Distribution of 2011 Official Medical Fee Schedule Payments, by Locality: Percentage of Total 2011 Official Medical Fee Schedule Payments**



## Services Under the Resource-Based Relative Value Scale

### *Distribution of Maximum Allowable Amounts, by Type of Service*

In cross-walking service volumes and payments under the OMFS to their 2013 CPT equivalents, we adjusted for any definitional differences in units of service between the OMFS codes and the CPT replacement codes. As a result, the service volumes changed after the cross-walking was completed. Most differences fall within the medicine codes.<sup>23</sup> We then matched the new codes to their status codes under the MPFS. Table 4.2 shows the distribution of services and maximum allowances by status code. The service counts are after adjustments for multiple-procedure discounting. For example, if a surgical procedure is discounted 50 percent, the unit count for that procedure is 0.5. The MAAs include both services that are priced using RVUs and services that we modeled as priced BR. Some of these, such as WC-mandated reports, actually

<sup>23</sup> In particular, the first 30 minutes of PT procedures under the OMFS (CPT 97110–97139) is reported as a single unit, with additional time reported in 15-minute increments (CPT 97145). The 2013 CPT codebook defines therapeutic procedures in 15-minute increments. Adjusting for this definitional difference increased the PT units before application of multiple-procedure discounting by 32 percent. Changes to the nerve-conduction codes reduced the affected service volume for these services. Under the OMFS, each nerve was reported as a unit. The CPT 2013 codebook has separate codes defined by the number of tests that were conducted; for example, five or six studies are reported as a single unit under CPT 95909. For these codes, service volume was reduced 70 percent after adjusting for the definitional differences.

have fee-schedule rates attached to the services. As a result, the percentage of MAAs that will be priced based on RVUs shown in the last column is understated. Across all procedures, 95.6 percent of allowances will be based on RVUs determined either under the Medicare RBRVS or the OWCP fee schedule (if the procedure is not priced under the Medicare RBRVS). The remaining allowances will be determined BR or using current OMFS prices. Most status code C services are for unlisted procedures (for example, CPT 99199, unlisted special service, procedure, or report), so that BR pricing is likely to decrease as coding improves. Reports account for most of the estimated payments in the status code B (CPT 99080 for certain consultation reports and PR-3 reports and WC-required CPT 90889 reports) and “none” (CPT 99081) categories that will continue to be paid using current OMFS allowances. Estimated payments do not include certain supplies that will be paid using HCPCS alphanumeric codes, such as casting materials and contrast media.

**Table 4.2 Service Volume and Total Maximum Allowable Amounts Under the Resource-Based Relative Value Scale, by Status Code**

Status Code	MPFS Description	Units of Service (millions)	% of Total Units of Service	RBRVS 2014 MAAs (\$ millions)	% of Total 2014 MAAs	% of 2014 MAAs Priced with RVUs
A	Active code with RVUs	10.17	70.20	779.4	86.4	100.0
B	Bundled	0.87	6.03	6.0	0.7	41.7
C	Priced by Medicare contractor	0.11	0.75	14.0	1.6	4.5
I	Priced using a different code	1.31	9.07	47.5	5.3	96.7
J	Anesthesia <sup>a</sup>	—	—	24.5	2.7	100.0
N	Noncovered	0.21	1.44	7.1	0.8	99.1
R	Restricted coverage; contractor priced	0.35	2.43	4.7	0.5	99.8
T	Injection codes payable only when another service is not provided	0.00	0.01	0.0	0.0	100.0
None	Not a 2013 CPT code	1.46	10.08	19.2	2.1	0.0
Total		14.49	100	902.3	100	95.6

<sup>a</sup> Anesthesia service volume not included because units are not reported on a per-service basis. We have adjusted the anesthesia CFs for the differences between the OMFS and the Medicare ground rules.

NOTE: Because of rounding, totals might not sum precisely.

### *Budget-Neutral Conversion Factors, by Type of Service*

As explained in Chapter Two, the budget-neutral CF is calculated using the following formula:

$$CF = \frac{\sum_i \text{OMFS maximum allowed amounts}_i}{\sum_i (RVU \times GPCI)_i}$$

The numerator in the equation is the aggregate OMFS-allowed amounts for services that will be priced using RVUs under the RBRVS, including bundled services. Table 4.3 shows the total OMFS-allowed amounts, the total RVUs under the RBRVS before geographic adjustment, the total RVUs after geographic adjustment, and the budget-neutrality CF that result from dividing the OMFS MAAs by the GAF-adjusted RBRVS RVUs.<sup>24</sup> For reference, we have included the CFs that were calculated by The Lewin Group (Welch, Koenig, and Schuster, 2010) that were used to establish the default transition CFs in Labor Code §5307.1(a)(2). The last line is presented for informational purposes only and is not used in the impact analysis.

**Table 4.3 Components of Budget-Neutral Conversion-Factor Calculations**

Type of Service	OMFS MAA for Services Priced with RVUs (\$)	Total RBRVS RVUs	Total GAF-Adjusted RBRVS RVUs	Revised Budget-Neutral CFs (\$)	Lewin Budget-Neutral CF ÷ 1.078 GAF (\$)
Anesthesia <sup>a</sup>	24,805,166	702,227	717,114	34.5903	31.52
Surgery	162,318,817	2,777,066	2,918,580	55.6849	52.43
Radiology	104,139,053	1,744,160	1,966,286	52.9434	61.36
All other services	546,409,680	14,672,380	15,877,528	34.4566	35.95
All services other than anesthesia	812,867,550	19,193,606	20,762,394	39.1935	—

<sup>a</sup> The OMFS-allowable amounts for anesthesia are based on paid amounts. The total RBRVS-RVUs for anesthesia are estimated by dividing OMFS-allowed amounts by the OMFS CF multiplied by the estimated percentage reduction in RVUs under the RB-RVS and the statewide GPCI values. Rounding may result in slight differences in the CF calculation.

Table 4.4 shows the transition CF before adjustment for inflation and geographic adjustment. The 2014–2017 CFs are a blend of the revised budget-neutral CF and 120 percent of the Medicare CF.

<sup>24</sup> The allowed amounts are lower than the allowed amounts shown in the Chapter Five impact analysis because the impact analysis includes services that will be priced BR and the CF calculation excludes these services. The GAF-adjusted RVUs are determined by multiplying the RVUs for each component of the RBRVS by the applicable statewide GPCI value. The sum applicable to services provided in HPSAs is further increased by 10 percent so that the total GAF-adjusted RBRVS RVUs reflect both the application of the statewide GPCI values and the HPSA bonus.

**Table 4.4 Revised Transition Conversion Factor Before Adjustments for Inflation and Geography**

Type of Service	RAND Budget-Neutral CF	120% 2012 Medicare <sup>a</sup>	2014 75/25 Blend	2015 50/50 Blend	2016 25/75 Blend	2017 120% Medicare
Anesthesia	34.5903	25.6896	32.3651	30.1400	27.9148	25.6896
Surgery	55.6849	40.8451	51.9750	48.2650	44.5551	40.8451
Radiology	52.9434	40.8451	49.9188	46.8943	43.8697	40.8451
All other services	34.4566	40.8451	36.0537	37.6509	39.2480	40.8451

<sup>a</sup> The Medicare 2012 CFs for anesthesia and all other services are \$21.408 and \$34.042, respectively.

We estimate that aggregate OMFS allowances for all services were 116 percent of Medicare in 2012. This estimate is derived by comparing OMFS MAAs to the product of the RBRVS RVUs after geographic adjustment and the applicable Medicare 2012 CFs (which are shown in the Table 4.4 note). We have chosen to compare estimated OMFS allowances with allowances based on the 2012 Medicare CF rather than the 2013 CF because the 2012 CF is the baseline CF for the RBRVS CF. The differentials by type of service are shown in Table 4.5. The RVUs in the numerator are after rules for multiple-procedure discounting have been applied, including the adjustments to the PE portion of therapy services. The estimated aggregate increase in MAA based on 120 percent of the Medicare 2012 CF before accounting for inflation is 3.4 percent

$$\left(1 - \frac{1.20}{1.16}\right).$$

**Table 4.5 Comparison of Official Medical Fee Schedule Allowances and Medicare 2012 Allowances**

Type of Service	OMFS MAA for Services Priced with RVUs	Allowances Based on 2012 Medicare CF	Ratio of OMFS MAA to Medicare 2012 Allowances
Anesthesia	24.81	15.31	1.620
Surgery	162.32	99.47	1.632
Radiology	104.14	66.49	1.566
Pathology	1.79	0.98	1.837
Medicine	279.75	254.97	1.097
E&M	264.87	284.56	0.931
Total	837.67	721.87	1.159

## Chapter Five. Impact Analysis

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This chapter summarizes the impact of RBRVS implementation based on the policies in the AD’s notice of modifications to the proposed rulemaking issued August 2, 2013 (DWC, 2013b). This notice proposes to use a single statewide locality for GPCI values. Other than this policy and policies for certain WC-related reports and services, we assumed that Medicare ground rules would apply. In Chapter Six, we discuss alternative policies that might be considered in lieu of the Medicare ground rules.

Using the formula provided in Chapter Four to model allowances, we estimated the sum of the MAAs that would be payable for the services priced with RVUs and the MAAs for services that we treated as BR services. Table 5.1 provides a breakdown of the MAA calculations. For each type of service, we have separated the OMFS MAAs and the RBRVS MAAs into two categories: those for services that we priced with RVUs and those that we passed through as BR. Taking surgery as an example, an estimated \$162.32 million in OMFS MAAs will be paid using RVUs under the RBRVS. This amount includes any services separately paid under the OMFS that will be bundled under the RBRVS and is consistent with the MAAs used to calculate the budget-neutral CF for surgery in Table 4.3 in Chapter Four. In addition, an estimated \$2.58 million in allowances was treated as BR in the modeling, bringing the total OMFS MAAs to \$164.89 million. These amounts are used as the baseline for the impact modeling. In 2014, the MAAs for surgery is the sum of the RBRVS-allowed amounts based on the blended CF before inflation and the BR amounts (\$151.57 million + \$2.58 million) multiplied by the 1.0184 inflation factor for 2014, or \$156.98 million. This amount is shown in Table 5.2 as the MAAs for surgery in 2014.

Table 5.2 summarizes the impact during the transition (2014–2017) by type of service. As discussed previously, the impacts by type of service do not represent specialty impacts because most specialties furnish a mix of services. Overall, there is a 2.8-percent increase in aggregate MAAs in 2014 relative to estimated OMFS MAAs. Over the four-year period, total MAAs are estimated to increase 11.9 percent. The increase represents the combined effect of inflation and the transition from current OMFS payment levels to 120 percent of Medicare in 2017.

Aggregate allowances are redistributed with all types of services other than E&M experiencing a net decrease in aggregate allowances in 2014. For anesthesia, allowable fees decline 19.8 percent over the transition. There are also declines in surgery (–20.1 percent) and radiology (–15.9 percent). Within the “all other services” category, there are significant increases for medicine (17.3 percent) and E&M (39.5 percent). In contrast, there are significant reductions in pathology (–29.0 percent). Because pathology is grouped with other services that have relatively low OMFS payments, the transition policy does not work as intended for pathology services. The reduction is greatest in the first year (–41.0 percent) and lessens over the transition

as the CF increases (–29.0 percent). In Chapter Six, we discuss alternative transition CFs that might be considered to address this issue.

**Table 5.1 Maximum Allowable Amounts, by Type of Service, Pricing Method, and Year, Before and After Inflation, in Millions of Dollars**

Type of Service		OMFS MAAs <sup>a</sup>	RBRVS MAAs			
			2014	2015	2016	2017
Anesthesia	RBRVS allowances before inflation	24.81	23.21	21.61	20.02	18.42
	RBRVS BR allowances before inflation	—	—	—	—	—
	Total MAAs before inflation	24.81	23.21	21.61	20.02	18.42
	Total MAAs after inflation	24.81	23.64	22.36	21.19	19.95
Surgery	RBRVS allowances before inflation	162.32	151.57	140.76	129.94	119.13
	RBRVS BR allowances before inflation	2.58	2.58	2.58	2.58	2.58
	Total MAAs before inflation	164.89	154.15	143.33	132.52	121.71
	Total MAAs after inflation	164.89	156.98	148.31	140.27	131.78
Radiology	RBRVS allowances before inflation	104.14	98.74	92.78	86.83	80.88
	RBRVS BR allowances before inflation	0.21	0.21	0.21	0.21	0.21
	Total MAAs before inflation	104.35	98.94	92.99	87.04	81.09
	Total MAAs after inflation	104.35	100.76	96.22	92.13	87.80
Pathology	RBRVS allowances before inflation	1.79	1.03	1.08	1.13	1.17
	RBRVS BR allowances before inflation	0.01	0.01	0.01	0.01	0.01
	Total MAAs before inflation	1.80	1.04	1.09	1.14	1.18
	Total MAAs after inflation	1.80	1.06	1.13	1.20	1.28
Medicine	RBRVS allowances before inflation	279.75	270.07	282.03	293.99	305.96
	RBRVS BR allowances before inflation	35.27	35.27	35.27	35.27	35.27
	Total MAAs before inflation	315.01	305.33	317.30	329.26	341.22
	Total MAAs after inflation	315.01	310.95	328.3`	348.52	369.48
E&M	RBRVS allowances before inflation	264.87	301.39	314.74	328.09	341.44
	RBRVS BR allowances before inflation	1.15	1.15	1.15	1.15	1.15
	Total MAAs before inflation	266.01	302.54	315.89	329.24	342.59
	Total MAAs after inflation	266.01	308.10	326.85	348.50	370.96

<sup>a</sup> OMFS MAAs are broken down by whether the amount was carried over or not, and they are not updated for inflation.

NOTE: Because of rounding, totals might not sum precisely.

Services are assigned in Table 5.2 consistently with how they are classified in the 2013 CPT codebook. For example, reports and supplies are classified as “medicine” so that the changes in ground rules for bundling these services under the RBRVS are included in the medicine rather than E&M service category. This explains why the percentage change in allowances for specialties that predominantly furnish E&M services (Table 5.3) is lower than the increase seen in Table 5.2 for E&M services. It also explains why the percentage change for physical medicine

specialties is higher than the increase for the medicine category. Because surgeons furnish a substantial amount of E&M services in addition to surgical services, the reduction in allowances for the surgical specialties is smaller than the reduction for surgical procedures. The percentage change for radiologists (-23.3 percent) reflects the elimination of radiology consultation reports and bundling of supplies, as well as the reduction in allowances for radiology. The reduction may be overstated to the extent that certain contrast media reported under CPT 99070 will continue to be paid separately under the RBRVS.

**Table 5.2 Impact of Resource-Based Relative Value Scale Implementation on Maximum Allowable Amounts, by Type of Service and Year**

Type of Service	OMFS		RBRVS 2014		RBRVS 2015		RBRVS 2016		RBRVS 2017	
	Total MAAs (\$ millions)	Percentage of Total	Total MAAs (\$ millions)	Change (%)						
Anesthesia	24.81	2.8	23.64	-4.7	22.36	-9.8	21.19	-14.6	19.95	-19.6
Surgery	164.89	18.8	156.98	-4.8	148.31	-10.1	140.27	-14.9	131.78	-20.1
Radiology	104.35	11.9	100.76	-3.4	96.22	-7.8	92.13	-11.7	87.80	-15.9
Pathology	1.80	0.2	1.06	-41.0	1.13	-37.5	1.20	-33.3	1.28	-29.0
Medicine	315.01	35.9	310.95	-1.3	328.31	4.2	348.52	10.6	369.48	17.3
E&M	266.01	30.3	308.10	15.8	326.85	22.9	348.50	31.0	370.96	39.5
Total	876.88	100	901.50	2.8	923.18	5.3	951.82	8.5	981.25	11.9

NOTE: Because of rounding, totals might not sum precisely. Change percentages are dollar-weighted averages.

**Table 5.3 Impact of Resource-Based Relative Value Scale Implementation on Maximum Allowable Amounts, by Provider Specialty and Transition Period**

Provider Specialty	OMFS		RBRVS 2014		RBRVS 2015		RBRVS 2016		RBRVS 2017	
	Total MAAs (\$ millions)	Percentage of Total	Total MAAs (\$ millions)	Change (%)						
Practice groups										
Multispecialty	44.99	5.1	49.61	10.3	51.20	13.8	53.20	18.2	55.27	22.8
Single specialty	2.52	0.3	2.48	-1.8	2.51	-0.4	2.57	1.7	2.62	3.8
Individual providers										
Family medicine or general practice	190.82	21.8	195.56	2.5	200.56	5.1	207.09	8.5	213.80	12.0
Surgery	133.51	15.2	121.76	-8.8	121.29	-9.2	121.61	-8.9	121.87	-8.7
PT	62.76	7.2	86.82	38.3	91.74	46.2	97.46	55.3	103.38	64.7
Radiology	56.62	6.5	48.95	-13.5	46.98	-17.0	45.24	-20.1	43.40	-23.3
Physical medicine and rehabilitation	45.33	5.2	57.75	27.4	61.03	34.6	64.84	43.0	68.79	51.7
Occupational medicine	35.89	4.1	41.11	14.5	42.62	18.8	44.48	23.9	46.39	29.2
Chiropractic	34.38	3.9	35.28	2.6	37.29	8.5	39.63	15.3	42.05	22.3
Anesthesiology	26.63	3.0	24.62	-7.5	23.86	-10.4	23.23	-12.8	22.55	-15.3
Internal medicine	19.77	2.3	18.94	-4.2	19.39	-2.0	19.99	1.1	20.60	4.2
Acupuncture	11.82	1.3	10.84	-8.3	11.46	-3.1	12.17	3.0	12.91	9.2
Neurology	11.15	1.3	7.53	-32.5	7.88	-29.4	8.29	-25.6	8.73	-21.8
Occupational therapy <sup>a</sup>	7.96	0.9	11.24	41.2	11.90	49.5	12.67	59.2	13.46	69.1
Emergency medicine	7.44	0.8	8.14	9.3	8.43	13.3	8.79	18.1	9.16	23.1
Psychiatry	6.43	0.7	5.54	-13.9	5.85	-9.0	6.22	-3.3	6.60	2.6

Provider Specialty	OMFS		RBRVS 2014		RBRVS 2015		RBRVS 2016		RBRVS 2017	
	Total MAAs (\$ millions)	Percentage of Total	Total MAAs (\$ millions)	Change (%)						
Podiatry	4.55	0.5	5.36	17.7	5.40	18.7	5.49	20.5	5.57	22.3
Pathology	1.25	0.1	1.00	-20.5	1.05	-16.5	1.10	-11.8	1.16	-6.9
Other	173.03	19.7	168.98	-2.3	172.72	-0.2	177.76	2.7	182.93	5.7
Total	876.88	100.0	901.50	2.8	923.18	5.3	951.82	5.6	981.25	11.9

<sup>a</sup> Includes speech-language therapy and hearing providers. Change percentages are dollar-weighted averages.

## Chapter Six. Alternative Ground Rules for the Resource-Based Relative Value Fee Scale

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The impact analysis in Chapter Five is consistent with policies that DWC proposes to adopt (DWC, 2013b). When there are differences between the OMFS ground rules and the Medicare ground rules, the proposed policies follow the Medicare rules. Labor Code §5307.1(a)(2) provides that the OMFS shall include payment ground rules that differ from Medicare payment ground rules “including, as appropriate, consultation codes and payment for E&M services provided during a global period of surgery.” This chapter contains an analysis of potential alternative policies to the Medicare ground rules. The topics that we examine were drawn from public comments received during the 2010 pre-rulemaking activities, a stakeholders’ meeting convened by DWC in November 2012, and postings to a public forum on the physician fee schedule in early 2013. The fee-schedule topics include geographic adjustments, payment for nonphysician-practitioner services, bundling policies, consultations, and global fees. In Chapter Seven, we discuss allowances for PADs and for services provided by hospitals and ASCs that are currently paid under the OMFS for physician services, as well as other fee-schedule issues.

Section 5307.1(a)(2) limits aggregate allowances under the physician fee schedule to 120 percent of the amounts payable under the Medicare payment system for comparable services. In determining the maximum reasonable fees, any services that are not covered by Medicare are to be included at the rate established by the AD for the services. As a result, if a policy is implemented that deviates from the Medicare ground rules for a Medicare-covered service, an adjustment may be required to limit aggregate payments to 120 percent of Medicare payments. The general formula for determining the offsetting factor is as follows:

$$\text{adjustment factor} = \frac{\sum \text{estimated aggregate allowances using Medicare ground rules} \times 1.2}{\left( \sum \text{estimated aggregate allowances using Medicare ground rules} \times 1.2 \right) + \text{additional allowances for alternative policies}}$$

Several issues would need to be addressed in making the offsetting adjustment:

- *What allowances should be affected by an offsetting adjustment?* For some alternative policies, it may be more appropriate to make an across-the-board offsetting adjustment to total aggregate allowances; for other policies, it might be more appropriate to apply the offsetting adjustment to aggregate allowances for selected services. The preferred approach is not necessarily clearly evident. For example, if the higher RVUs were implemented for the consultation codes, the offset could be made through identifying specific policies that might be implemented to offset the higher allowances, adjusting allowances for some or all E&M visits so that total allowances for E&M services remain at 120 percent of aggregate Medicare payments (as CMS did when payments for

consultations were eliminated), or applying an across-the-board offsetting adjustment to the CF for all services.

- *Should the adjustment be permanent or redetermined periodically?* The impact of a deviation from Medicare ground rules on aggregate allowances is likely to change over time as new Medicare policies are implemented and there are changes in the mix of services provided to WC patients. Would it be sufficient to determine a “one-time” offsetting adjustment when the policy is first implemented, or would the impact need to be redetermined annually or on a periodic basis to ensure that the aggregate limitation is not exceeded?
- *During the transition period, does the limitation on aggregate fees apply to the total allowances under the blended rate or only to the portion of the rate based on Medicare rates?* If the limitation applies to total aggregate allowances, it would be possible to provide some deviation from the Medicare ground rules at the outset without exceeding the limitation because current OMFS allowances are approximately 116 percent of Medicare. However, the need for an adjustment would change as the proportion of the rate based on Medicare increases.
- *In applying an offsetting adjustment, should services that are not covered by Medicare be included in the calculation?* For example, if an across-the-board adjustment were made to account for the higher allowances for the consultation codes, should the allowances for the services based on the federal OWCP fee schedule and other services that Medicare does not cover, such as acupuncture, be included in the calculation of the offsetting adjustment?

Our discussion of alternative policies includes, where relevant, estimates of the impact that the alternative policy would have on aggregate allowances. It does not address how the offsetting adjustment required to implement the policy might be made for the particular alternative.

## Geographic Adjustments

Currently, the OMFS uses a statewide fee schedule that makes no adjustment for differences in the cost of maintaining a practice across geographic areas. The Medicare program adjusts for geographic differences using nine payment localities in California. Separate GPCI adjustments are made to the work, PE, and malpractice RVUs on a code-by-code basis. The work GPCI adjusts for geographic differences in the cost of living. The PE GPCI adjusts for differences across payment localities in the costs of maintaining an office, such as employee compensation and office rent. Equipment costs are assumed to not vary across payment localities. The malpractice GPCI value adjusts for overall differences in the cost of malpractice insurance. (Specialty differences in malpractice insurance are accounted for in the RVUs.) Collectively, these are called the GAF. The PE and malpractice GPCI values reflect the estimated prices in each locality relative to the national average. In contrast, the work GPCI, by law, accounts for only 25 percent of the difference in cost of living across payment localities.

On average, physician work accounts for 48.27 percent of the GAF, PE accounts for 47.44 percent, and malpractice accounts for 4.295 percent (CMS, 2012c). However, the actual

percentages vary by type of service. In particular, work accounts for a higher percentage of the GAF for anesthesia services and a lower percentage of the GAF for radiology, for which a higher percentage of costs is attributable to PE. Because they have different CFs, we show in Table 6.1 the cost shares separately for anesthesia and for other services.

**Table 6.1 Geographic Practice Cost Index Cost Shares, by Type of Conversion Factor**

Service	Cost Shares (percentage of GAF)		
	Work	PE	Malpractice
Other than anesthesia	48.266	47.439	4.295
Anesthesia	75.10	16.35	8.55

States that have a single statewide locality under the MPFS have separate statewide GPCI values for each RVU component. The separate values adjust for price differences in the cost shares across services while providing the same payment across the state for a given service. To determine the statewide GPCI values for each component, we computed the aggregate GPCI-adjusted RVUs using the locality-specific GPCI and divided these amounts by the aggregate allowances for the component with no geographic adjustment. The results (Table 6.2) are budget-neutral to using the locality-specific GPCI and were used for the baseline impact analysis in Chapter Five. The overall GPCI adjustment for all services other than anesthesia (1.0799) is slightly higher than the statewide GAF specified as the default in Labor Code §5307.1(a)(2).<sup>25</sup> The lower GAF for anesthesia services is attributable to a higher cost weight for the work component of anesthesia services. There is less variation in the work GPCI because it reflects only 25 percent of the variation in cost of living across localities. The 1.0212 value is based on the locality-specific GPCI. When the statewide GPCI values for the cost components are substituted, the average GAF for anesthesia is reduced to 1.0185. Unlike other procedures, the cost shares for anesthesia do not vary across services, so the statewide GAF (1.0212) provides a more accurate adjustment for anesthesia services. There is no change in the overall average GAF for other services.

<sup>25</sup> The default option in §5307.1(a)(2) was derived by The Lewin Group in its analysis of options for implementing an RBRVS (Welch, El-Gamil, et al., 2008; Welch, Koenig, and Schuster, 2010). The average GPCI-adjusted values do not include the 10-percent bonus payment for services furnished in HPSAs. When these are included in the calculation, the average locality-specific adjustment is 1.0811. The budget-neutral CF calculations are based on RVUs that have been adjusted for both the statewide GPCI values and the HPSA adjustments.

**Table 6.2 Geographic Practice Cost Index Values and Geographic Adjustment Factors, by Type of Conversion Factor and Service**

Payment Locality	Percentage of OMFS Allowances	GPCI Value			Average WC Locality-Specific GAF	
		Work	PE	Malpractice	All Services Other Than Anesthesia	Anesthesia
Marin/Napa/Solano	1.4	1.051	1.248	0.456	1.124	1.032
San Francisco	2.3	1.072	1.360	0.516	1.176	1.071
San Mateo	1.3	1.072	1.354	0.516	1.184	1.070
Oakland/Berkeley	6.5	1.058	1.254	0.516	1.131	1.043
Santa Clara	3.4	1.077	1.337	0.516	1.181	1.071
Ventura	1.9	1.034	1.193	0.605	1.097	1.023
Los Angeles	34.3	1.036	1.154	0.642	1.081	1.021
Anaheim/Santa Ana	10.3	1.044	1.218	0.676	1.118	1.040
Rest of California <sup>a</sup>	31.7	1.024	1.085	0.547	1.035	0.993
Unknown	7.0					
Statewide	100.0	1.0370	1.1585	0.5877	1.0799	1.0212

<sup>a</sup> Rest of California is made up of the urban and rural counties that are not included in a locality for specific counties.

The purpose of the geographic adjustment is to improve payment accuracy by accounting for the differences in input prices that providers face in each locality. The methodology that Medicare uses to make the adjustments has been subject to considerable criticism (Institute of Medicine, 2011). The payment localities are outdated and do not reflect changes in demographic and local economic conditions that have taken place since the localities were last configured. In California, 14 urban counties, including San Diego, Monterey, and Sacramento, do not have separate payment localities and are included with rural counties in a “rest-of-California” payment locality. To improve payment accuracy, an Institute of Medicine committee recommended that localities be reconfigured based on metropolitan statistical areas (Institute of Medicine, 2011). Implementing this recommendation in California would increase the allowances for urban areas and reduce the allowances for rural areas within the rest-of-California locality. This approach would more accurately reflect geographic variation in the costs of maintaining an office. However, it would require the AD to develop and update the GAF on an ongoing basis. An alternative, which is the default option specified in Labor Code §5307.1(a)(2) if the AD does not issue a regulation effective January 1, 2104, is to use a statewide average adjustment. Advocates for a statewide GAF argue that it rests on the precedent of the current statewide OMFS allowances, is less likely to raise access issues in the areas included in the rest-of-California locality than the alternatives, and simplifies bill processing.

The Medicare program addresses access in underserved areas by providing an additional 10-percent payment for physician and other-practitioner services provided in primary care HPSAs.

Areas are designated as HPSAs by the U.S. Health Resources and Services Administration (HRSA) based on census tracts, townships, and counties. HRSA also designates mental health shortage areas, where psychiatrists furnishing services are eligible for a 10-percent bonus.<sup>26</sup> If an area has been designated as both a primary care and mental health shortage area, only one bonus is payable to a psychiatrist. If an area has been designated as an HPSA by December 31 of the prior year, providers furnishing services in the current year are eligible for an HPSA bonus throughout the current year (CMS, 2012b). Our impact analysis assumes that the HPSA bonus payments would be made. Estimated bonus payments are \$0.76 million, or 0.09 percent of MAA under the RBRVS in 2014.

Table 6.3 compares total MAAs under OMFS and total RBRVS 2014 MAAs determined with three different geographic adjustments: (1) the locality-specific GPCI that is used by the MPFS, (2) statewide GPCI values for each RVU component that is comparable to a statewide locality and is used in the baseline impact analysis for all services other than anesthesia, and (3) a single statewide GAF applied to all services other than anesthesia that is comparable to the default option and a separate statewide GAF (1.0212) for anesthesia that is used in the baseline analysis. HPSA bonus payments and services priced BR are included in the total MAAs. As expected, the localities with higher GAF receive lower allowances using the statewide GPCI values. For example, the allowances for San Francisco increase 10.7 percent in 2014 using the locality-specific GAF, compared with a 1.7-percent increase using the statewide GPCI values. If the single statewide GAF were used, the increase would be 2.3 percent. For the areas included in the rest-of-California locality, the locality-specific GAF would increase RBRVS allowances 3.3 percent, compared with a 7.4-percent increase using the statewide GPCI values.

The difference between the MAA using the statewide GPCI values and the single statewide GAF reflects differences in the mix of services furnished in each locality. The single statewide GAFs (1.021 for anesthesia and 1.0799 for all other services) provide the same adjustment for all services regardless of the relative proportions of work, PE, and malpractice RVUs associated with the services. As noted earlier, the statewide GPCI adjustment used in the baseline analysis takes the service mix into account by applying separate adjustments to each component of the RVUs. Because GPCI values are higher for the PE component of the RVUs than for the work component, applying the GPCI values results in higher geographic adjustments for services with higher PEs, such as office visits and other services performed in nonfacility settings, than for services provided in facility settings, for which a portion of the PEs is assumed by the facility.

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<sup>26</sup> More information on the HPSA designations is available (CMS, 2013b).

**Table 6.3 Comparison of 2014 Total Maximum Allowable Amounts Under the Official Medical Fee Schedule and Resource-Based Relative Value Scale Using Nine Payment Localities, Statewide Locality Geographic Practice Cost Index, and Single Statewide Geographic Adjustment Factor, by Locality**

Medicare Locality	Total OMFS Allowances		RBRVS Total Allowances (including BR)		
	Statewide GAF		9 Payment Localities and HPSA Bonus Payments	Statewide GPCI and HPSA Bonus Payments <sup>a</sup>	Single Statewide GAF <sup>b</sup>
	Total Allowances (\$ millions)	Percentage of Total Allowances			
Marin/Napa/Solano	12.55	1.4	6.7	3.0	3.1
San Francisco	20.16	2.3	10.8	1.7	2.7
San Mateo	11.18	1.3	12.6	3.5	3.7
Oakland/Berkeley	56.68	6.5	6.0	1.5	1.7
Santa Clara	29.43	3.4	13.2	4.5	4.6
Ventura	16.25	1.9	2.2	0.8	0.7
Los Angeles	301.16	34.3	0.3	0.4	0.2
Anaheim/Santa Ana	90.31	10.3	-1.2	-4.1	-4.2
Rest of California	278.03	31.7	3.2	7.4	7.3
Unknown	61.14	7.0	4.9	5.0	3.9
Total	8,760.88	100	2.8	2.8	2.8

<sup>a</sup> The statewide GPCI values are as follows: work = 1.0370, PE = 1.1585, and malpractice expense = 0.5877. The statewide GAF was used for anesthesia.

<sup>b</sup> The statewide GAFs used in the modeling are as follows: anesthesia = 1.0212, and all other services = 1.0799. NOTE: Change percentages are weighted averages.

## Alternative Conversion Factors

The default option specified in Labor Code §5307.1(a)(2) is to transition from separate CFs for anesthesia, surgery, radiology, and all other services to a single CF for all services other than anesthesia, which will continue to have its own CF. The impact analysis in Chapter Five follows the structure of the default provision. The results indicate that the policy does not work as intended for pathology services, which are expected to have lower allowances under the RBRVS than under the OMFS. Grouping pathology with services that will have higher allowances under the RBRVS (namely, medicine and E&M) results in a 41-percent reduction in the first-year allowances for pathology that lessens over the transition to a 29-percent reduction in 2017 as the “all other services” CF increases under the RBRVS. Ideally, the transition would provide for a smaller reduction in the initial year that increases over the transition to the 29-percent reduction in 2017.

The OMFS transition budget-neutral CFs are calculated by dividing total OMFS allowances by the total RVUs after adjustments for statewide GPCI values and HPSA bonuses. Pathology services represent 0.2 percent of OMFS allowances, so a change in the transition CF for these services has little impact on the CFs for other services. Alternatives for budget-neutral CFs are shown in Table 6.4. The first alternative is the default option used in the Chapter Five impact analysis, which combines pathology with medicine and E&M services. The second alternative combines pathology with radiology. It results in a 40.54-percent increase in aggregate allowances for pathology relative to the default option in 2014 (when 75 percent of the CF is based on the budget-neutral CF).<sup>27</sup> The impact declines as the Medicare RBRVS CF is phased in. There is also a slight increase in the aggregate allowances for radiology (0.20 percent in 2014) and a slight reduction in aggregate allowances for medicine and E&M (–0.11 percent in 2014).

The third alternative would group the three types of service that will have payment reductions under the RBRVS into a single grouping for purposes of determining the OMFS CFs. This would result in two OMFS budget-neutral CFs: one for services that would have an overall increase in aggregate allowances under the RBRVS and one that would have an overall reduction. Because the OMFS CF for surgery is higher than the CF for radiology, this alternative would reduce aggregate allowances for surgery 1.43 percent relative to the allowances under the default option. The allowances for radiology and pathology would increase 2.38 percent and 43.90 percent, respectively, relative to the default option. The impact on medicine and E&M is the same as in the second alternative (–0.11 percent in 2014).

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<sup>27</sup> The impact is estimated as

$$\left( \frac{\text{revised OMFS CF}}{\text{default OMFS CF}} \right) - 1 \times \text{applicable percentage of the CF based on the OMFS CF, e.g., 75 percent in 2014.}$$

**Table 6.4 Impact of Alternative Transition Conversion Factors on Aggregate Allowances, by Type of Service, Relative to the Default Conversion Factor**

Alternative	Surgery	Radiology	Pathology	Medicine	E&M
OMFS maximum fees (\$)	162,318,817	104,139,053	28,693	279,747,586	264,868,069
Total GAF-adjusted RVUs (\$)	2,922,028	1,953,275	31,904	7,489,981	8,358,948
Separate CFs for surgery; radiology; and pathology, medicine, and E&M					
Budget-neutral CFs	55.6849	52.9434	34.4566	34.4566	34.4566
Separate CFs for surgery; radiology and pathology; and medicine and E&M					
Budget-neutral CFs	55.6849	53.0811	53.0811	34.4057	34.4057
Change in 2014 allowances (%)	0.00	0.20	40.54	-0.11	-0.11
Change in 2015 allowances (%)	0.00	0.13	27.03	-0.07	-0.07
Change in 2016 allowances (%)	0.00	0.06	13.51	-0.04	-0.04
Separate CFs for surgery, radiology, and pathology and for medicine and E&M					
Budget-neutral CFs	54.6268	54.6268	54.6268	34.4057	34.4057
Change in 2014 allowances (%)	-1.43	2.38	43.90	-0.11	-0.11
Change in 2015 allowances (%)	-0.95	1.59	29.27	-0.07	-0.07
Change in 2016 allowances (%)	-0.48	0.79	14.63	-0.04	-0.04

## Nonphysician Practitioners

### *Background*

Allowances under the current OMFS are identical for services provided by physicians and by nonphysician practitioners providing services within their scope of practice, including NPs, PAs, clinical social workers, and clinical nurse specialists.

Medicare and other health care payers pay nonphysician practitioners at a specified fraction of physician payment levels. These lower rates may reflect the fact that they provide different products from those that physicians provide. For example, NPs and PAs might see healthier patients with less complex illnesses than physicians see. However, there is little empirical evidence on whether, within specific billing codes, NPs or PAs provide different products from those that physicians provide (Everett et al., 2009; Sox, 1979). Similarly, there is little empirical evidence justifying specific payment reductions for their services relative to physicians. When the Medicare Payment Advisory Commission (MedPAC) looked at this issue, the commission decided that there was too much uncertainty regarding product differences to recommend any changes to the Medicare payment differentials (MedPAC, 2002).

Under its RBRVS, CMS pays 85 percent of the allowed amount for services provided by PAs and NPs.<sup>28</sup> However, CMS pays 100 percent of the allowed amount for services provided “incident to” care furnished by a physician. The CMS incident-to provision applies if the service provided by a PA, NP, or other health professional meets all these criteria:

- an integral, although incidental, part of the physician’s professional service
- commonly rendered without charge or included in the physician’s bill
- of a type that is commonly furnished in physician’s offices or clinics
- furnished by the physician or by auxiliary personnel under the physician’s direct supervision (CMS, 2012a).

Most state WC programs adopt the Medicare approach or a variation of the Medicare approach to set payment rates for nonphysician practitioners. Table 6.5 summarizes nonphysician-practitioner payment-rate policies in Medicare and six state WC programs. Two state programs (Tennessee and Texas) explicitly follow Medicare’s policy. Other programs adopt Medicare’s 85-percent allowance but do not specify whether services incident to care furnished by a physician are reimbursed at the physician rate. All states in Table 6.5 have the same payment rates for NPs and PAs. Clinical or independent social worker rates are usually fixed at 75 percent or 85 percent of the clinical psychologist or psychiatrist fees. The Oregon WC fee schedule is an exception to this rule; social worker evaluations are paid for at a fixed rate of \$72.76. Other psychosocial services are similarly paid for at different fixed rates. Michigan, Florida, and Oregon designate separate payment rates for nonphysician practitioners who assist in surgery (see notes to Table 6.5).

### *California Workers’ Compensation Nonphysician-Practitioner Billing and Payment Patterns*

Less than 1 percent of services and payments are billed by the nonphysician practitioners included in this analysis (see Figure 6.1). Physicians represent the largest share of services and payments and may bill for services provided by nonphysician practitioners under a de facto incident-to policy. Because there is currently no distinction in payment rates for services provided by physicians and nonphysician practitioners, this arrangement does not affect the total cost of care. Nonphysician-practitioner services are also provided in multispecialty groups (i.e., those in which clinicians of different specialties work in a single, integrated practice). These groups represent a relatively small share of total volume and payments. PAs, NPs, and clinical nurse specialists primarily bill routine office and outpatient visits and for completion of required reports (CPT 99081). E&M outpatient office visits account for about 60 percent of payments for

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<sup>28</sup> Medicare payments for services provided by federally qualified health centers are made on a per-encounter basis. No distinction is made between encounters to physicians, nurse practitioners, and physician assistants. However, the rate per encounter is cost based, so a clinic that uses a high proportion of nonphysician practitioners would presumably have lower costs than a clinic that is staffed primarily by physicians.

services that are billed directly. Table 6.6 reports the top five specific codes (by payments) billed directly by these practitioner types.<sup>29</sup>

**Table 6.5 Workers' Compensation Nonphysician-Practitioner Payment Policies**

State	NP	PA	Clinical Social Worker
Medicare	85% of physician fee schedule, 100% if billed incident to services in a physician office or clinic	85% of physician fee schedule, 100% if billed incident to services in a physician office or clinic	75% of the clinical psychologist or psychiatrist fees
Florida	85% of a physician's allowable fee <sup>a</sup>	85% of a physician's allowable fee <sup>a</sup>	75% of the clinical psychologist or psychiatrist fees
Michigan	85% of a physician's allowable fee <sup>b</sup>	85% of a physician's allowable fee <sup>b</sup>	85% of the clinical psychologist or psychiatrist fees
Ohio	85% of a physician's allowable fee	85% of a physician's allowable fee	85% of the clinical psychologist or psychiatrist fees
Oregon	85% of a physician's allowable fee <sup>c</sup>	85% of a physician's allowable fee <sup>c</sup>	Fixed fee: \$72.76 <sup>d</sup>
Tennessee <sup>e</sup>	Same as Medicare	Same as Medicare	Same as Medicare
Texas <sup>f</sup>	Same as Medicare	Same as Medicare	Same as Medicare

<sup>a</sup> PA or NP as surgical assistant: Payment will be 75% of 25% of the surgeon's allowable fee.

<sup>b</sup> PA or NP as surgical assistant: Payment will be 13% of the surgeon's allowable fee or the practitioner's usual and customary charge, whichever is less.

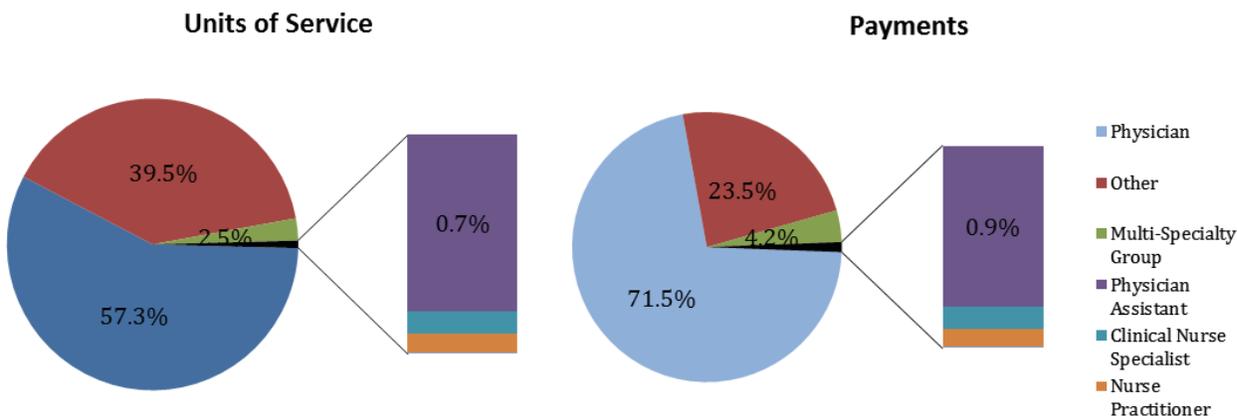
<sup>c</sup> PA or NP as surgical assistant: Payment will be 15% of the surgeon's allowable fee.

<sup>d</sup> Social-worker evaluation: 30 minutes.

<sup>e</sup> Uses locked-in CF of 33.9764.

<sup>f</sup> Uses Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) CF.

**Figure 6.1 Units of Services and Payments, by Provider Type**



<sup>29</sup> Clinical social workers are excluded because of the low unit and payment amounts for specific procedure codes.

**Table 6.6 Top Five Codes Billed Directly by Nurse Practitioners, Clinical Nurse Specialists, and Physician Assistants**

OMFS Procedure Code	Payments Directly Billed by Practitioner Type (%)	Payments (\$ 000s)	Description
PA			
99214	28.2	3,198.9	Established-outpatient visit
99204	11.6	1,310.6	New-outpatient visit
99213	8.5	964.6	Established-outpatient visit
99215	6.6	742.6	Established-outpatient visit
99081	4.3	484.4	Required reports
NP			
99214	30.4	798.3	Established-outpatient visit
99215	13.3	348.3	Established-outpatient visit
99204	8.0	209.8	New-outpatient visit
99213	6.6	173.7	Established-outpatient visit
99081	5.1	134.0	Required reports
Clinical nurse specialists			
99214	22.3	234.9	Established-outpatient visit
99213	18.9	199.7	Established-outpatient visit
99203	5.8	61.1	New-outpatient visit
99204	5.6	59.6	New-outpatient visit
99081	5.0	52.9	Required reports

### *Policy Considerations*

The OMFS policy for nonphysician practitioners must balance the desire to ensure access to nonphysician practitioners with efforts to provide appropriate care at the lowest possible cost. In this section, we outline key considerations that may affect choices related to payment of nonphysician practitioners.

As noted above, the two main considerations, apart from consistency with Medicare rules and budget-neutrality requirements, are as follows:

- Nonphysician practitioners fill vital primary care functions in rural and underserved areas (Agency for Healthcare Research and Quality [AHRQ], 2012; Grumbach et al., 2003; Larson et al., 2003). Reducing payment rates for nonphysician practitioners may reduce access to these practitioners in these areas.<sup>30</sup>
- If the services furnished by nonphysician practitioners differ from the services provided by physicians (i.e., within a given procedure code), then reducing payment rates may better align payment to services provided.

<sup>30</sup> We did not identify empirical studies that directly test this hypothesis.

Other considerations include the following:

- Claim administrators will face an administrative burden under any policy alternative. Under the verbatim Medicare policy, documentation may be required to justify incident-to payment. In general, following Medicare’s rules will result in minimal administrative burden for practitioners already accustomed to this system. However, maintaining the status quo of 100-percent payment poses no increase in administrative burden.
- Nonphysician practitioners will experience a significant increase in payment rates from the OMFS rates regardless of whether payment is 100 percent or 85 percent of the RBRVS allowances.<sup>31</sup> See Table 6.7 for a comparison of the current OMFS allowance, 100 percent of the RBRVS allowance, and 85 percent of the RBRVS allowance for procedure code 99214.
- The numbers of practicing PAs and NPs are expected to increase dramatically over the next two decades (Auerbach, 2012; Hooker, Cawley, and Everett, 2011). This dramatic growth may result in the increasing substitution of physician services by nonphysician practitioners.
- Nonphysician practitioners may more frequently bill directly in certain settings, e.g., in rural areas, where the impacts of policy change on access warrant close scrutiny. The patient-centered medical home (AHRQ, undated) and accountable care organization (CMS, 2013c) delivery models emphasize care provided by teams of physicians and other practitioners. Medicare’s incident-to requirements set payment conditions that require nonphysician practitioners to affiliate with physicians to receive a higher payment rate. Although the additional payment may be justified by the fact that the nonphysician practitioner is working closely with the physician, it is unclear how well the incident-to requirements are monitored or enforced.

**Table 6.7 Comparison of Allowances for Current Procedural Terminology Code 99214 Under the Current Official Medical Fee Schedule and Resource-Based Relative Value Scale During the Transition, in Dollars**

<b>Allowance</b>	<b>Current Policy: 100% of Physician Allowance</b>	<b>Proposed Allowance: 85% of Physician Allowance</b>
<b>Current OMFS</b>	<b>89.57</b>	<b>Not applicable</b>
2014 RBRVS	159.22	135.34
2015 RBRVS	167.10	142.04
2016 RBRVS	175.39	149.08
2017 RBRVS	193.20	164.22

NOTE: Estimates are based on 2013 RVUs for CPT 99214; transition CFs updated for inflation and RVUs adjusted by the average statewide GPCI values.

<sup>31</sup> The access concern mentioned above is still relevant: All else equal, and assuming that there is an effect of payment rate on access, access would be higher under the 100-percent RBRVS payment level than under the 85-percent RBRVS payment level.

## *Specific Policy Alternatives*

1. Retain status quo policy, under which nonphysician practitioners are paid the same fees as physicians.
  - Advantages
    - Minimized potential access concerns to primary care services
  - Disadvantages
    - Possible overpayment if services provided by physicians and nonphysician practitioners differ in complexity, difficulty, or quality
    - Requires an offsetting reduction for other services under the budget-neutrality rules
2. Adopt the Medicare policy, including the incident-to provision.
  - Advantages
    - Better match of payment to services provided if services by physicians and nonphysician practitioners differ in complexity, difficulty, or quality
    - Consistent with general objective of adopting Medicare unless compelling reason not to
  - Disadvantages
    - Potential access concerns associated with lower payment rate for nonphysician practitioners
    - Possible administrative burden in monitoring incident-to distinction
3. Adopt the Medicare policy only with respect to the work component and pay the PE component at 100 percent.
  - Advantages
    - Better match of payment to services provided if services by physicians and nonphysician practitioners differ in complexity, difficulty, or quality but office expenses are comparable
    - Raises fewer access concerns about across-the-board reductions
  - Disadvantages
    - Adds to administrative burden
    - Inconsistent with general objective of adopting Medicare unless compelling reason not to
    - Requires an offsetting reduction in payment for other services under budget-neutrality rules.

The proposed rule incorporates option 2 and is reflected in the baseline impact analysis. The impact that continuing current policies could have on aggregate allowances is shown in Table 6.8. Setting the allowances at 100 percent of the RBRVS allowances for physicians would increase aggregate allowances an estimated \$3.42 million in 2014 and \$3.63 million in 2017. This represents a 0.40-percent increase in total aggregate allowances for all services under the RBRVS that are paid using RVUs in 2014 and a 0.39-percent increase in 2017.

**Table 6.8 Comparison of Total Allowances for Nonpractitioner Services Under Proposed Policy and Current Policy, in Millions of Dollars**

Total RBRVS for All Services <sup>a</sup>		Total RBRVS Amounts Under the Proposed Policy (85% of Medicare × 1.2)		Total RBRVS Amounts Based on 100% of Medicare × 1.2	
2014	2017	Using Medicare Rules in 2014	Total RBRVS Amounts Using Medicare Rules in 2017	Total RBRVS Amounts at 100% in 2014	Total RBRVS Amounts at 100% in 2017
852.90	936.94	19.38	20.58	22.81	24.22

<sup>a</sup> Sum of MAA for services priced under the RBRVS only using statewide GPCI values and HPSA bonuses.

## Bundling Policies

### *Supplies*

#### Background

Under the OMFS, supplies and materials normally necessary to perform services are not separately payable. Supplies and materials provided over and above those usually included with office visits or other services may be charged for separately. This applies to providers furnishing services in their office or other settings in which a facility fee is not payable. Supplies that are not payable separately include applied hot or cold packs, trays, needles, sterile gloves, tissues, cotton balls, dressing for simple wounds, gauze, cotton balls, Band-Aids, tape, and urine-collection kits. Reimbursable supplies include cast and strapping materials, sterile trays for laceration repair, applied dressings beyond simple wound occlusion, taping supplies for sprains, and reusable patient electrodes.

CPT 99070 is used to bill for items that are separately payable. Items are priced at cost (i.e., purchase price including sales tax) plus 20 percent of cost up to a maximum of \$15. Items that are dispensed to the patient (e.g., crutches, dressings, transcutaneous electrical nerve stimulation electrodes, hot or cold packs) are payable under the DMEPOS fee schedule and are not affected by the RBRVS.

Under Medicare rules, most supplies and materials are not separately payable; rather, the PE RVUs include the estimated costs for supplies used during an office-based procedure. (No supplies are payable for services provided in facility settings because the facility assumes the supply and equipment costs.) The only exceptions to this rule for office-based procedures are injectable drugs, biological, and casting materials billed using HCPCS alphanumeric codes. In addition, certain drugs used during radiologic procedures and implants used in physician-office

surgical procedures are separately payable using HCPCS alphanumeric codes.<sup>32</sup> The nonspecific CPT code 99070 is not payable in any setting.

We examined the WC fee schedule for several states that have adopted the RBRVS. Texas and Washington bundle supplies following Medicare’s policy (Table 6.9).

**Table 6.9 Bundling of Current Procedural Terminology Code 99070 for Selected Comparison States Using the Resource-Based Relative Value Scale**

<b>State WC Program</b>	<b>Pay for Code 99070</b>
Florida	Yes
Michigan	Yes
Tennessee	Yes
Texas	No
Washington	No

Michigan, Tennessee, and Florida have similar policies for when CPT 99070 is separately payable. Minor medical and surgical supplies routinely used by the practitioner or health care organization in the office visit are not to be billed separately. Supplies or other services over and above those usually incidental to an office visit or other outpatient visit are to be billed separately under CPT 99070.

Several comments on the DWC forum were about payment for supplies. Many physical therapists urged that separate payment be made for supplies furnished during PT visits. The commenters argued that WC patients use more supplies but provided no data to support their argument. A physical therapist who is unaffected by the fee schedule advised us that there is no apparent reason that WC patients would require more supplies during a visit. Any additional supplies dispensed to the patient would be separately payable under the DMEPOS fee schedule. One large provider indicated that billing and receiving payment for supplies under the current OMFS ground rules has been problematic and that bundling would reduce administrative burden.

At the stakeholder meeting on the RBRVS, a provider requested that separate payment continue for surgical trays (but that provider’s comments on the forum did not discuss supplies). Under the RBRVS, separate rates apply to the PE component of the fee schedule. For services provided in a physician’s office, the PE RVUs reflect the costs of equipment and supplies used during provision of the service. A listing of the supplies that are included for different services is

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<sup>32</sup> When furnished to patients in settings in which a TC is payable, separate payments may be made for contrast material used during intrathecal radiologic procedures, pharmacologic stressing agents used in connection with nuclear medicine and cardiovascular stress-testing procedures, and radionuclides used in connection with nuclear medicine procedures.

available on the CMS website.<sup>33</sup> Surgical trays are included in the RVUs for wound repairs. A separate allowance for surgical trays would, in essence, be a duplicate payment.

### Specific Policy Alternatives

We identified two options that might be considered. The first follows the Medicare rules without modification. The second would make a separate payment for atypically high supply costs.

1. Adopt Medicare policy of bundling payment policies for encounters. Code 99070 would not be payable.
  - Advantages
    - Decreases administrative burden and additional bill-processing costs
    - Discourages providers from providing potentially unnecessary supplies
    - Consistent with Medicare policies
  - Disadvantages
    - Potential to create access issues for medically necessary high-cost supplies
2. Allow payments for supplies above a threshold. Payment for supplies above this threshold would be on a BR basis using code 99070. This threshold could be set to a certain fixed value, e.g., 95th percentile of supply costs.
  - Advantages
    - Bundles all but unusually high-cost supplies
    - Discourages providers from providing potentially unnecessary supplies
    - Protects against potential access issues
  - Disadvantages
    - Higher administrative burden
    - Requires budget-neutrality adjustment

We have summarized payments for supplies under CPT 99070 in Tables 6.10, 6.11, and 6.12. These are the total amounts paid for supplies (50 percent of which was incorporated into the impact analysis). Table 6.10 uses the 95th percentile as an example for a threshold above which payment of supplies will no longer be bundled and will instead be on a BR basis.<sup>34</sup> Using a monetary threshold value of \$442 (95th percentile) drops the number of total bills for supplies by 96 percent and cuts payment for supplies by about 50 percent. This represents a large decrease in administrative costs and burden by reducing the number of bills processed on a BR basis. Bills

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<sup>33</sup> Calendar year (CY) 2013 PFS direct PE inputs are available (CMS, 2012c).

<sup>34</sup> Currently, all supplies are billed BR, so the types of supplies cannot be determined. Also, nearly 75 percent of CPT 99070 supplies were billed without accompanying billings for other services and cannot be linked to services provided. This might arise as a result of inappropriate provider use of the CPT 99070 for physician-dispensed items. Additionally, certain drugs are also billed using CPT 99070 that cannot be parsed from the supply data billed under CPT 99070.

above the 95th percentile appear to be very high-cost supplies with a mean of \$986, which is nine times that of the mean of costs of all supplies taken together (data not shown). The mean payment for supply costs exceeding the 95th-percentile threshold would be \$913.72.

**Table 6.10 Official Medical Fee Schedule Payments for Supplies Related to Diagnostic and Therapeutic Procedures**

Payment Type	Payments (\$)	Times Billed	Mean (\$) <sup>a</sup>	Median (\$) <sup>a</sup>
Total paid for CPT 99070	13,305,378	162,676	81.79	13.54
Total paid for CPT 99070 with \$422 threshold (95th percentile)	6,089,916	6,665	913.72	413.49
Total paid for CPT 99070 with \$1,873 threshold (99th percentile)	2,005,777	1,211	1,656.30	850.95

<sup>a</sup> The mean and median are calculated for amounts that would be paid above the listed thresholds. For example, under the \$422 threshold, a bill for \$423 would be paid at most \$1.

Tables 6.11 and 6.12 show the distribution of CPT 99070 payments across diagnostic and therapeutic services that were billed on the same day by the same or a different provider. Nearly \$5.6 million of the payments were for supplies that were the only item billed on that day for that patient in the WCIS. Further, only \$2.9 million were billed on the same bill as a medical or surgical service. We would have expected that supplies that are dispensed to patients would be billed using an HCPCS alphanumeric code rather than CPT 99070. Both WCIS incompleteness and inconsistencies in billing practices may explain why only supplies are being billed on a given day. It appears that several of the costly bills that would qualify for the additional payment might be associated with surgical procedures. Of the supplies that are billed on the same day as a diagnostic or therapeutic service, surgery accounts for 10.2 percent of the supply costs but 22.4 percent of supplies above the 99th percentile. We are unable to determine the types of supplies that are being billed in connection with surgery. Note that, if a facility fee was also payable for the services, the items should not have been separately billable.

**Table 6.11 Distribution of Total Payments for Current Procedural Terminology Code 99070 Across Types of Service with the Same Patient and Date of Service: Amount Paid, in Dollars**

Paid Amount	All 99070	Payment Threshold at 95th Percentile (\$422)	Payment Threshold at 99th Percentile (\$1,873)
Total	13,305,378	6,089,916	2,005,777
Supply-only bills <sup>a</sup>	5,567,158	3,142,151	1,087,549

<sup>a</sup> This sum includes bills on which the only paid service is CPT 99070.

**Table 6.12 Distribution of Total Payments for Current Procedural Terminology Code 99070 Across Types of Service with the Same Patient and Date of Service: Percentage of Apportioned Supply Costs for Bills with Supplies and Other Services**

Type of Service by CPT Code Range	All 99070	Payment Threshold at 95th Percentile (\$422)	Payment Threshold at 99th Percentile (\$1,873)
E&M	49.1	50.5	46.0
Anesthesiology	1.0	1.8	2.7
Surgery	10.2	14.6	22.4
Radiology	4.7	2.9	3.1
Pathology and laboratory	0.0	0.0	0.0
Medicine	3.5	3.1	2.4
Physical medicine	14.8	7.6	4.9
Manipulative treatment	0.6	0.4	0.3
Special services	9.9	10.3	8.0
Other	6.0	8.9	10.2

We included 50 percent of the paid amounts for supplies in our analysis file and assumed that these would be bundled under the RBRVS.

### *Reports*

Under current OMFS rules, certain reports are separately reimbursable under three codes:

- 90889: preparation of report of patient’s psychiatric status, history, treatment, or progress (other than for legal or consultation purposes) for other individuals, agencies, or insurance carriers
- 99080: special reports (information in excess of mandated reports requested by claim AD or Workers’ Compensation Appeals Board [WCAB], consulting-physician reports [confirmatory or requested by a party to the claim, the AD, or WCAB], PR-3). CPT 99080 is paid at a per-page rate (capped at six pages unless additional length is authorized).
- 99081: required reports (PR-2, final PR-2).

The first two codes are current CPT codes. CPT 99081 is not a 2013 CPT code. In addition to the reimbursable reports listed above, there are non-reimbursable treatment reports that are already included in the OMFS allowance for E&M services: Doctor’s First Report of Occupational Illness or Injury (Form 5021), initial treatment report and plan (which should be in the Form 5021), and reports by a secondary physician to the primary treating physician. The rationale for paying separately for some required reports under CPT 99081 and not for others is not readily apparent. The first report of occupational injury or illness (Form 5021) is not separately reimbursable, while progress reports (PR-2) are.

Under the MPFS, reports are bundled into the payment for E&M services and are not separately paid. There are two related issues in creating a separate allowance for reports:

(1) whether a separate allowance would be a duplicate payment and (2) whether a budget-neutrality adjustment would be required because a separate payment deviates from Medicare's policies. Arguably, work-related reports are not the same as medical treatment reports that are an integral part of medical treatment. Separate payment for required reports recognizes the additional work-related documentation required for WC patients and responds to concerns that WC patients pose more administrative burden for E&M services. This rationale is strongest for the reports required for claim administration, e.g., those currently reimbursable under CPT 99081 and the PR-3 that is currently payable under CPT 99080 and WC-required reports under CPT 90889. It is less applicable to reports that are not WC-specific, such as consultation reports, except to the extent they are WC-required consultation reports performed in the context of medical-legal evaluations (OMFS modifier = 30) or other mandated consultations (OMFS modifier = 32).

In addition to reports, the OMFS has allowances for copies of medical records and duplicate reports. These are not valid 2013 CPT codes. The codes are not heavily utilized under the WC program, but, when they are used, we cannot determine from the WCIS data the reasons underlying the requested records.

The paid amounts for reports are shown in Table 6.13. Consistently with the proposed rule, we treat codes other than CPT 99080 and 990889 as if separate allowances will continue using OMFS prices under the RBRVS. We were unable to model the nuances of the proposed rule to continue to pay for certain consultation reports and the PR-3 under CPT 99080. To approximate the amount that would continue to be paid, we treated 19 percent of the paid amounts for CPT 99080 as BR allowances in the impact analysis. This represents the percentage of payments for CPT 99080 reports that are not billed within 30 days of a consultation visit.

**Table 6.13 Official Medical Fee Schedule Payments for Reports, by Current Procedural Terminology Code**

<b>OMFS CPT Code</b>	<b>Description</b>	<b>MPFS Status</b>	<b>Total 2011 OMFS Payments (\$ millions)</b>	<b>Treatment Under the RBRVS</b>
76175	Duplication of x-ray	Invalid code	0	OMFS rate: \$4.75 each
76176	Duplication of scan	Invalid code	0	OMFS rate: \$9.50 each
90889	Special report of patient's psychiatric status	Bundled	0.40	Pay for WC-required reports at the OMFS rate: (6.5 1st page; 4.0 additional) × \$6.15 × 0.95; bundle other reports
99080	Special reports or forms	Bundled	30.82	Pay for WC-required consultation reports and PR-3 at the OMFS rate: (6.5 1st page; 4.0 additional) × \$6.15 × 0.95; bundle other consultation reports
99081	Required reports	Invalid code	15.82	OMFS rate: \$11.69
99086	Reproduction of chart notes	Invalid code	0.27	OMFS rate: (\$10 first 15 pages; 0.25 each additional page) × 0.95
99087	Reproduction of duplicate reports	Invalid code	0.04	OMFS rate: (\$10 first 15 pages; 0.25 each additional page) × 0.95

***Other Items and Services with Status Code B under the Medicare Physician Fee Schedule***

Supplies and reports account for most of the allowances for services that are separately paid under the current OMFS that are assigned status code B under the RBRVS. Consistently with the proposed rule, we assumed that the remaining services would be bundled under the RBRVS. For modeling purposes, we included the OMFS allowances for these services in our estimation of current OMFS allowances, and we included no separate allowances for these services in our estimation of RBRVS allowances.

**Consultations**

***Background***

Consultations are defined under the OMFS as

a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or appropriate source (e.g., a party to the claim, the administrative director [AD] or Workers' Compensation Appeals Board [WCAB]).

If the treating physician is asked for medical information other than that required to be reported as treatment reports, the service qualifies as a consultation. The current OMFS has different

allowances for consultations and other E&M visits. In addition, a report by the consulting physician is separately reimbursable.

The CPT consultation codes have been revised and clarified regarding usage. Key elements of the current definition are that (1) the consultation must be at the request of a physician or other appropriate source to either recommend care or determine whether to accept responsibility for ongoing care; (2) care may be initiated at the initial consultation, in which case E&M codes for established patients are used for follow-up care; (3) if transfer of care occurs before the initial evaluation, the consultation code should not be used; (4) if an additional request for advice is received regarding the same or new problem, the codes may be used again; and (5) the referral should be documented in the medical record.

CMS eliminated payment for the consultation codes in 2010 because of inconsistent use of the consultation codes by physicians and Medicare contractors.<sup>35</sup> At issue were E&M documentation guidelines that distinguish a consultation from a transfer of care and the interchangeable use of the term *referral* by physicians to mean both a consultation and a transfer of care. The CPT Coding Guidelines were revised, effective January 2010, to clarify that a transfer of care occurs when a physician relinquishes responsibility for management of some or all of a patient's problem to another physician or qualified health care professional. However, CMS was skeptical that this would resolve the long-standing differences in interpretation regarding referrals and transfers of care. In addition, CMS was concerned that the consultation codes may be overvalued relative to the E&M codes for initial hospital care and new-patient office or outpatient visits. Physician work is clinically similar for these codes. According to CMS, many physicians contended that more work is actually involved with a new-patient visit than with a consultation service because of the postwork involvement with a new patient. The payment for a consultation service had been set higher than for initial visits because a written report must be made to the requesting professional. However, CMS had reduced the reporting burden for the consultation reports so that it was no longer a defining aspect of the service.<sup>36</sup> The elimination of the consultation codes was made budget neutral by increasing the work RVUs for new- and established-patient office visits by approximately 6 percent and for initial hospital and facility visits by approximately 0.3 percent (which also affected the incremental work RVUs for the E&M codes that are built into the global surgical codes) (CMS, 2009a). Although the MPFS does not use the consultation codes, the annual update includes values for the consultation codes in Addendum B as a courtesy to the AMA.

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<sup>35</sup> A 2006 report by the U.S. Department of Health and Human Services (HHS) Office of Inspector General found that Medicare had inappropriately paid for a substantial volume of services billed as consultations. Seventy-five percent did not meet Medicare requirements (billed at the wrong type or level), 19 percent did not meet the definition of a consultation, and the remainder were insufficiently documented.

<sup>36</sup> The change was to allow any form of written communication, including submitting a copy of the evaluation report taken directly from the medical record submitted without a letter format.

Table 6.14 summarizes the differences in OMFS allowances under three fee-schedule alternatives. Section A shows the distribution of the current OMFS consultation codes and their estimated allowances (\$27.77 million). Section B shows the current OMFS codes cross-walked into their 2013 equivalents for consultations. The codes for follow-up inpatient consultations and confirmatory consultations have been eliminated. Services billed under these codes have been cross-walked to their equivalents in CPT 2013—namely, follow-up inpatient consultation codes to codes for subsequent hospital and nursing-home care and the confirmatory consultations to the office and initial inpatient consultation codes. We priced these services using the published RVUs established by the AMA for these codes (which the MPFS does not recognize) and the 2014 equivalent of fully phased rates based on 1.2 times the Medicare rate. This CF is more reflective of final fee differences than the transition CF. Relative to the current OMFS, allowances would be 19 percent higher if the RBRVS recognized the consultation codes at 1.20 of the published RVUs (\$32.99 million ÷ \$27.77 million).

In section C, we cross-walked the 2013 CPT consultation codes into their CPT equivalents under Medicare rules (i.e., visit codes) and priced the visits using the MPFS RVUs for the visit codes and the 2014 equivalent of fully phased rates based on 1.2 times the Medicare rate. Total MAA for the visit codes are \$26.12 million. The MAA would be 94 percent of current OMFS allowances (\$26.12 million ÷ \$27.77 million). The MAA in section B, which use the consultation code RVUs, are 23 percent higher than those in section C (\$32.99 million ÷ \$26.12 million).

Changes in the allowances for consultation reports are not included in the Table 6.14 comparison. Under current OMFS ground rules, separate allowances apply to consultation reports. As noted earlier, the proposed rule provides for bundling consultation reports other than WC-required reports. Payments for CPT 99080 totaled \$30.82 million in our analysis file. For the impact analysis, we assumed that 81 percent of current OMFS payments for reports billed under CPT 99080, or \$24.96 million, would be bundled under the OMFS.<sup>37</sup> Aggregate allowances for both the consultation visits and reports total \$52.73 million under the OMFS (\$27.77 million + \$24.96 million), compared with \$26.12 million under the RBRVS. Total aggregate allowances under the RBRVS using the Medicare rules would be 51 percent of total OMFS allowances for consultations and related reports.

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<sup>37</sup> This is a higher amount than would be estimated assuming that one report is paid for each consultation code. Using the maximum page length without prior approval and the current OMFS allowance, we estimate that \$152 would be paid for each report ( $0.95 \times 6.15 \times (6 + 4 \times 5)$ ), or a total of \$22.7 million.



A. Current OMFS Code				B. CPT 2013 Consultation/Visit Codes				C. CPT Visit Codes Only			
Code	Volume	Allowed Fee (\$)	Total Allowances (\$ millions)	Code	Volume	Allowed Fee (\$)	Total Allowances (\$ millions)	Code	Volume	Allowed Fee (\$)	Total Allowances (\$ millions)
<b>Confirmatory Consultations</b>											
99271	10	73.48	0.00	99307	1	56.96	0.00	99304	66	118.15	0.01
99272	42	97.71	0.00	99308	4	88.47	0.00	99305	528	167.65	0.09
99273	395	127.59	0.05	99309	2	116.17	0.00	99306	710	211.60	0.15
99274	834	173.61	0.14	99310	0	171.97	0.00				
99275	1,332	227.72	0.30								
				<b>Initial Nursing-Home Care: New or Established Patient</b>							
				<b>Subsequent Nursing-Home Care</b>							
								<b>Subsequent Hospital and Nursing-Home Visits</b>			
								99321-	346		0.03
								99233			
								99307-	8		0.00
								99310			
Total	149,657		27.77		149,657		32.99		149,657		26.12

NOTE: Allowances in columns B and C priced by multiplying 1.20 x the 2012 Medicare CF updated for inflation by the applicable RVUs for each code adjusted for statewide GPCI values.

Other states using the RBRVS have adopted different policies regarding the consultation codes (Table 6.15).

**Table 6.15 Summary of Selected State Policies on Consultation Codes**

State	Policy
Florida	Allows an initial consultation but requires that any subsequent visits be billed using E&M visit codes
Maryland	Recognizes consultation codes
Tennessee	Follows Medicare rules
Washington	Recognizes consultation codes. Follows E&M documentation guidelines
Ohio	Recognizes consultation codes
Texas	Follows Medicare
Federal OWCP	Follows Medicare

### *Specific Policy Alternatives*

Three basic options that might be considered are (1) follow Medicare rules, (2) follow Medicare rules but continue to pay separately for consultation reports, and (3) pay for consultations but eliminate separate payment for consultation reports because they are part of the defined service and reason for higher relative values.

1. Follow Medicare ground rules.
  - Advantages
    - Consistent with Medicare rules and RVUs
    - Reduces opportunity for coding inconsistencies
  - Disadvantages
    - Could reduce the quality of consultation reports
    - Could discourage specialties from providing consultations for WC patients
2. Use E&M visit codes only but allow consultation reports.
  - Advantages
    - Addresses concern that consultation reports might be undervalued in visit codes
    - Pays for actual consultation reports
  - Disadvantages
    - Contrary to Medicare rules
    - Requires a budget-neutrality adjustment (estimated \$40 per report)
    - Adds to administrative burden
3. Allow consultation codes but bundle reports.
  - Advantages
    - Avoids creating potential difficulties in access to specialists for consultations
  - Disadvantages

- Budget-neutrality adjustment complicates fee-schedule updating
- Increases administrative burden of monitoring correct coding
- Does not create incentives to provide quality consultation reports.

Section 5307.1(a)(2)(A)(iii) limits aggregate payments to 120 percent of the aggregate fees under the Medicare system and further stipulates that any service provided under WC that is not covered under Medicare will be included in the limit calculation at the rate of payment established by the AD. As indicated by the status code I on Addendum B of the Medicare fee schedule, consultations are covered by Medicare but paid under different CPT codes (i.e., the E&M visit codes). DWC proposes to adopt the Medicare ground rules for consultations and related reports. If the Medicare rules are not adopted, an offsetting adjustment would need to be made to limit aggregate fees to 120 percent of payment under Medicare. Using the RVUs for consultation codes would increase aggregate allowances for E&M services 1.98 percent and total aggregate allowances 0.78 percent beginning in 2017, when the RBRVS is fully implemented.

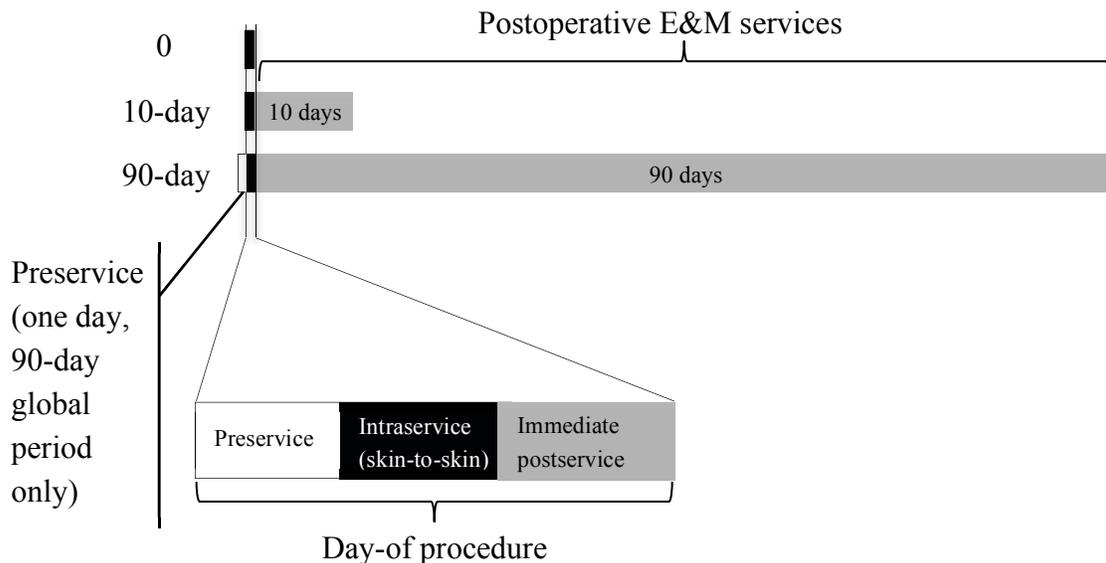
## Global Fees

### *Background*

Under the MPFS, CMS pays practitioners a single global surgical fee for a package of services that includes the surgical procedure itself, immediate pre- and postsurgical services, and E&M services routinely delivered after the surgery in a fixed period of time. Surgical procedures are assigned a global period length of zero, ten, or 90 days. The length of the global period determines which postoperative E&M visits are included in the global fee. Endoscopies and some minor procedures have a zero-day period, i.e., only services provided on the day of the procedure are included in the global fee. Other minor procedures have a ten-day global period, consisting of the day of the procedure and the following ten days (11 total days). Major procedures have a 90-day global period, consisting of one day before the procedure, the day of the procedure, and the following 90 days (92 total days). Figure 6.2 illustrates the various components of zero-, ten-, and 90-day global periods.

Services in the global surgery payment usually include preoperative visits after the decision to operate is made; intraoperative services considered usual and necessary; all follow-up care days; pain management; and supplies and miscellaneous services, such as dressing changes and removal of casts, tubes, or wires. Initial consultations, diagnostic tests, treatment for underlying conditions, and clearly distinct procedures are not included in this package. The same package of services is bundled across all medical settings, regardless of the setting in which the surgery is performed and the follow-up services that are provided.

**Figure 6.2 Global Period Definitions**



The total time and work values associated with surgical codes with global periods combine estimates of time and work on the day of the procedure and time and work from an estimated number of postoperative E&M services provided in the global period. Practitioner surveys were the initial basis for time and work values and are still used extensively to inform revisions. For the day-of-procedure component, practitioners are asked to provide time estimates specific to preservice, intraservice, and immediate postservice components for the procedure itself.<sup>38</sup> For postoperative E&M services in the global period, practitioners are asked to estimate the typical number of specific E&M services they perform for a typical patient.<sup>39</sup> Each E&M service is associated with its own time and work estimates. The total global fee amount is based on the sum of these component-specific time and work values. For example, the total work RVUs for CPT 29881 (arthroscopy of the knee with medial or lateral meniscectomy) is calculated from the components listed in Table 6.16. The global fee for the work component of the fee schedule is calculated from 7.03 total RVUs, which accounts for services provided on the day of the procedure and the day prior to the procedure, as well as the typical postoperative E&M services related to the procedure.

<sup>38</sup> In the case of a 90-day global period, practitioners also estimate time spent on the day before the procedure.

<sup>39</sup> These services include hospital visits (CPT 99231–99233, 99291, and 99292), discharge-day visits (99238, 99239), office visits (99211–99215), and prolonged services (99354–99237).

**Table 6.16 Service Components Included in the Work Component of the Global Fee for Current Procedural Terminology Code 29881, Arthroscopy of the Knee with Medial or Lateral Meniscectomy, 90-Day Global Period**

Day-of Components	Time		Intensity		Work
	Minutes		RVUs per Minute	Total RVUs	
Preservice: Evaluation	33		0.0224	0.74	
Preservice: Positioning	10		0.0224	0.22	
Preservice: Scrubbing, etc.	15		0.0081	0.12	
Intraservice	40		0.0637	2.55	
Immediate postservice	15		0.0224	0.34	
<b>Postoperative E&amp;M</b>	<b>Number</b>	<b>Minutes (each)</b>	<b>Total</b>	<b>RVUs per Service</b>	<b>Total RVUs</b>
Outpatient visit: 99212 <sup>a</sup>	1	16	16	0.48	0.48
Outpatient visit: 99213 <sup>b</sup>	2	23	46	0.97	1.94
Discharge management: 99238 <sup>c</sup>	0.5	38	19	1.28	0.64
<b>Total</b>		<b>Minutes</b>		<b>RVUs per Minute</b>	<b>RVUs</b>
			194	0.0362	7.03

<sup>a</sup> Outpatient office visit, established patient, with at least two of the following components: (1) a problem-focused history (see “Evaluation and Management Guidelines” later in this chapter), (2) a problem-focused examination, or (3) straightforward medical decisionmaking.

<sup>b</sup> Outpatient office visit, established patient, with at least two of the following components: (1) an expanded problem-focused history, (2) an expanded problem-focused examination, or (3) medical decisionmaking of low complexity.

<sup>c</sup> Hospital discharge-day management, 30 minutes or less.

California WC also uses global periods to pay for certain surgical procedures. The CMS and California global period definitions are nearly identical. Language describing other important details (e.g., the services included and excluded from the global payment, the use of modifiers, and other exceptions) are very similar in the California OMFS and CMS billing manuals.

The initial global periods assigned to CPT codes in the OMFS were adopted from the 1997 MPFS.<sup>40</sup> Since then, CMS has updated global period lengths for some services. Table 6.17 reports the current OMFS and MPFS global periods for the 20 surgical services with the highest WC payments. The surgical procedure associated with the greatest spending, CPT 29826 (shoulder arthroscopy or surgery), has a 90-day global period in the OMFS. It is an add-on code (ZZZ) in the MPFS that is billed in addition to the primary procedures—each of which has a 90-day global period.<sup>41</sup> Another code, CPT 63650 (implant neuroelectrodes), has a 90-day global period in the OMFS and a ten-day global period in the MPFS.

<sup>40</sup> See HHS (1996) and the 1999 OMFS Book, Surgery Ground Rules, No. 20. MPFS zero-day global periods or special alphanumeric codes (e.g., ZZZ) were converted to “blank” OMFS global periods.

<sup>41</sup> Under the MPFS, the global period for the primary procedure will determine the global period for 29826. This code is used in conjunction with 29806–29825, 29827, and 29828, each of which has a 90-day global period.

WC's current global periods closely align with those of CMS under the MPFS in terms of duration. The key difference is that CMS global periods have been revised over time, while OMFS global periods have not. Table 6.18 compares CMS and OMFS global periods for all surgical codes. Ninety-five percent of codes with an OMFS 90-day global period also have a 90-day CMS MPFS global period. Nearly 90 percent of codes with an OMFS ten-day global period also have a ten-day CMS MPFS global period.

Postsurgical E&M visits account for a considerable proportion of the total time and work associated with surgical procedures in the MPFS. For the 20 surgical codes listed in Table 6.17, postsurgical E&M visits accounted for 40.7 percent, on average (median 38.3 percent), of total service time. Nevertheless, there is concern regarding whether the global billing rules provide sufficient recognition of work-related components of follow-up care.

**Table 6.17 Comparison of Global Periods Under the Official Medical Fee Schedule and Medicare Physician Fee Schedule for High-Volume Procedures**

OMFS CPT	2013 CMS CPT	Brief Description	WC 2011 Payments (\$ millions)	OMFS Global <sup>a</sup>	CMS Global <sup>b</sup>
29826	Same	Shoulder arthroscopy/surgery	8.75	90	ZZZ
29881	Same	Knee arthroscopy/surgery	4.72	90	90
22845	Same	Insert spine-fixation device	3.87	0	ZZZ
63047	Same	Laminectomy, lumbar	3.91	90	90
29823	Same	Shoulder arthroscopy/surgery	3.57	90	90
29880	Same	Knee arthroscopy/surgery	3.44	90	90
62278	62311	Inject spine lumbar/sacral	3.36	0	0
22851	Same	Apply spine prosthetic device	3.15	0	ZZZ
27447	Same	Total knee arthroplasty	3.07	90	90
22842	Same	Insert spine-fixation device	2.74	0	ZZZ
64721	Same	Carpal-tunnel surgery	2.63	90	90
63650	Same	Implant neuroelectrodes	2.16	90	10
63030	Same	Low-back disk surgery	1.94	90	90
20610	Same	Drain/inject joint/bursa	1.9	0	0
29888	Same	Knee arthroscopy/surgery	1.88	90	90
22612	Same	Lumbar spine fusion	1.83	90	90
22554	Same	Neck spine fusion	1.58	90	90
22558	Same	Lumbar spine fusion	1.53	90	90
63048	Same	Remove spinal lamina add-on	1.46	0	ZZZ
20550	Same	Inject tendon sheath/ligament	1.37	0	0

<sup>a</sup> DWC, 2007.

<sup>b</sup> CMS, 2013a.

**Table 6.18 Summary Comparison of Official Medical Fee Schedule and Medicare Physician Fee Schedule Global Periods for Surgical Procedures, Percentages for Each Code**

OMFS	CMS MPFS						
	Blank	XXX <sup>a</sup>	YYY <sup>b</sup>	ZZZ <sup>c</sup>	0	10	90
Blank <sup>d</sup>	19	49	2	5	14	3	9
10	9	0	0	0	4	87	0
90	4	0	0	0	0	1	95

<sup>a</sup> The CMS XXX designation indicates that the global fee concept does not apply to the specific code.

<sup>b</sup> The CMS YYY designation indicates that Medicare contractors, not CMS, determine whether the global fee concept applies to the specific code. Contractors may assign these codes a zero, ten-day, or 90-day global period.

<sup>c</sup> The CMS ZZZ designation indicates that the code is always included in the global period of another service and therefore does not have its own global period.

<sup>d</sup> Codes without an OMFS ten- or 90-day global period may have a zero-day global period or a special global period code, such as a CMS XXX, YYY, or ZZZ code.

NOTE: Shaded areas indicate procedures with common global periods.

### *Policy Considerations*

Global-period policy aims to incentivize the appropriate and efficient provision of postsurgical E&M visits. The global period also simplifies billing and adds predictability in terms of payment for providers and payers. The rationale for a global period is tied to the rationale for bundled, capitated, or prospective payment generally. Given a fixed payment rate, practitioners will provide only appropriate services. However, any global-period payment is subject to the same potential adverse effects of bundled and capitated payment, including incentives to provide fewer services at the potential expense of quality of care and health. The tension between promoting quality and controlling utilization and spending is a hallmark of the more general debate between fee-for-service and capitation payment arrangements. In most cases, hybrid payment systems develop over time to offset the most-serious adverse effects of each individual payment approach.

The global payment issue also raises questions related to data collection, data analysis, and the use of data as a quality and value-improvement tool. It is extremely difficult to assess whether, when, and how postsurgical E&M services are provided to Medicare beneficiaries or to WC patients given the current global billing policies. As a result, neither CMS nor WC data can inform whether changes to the global billing policy are warranted to evaluate the appropriateness of postoperative care, target interventions to improve the quality of postsurgical care, or prevent double-billing by multiple practitioners.

In weighing whether the WC program should continue to use the global periods, important considerations include the following:

- *Global periods are consistent with both OMFS current policy and Medicare policy.* They have not been an issue under the OMFS, although this may be because the current allowances are substantially higher than the Medicare allowances. One implication is that

the continuation of the global periods should not be an issue if the reduced payment rates are phased in.

- *Because both Medicare and WC use global periods, data are not available to determine whether WC patients require more follow-up visits.*<sup>42</sup> Because WC patients have a shorter length of stay than Medicare patients, it is likely they have fewer inpatient visits associated with inpatient surgeries. It is also likely that more surgeries are performed on an outpatient basis than inpatient. Data are not available to determine the impact that this might have on the number and intensity of postoperative office visits and whether fewer hospital visits offset any additional office visits. However, because WC patients are younger and healthier, they are likely to require fewer follow-up visits for *medical* reasons.
- *Work-related issues may require additional visits or more visit time.* Several commenters during pre-rulemaking activities noted that visits solely to address work-related reporting requirements may be needed during the global period. Separate allowances for these visits and for WC-required reports is one approach to address this issue. In addition, it could be argued that the 1.2 multiplier provides a cushion for longer visits. Regardless of whether the visits are covered in the global fee or separately billed, there is no assurance that work-related services are actually provided during the visit unless data are collected about the nature of the postoperative services.
- *If global billing is eliminated, an adjustment is needed to avoid duplicate payment.* Because the RBRVS pricing covers postoperative visits, the RVUs would need to be adjusted so that WC payers do not pay twice for the care: once in the allowance for the surgical procedure and again in the separate billings for E&M services.
- *Available data to make an adjustment are problematic.* Empirical data are not available to decompose the global RVUs into separate and appropriate RVUs for the surgery from the postoperative E&M services.<sup>43</sup> Medicare publishes separate values that are to be used when a surgeon transfers the responsibility for postoperative care to another practitioner.<sup>44</sup> These situations are identified by modifier. Modifier –54 is reported by the surgeon, and the RVUs cover services provided in the preoperative and intraoperative periods and postoperative hospital visits. Modifier –55 is reported for the postoperative care and covers office visits. The intraoperative and postoperative percentages are used only infrequently (primarily for cataract surgery) and have not undergone much scrutiny. Although the modifiers and percentages could be used to establish separate allowances, it is unlikely to be budget neutral. If, for example, a higher proportion of WC postoperative

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<sup>42</sup> It should be noted that the estimated services provided during the global periods are based on the “typical” patient receiving the services and not necessarily Medicare patients.

<sup>43</sup> Although time data are collected as part of the valuation process, they are not a direct input into the total RVU estimation. Instead, total work RVUs for a global surgery are estimated as a single value without regard to the time and intensity values for the individual service components. This disconnect can produce anomalous results if an allowance for the surgical procedure only is estimated by subtracting the RVUs for the E&M visits from the total RVUs for the global surgery. In particular, if the pre or post services are overvalued, the estimated value for the surgical procedure only will be undervalued. See Braun and McCall, 2011.

<sup>44</sup> The CMS methodology for splitting the fees is based on findings from when the RBRVS study was initially implemented that the intraoperative portion of surgical procedures accounts for roughly 50–65 percent of the total work of most hospital-based procedures (Braun and McCall, 2011).

visits occur as office visits, the CMS RVU allocation would overpay for the intraoperative time and increase total expenditures before accounting for any increases in the total number of E&M services for WC patients that might occur if the global period were eliminated.

- *Global periods are the norm in payment policies.* Our analysis of other state fee schedules indicates that other WC programs are using the Medicare global periods (some with separate payments for reports). To date, we have not been able to identify any group health payers that do not use global fee structures.

### ***Specific Policy Alternatives***

In this section, we outline several policy options and their potential advantages and disadvantages from the perspective of how they might influence the efficient delivery of high-quality care and affect administrative burden.

1. Allow separate billing of postsurgical E&M visits.
  - Advantages
    - Avoids potentially penalizing practitioners who provide services to WC patients with complex postsurgical care needs
    - Provides data on utilization of postsurgical E&M visits that could be used to refine the policy in the future
  - Disadvantages
    - To avoid duplicate payments, requires adjustments that are not empirically based in the MPFS
    - Budget neutrality cannot be assured
    - Individual fee-for-service payments would incentivize practitioners to provide potentially unnecessary postsurgical E&M visits
    - Increases administrative burden of additional bill processing
2. Adopt the CMS MPFS rule and integrate *all* postsurgical visits into the global period.
  - Advantages
    - Consistent with the RVUs established for the services under both the OMFS and the MPFS
    - Provides incentives for provision of only medically necessary postoperative visits
    - Avoids budget-neutrality issues
    - Avoids additional bill-processing costs
  - Disadvantages
    - May incentivize practitioners to avoid WC patients with complex postsurgical E&M care needs, “cherry-pick” WC patients with few postsurgical E&M care needs, or informally hand off care to other providers
    - Payment based on estimated “average” care is less accurate than payments based on actual care provided.
    - May disadvantage surgeons who performed work-related activities during the global period

3. Integrate typical postoperative services (as defined in the CMS MPFS) into the global period and allow separate payment for visits beyond typical postoperative services. These services could include WC-required visits that are not related to postoperative medical care and visits in excess of the estimated number included in the RVU estimation (or above an “outlier” threshold).
  - Advantages
    - Allows automatic payment for typical postsurgical E&M visits without administrative burden or separate payment
    - Practitioners retain flexibility to provide and bill for additional services above typical levels when either WC-required or medically necessary.
    - WC will collect and aggregate data on atypical postsurgical E&M visits.
  - Disadvantages
    - Requires documentation when atypical services are billed separately
    - A practitioner may still avoid WC patients with complex needs if he or she does not believe that the 1.2 multiplier is sufficient to compensate for additional WC administrative burden.
    - Pays surgeons for “average” postoperative care even when less care is provided.

DWC proposes to adopt option 3 and allow separate payment for visits in excess of the estimated number included in the RVU estimation. Because postoperative visits are bundled into the global payment and are not separately reported, we are unable to estimate the impact on aggregate expenses and have not included an adjustment for budget neutrality in our impact analysis. Ultimately, when actual billing data are available under the RBRVS, an adjustment could be made either to total aggregate allowances for surgical procedures only (which would function as an outlier policy for surgical procedures) or to total aggregate expenditures.



## Chapter Seven. Other Official Medical Fee Schedule Issues

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In this chapter, we discuss fee-schedule issues that are not directly related to how the prices are determined under the RBRVS. The issues include allowances for PADs, allowances for nonprofessional services provided by hospitals and ASCs that are currently covered by the OMFS for physician services, guidelines and edits for correct coding and documentation, and opportunities to introduce pay-for-performance (P4P) incentives into the fee schedule.

### Physician-Administered Drugs

#### *Background*

California WC pays for outpatient pharmaceuticals dispensed to patients, as well as pharmaceuticals administered directly to patients by physicians. PADs are injected or infused in the office setting and include low-cost generic drugs, high-cost specialty drugs of biologic origin, and immunizations. Our discussion focuses primarily on different payment options for PAD materials. It also covers payment for injection services related to PADs. We do not address physician-dispensed repackaged or compounded drugs.

WC currently applies the OMFS pharmaceutical formula to set allowable fees for therapeutic or diagnostic PADs.<sup>45</sup> Fees for brand-name and generic pharmaceuticals are set at average wholesale price (AWP) plus 10 or 40 percent, respectively.<sup>46</sup> Providers are expected to report the NDC when they bill for PADs. But providers often bill using HCPCS J-codes that group comparable PADs into a single code. Because NDCs have AWP, the allowances for the therapeutic and diagnostic PADs are regularly updated when providers bill NDCs. We do not know how WC J-code-allowed fees are priced, and the allowances may be outdated. There is no additional dispensing fee for PADs, but practitioners can bill a separate injection service code (90700–90799) when injecting drugs. There are also separate codes for infusion procedure-related PADs.

WC uses a different system to determine allowable fees for most immunizations. The OMFS has RVUs for certain immunizations (including the injection fee), while others are BR. The BR allowance is the acquisition cost of the immunization plus a \$14.30 injection fee.<sup>47</sup> The CPT

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<sup>45</sup> The specific OMFS language is as follows: “Pharmaceutical injection materials administered during therapeutic, diagnostic, or antibiotic injections are separately reimbursable using the Pharmaceutical Formula. A dispensing fee is not allowable with these injections.”

<sup>46</sup> AWP is a metric published by third-party data aggregates using industry-reported transaction prices.

<sup>47</sup> This policy applies to CPT codes 90725–90749 and 90710–90711. Practitioners must submit an invoice for the vaccine product. The \$15 injection fee was discounted 5 percent under SB 228 (2003) and remains discounted.

codes used to describe the immunizations and the RVUs are outdated. For most other drugs that are not PADs (including physician-dispensed drugs), the OMFS adopts Medi-Cal's allowable fees, which are generally equal to 83 percent of AWP.

There are significant differences between the current OMFS approach to PAD allowances and Medicare's approach. CMS uses HCPCS J-codes rather than NDCs for drugs and biologicals. CPT codes describe immunizations and vaccines (most of which are not covered by Medicare). In 2003, CMS transitioned from an AWP-based payment system to an average sales price (ASP)-based system because of uncertainty surrounding the accuracy and applicability of AWP estimates. Under the old policy, practitioners were paid AWP minus 5 percent for PADs. Practitioners are currently paid ASP, a more robust and reliable estimate of acquisition cost, plus 6 percent for PADs. Several classes of PADs—including blood and blood products other than clotting factors, infusion drugs administered via DME, and immunizations<sup>48</sup>—are exempt from the new ASP-based policy and continue to be paid at 95 percent of AWP.

Currently, the reimbursement rate for PADs under Medi-Cal is equal to the Medicare Part B reimbursement rate for drugs, biologicals, and vaccines when available and published by CMS, currently defined as ASP plus 6 percent.<sup>49</sup> If a CMS rate is not available, the pharmacy rate of reimbursement applies. The pharmacy rate is defined as the lower of (1) AWP minus 17 percent, (2) the federal upper limit, or (3) the maximum allowable ingredient costs. Providers are instructed to report the NDC paired with the appropriate HCPCS J-code except for vaccines, for which the NDC is not required.<sup>50</sup> The prices listed under Medi-Cal rates for PADs include a one-time injection-administration fee of \$4.46 for injections and immunizations.<sup>51</sup>

Other state WC programs follow three general approaches (Table 7.1). Like California, some states (e.g., Michigan, Oregon, Tennessee, and Washington) set PAD-allowable fees at AWP times a multiple (from 0.835 to 1). California uniquely adds a significant margin (10 and 40 percent for brand and generic drugs, respectively) on top of AWP. Texas pays a multiple (125 percent) of Texas Medicaid rates, which follow the Medicare ASP-plus-6-percent approach. Ohio leaves PAD payment decisions to managed-care contractors.

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<sup>48</sup> Only influenza, pneumococcal, and hepatitis B vaccines are covered by Medicare. Payment rates for these vaccines are established annually based on the AWP methodology.

<sup>49</sup> The medical-services provider manual outlining PAD billing and reimbursement is at California Department of Health Care Services, undated.

<sup>50</sup> The NDC is required because physician-administered drugs other than vaccines are subject to the drug rebate program. The NDC is also needed to price drugs that do not have a Medicare price. Crosswalks are available to link NDCs to J-codes.

<sup>51</sup> The injection fee is applied only once for the first billed unit of the drug and is subtracted from the published rate for additional units.

**Table 7.1 Payment Approaches Related to Physician-Administered Drugs**

<b>Payer</b>	<b>PAD Material Fees</b>	<b>Administration Fees</b>	<b>Immunization Provisions</b>
California OMFS	AWP + 10 or 40% for brand and generic drugs, respectively; no dispensing fee	Injection codes billable alongside E&M services	RVUs (including injection fee) for most immunizations. Acquisition cost + \$15 injection fee payable for BR immunization codes
Medicare	ASP + 6% for most drugs. AWP – 5% for certain categories (e.g., blood products)	Bundled with E&M services if provided at the same time	Few immunizations covered. Paid AWP – 5%
Medi-Cal	ASP + 6% when there is a Medicare-allowed amount. Other drugs reimbursed at the pharmacy rate	One-time drug injection–administration fee of \$4.46 for the first unit included in the pricing	Same as other PADs
Florida <sup>a</sup>	J-codes reimbursed at contract price. Exceptions for 90749 and J3490 (paid no more than 20% of the actual cost of material)	Injection codes are not on the fee schedule.	Unclear which vaccines are covered. No separate administration fee mentioned
Michigan <sup>b</sup>	Generally AWP	Injection codes not billable alongside E&M services	Both vaccine and injection fee paid separately. AWP + administration fee (90471 and 90472)
Ohio <sup>c</sup>	At MCO discretion; generally not covered	Surgical injection codes paid at medical CF of \$51. Otherwise not paid	At MCO discretion; generally not covered
Oregon <sup>d</sup>	83.5% AWP	No mention	No mention
Tennessee <sup>e</sup>	Generally AWP	Administration can be billed only once per visit.	No mention
Texas <sup>f</sup>	Uses 125% of Medicaid rates for J-codes. <sup>g</sup> Most Medicaid rates are ASP + 6%, with exceptions for drugs administered via DME or new drug (89.5% of AWP). <sup>h</sup>	Appears to follow Medicare, so no separate payment	Appears to follow Medicare, so no separate administration fee
Washington <sup>i</sup>	Must use J-codes. Percentage of AWP. Providers must bill acquisition costs: Payment is less than published fee-schedule amount or acquisition cost.	Appears to follow Medicare, so no separate payment	Immunization materials payable when authorized. 90471 and 90472 payable in addition to immunization material codes. 90472 is an add-on code for additional vaccines administered at the same time.

<sup>a</sup> Florida Department of Financial Services, 2008.

<sup>b</sup> Michigan Workers' Compensation Agency, 2005, 2013.

<sup>c</sup> Ohio Bureau of Workers' Compensation, 2011.

<sup>d</sup> Oregon Workers' Compensation Division Health Care Providers, undated.

<sup>e</sup> Tennessee Department of Labor and Workforce Development, undated.

<sup>f</sup> Texas Department of Insurance, 2013b.

<sup>g</sup> Texas Annotated Code, 2007.

<sup>h</sup> Texas Medicaid and Healthcare Partnership, undated.

<sup>i</sup> Washington State Department of Labor and Industries, 2012.

NOTE: MCO = managed-care organization.

## *Policy Considerations*

The three key policy issues are (1) selecting a price benchmark, (2) setting an adjustment above or below the benchmark, and (3) determining when additional services (for example, injection services) are billable in addition to the material itself.

Physicians purchase PADs from manufacturers and wholesalers, and, when they administer a drug, they keep the difference between the amount paid by insurers and what they paid to acquire the drug. In one approach, payers use a price benchmark to approximate the prices at which physicians buy drugs. Payers use benchmarks to avoid significantly under- or overestimating physicians' costs. Physicians might increase utilization if payment is much higher than acquisition cost or not provide PADs at all if payment is much lower than acquisition cost.

One particular benchmark— AWP—was widely used by payers, including Medicare and state Medicaid programs, in the early 2000s and continues to be used as a benchmark by some payers. Estimates of AWP were published by aggregators of industry-reported data. But because pharmaceutical transactions often involve proprietary rebates, volume discounts, and other adjustments, these industry-reported amounts do not necessarily reflect final prices paid by purchasers. Furthermore, publishers of AWP were involved in legal action related to manipulation of AWP, and two publishers announced that they would discontinue publication of AWP (although one publisher subsequently reversed this decision) (Curtiss, Lettrich, and Fairman, 2010).

ASP is an alternative to AWP.<sup>52</sup> ASP is defined in Medicare statute<sup>53</sup> and is calculated using actual transaction data. The definition of ASP includes a comprehensive list of rebates and other discounts that might reduce actual transaction costs. A report issued by the HHS Office of Inspector General found that ASP was 49 percent lower than AWP at the median in a sample of drugs (HHS, 2005). As described above, Medicare currently pays ASP plus 6 percent for most drugs and AWP minus 5 percent for special categories of PADs. There may be some PADs that are not currently priced by Medicare. Medi-Cal pays the same as Medicare when a Medicare rate is available and uses its pharmacy rate of reimbursement when Medicare does not have a listed rate. The pharmacy rate is currently defined as the lower of (1) AWP minus 17 percent, (2) the federal upper limit (FUL); or (3) the maximum allowable ingredient cost (MAIC).

Current WC payment is calculated using the higher of the two common benchmarks (AWP as opposed to ASP) and adds rather than subtracts a margin on top of the benchmark. As a result, switching to the Medicare, Medi-Cal, or another payment approach would result in lower payment rates for most PAD materials. There is consensus that changes in payment rates can

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<sup>52</sup> Other, less frequently used benchmarks include wholesale acquisition cost (WAC) and average manufacturer price (AMP). Neither WAC nor AMP is used by Medicare or Medi-Cal.

<sup>53</sup> Section 1847A(c) of the Social Security Act, as added by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108-173).

drive changes in utilization by physicians, although the net effect that payment changes can have on utilization is not entirely clear. Policymakers should be interested in the impacts that changes in utilization may have on spending and outcomes, but these changes too are ambiguous. Lower utilization of wasteful or inappropriate prescriptions may decrease spending and improve quality. Lower utilization of clinically appropriate drugs may decrease spending but adversely affect patient health. These impacts are context-dependent, and there is insufficient evidence to speculate how changes in amount might play out in the WC context.

### Immunizations and Other Special Categories

The Medicare ASP-plus-6-percent policy excludes immunizations and other specific categories of PADs. There are two practical reasons for doing so. First, under the assumption that physicians are more likely to use services for which they receive a large margin, policymakers may pay for services with special health or public health relevance at a higher rate than other PADs. Second, ASP may be less meaningful or reliable for specialized categories of PADs, such as immunizations.

### Administration Fees

More than 54,000 injection codes (90780–90799) were billed by WC providers in 2011. More than 90 percent of these codes were billed at the same time as an E&M code. In other words, in most cases, providers are billing separately for three components: (1) the injectable material, (2) administration, and (3) an E&M visit. The effect of separate administration fees may be significant when the payment for the injectable material is small (for example, with generic drugs and some routine immunizations). Medicare’s policy is to bundle payment for the immunization service itself into another clinical service, such as an E&M visit. Medi-Cal takes an alternative approach and includes an administration fee in the ingredient payment amount.

### *Specific Policy Alternatives*

Implementation of the RBRVS presents an opportunity to revise the policies for PAD ingredients. The current OMFS codes and allowances for immunization injections are outdated and need to be updated. The BR pricing for some codes is administratively burdensome. The OMFS pharmaceutical formula provides excessive AWP allowances. We assume that the bundling policies for injections will be implemented as an RBRVS ground rule. We focus on fee-schedule options for the ingredient cost allowances that are consistent across all ingredients and can be automatically updated.

1. Status quo: Continue AWP-plus-percentage pricing.
  - Advantages
    - Limits concerns surrounding access to PADs because payment rates are almost certainly above acquisition costs
    - AWP available for all PADs

- Provides a mechanism for automatic updating
- Disadvantages
  - Rates significantly higher than those of Medi-Cal and other payers
  - Relies on a fundamentally flawed proxy for ingredient costs when more-accurate and objective estimates are available
  - Other payers are migrating away from AWP-based payment (HHS, 2011b).
  - May provide excessive margins, resulting in overutilization
  - More administrative burden than linking to a fee schedule
- 2. Adopt the Medicare fee schedule.
  - Advantages
    - Ingredient payment rates better reflect actual acquisition costs.
  - Disadvantages
    - Some providers may not offer PADs because ASP plus 6 percent may not be greater than acquisition costs for some independent physicians or small group practices.
    - ASP not used by Medicare for some classes of PADs, e.g., immunizations. Would need to develop policies for those services
- 3. Adopt the Medi-Cal fee schedule.
  - Advantages
    - Relies on the Medicare approach and prices in most cases
    - Uses AWP-based payment to fill in gaps in Medicare pricing
    - Builds on the OMFS using Medi-Cal for outpatient prescription drugs
  - Disadvantages
    - Other payers are migrating away from AWP-based payment (HHS, 2011b).
    - Pricing includes administration fee for injections that would be bundled under Medicare RBRVS rules.

#### Payment for Administration

Under the Medicare approach, administration services are not reimbursed separately if they occur at the same time as an E&M service. Under the Medi-Cal approach, a separate administration fee is integrated into the ingredient allowed amount for the first unit of the drug. This amount could be subtracted in determining the MAA. At a minimum, it should be subtracted from the published price for additional units.

We analyzed the WCIS 2011 data to compare the PAD pricing alternatives. An explanation of our methodology and data limitations is in Appendix D. Table 7.2 compares maximum allowed fees under the CMS PAD fee schedule and the Medi-Cal fee schedule. Allowed fees are, for the most part, similar across the two fee schedules, which reflects Medi-Cal's recent transition to ASP-plus-6-percent pricing.

**Table 7.2 Comparison of Centers for Medicare & Medicaid Services and Medi-Cal Maximum Allowed Amounts for Physician-Administered-Drug Ingredients in Aggregate and for the Top 25 Healthcare Common Procedure Coding System Codes Ranked by 2011 Official Medical Fee Schedule Paid Amount**

	CMS MAAs (\$ 000s)	Medi-Cal MAAs (\$ 000s) <sup>a</sup>	Ratio of CMS to Medi-Cal MAAs
All J-codes	47,419.9	49,940.6	0.96
J7324 Orthovisc injection, per dose	1,123.3	1,665.5	0.67
J0878 Daptomycin injection	315.1	298.5	1.06
J7321 Hyalgan/supartz injection, per dose	1,414.1	2,281.6	0.62
J9035 Bevacizumab injection	310.4	304.9	1.02
J1650 Injection, enoxaparin sodium	43.1	52.7	0.82
J0696 Ceftriaxone sodium injection	15.2	15.1	1.01
J7323 Euflexxa injection, per dose	398.2	382.8	1.04
J1885 Ketorolac	39.6	31.1	1.27
J0475 Baclofen, 10 mg injection	41,172.4	42,134.3	0.98
J0585 Botulinum toxin type A, per unit	283.3	283.3	1.00
J2357 Omalizumab injection, 5 mg	76.5	76.4	1.00
J3010 Fentanyl citrate injection	92.2	155.7	0.59
J1745 Infliximab injection	174.8	171.6	1.02
J3370 Vancomycin hydrochloride injection	54.9	54.6	1.01
J0735 Clonidine hydrochloride, 1 mg	197.4	188.7	1.05
J1170 Injection, hydromorphone, <5	104.9	108.5	0.97
J1815 Insulin injection	8.2	76.6	0.11
J7325 Synvisc or Synvisc-One, 1 mg	106.1	147.1	0.72
J2278 Ziconotide injection	75.5	75.4	1.00
J0135 Adalimumab injection	79.5	74.8	1.06
J2001 Lidocaine injection	1.7	1.9	0.90
J0702 Betamethasone acetate and sodium phosphate	104.7	104.9	1.00
J1030 Methylprednisolone, 40 mg injection	62.6	87.3	0.72
J1100 Dexamethasone sodium phosphate	3.7	3.9	0.94
J3301 Injection, triamcinolone acetonide	48.3	44.9	1.08
All other J-codes	1,114.3	1,118.7	0.99

NOTE: Uses January 1, 2013, CMS and Medi-Cal payment rates applied to unadjusted OMFS-reported volume. Only for PADs with both CMS- and Medi-Cal-listed MAAs.

<sup>a</sup> Subtracts an administration fee of \$4.46 for drugs with a 030 modifier in the Medi-Cal fee schedule. The Medi-Cal fee schedule may not fully reflect the recent transition to Medicare-based allowed fees for PADs.

We also estimated MAAs under the current OMFS approach (pay administration codes separately), the CMS approach (pay administration codes only when they occur outside the

context of an E&M visit), and the Medi-Cal approach (pay a flat injection-administration fee for most drugs). Table 7.3 compares the MAAs using these three approaches. Either the Medicare or Medi-Cal approach results in significantly lower MAAs than the current OMFS approach because administration is bundled when an E&M service is provided. If the Medi-Cal fee schedule were adopted and the flat fee were included as a drug ingredient cost in addition to the Medicare separate payments for drug administration when no other service is provided, the total allowable fees would be \$1.9 million.

**Table 7.3 Comparison of Official Medical Fee Schedule, Centers for Medicare & Medicaid Services, and Medi-Cal Administration-Fee Approaches**

<b>Approach</b>	<b>Description</b>	<b>MAAs, Administration Only (\$ millions)</b>
OMFS	Pay administration separately	12.4
CMS	Pay administration only when separate from E&M	1.3
Medi-Cal	Pay flat \$4.46 administration fee	0.6

## Hospital Outpatient Services

### *Background*

The OMFS for physician services currently applies to all covered medical services provided, referred, or prescribed by physicians, regardless of the type of facility in which the services are provided. With the exception of facility fees for the use of emergency rooms or ambulatory surgical suites, the OMFS for physician services applies to services furnished to hospital outpatients, including clinic services and diagnostic tests (other than tests that are payable under the OMFS for diagnostic laboratory services). As a result, regardless of whether a diagnostic test is provided in a physician’s office or a freestanding diagnostic testing facility or to a hospital outpatient, the same allowances apply. OMFS allowances for most diagnostic procedures have a professional component (PC) that covers the physician’s professional services related to supervising and interpreting the test results and a TC that covers the staff and equipment costs associated with providing the actual test. When the complete service is performed, the payment equals the sum of the payments for these two components.

Under Medicare, the outpatient prospective payment system fee schedule (OPPS) applies to services furnished by hospitals to outpatients.<sup>54</sup> The OPPS rate covers the facility fees for providing the services. A separate payment is made under the RBRVS for the physician’s

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<sup>54</sup> The OPPS does not apply to outpatient rehabilitation services. The RBRVS fee schedule applies to services provided by hospitals and by therapists in community-based practices.

services. The RBRVS PE component is typically lower for comparable services provided in hospitals and other facility settings than for services provided in physician offices and other nonfacility settings. The lower PE rate accounts for the separate payment to the hospital for the clinical staff, supplies, and equipment costs that would be incurred by the physician if the service were furnished in an office setting. For most diagnostic tests, the allowances are split into TC and PC, similarly to the OMFS allowances. Only the PC is payable if the service is furnished in a facility setting.

Labor Code §5307.1(a)(2) is silent on how the services furnished by hospitals that are currently payable under the OMFS for physician services should be paid when the RBRVS is implemented. The provision specifies that the AD shall adopt the RBRVS-based fee schedule “for physician services and nonphysician practitioner services, as defined by the administrative director.” Section 5307.2(a)(2)(C) provides that the default option shall apply to the maximum reasonable fees “for physician services and nonphysician practitioner services, including, but not limited to, physician assistant, nurse practitioner, and physical therapist services.” Section 5307.1(a)(1), which was not amended by SB 863, requires the AD to adopt fee schedules for items other than physician services, including health care facility fees. The labor code does not define health care facility fees, but, when the AD implemented Medicare-based fee schedules for nonphysician services, health care facility fees for outpatient services were defined by CPT code as including only surgical codes and emergency department (ED)–visit codes. One rationale for doing so was that the OMFS allowances for medical services did not differentiate by setting. Because the costs of providing clinic services were already reflected in the OMFS allowance, making a separate payment for facility costs under the OPDS would have resulted in a duplicate payment. With the PE payment differential under the RBRVS, this rationale is no longer applicable.

There are other reasons, however, that the AD might want to continue to pay for hospital outpatient services under the physician fee schedule. The underlying policy question is whether WC should pay a premium for services that could appropriately be provided in a less costly setting. MedPAC, for example, has recommended that Medicare pay for clinic visits at the same rate as office visits (MedPAC, 2012) and is considering whether to extend the recommendation to other services (MedPAC, 2013). The principles that MedPAC has laid out to make this evaluation are as follows (Zabinski and Winter, 2013):

- Patients should have access to settings that provide an appropriate level of care.
- A prudent purchaser should not pay more for a service in one setting than another.
- Payment rates should be based on the resources needed to treat patients in the lowest-cost clinically appropriate setting.

Payment rates for hospital outpatient department (HOPD) services are typically higher for three reasons: (1) hospitals incur costs for standby capacity for emergencies and have higher

infrastructure and regulatory costs, (2) patient severity might be greater in HOPDs than in office settings, and (3) the OPSS has broader bundling policies than the RBRVS fee schedule.<sup>55</sup>

In recommending that the clinic visits be paid at the same rate as office visits, MedPAC concluded that these higher costs should not affect the costs of E&M visits outside the ED. Moreover, MedPAC was concerned about the growing trend toward hospital purchases of physician practices. When a hospital purchases a physician practice, Medicare's fee schedule changes from the RBRVS to the OPSS with no change in the nature of the services. Others have also highlighted the inappropriateness of OPSS and MPFS differentials for comparable services.<sup>56</sup>

For WC, the issue largely involves the TC of imaging and other diagnostic tests. For most of these procedures, separate payments apply to the facility and staffing costs involved in performing the procedure (the TC) and to the professional services involved in supervising the procedure and interpreting the results (the PC).<sup>57</sup> The professional services would be payable under the OMFS physician fee schedule regardless of where the services are furnished. The issue is whether the TC should be paid under the OMFS based on the OPSS rate or the RBRVS rate. Table 7.4 compares the payment rates for procedures with the highest aggregate technical allowances under the current OMFS and what would be payable using the OPSS rate (with 1.2 multiplier) and the RBRVS rate for the TC only *after* cross-walking any outdated CPT codes to their 2013 equivalents. In general, the OPSS has broader bundling policies than the RBRVS, which means that the RBRVS allowance may be slightly understated relative to the OPSS payments.

Across all procedures, the rate is higher when the procedure is paid under the OPSS than the payment under the RBRVS. Generally, the differential is greater for less resource-intensive services, e.g., radiologic examinations, than for more resource-intensive services, such as magnetic resonance imaging (MRI) and computerized tomography (CT) scans. Overall, aggregate allowances would be 85 percent higher if based on the OPSS rates than if based on the RBRVS rates. Further, the OPSS rates represent a 73-percent increase over current OMFS rates, while the RBRVS would result in a 6.5-percent reduction.

In addition to diagnostic services, several other high-volume services were provided to WC outpatients by hospitals (see Table 7.5). For these services, the basic choice is between two payment approaches:

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<sup>55</sup> For example, stress agents, contrast material, and radionuclides are separately payable under the RBRVS but not the OPSS.

<sup>56</sup> See, for example, National Commission on Physician Payment Reform, 2013.

<sup>57</sup> For a few services, there are separate procedure codes for the TC and PC. For example, 93000 applies to the full electrocardiogram (ECG) (routine), 93005 to only the tracing, and 93010 to the interpretation and report only.

- Pay an OPSS facility fee and, when appropriate, a professional fee that reflects PEs for services furnished in a facility setting. This is Medicare’s policy and is also the policy adopted by other WC fee schedules that used Medicare-based fee schedules for both outpatient and physician services.
- Pay a single professional fee that reflects PEs for services furnished in a nonfacility setting. This is consistent with current OMFS policies.

### *Specific Policy Alternatives*

1. Pay for HOPD services under the OPSS at 120 percent of the Medicare rate.
  - Advantages
    - Most straightforward reading of the labor code
    - Consistent with Medicare rules and other payers
  - Disadvantages
    - Increases expenditures unnecessarily when services could be provided in a less costly medically appropriate setting
    - The move would be contrary to prudent buyer policy directions.
2. Pay for HOPD services consistently with current OMFS rules.
  - Advantages
    - Encourages provision of care in the least costly setting
    - Levels the playing field across hospitals and community-based providers for comparable services
    - Consistent with the policy direction advocated under Medicare payment reform
  - Disadvantages
    - Fails to recognize that hospitals have higher infrastructure costs
    - Results in about a 20-percent reduction in payments for services furnished to hospital outpatients
3. Pay for services furnished in conjunction with ED visits using OPSS rates and remaining services under the RBRVS.
  - Advantages
    - Strikes a balance between prudent buyer objectives and recognizing when higher costs may be justified
  - Disadvantages
    - Could result in unnecessary provision of ED services to obtain higher allowances
    - Complicates administration but arguably not more so than current rules
4. Pay for services using OPSS rates but with a lower multiplier.
  - Advantages
    - Avoids large and arguably unjustifiable increase in payments. Aggregate payments would be about 17 percent higher than under the current OMFS with a 1.0 multiplier (versus 40 percent)
    - Avoids potential gaming between ED and clinic visits

- Recognizes that the higher costs for WC patients are most likely to be associated with the E&M services rather than diagnostic services
- Consistent with following Medicare's lead in determining appropriate payment rates
- Disadvantages
  - May result in lower payment than 120 percent of RBRVS (this occurs only once among the top 20 diagnostic services).<sup>58</sup>

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<sup>58</sup> The CMS proposed rule for 2014 physician services would cap RBRVS payments at the amount payable under the OPFS. If this rule is adopted, the issue of higher RBRVS payments for certain services would be moot. If it is not adopted, a policy alternative would be to pay the higher of the RBRVS rate or the Medicare OPFS rate. However, this would be administratively burdensome to implement because the bundling rules under the two fee schedules are not identical. Generally, there is more bundling under the OPFS than the MPFS.

**Table 7.4 Comparison of Allowances for Highest-Expenditure Diagnostic Procedures**

<b>Code</b>	<b>Description</b>	<b>HOPD Volume<sup>a</sup></b>	<b>OMFS TC Allowance<sup>b</sup> (\$)</b>	<b>OPPS TC (\$)<sup>c</sup></b>	<b>RBRVS TC<sup>a</sup></b>	<b>Ratio OPPS to RBRVS</b>	<b>Estimated OMFS Allowances (\$)</b>	<b>Estimated OPPS Allowances (\$)</b>	<b>Estimated RBRVS Allowances (\$)</b>
72148	MRI, spinal canal and lumbar, without contrast	1,379	512.00	501.11	388.16	1.1	706,000	690,984	605,065
73721	MRI, any joint of lower extremity	1,020	532.00	501.11	269.71	1.6	542,488	510,989	310,900
73221	MRI, any joint of lower extremity, without contrast	1,131	521.91	501.11	269.71	1.6	590,083	566,566	344,733
72141	MRI, spinal canal, without contrast	703	516.8	501.11	387.74	1.1	363,415	352,382	308,117
93005	ECG tracing	11,506	35.06	39.48	12.78	2.8	403,386	454,240	163,609
72100	Radiologic exam, spine, lumbosacral; anteroposterior and lateral	6,387	31.35	68.03	31.96	1.9	200,228	434,497	229,324
73030	Radiologic exam, shoulder; complete, minimum 2 views	4,912	34.73	68.03	27.70	2.2	170,583	334,143	152,694
70450	CT scan, head/brain; without contrast	642	223.61	256.97	158.50	1.4	143,500	164,909	114,936
73130	Radiologic exam, hand; minimum 3 views	5,064	24.94	68.03	31.53	1.9	126,296	344,504	179,382
73610	Radiologic exam, ankle; complete, minimum 3 views	4,307	27.79	68.03	32.81	1.8	119,687	292,995	158,793
73110	Radiologic exam, wrist; minimum 3 views	3,986	29.33	68.03	38.35	1.6	116,896	271,137	171,929
72110	Radiologic exam spine lumbosacral; complete with oblique views	2,481	43.46	104.87	43.46	2.1	107,811	260,151	121,361
73630	Radiologic exam, foot; minimum 3 views	3,885	28.56	68.03	30.68	2.0	110,951	264,286	133,874
72131	CT scan, lumbar spine;	315	275.2	256.97	206.22	1.1	86,672	80,931	73,395

Code	Description	HOPD Volume <sup>a</sup>	OMFS TC Allowance (\$) <sup>b</sup>	OPPS TC (\$) <sup>c</sup>	RBRVS TC <sup>d</sup>	Ratio OPPS to RBRVS	Estimated OMFS Allowances (\$)	Estimated OPPS Allowances (\$)	Estimated RBRVS Allowances (\$)
	without contrast								
73222	MRI any joint of lower extremity; with contrast	168	521.91	672.94	455.91	1.3	87,810	113,220	86,586
73564	Radiologic exam, knee; complete, 4+ views	2,637	33.49	104.87	42.18	2.2	88,308	276,526	125,179
93971	Duplex scan, extremity veins	989	85.98	147.03	119.30	1.1	85,022	145,391	133,212
72050	Radiologic exam, spine, 4–5 views	1,845	42.75	104.87	42.61	2.2	78,867	193,469	88,472
73562	Radiologic exam, knee; minimum 3 views	2,764	28.5	67.61	36.64	1.6	78,774	186,874	113,893
78452	Myocardial perfusion imaging, single-photon emission CT, multiple studies	130	360	1,006.21	533.03	1.7	46,688	130,495	78,247
	Total estimated allowances, 20 codes						4,253,467	6,068,691	3,693,702
	Total estimated allowances, all diagnostic codes						6,902,472	11,941,012	6,450,508

<sup>a</sup> Sum of HOPD volume for all procedures except PC modifiers.

<sup>b</sup> Crosswalk-weighted OMFS-allowed amount (off most recent Table A from 2005 with 2007 E&M update).

<sup>c</sup> CY 2013 OPPS standard payment rates adjusted for difference in OMFS CF (70.761 versus 71.313), estimated statewide wage index applicable to hospitals for outpatient services furnished to WC patients (1.35) and updated to 2014 by estimated increase in the hospital market basket (1.027 percent).

<sup>d</sup> CY 2013 relative values for TC multiplied by 120 percent of the 2012 Medicare CF (\$40.8451) and the statewide GPCI values and updated to 2014 by the estimated increase in the MEI (1.0184 percent).

**Table 7.5 Nondiagnostic High-Volume Hospital Outpatient Services**

Option	99213 (intermediate office visit)	96372 (therapeutic, prophylactic, or diagnostic injection)	96374 (therapeutic, prophylactic, or diagnostic injection IV push, single or initial substance/drug) <sup>a</sup>	96365 (IV infusion therapy, prophylaxis, or diagnosis; initial, up to 1 hour)	90471 (immunization administration, 1 vaccine)
HOPD volume	2,267	4,886	3,172	1,078	2,778
Current OMFS allowance (\$)	56.93	15.38	31.37	95.33	15.00 <sup>b</sup>
1. Pay under Medicare rules (\$)					
OPPS facility fee	109.0 8	57.93	57.93	216. 50	57.93
RBRVS facility-setting fee	65.59	0	0	0	0
Total allowance	174.67	57.93	57.93	216. 50	57.93
Aggregate allowances	395,974	282,5 58	183,69 2	232,873	160,9 17
2. Pay under OMFS rules (\$)					
RBRVS non- facility-setting fee	96.14	34.14	75.92	99.73	34.14
Aggregate allowances	469,731	166,820	370,956	487,291	166,820
Difference in aggregate allowances	(73,757)	116,240	(187,192)	(253,882)	(5,882)

<sup>a</sup> Bundled.

<sup>b</sup> BR Allowance.

NOTE: IV = intravenous. Priced using 120 percent of Medicare 2012 CF (\$40.8451), statewide average GAF (1.080), and inflation adjustment of 1.0184. Aggregate allowances may differ from the product of volume and procedure allowance because of rounding.

## Ambulatory Surgery Center Services

Under the OMFS, surgical procedures furnished in an ASC are paid based on the Medicare OPPS relative values. For services rendered in ASCs on or after January 1, 2013, the WC multiplier is 0.80 of the Medicare CF (or 0.82 with payment for high-cost outlier cases). The lower multiplier reflects the lower costs of performing ambulatory surgery in an ASC than in a hospital. By linking the OMFS to the Medicare OPPS rates, payment is made without regard to whether the surgery is on Medicare's list of covered ASC procedures.

Under Medicare ground rules, an ASC is recognized for the limited purpose of providing ambulatory surgical services. Medicare's payment under its ASC fee schedule is limited to procedures that Medicare has determined can safely be performed in an ASC and are not commonly performed in an office setting. For surgical procedures that are commonly performed in an office setting (and therefore are not on the ASC list of covered procedures), Medicare pays the ASC for the lower of the amount that would be payable under the ASC fee schedule or the PE component of the MPFS. In addition, the physician receives the MPFS payment for performing the service in a facility setting. The facility portion of these services is currently paid under the OMFS based on 0.80 times the Medicare OPFS CF.

For nonsurgical services furnished in an ASC (other than diagnostic services that are an integral part of the surgical procedure), Medicare rules for physician and supplier services apply. We assume that these services will be paid under the RBRVS instead of the OPFS fee schedule. We found that about \$200,000 was paid for these services under the OMFS in 2011. It may be that the place-of-service code is the physician's office when services are provided for which an ASC facility fee is not payable.

## Coding and Documentation Policies

### *National Correct Coding Initiative Edits*

#### Background

The National Correct Coding Initiative (NCCI) edits are a set of coding guidelines developed by CMS to minimize the incidence of improper coding and inappropriate payments (HHS, 2004). There are two types of NCCI edits:

- edits that define pairs of HCPCS/CPT codes that should not be reported together
- medically unlikely edits (MUEs) that define, for each HCPCS/CPT code, the number of units of service beyond which the reported number is unlikely to be correct.

NCCI edits are operationalized in a set of tables provided and updated quarterly by CMS. There are nearly 1 million NCCI edits (see Table 7.6). Selected edits are shown in Table 7.7. If a provider reports both codes in columns 1 and 2 of Table 7.7, only the code in column 1 is eligible for payment. Payment for the second code is denied.

The NCCI edits are based on a few general principles:

- *no "unbundling" of services*: Multiple codes should not be used to report a provided service when there is a comprehensive CPT code that describes the services performed.
- *"integral" services*: Some services are considered to be integral to the provision of other services and should not be reported separately.
- *mutually exclusive services*: Certain procedures are considered to be mutually exclusive and therefore cannot be reported together.

- *sequential procedures*: Some surgical procedures may be performed using different approaches. If an initial surgical approach fails and a second surgical approach (described by a different CPT code) is utilized at the same patient encounter, the two procedures are considered sequential, and only the code corresponding to the second surgical approach may be reported.

**Table 7.6 Distribution of National Correct Coding Initiative Edits, by Current Procedural Terminology Code Ranges**

Code Range	Column 1 Count	Column 2 Count
Anesthesia	75,896	4,331
E&M	8,265	36,588
Medicine	35,216	225,086
Pathology	4,616	4,978
Radiology	11,626	16,189
Surgery	811,912	640,227
Other	16,993	37,125
Total	964,524	964,524

NOTE: Counts include only active edits.

Exceptions to these edits are allowed in certain cases, and appropriate modifiers are provided for this purpose. As an example, E&M services provided during the global surgery period are generally not reportable separately, but, if the E&M service is significant and separately identifiable from other services reported on the same date of service, the provider is allowed to use modifier 25 to bypass this edit. In the edit tables (see Table 7.7), codes that allow use of a modifier are indicated by a 1.

**Table 7.7 Selected National Correct Coding Initiative Edits**

Column 1 Code	Column 2 Code	Modifier Status
00160	99479	0
00222	93316	1
00300	99303	0
00454	31622	1
00908	99318	0
01112	92520	1
17272	96372	1
24066	64408	0
25119	64435	0
25270	51702	1
25505	64517	0

Column 1 Code	Column 2 Code	Modifier Status
26530	64446	0
27047	64420	0
27356	96372	1
33403	32557	1
35518	94681	1
41018	12007	1
42844	94002	1
47125	64447	1
47135	12006	1
61312	64508	1
64493	93040	1
91112	94770	1
95829	95939	9
95851	97530	9

### Medically Unlikely Edits

The NCCI includes a set of edits known as MUEs that define the maximum allowable number of units of service reportable by a provider for the same beneficiary on the same date of service.<sup>59</sup> Each line of a claim is adjudicated separately against the MUE value for the code reported on that line (Tomkins, 2011). If the unit of service for the line item exceeds the MUE value, the entire line is denied. The MUE value is chosen to allow the vast majority of appropriately coded claims to successfully pass through and is based on several considerations, including these:

- anatomic considerations (e.g., the MUE value for an appendectomy is 1 because there is only one appendix)
- coding instructions in the CPT manual (a CPT code for the initial 30 minutes of a service has an MUE value of 1 because of the use of the term *initial*)
- clinical judgment of physicians and coders
- claim history.

### Policy Considerations

The main benefit of adopting the NCCI edits is its potential to reduce inappropriate payments. A 2004 study commissioned by the AMA found that 30 percent of physicians' claims submitted to a major commercial insurer were paid incorrectly.<sup>60</sup> This study found that

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<sup>59</sup> Not all MUE values are published online. Some are considered to be confidential by CMS and are not publicly available.

<sup>60</sup> Inaccurate claims included underpayments and overpayments.

application of NCCI-type edits resulted in savings of \$0.03 for every dollar in physician charges (AMA, 2005).<sup>61</sup>

The impact of adopting the NCCI edits will depend to a large extent on how much overlap there is with edits that are currently used by WC. On one extreme, if NCCI edits are fully subsumed by edits already in use, then implementation of NCCI edits will add little value. On the other extreme, if current edits and NCCI edits do not overlap at all, then adoption of the NCCI edits will have the maximum possible benefit.

The 2010 pre-rulemaking version of the RBRVS proposed rule required that payers adopt the NCCI edits. The requirement was generally supported because the NCCI edits provide a uniform method for ensuring that adjustments for correct coding are uniformly handled, with consistent rules known to both payers and providers. Having all parties use the same ground rules should reduce a source of friction with the WC program.

In its comments on the DWC forum, the California Orthopaedic Association suggested that, instead of the NCCI edits, the American Association of Orthopaedic Surgeons' (AAOS) Global Service Data bundling edits be adopted (AAOS, 2010). The AAOS argues that these edits are superior because they are compiled by orthopedic surgeons who are coding experts and are more comprehensive than the NCCI edits. One difference between the AAOS edits and the NCCI edits is that the NCCI edits were developed primarily for high-volume codes and do not include all possible combinations of correct coding edits or types of unbundling that exist. The lack of an NCCI edit does not excuse incorrect coding. In our view, there are several drawbacks to adopting the AAOS edits:

- Using one set of internally consistent edits for all services is preferable to using two different sets of edits. The latter might have inconsistencies that would need to be reconciled.
- The NCCI edits are consistent with the Medicare payment rules underlying the RBRVS.
- The AAOS guidelines would need to be purchased, whereas an electronic version of the NCCI is available for free download.

Other policy considerations include the following:

- *cost of implementation:* There are likely to be nontrivial costs associated with modifying claim-processing architecture to enable utilization of NCCI edits. There are nearly 1 million edits (Table 7.6), and updated tables have to be downloaded and applied quarterly. It is expected, however, that the availability of commercial software and vendors should minimize these costs. There are also costs associated with training claim-processing staff to be fully conversant with these guidelines that need to be taken into account.
- *cost of adoption for physician practices:* One concern with adoption of NCCI edits is the administrative burden on providers, but, given that these edits are used by Medicare and

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<sup>61</sup> Edits were based on CPT code guidelines, NCCI guidelines, and CMS payment rules.

many commercial payers, costs of adoption (including learning costs) for providers are likely to be low. Providers are likely to already be familiar with NCCI edits from their billing experiences with other payers. We also note that the Patient Protection and Affordable Care Act (Pub. L. 111-148, 2010) mandates adoption of NCCI edits by state Medicaid agencies, increasing the likelihood that providers will have some experience with NCCI edits. There may be other costs to providers, particularly costs associated with appeal of denied claims (including the cost of researching the denial, identifying the appropriate action, and completing the refiling or reopening of claims). Costs of audit and appeal can, however, be minimized by taking advantage of electronic data interchange standards and by following basic review and auditing procedures. Note also that, because of the complexity of claim-edit systems, payer errors (i.e., denials for services validly provided) may go undetected and result in losses to providers.

- *operational costs*: Prior experience suggests that providers are likely to see an increase in the number of denied claims as a result of adoption of the edits (Tomkins, 2011). Ultimately, however, it remains to be seen whether administrative costs related to claim review will increase, decrease, or stay the same. Although an increase in the number of claims reviewed may result in higher administrative costs, standardization may lead to processing efficiencies that reduce costs.

### *Policy Considerations*

Modifications to the NCCI edits may be required because of the peculiarities of the WC system. The extent of modification will depend on how closely the new WC ground rules mirror Medicare ground rules. For example, the proposed rule for the OMFS allows for separate reporting and payment of WC-related reports. The NCCI edits do not allow for the separate payment for reports. Modification of the NCCI edits will be needed to take this into account.

## Evaluation and Management Guidelines

### *Background*

To provide a standardized framework for proper documentation of E&M services, CMS released a set of guidelines in 1995 and an updated version in 1997.<sup>62</sup> The guidelines consist of a set of general principles, in addition to providing specific guidance regarding documentation of the different components of E&M services (see Box 7.1).

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<sup>62</sup> There are some differences between the two, and CMS recommends that either one or the other be used, not both. In general, the 1997 guidelines provide more-detailed instructions.

### Box 7.1 General Principles of Documentation for Medical Records

1. The medical record should be complete and legible
2. The documentation of each patient encounter should include the following:
  - reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results
  - assessment, clinical impression, or diagnosis
  - plan for care
  - date and legible identity of the observer.
3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred
4. Past and present diagnoses should be accessible to the treating and/or consulting physician
5. Appropriate health risk factors should be identified
6. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented
7. The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record

Three E&M components—history, examination and medical decisionmaking—are recognized as key in selecting the level of E&M services. We discuss the documentation guidelines for each component briefly in this section.

#### *Documentation of History*

The medical history consists of four key elements: chief complaint; history of present illness (HPI); review of systems (ROS); and past, family, and social history (PFSH). The amount of information collected by the provider for the latter three elements is used in classifying a history as *problem focused*, *expanded problem focused*, *detailed*, or *comprehensive*.

CMS includes specific guidelines for how each of these elements (and their subcomponents) is defined and how they should be documented (see Table 7.8).<sup>63</sup> For example, a *problem-pertinent* ROS inquires about the system directly related to the problem identified in the HPI and requires that the patient's positive responses and pertinent negatives for the system related to the problem be documented. For an *extended* ROS, the patient's positive responses and pertinent negatives for *two to nine systems* should be documented.

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<sup>63</sup> To highlight a difference between the 1995 and 1997 guidelines, the former state that, for an HPI to be considered *extended*, it should describe four or more elements (e.g., location, quality, severity, duration) or associated comorbidities; in the latter, an *extended* HPI consists of four or more elements or the status of at least three chronic or inactive conditions.

**Table 7.8 Clinical-History Matrix**

Type of History	HPI	ROS	PFSH
Problem focused	Brief	Not applicable	Not applicable
Expanded problem focused	Brief	Problem pertinent	Not applicable
Detailed	Extended	Extended	Pertinent
Comprehensive	Extended	Complete	Complete

### *Documentation of Examination*

A clinical examination can also be *problem focused*, *expanded problem focused*, *detailed*, or *comprehensive*. Like with the medical history, guidelines are provided for how these are defined and how they should be documented.

For purposes of documentation, approximately ten body areas and 12 organ systems are recognized.<sup>64</sup> The 1997 guidelines also outline specific documentation elements within each body area or organ system and distinguish between documentation requirements for single organ and multisystem examinations. According to the documentation guidelines for clinical examinations, a notation of “abnormal” without elaboration after an examination of the affected or symptomatic body area or organ system is insufficient, but a brief statement or notation indicating “negative” or “normal” is sufficient documentation for normal findings related to unaffected areas or asymptomatic organ systems.

### *Documentation of Medical Decisionmaking*

*Medical decisionmaking* refers to the complexity of establishing a diagnosis or selecting a management option. Three elements of decisionmaking are recognized:

- number of diagnoses or management options
- amount or complexity of data to be reviewed
- risk of complications, morbidity, or mortality.

These elements are combined to create four levels of decisionmaking complexity (see Table 7.9).

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<sup>64</sup> The body areas recognized are the head, including the face; neck; chest, including breasts and axillae; abdomen; genitalia, groin, and buttocks; back, including spine; and each extremity. The organ systems recognized are the constitutional (e.g., vital signs, general appearance); eyes; ears, nose, mouth, and throat; cardiovascular; respiratory; gastrointestinal; genitourinary; musculoskeletal; skin; neurologic; psychiatric; and hematologic, lymphatic, and immunologic.

**Table 7.9 Medical Decisionmaking Matrix**

<b>Type of Decisionmaking</b>	<b>Number of Diagnoses or Management Options</b>	<b>Amount or Complexity of Data to Be Reviewed</b>	<b>Risk of Complications, Morbidity, or Mortality</b>
Straightforward	Minimal	Minimal or none	Minimal
Low complexity	Limited	Limited	Low
Moderate complexity	Multiple	Multiple	Multiple
High complexity	Extensive	Extensive	Extensive

To qualify for a given type of decisionmaking, two of the three elements in Table 7.9 must be either met or exceeded. The guidelines include specific documentation requirements for each cell in Table 7.9.

### *Policy Considerations*

The documentation guidelines were developed in the context of the RBRVS and in collaboration with the AMA. They have been in effect for more than a decade and are generally accepted as a template to guide physicians and their staffs on documenting E&M visits and for reviewers to assess coding accuracy. The guidelines have been adopted by other payers, including the Washington State WC program. The Texas WC program has adopted a more generic requirement for medical records “satisfying the AMA’s requirements for use of those CPT codes.”

The CMS documentation guidelines provide a common operational definition of the CPT codes. There is a need for such guidelines in California, where Workers’ Compensation Research Institute (WCRI) data indicate that WC providers in California tend to bill a higher-intensity visit level than WC providers in other states. Having a common standard has the potential to reduce friction between providers and payers. However, there are also concerns within the physician community that providers will be unfairly penalized for inadvertent coding or documentation errors or omissions. Some see these guidelines as rigid rules that must be followed to the letter in every instance if penalties are to be averted. If payers use these guidelines in this manner, frictional costs will increase.

## **Incorporating Pay-for-Performance Elements into the Official Medical Fee Schedule**

### *Background*

*Pay for performance*, or *P4P*, is a general term used to describe programs that reward health care organizations, physician practices, or individual health care providers for meeting specified

targets on selected metrics.<sup>65</sup> This section focuses exclusively on P4P for physician services. Although most P4P programs use financial rewards, it is important to recognize that incentives may also be nonfinancial (e.g., public reporting). P4P programs generally reward performance in one or more of the following domains: quality, cost and efficiency, or administrative processes (e.g., reporting requirements).

### *The Promise of Pay for Performance*

Economic theory and decades of empirical research show that individuals respond to incentives. The premise (and the promise) of P4P is that tying payment to performance will induce providers to change their behavior. A landmark report on the quality of health care in the United States released by the Institute of Medicine (IOM) in 2001 (IOM, 2001) is often credited with catalyzing discussions about quality of care in the United States, and one of the issues highlighted in the report was the potential role of P4P in reforming health care. Since the release of the IOM report, P4P has become increasingly popular. In 2007, according to the Integrated Healthcare Association, there were more than 148 sponsors of P4P programs covering more than 60 million insured lives (IHA, undated). CMS is also increasingly involved in various P4P pilots and demonstration projects (James, 2012).

### *Reviewing the Evidence*

Early P4P efforts mostly focused on quality improvements, and evaluations of these programs have found mixed evidence regarding their effectiveness (Rosenthal and Frank, 2006; Petersen et al., 2006). Early P4P experiments, however, tended to be of fairly short duration (six months to a year) and involved relatively small financial incentives (Damberg, 2009). In many cases, payers also accounted for only a small fraction of the targeted provider's panel (Rosenthal and Frank, 2006). Evidence emerging from newer experiments continues to show inconsistent results. A few studies have found modest improvements in quality (Campbell et al. 2007; Young et al., 2007), but the extent to which these are causal remains unclear. A recent Cochrane review concludes that there is insufficient evidence to support or not support the use of financial incentives to improve quality (Scott et al., 2011). A Cochrane review of reviews, however, concludes that "financial incentives may be effective in changing healthcare professional practice" while noting that the existing evidence has serious methodological limitations (Flodgren et al., 2011).

Despite the less-than-overwhelming evidence about the effectiveness of P4P and some recent criticism of P4P in general (Woolhandler, Ariely, and Himmelstein, 2012), enthusiasm remains

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<sup>65</sup> P4P is in use in other sectors, including education, for example; however, in many ways, the term *P4P* has come to be most associated with health care.

strong.<sup>66</sup> A recent study of stakeholders involved in the Integrated Healthcare Association (IHA) program, the largest P4P program in the United States, found that more than two-thirds of the physician organizations reported that the positives of the program outweighed the negatives, and more than half reported a positive return on investment (Damberg, Raube, Teleki, and dela Cruz, 2009).<sup>67</sup> Within the public-payer system, there also continues to be strong support for P4P, as clearly highlighted by recent provisions of the Affordable Care Act expanding the use of P4P (James, 2012). Current research is focused on program optimization (for example, finding better measures and identifying the right size and mix of incentives).

### *Pay for Performance in the Context of Workers' Compensation*

P4P is not widely used in WC programs, even though the same problems of inconsistent quality and inefficient provision of care that have led to the increasing use of P4P within the health care system in general also exist in WC programs.<sup>68</sup> There are indications that these problems may even be worse in WC (Wickizer, Franklin, Mootz, et al., 2004). Considering the relative lack of P4P initiatives, there are few published evaluations of WC P4P programs. Wickizer, Franklin, Mootz, et al. (2004) report results from an evaluation of a P4P program implemented in Washington State. In this program, known as the Occupational Health Services (OHS) project, physicians were offered financial incentives for meeting targets on various performance indicators.<sup>69</sup> Financial incentives included payment for previously unreimbursed activities, as well as higher fees for already-reimbursed activities.

A simple before-and-after comparison using data from one of the two pilot sites (representing approximately 2,700 cases treated by high-volume providers<sup>70</sup>) showed improvements on some measures but not on others. For example, the authors found that the rate of completing activity prescription reports<sup>71</sup> increased dramatically, from 11 percent in the first quarter of 2003 to 79 percent in the second quarter, but found no change in the percentage of accident reports submitted within two business days. Attributing observed changes to the P4P initiative is,

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<sup>66</sup> There is also some concern about possible undesired consequences, such as cherry-picking (providers avoiding sicker patients) and worsening of health care disparities (Shen, 2003; Friedberg et al., 2010).

<sup>67</sup> The program targets 225 capitated integrated medical groups and independent practice associations contracting with the seven largest health maintenance organizations (HMOs) in California (Damberg, Raube, Williams, and Shortell, 2005). The physician organizations represent approximately 35,000 physicians.

<sup>68</sup> The rationale for P4P in the specific context of the California WC program has been discussed in an earlier RAND report (Wynn and Sorbero, 2008).

<sup>69</sup> The threshold was set at 80 percent over a given period.

<sup>70</sup> Providers who treated more than 250 WC patients within the first year.

<sup>71</sup> This communicates an injured worker's physical restrictions and ability to work and the provider's treatment plans.

however, difficult because of the lack of a comparison group and changes in the composition of providers joining the program over time.

A larger and more comprehensive evaluation published in 2011 analyzed 105,606 claims—33,910 in the preintervention period (July 2001 to June 2003) and 71,696 in the postintervention period (July 2004 to June 2007)—and found that workers exposed to the P4P program were less likely to be off work and on disability after one year (Wickizer, Franklin, Fulton-Kehoe, et al., 2011). The authors also found a 20-percent decrease in the number of disability days and an average decrease of \$510 per claim postimplementation. The methodological limitations of the earlier study, however, still apply here.

### *Implementing Pay for Performance in California's Workers' Compensation Program*

#### What Outcomes Should Be Rewarded?

The two domains generally considered in P4P programs are quality and efficiency. Although earlier P4P programs focused on quality, newer programs include measures of both quality and efficiency. This reflects the priorities of better care, better health, and lower cost that are outlined in the National Quality Strategy (HHS, 2011).

The research on quality measurement is quite advanced, and numerous measures of quality for various medical conditions have been developed by such organizations as the National Quality Forum (NQF), the National Committee for Quality Assurance (NCQA), and AHRQ. In general, quality indicators can be grouped into three categories:

- *structural indicators* (e.g., adoption of health information technology [IT])
- *process indicators* (e.g., whether a heart-attack patient received aspirin in the ED)
- *outcome indicators* (e.g., mortality rates or patient experience).

Earlier P4P programs focused on structure and process because of the difficulties associated with paying providers based on outcomes, such as the longer time frame required for measurement, and the challenge of assigning accountability for outcomes when multiple providers are responsible for care. Ultimately, however, outcomes are what decisionmakers care about, and newer programs, such as the Massachusetts Blue Cross Blue Shield Alternative Quality Contract and the California IHA program track intermediate outcomes, such as blood-pressure control and rates of hospital-acquired infections, that influence longer-term outcomes. In the context of WC, rates of worker disability are an example of an outcome that could be used for performance measurement. Adjusting for underlying differences in patient risk between providers will, however, be critical in order to avoid unintended consequences, such as avoidance of high-risk patients (Shen, 2003). Any measure is likely to be imperfect given the importance of psychosocial and workplace factors that are difficult to measure and are often beyond the physician's control.

The research on efficiency measurement is not as well developed. There are only a small number of efficiency measures available, and many have not been fully tested for their validity

or reliability (Damberg, 2013). A commonly used indicator of efficiency is average costs. In the context of WC, this could be average medical costs or total costs (medical plus disability) or the average cost per claim (Wickizer, Franklin, Fulton-Kehoe, et al., 2011). The time taken for an injured worker to return to sustained work is another measure that has been proposed (Wynn and Sorbero, 2008).

Administrative measures, such as timely submission of the first report of occupational injury or illness, can also be included as a component of a P4P program. The WC system has unique reporting requirements that place an additional burden on providers; because, in many cases, providers are not separately reimbursed for these administrative tasks, necessary forms are not submitted on time or are incomplete when submitted. Providers can also be rewarded for timely communication with employers.

In Table 7.10, we outline a few potential performance indicators drawn from various sources. The choice of the final subset of indicators should be dictated by program objectives and practical considerations of feasibility and data-collection costs.

**Table 7.10 Example Performance Indicators**

Type of Measure	Potential Indicator
Administrative	<ul style="list-style-type: none"> <li>• Timeliness of submitting report of accident (e.g., report submitted within x days)</li> <li>• Provider writing a modified duty prescription for the patient</li> <li>• Provider performing work activity assessments</li> <li>• Communication between provider and employer about workers' return to work or work modification</li> </ul>
Quality	<p>Structure</p> <ul style="list-style-type: none"> <li>• Complete a continuing-education course on caring for injured workers and disability management</li> <li>• Use of electronic health records</li> <li>• Use of computerized, physician order-entry systems</li> <li>• Board certification</li> <li>• Maintain active medication list</li> </ul> <p>Process</p> <ul style="list-style-type: none"> <li>• Timeliness of access to care</li> <li>• Referrals consistent with guidelines</li> <li>• Activity prescription at each evaluation</li> <li>• Condition-specific indicators (these will depend on the condition of focus)</li> </ul> <p>Outcome</p> <ul style="list-style-type: none"> <li>• Number of disability days</li> <li>• Rates of disability</li> <li>• Patient-retention rate</li> <li>• Intermediate health outcomes (depending on condition of focus)</li> </ul>
Efficiency	<ul style="list-style-type: none"> <li>• Average medical cost per claim</li> <li>• Average total cost per claim</li> <li>• Time to return to work</li> <li>• Total compensation days</li> <li>• Measures of utilization (e.g., use of PT visits or rates of back surgery)</li> <li>• Outpatient surgeries done in ASCs</li> </ul>

## Collecting Performance Data

A central issue is collecting the data required to measure provider performance. The WC system in California has more than 100 participating insurers.<sup>72</sup> Payers maintain their own databases, and the information available differs from one payer to the next. Although individual payers can operate their own P4P programs and define their own metrics, a standardized cross-payer incentive program has clear advantages. For example, it allows data on WC patients to be pooled across multiple payers at the provider level. As we noted earlier, WC patients are generally a small fraction of a provider's patient pool; splitting this by payer only exacerbates this problem. The CWCI and WCIS databases are existing databases that collect data from multiple payers and could therefore serve as a base on which to build. Currently, CWCI reporting is voluntary and therefore incomplete, while the WCIS database contains detailed medical information but limited administrative data.

Although some data are already available, data on other measures will need to be collected. A related issue is that many existing quality measures require medical-record review, and medical records are costly to abstract. A solution that has been advocated is to pay providers to collect and report the information required for performance measurement. This is known as pay for reporting, or P4R. Medicare has a P4R program known as the Physician Quality Reporting Initiative or PQRI, in which physicians earn a bonus payment for reporting on specific quality measures for their patients. The Affordable Care Act of 2010 extends the PQRI until 2014, after which physicians who do not submit measures will have their Medicare payments reduced. Audit processes and protocols for review and correction of data will also need to be developed and built in. In the WC context, this could mean paying for prompt filing of the doctor's FROI and other reports.

There are many other important considerations, such as how rewards should be structured, mechanisms for financing, and how results should be reported to providers or employers, that are not considered in this section, but interested readers are directed to a RAND report that explores these issues in greater depth (Wynn and Sorbero, 2008).

## *Road Map for the Future*

Considerable uncertainty remains about how best to design and implement P4P programs (Schneider, Hussey, and Schnyer, 2011), but previous experience suggests that two important components are (1) a robust set of performance indicators and (2) an integrated health information system that is conducive to performance measurement and supports physicians in their quality-improvement efforts (Stecher et al., 2010). Here, we lay out a few points to serve as guidelines in development of a P4P system:

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<sup>72</sup> Self-insured employers cover about 20 percent of the WC population in California.

- *Agree on program priorities.* Getting structured input and feedback from all the relevant stakeholders, including providers, payers, and employers, is important for identifying program priorities (for example, the conditions on which to focus, what performance measures to include).
- *Start with low-hanging fruit.* A reasonable starting point, once priorities and indicators are agreed on, is to pay providers for reporting the required data. As the program is expanded, performance on these indicators can then be gradually included in the reward structure.
- *Start small.* Piloting the program among providers who voluntarily agree to participate is critical for working out potential kinks. The experience of the Washington State program suggests that providers are interested in quality improvement and are willing to participate in pilot initiatives (Wickizer, Franklin, Mootz, et al., 2004). Pilots can target high-volume providers to reduce the problem of small numbers.
- *Build in a rigorous evaluation.* We are not aware of any randomized experiments of P4P in WC or even any good quasi-experiments. This would be an opportunity to build in a proper evaluation. Demonstrating effectiveness of the program will be important in building consensus among all the relevant stakeholders. A process evaluation will also help to identify key facilitators and barriers to program effectiveness.
- *Expand incrementally.* The P4P program can begin with paying for performance on a base set of indicators and then slowly including more quality measures as they are developed.



## Chapter Eight. Summary

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SB 863 requires that DWC implement an RBRVS fee schedule to establish maximum allowances for physician and other-practitioner services. The RBRVS would address major shortcomings in the current system:

- The OMFS uses outdated procedure codes to describe medical services. This poses an administrative burden on providers, who must maintain a separate coding system for WC patients and increases fee disputes between providers and payers over services that are not described in the OMFS. The RBRVS would replace 983 outdated codes. The percentage of payments that would be using fee-schedule rates (rather than BR) would increase from 90 percent to 96 percent. This percentage would increase with improved coding and less-frequent use of unlisted procedure codes.
- The relative values in the current fee schedule are based on historical charges, which tended to undervalue E&M services relative to procedures. The RBRVS would reflect the resources (costs) required to furnish services and offer neutral incentives for providing services.
- The current fee schedule does not provide for regular updates for changes in coding, practice patterns, or inflation. Linking the OMFS to the MPFS provides a mechanism for annual updates.

We used 2011 WCIS medical data to model the impact of implementing the RBRVS over a four-year transition period. Following the framework for the transition specified in Labor Code §5307.1(a)(2), we computed separate CFs for anesthesia, surgery, radiology, and all other services based on current OMFS allowances and assessed the impact by comparing estimated total MAAs under the OMFS with estimated MAAs under the RBRVS during 2014–2017.

Over the four-year period, total MAAs are estimated to increase 11.9 percent. The increase represents the combined effect of estimated inflation (which increases the rates 8 percent over the period) and the transition from current OMFS payment levels in the aggregate at 116 percent of Medicare to 120 percent of Medicare in 2017. For anesthesia, allowable fees would decline 19.8 percent over the transition. There would also be declines in surgery (–20.1 percent) and radiology (–15.9 percent). Within the “all other services” category, there would be significant increases for medicine (17.3 percent) and E&M (39.5 percent) and significant reductions in pathology (–29.0 percent).

Because most specialties furnish a range of services, the impacts by specialty are generally less than the impacts by type of service. For example, surgeons furnish a substantial amount of E&M services in addition to surgical services, so the percentage change in allowances for the surgical specialties would be –8.7 percent, compared with the –20.1-percent change for surgery.

Consistently with the policies that DWC proposes to implement, our impact analysis assumes that the fee schedule would follow Medicare ground rules with two important exceptions:

(1) statewide GPCI values would be used in lieu of locality-specific values in accounting for price differences and (2) certain WC-required services and reports would remain separately reimbursable. For certain issues, we examined alternative policies that might be considered and separately analyzed their impact.

# Appendix A. Comparison of the Official Medical Fee Schedule and Medicare Ground Rules

**Table A.1 Comparison of the Official Medical Fee Schedule and Medicare Ground Rules**

Ground Rule or Issue	WC	Medicare Policy CY 2013
Overall fee-schedule design		
CF	Separate CFs for E&M, medicine, surgery, radiology, pathology, and anesthesia	Single CF for all services other than anesthesia
GPCI	Statewide fee schedule with no geographic adjustments	Geographic adjustments for eight localities
Site-of-service differential	Payment is the same for all sites of service.	Facility (hospital) and nonfacility (office) differentials for the PE component of most services
Nonphysician practitioners	No reduction for services provided by a nonphysician practitioner if acting within the scope of his or her practice	NP and PA services paid at 85% of the Medicare-allowed amount unless billed under incident-to rules (use modifiers to identify) Clinical social workers paid at 75% Incident-to reimbursed at 100%
Hospital outpatient services (other than emergency and surgery services)	Paid under the OMFS for physician services	Paid under the Medicare prospective payment system for hospital outpatient services
Coding rules		
HCPCS	OMFS uses CPT 1997 revision (1994 for physical medicine), NDC for pharmaceuticals, California-only codes, and BR HCPCS level II not recognized for physician services (however, HCPCS level II used for DMEPOS fee schedule and dental service billing)	Medicare uses HCPCS coding system. Level I: 2013 CPT codes Level II: a system of letter and number codes assigned to services (mostly nonprofessional) services, medications, supplies, and equipment HCPCS codes updated quarterly and annually CMS maintains a crosswalk between NDC codes and HCPCS drug codes.
Modifiers	Uses 1997 CPT modifiers with some variation in description and modifiers unique to California WC. See OMFS for complete description of California WC modifiers.	Medicare adopts current-year AMA CPT modifiers and descriptions effective January 1 of each year.
Bundled procedures	No specific rule, with use of bundling edits varying by payer	NCCI has bundling edits for coding and bill-processing system; applies standard bundling rules for payment purposes
Unlisted service procedure	Services may be determined by the value assigned to a comparable procedure (BR); must use unlisted procedure code	Similar policy

Ground Rule or Issue	WC	Medicare Policy CY 2013
E&M and related services		
Consultations	Separate payment rates apply to consultations and consultation reports.	Medicare pays for consultations using the E&M visit codes (99201–99215). Medicare does make a separate payment for documentation of any kind, including consultation reports.
New- and established-patient definition	A new patient is either new to the physician or is an established patient with a new industrial injury or condition. If a physician is on call or covering for another physician, the patient's encounter would be the same as if the patient were treated by his or her own physician.	A new patient has not received any professional services within the past three years from the physician or another physician of the same specialty who belongs to the same group practice. An established patient has received professional services within the past three years from the physician or another physician of the same specialty who belongs to the same group practice. If a physician is on call for or covering for another physician, the patient's encounter will be classified the same as if the physician had been available.
Interpreter used by patient	Payment is 110% of the normal value of the service. Use modifier –93 to report for billing purposes.	Patient use of interpreters does not affect physician's payment.
Venipuncture (routine)	Allows for the payment of routine venipuncture or needle stick for collection of specimen	36415 (collection of venous blood by venipuncture) is paid under the clinical laboratory fee schedule. 36416 (collection of capillary blood specimen [e.g., finger, heel, ear stick]) is bundled into the office-visit payment.
Specimen handling	Allows for the reimbursement of transfer or conveyance of specimens from the physician's office to a laboratory	Medicare does not pay separately for the transfer or conveyance of specimens from the physician's office to a laboratory.
Anesthesia		
Base units	1993 ASA RVU guide	Mostly ASA RVU guide for current CPT, but some of the new codes have lower base units than those in the ASA guide.
Time units	1 unit per 15 minutes for first 4 hours and 1 unit for each 10 minutes thereafter; 5 minutes or more is considered a unit. No time unit recognized for 01995.	Billed in minutes; converted to 15-minute units by contractor and rounded to one decimal place. No time unit recognized for 01995 or 01996.
Time definition	Anesthesia time begins when the anesthesiologist physician starts to prepare the patient for induction of anesthesia in the OR (or its equivalent) and ends when anesthesiologist is no longer in constant attendance.	Similar to OMFS except that the anesthesia provider can add blocks of time around an interruption in anesthesia time, as long as the anesthesia provider is furnishing continuous anesthesia care within the time periods around the interruption
Monitored anesthesia care	BR	Paid same as other procedures; modifier QS reported for informational purposes only
Qualifying circumstances.	Additional RVUs payable for codes 99100–99140	Not paid
Patient status	Additional units paid for Patient Status Code 3	Not paid

Ground Rule or Issue	WC	Medicare Policy CY 2013
modifiers	(1), Code P4 (2), and Code P5 (3)	
Services performed by physician (modifier = 47)	Covered separately when performed by surgeon; use code 01995 (in CPT 1997 but not CPT 2013); regional anesthesia is paid for base units only.	Not separately paid if the anesthesia is provided by the physician performing the procedure and conscious sedation is included for a code listed in Appendix G of CPT; anesthesiologist uses 01991 for anesthesia furnished for nerve blocks or injections
Anesthesia supervision (medical direction) (modifier = 48)	Combined payment for an anesthesiologist supervising a nurse anesthetist cannot exceed what would have been payable if only the anesthesiologist furnished the service.	CRNAs may work and bill independently; anesthesiologist's assistant cannot. Specific rules and modifiers apply for supervision of concurrent procedures and for medical direction of nurse anesthetists.
<b>Surgery</b>		
Assistant surgeon	Paid at 20% of the allowed surgical fee	Paid at 16% of the allowed surgical fee
Nonphysician surgical assistant	Paid at 10% of the allowed surgical fee	PAs paid at 13.6% (85% of 16%) of the allowed surgical fee
Co-surgeons	Procedure paid at 125% of the OMFS	Procedure paid at 125% of Medicare-allowable surgical fee
Multiple- or bilateral-procedure reduction	100% for first procedure; 50% for the second procedure; 25% for the third procedure The procedures are ranked from highest value to lowest. If there are four or more procedures, a global fee should be charged by the physician and be supported by a report.	100% for first procedure; 50% for the second through fifth procedures. The procedures are ranked from highest value to lowest. Any procedures beyond the fifth require supporting documentation and <i>may</i> be paid upon carrier review.
Arthroscopy	Special billing provision for multiple arthroscopic procedures performed on the same joint during the same surgery. Payment is at 100% for the first procedure and 10% for the second and additional procedures. CPT codes covered by this provision are as follows: shoulder (29815, 29819, 29820, 29822, 29825), elbow (29830, 29834, 29835, 29837), wrist (29840, 29844), knee (29870, 29872, 29874, 29875, 29877, 29884), and ankle (29894, 29895, 29897). All other arthroscopic procedures not listed above fall under the multiple or bilateral formula.	Payment 100% of Medicare allowable for 1st procedure in the same joint. All other procedures are considered bundled, unless modifier -59 is used to indicate different site, joint, or compartment.
Endoscopy, multiple	Multiple-surgery payment rules apply	Special rules for payment of multiple endoscopies with the same base code Medicare will pay the full value of the higher-valued endoscopy plus the difference between the next-highest endoscopy and the base endoscopy.
Global surgical rule	Global surgery delineates the number of days allowed for pre- and postoperative management (0, 10, or 90 days). 0 days: minor surgical or endoscopic procedure with 0 days postoperative care 10 days: minor surgical procedure with	Similar policy

Ground Rule or Issue	WC	Medicare Policy CY 2013
Starred-procedure rule	<p>10 days postoperative care 90 days: major surgical procedure with 90 days postoperative and one day preoperative care</p> <p>OMFS-only rule Allows separate payment for associated pre and postoperative services AMA discontinued starred-procedure designations.</p>	<p>Payment for minor surgery codes generally includes the E&amp;M services provided in order to perform the procedure on the day of surgery or service. Codes are assigned 0- or 10-day global periods beginning the day following the procedure. Modifier –25 is allowed to bypass the rule if an unrelated E&amp;M service is provided on the same day.</p>
Radiology	<p>No payment reductions are applied when multiple services are furnished on the same day.</p>	<p>MPPR applies to advanced imaging (CT scans, MRI, and ultrasound) furnished in the same session by a single physician or multiple physicians in the same practice, regardless of imaging modality. Payment is reduced 25% for both the TC and PC of the service.</p>
Physical medicine	<p>Multiple-procedure discounting</p> <p>There are limits on how much can be billed on a single date of service, and there is a multiple-procedure formula for determining the billing amount. <i>Modalities:</i> No more than two are paid for one date of service. <i>Procedures:</i> Codes have an assigned time, and, if not specified, the time is considered to be 30 minutes. When not otherwise specified, time past the first 30 minutes is billed in 15-minute increments and may be billed more than once for a single visit. There is a 60-minute limitation without prior authorization; this limits the number of procedures to two in a single visit. Additional time codes do not count in the two-procedure limit. <i>Combined billing:</i> There is combined maximum of four procedures or modalities for a single visit. If one procedure is billed, then a maximum of four codes (including additional time codes) can be billed for one visit. For example, a physician can bill for two modalities and two procedures or for two modalities, one procedure, and two additional time codes. When combining the modalities and procedures for billing, the physician must use the multiple billing formulas. Payment formula 100% for the first procedure or modality, 75% for the second, 50% for the third, and 25% for the fourth. The procedures or modalities should be ranked using the highest value.</p>	<p>MPPR applies to the HCPCS codes contained on the list of “always therapy” services that are paid under the MPFS. The list of procedures is published as Addendum H of the MPFS. The MPPR applies to the PE payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as to multiple procedures. It does not apply to add-on or bundled codes. Full payment is made for the unit or procedure with the highest PE payment. Effective April 1, 2013, the remaining procedures or units are reimbursed at 50% payment in all settings (as required by the American Taxpayer Relief Act of 2012, Pub. L. 112-240).</p>

Ground Rule or Issue	WC	Medicare Policy CY 2013
Patient assessments	Physicians use E&M evaluation codes (95831–95852). Therapists use codes 98770–98778 for their assessments, evaluations, and consultations. Values for physical-medicine codes and acupuncture codes include routine follow-up assessment for E&M purposes. 2.4 RVUs are deducted when treatment and E&M or physical-therapist assessment codes are billed for the same visit by the same medical provider. If the physical therapist has a separate facility or is not employed by the physician, then full value is paid for both treatment and E&M and physical-therapist assessment codes.	CPT 2013 has codes for PT and occupational-therapy evaluation and reevaluation that apply to all qualified practitioners. The RVUs for PT do not include RVUs for patient assessments.
Acupuncture	Acupuncture codes may be combined with physical-medicine modalities and procedures or may be billed alone using this formula. Additional time codes are not included for these services.	Not a Medicare-covered service but RVUs are published as part of the annual fee-schedule update.
Chiropractic services	Chiropractic services are subject to multiple-procedure discounting.	Chiropractic services are extremely limited in Medicare and are not included in the “always therapy” codes and therefore not subject to the multiple-procedure reduction.
Work hardening and conditioning	Covered service	Not a Medicare-covered service, and no RVUs are published as part of the annual fee-schedule update
Drugs, immunizations, other pharmaceuticals, and supplies		
Supplies, materials, and DME	Supplies and materials provided beyond those usually included with the service or procedure may be charged for separately. Paid at cost (purchase price plus sales tax) plus 20% of cost up to a maximum of cost plus \$15.00 Dispensed items separately reimbursed include cast and strapping materials, iontophoresis electrodes, supplies for strains, reusable electrodes, canes, braces, slings, ace wraps, transcutaneous electrical nerve stimulation electrodes, crutches, splints, back supports, and hot or cold packs. Examples of supplies that are usually not separately reimbursable include applied hot or cold packs, eye patches, injections or debridement trays, Steri-strips, needles, syringes, eye or ear trays, drapes, sterile gloves, eyewash or drops, creams (massage), fluorescein, ultrasound pads and gel, tissues, urine-collection kits, gauze, cotton balls, sterile water, dressings (simple wound), head sheet, aspiration trays, and tape for dressing. Dangerous device dispensed by a physician: reimbursement not to exceed either (1) the fee-schedule amount, (2) 120% of documented paid cost but not less than 100% of documented paid cost plus the dispensing fee	With the exception of administration of injectable drugs and biologicals and casting materials, supplies used in a doctor’s office are not separately reimbursed under Medicare and are included in either the E&M service or surgical procedure. Recasting (as well as casting) supplies are separately paid. Medical supplies and equipment for home use are payable under the DMEPOS, same as OMFS.

Ground Rule or Issue	WC	Medicare Policy CY 2013
	allowed for prescription-drug dispensing and not more than 100% of documented paid cost plus \$250	
Physician-dispensed drugs	Medi-Cal fee-schedule rate for NDC applies. For repackaged drugs whose NDC is not in the Medi-Cal database, the Medi-Cal rate for the underlying NDC applies. Reimbursement for compounded medications dispensed in a physician's office cannot exceed 300% of documented paid costs but in no case exceed \$20 above documented paid costs.	Medicare does not reimburse for the dispensing of pharmaceuticals other than drugs and biologicals administered in the physician's office (e.g., injectable and infusible drugs and therapeutics).
Injectable drugs	Injectable materials administered during therapeutic, diagnostic, or antibiotic injections are separately reimbursable at 110% of the AWP for brand or 140% of the AWP for generic. No dispensing fee is allowed.	Most drugs and biologicals reimbursed under the Medicare program are listed in the MPFS. Those that are do not require copy of invoice submitted with bill. Medicare uses HCPCS level II J-codes to describe drugs, vaccines, and supplies. Drugs and biologicals are paid using the ASP methodology.
Immunizations	Immunizations provided under OMFS codes 90725–90749 and 90710–90711 are reimbursable. Cost of the vaccine plus a \$14.25 injection fee BR and invoice required	Generally, vaccines are not covered, with the exception of influenza, pneumococcal, and hepatitis B vaccines. Vaccine rates are updated annually as part of the fee-schedule update.
<b>Reports</b>		
OMFS-reimbursable reports	The following reports are separately reimbursable. If an office visit is involved, separate payment is made in addition to the office visit: PR-2 (at least every 45 days or change in patient status), final PR-2, and PR-3. Consultation reports are separately reimbursable.	Medicare does not separately pay for reports. A physician may charge Medicare beneficiaries for the completion of forms (e.g., life-insurance applications, disability forms) at the physician's usual and customary charge. A physician may charge Medicare beneficiaries for the completion of forms (e.g., life-insurance applications, disability forms, but not CMS 1500 or UB claim forms).
Duplicate reports	When requested by a claim administrator, duplicate reports are separately reimbursable at \$10 for up to the 1st 15 pages and at \$0.25 for each additional page. Use CPT code 99087 to describe duplicate reports	Medicare does not pay separately for reports.
Medical records	Chart note requests are separately reimbursable at 95% of a fee set at \$10 for up to the first 15 pages and \$0.25 per page in excess of 15. Chart note requests shall be made only by the claim administrator and shall be in writing. Use code 99086 to identify.	Medicare does not pay for furnishing medical records.

NOTE: CRNA = certified registered nurse anesthetist. MPPR = multiple-procedure payment reduction. UB = uniform bill.

## Appendix B Crosswalk: Official Medical Fee Schedule to 2013 Current Procedural Terminology

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**Table B.1 Crosswalk: Official Medical Fee Schedule to 2013 Current Procedural Terminology**

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
00320	00320	Lewin	01906	01936	Lewin
00320	00326	Lewin	01908	01935	Lewin
00420	00300	Lewin	01908	01936	Lewin
00528	00528	Lewin	01910	01935	Lewin
00528	00529	Lewin	01910	01936	Lewin
00544	00542	Lewin	01912	01935	Lewin
00850	01961	Lewin	01912	01936	Lewin
00855	01963	Lewin	01914	01935	Lewin
00857	01968	Lewin	01914	01936	Lewin
00857	01969	Lewin	01918	01916	Lewin
00884	01930	Lewin	01921	01924	Lewin
00900	00300	Lewin	01921	01925	Lewin
00900	00400	Lewin	01921	01926	Lewin
00946	01960	Lewin	01995	01200	Lewin <sup>a</sup>
00955	01967	Lewin	01995	01202	Lewin <sup>a</sup>
01000	00400	Lewin	01995	01210	Lewin <sup>a</sup>
01110	00300	Lewin	01995	01212	Lewin <sup>a</sup>
01214	01214	Lewin	01995	01214	Lewin <sup>a</sup>
01214	01215	Lewin	01995	01215	Lewin <sup>a</sup>
01240	00400	Lewin	01995	01220	Lewin <sup>a</sup>
01300	00400	Lewin	01995	01230	Lewin <sup>a</sup>
01460	00400	Lewin	01995	01232	Lewin <sup>a</sup>
01600	00400	Lewin	01995	01234	Lewin <sup>a</sup>
01632	01630	RAND	01995	01250	Lewin <sup>a</sup>
01632	01638	RAND	01995	01260	Lewin <sup>a</sup>
01700	00400	Lewin	01995	01270	Lewin <sup>a</sup>
01784	01770	Lewin	01995	01272	Lewin <sup>a</sup>
01784	01780	Lewin	01995	01274	Lewin <sup>a</sup>
01800	00400	Lewin	01995	01320	Lewin <sup>a</sup>
01900	00952	Lewin	01995	01340	Lewin <sup>a</sup>
01902	00214	Lewin	01995	01360	Lewin <sup>a</sup>
01904	01935	Lewin	01995	01380	Lewin <sup>a</sup>
01904	01936	Lewin	01995	01382	Lewin <sup>a</sup>
01905	01935	RAND	01995	01390	Lewin <sup>a</sup>
01905	01936	RAND	01995	01392	Lewin <sup>a</sup>
01906	01935	Lewin	01995	01400	Lewin <sup>a</sup>

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
01995	01402	Lewin <sup>a</sup>	01995	01710	Lewin <sup>a</sup>
01995	01404	Lewin <sup>a</sup>	01995	01712	Lewin <sup>a</sup>
01995	01420	Lewin <sup>a</sup>	01995	01714	Lewin <sup>a</sup>
01995	01430	Lewin <sup>a</sup>	01995	01716	Lewin <sup>a</sup>
01995	01432	Lewin <sup>a</sup>	01995	01730	Lewin <sup>a</sup>
01995	01440	Lewin <sup>a</sup>	01995	01732	Lewin <sup>a</sup>
01995	01442	Lewin <sup>a</sup>	01995	01740	Lewin <sup>a</sup>
01995	01444	Lewin <sup>a</sup>	01995	01742	Lewin <sup>a</sup>
01995	01462	Lewin <sup>a</sup>	01995	01744	Lewin <sup>a</sup>
01995	01464	Lewin <sup>a</sup>	01995	01756	Lewin <sup>a</sup>
01995	01470	Lewin <sup>a</sup>	01995	01758	Lewin <sup>a</sup>
01995	01472	Lewin <sup>a</sup>	01995	01760	Lewin <sup>a</sup>
01995	01474	Lewin <sup>a</sup>	01995	01770	Lewin <sup>a</sup>
01995	01480	Lewin <sup>a</sup>	01995	01772	Lewin <sup>a</sup>
01995	01482	Lewin <sup>a</sup>	01995	01780	Lewin <sup>a</sup>
01995	01484	Lewin <sup>a</sup>	01995	01782	Lewin <sup>a</sup>
01995	01486	Lewin <sup>a</sup>	01995	01810	Lewin <sup>a</sup>
01995	01490	Lewin <sup>a</sup>	01995	01820	Lewin <sup>a</sup>
01995	01500	Lewin <sup>a</sup>	01995	01829	Lewin <sup>a</sup>
01995	01502	Lewin <sup>a</sup>	01995	01830	Lewin <sup>a</sup>
01995	01520	Lewin <sup>a</sup>	01995	01832	Lewin <sup>a</sup>
01995	01522	Lewin <sup>a</sup>	01995	01840	Lewin <sup>a</sup>
01995	01610	Lewin <sup>a</sup>	01995	01842	Lewin <sup>a</sup>
01995	01620	Lewin <sup>a</sup>	01995	01844	Lewin <sup>a</sup>
01995	01622	Lewin <sup>a</sup>	01995	01850	Lewin <sup>a</sup>
01995	01630	Lewin <sup>a</sup>	01995	01852	Lewin <sup>a</sup>
01995	01634	Lewin <sup>a</sup>	01995	01860	Lewin <sup>a</sup>
01995	01636	Lewin <sup>a</sup>	11040	97597	RAND
01995	01638	Lewin <sup>a</sup>	11040	97598	RAND
01995	01650	Lewin <sup>a</sup>	11041	97597	RAND
01995	01652	Lewin <sup>a</sup>	11041	97598	RAND
01995	01654	Lewin <sup>a</sup>	11042	11042	RAND
01995	01656	Lewin <sup>a</sup>	11042	11045	RAND
01995	01670	Lewin <sup>a</sup>	11043	11043	RAND
01995	01680	Lewin <sup>a</sup>	11043	11046	RAND
01995	01682	Lewin <sup>a</sup>	11044	11044	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
11044	11047	RAND	15320	15275	RAND
11050	11055	Lewin	15320	15276	RAND
11050	17000	Lewin	15321	15277	RAND
11051	11056	Lewin	15321	15278	RAND
11051	17003	Lewin	15330	15271	RAND
11052	11057	Lewin	15330	15272	RAND
11052	17003	Lewin	15331	15273	RAND
11052	17004	Lewin	15331	15274	RAND
11731	11732	Lewin	15335	15275	RAND
11975	11981	RAND	15335	15276	RAND
11977	11976	RAND	15336	15277	RAND
11977	11981	RAND	15336	15278	RAND
13300	13102	Lewin	15340	15271	RAND
13300	13122	Lewin	15340	15275	RAND
13300	13133	Lewin	15341	15272	RAND
13300	13153	Lewin	15341	15276	RAND
14300	14301	RAND	15350	15271	Lewin <sup>a</sup>
14300	14302	RAND	15350	15272	Lewin <sup>a</sup>
15000	15002	Lewin	15350	15273	Lewin <sup>a</sup>
15000	15003	Lewin	15350	15274	Lewin <sup>a</sup>
15000	15004	Lewin	15350	15275	Lewin <sup>a</sup>
15000	15005	Lewin	15350	15276	Lewin <sup>a</sup>
15001	15003	RAND	15350	15277	Lewin <sup>a</sup>
15001	15005	RAND	15350	15278	Lewin <sup>a</sup>
15170	15271	RAND	15360	15271	RAND
15170	15272	RAND	15360	15272	RAND
15171	15273	RAND	15361	15273	RAND
15171	15274	RAND	15361	15274	RAND
15175	15275	RAND	15365	15275	RAND
15175	15276	RAND	15365	15276	RAND
15176	15277	RAND	15366	15277	RAND
15176	15278	RAND	15366	15278	RAND
15300	15271	RAND	15400	15271	Lewin <sup>a</sup>
15300	15272	RAND	15400	15272	Lewin <sup>a</sup>
15301	15273	RAND	15400	15273	Lewin <sup>a</sup>
15301	15274	RAND	15400	15274	Lewin <sup>a</sup>

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
15400	15275	Lewin <sup>a</sup>	17001	17003	Lewin
15400	15276	Lewin <sup>a</sup>	17001	17004	Lewin
15400	15277	Lewin <sup>a</sup>	17002	17003	Lewin
15400	15278	Lewin <sup>a</sup>	17002	17004	Lewin
15401	15273	RAND	17010	NONE	Lewin
15401	15274	RAND	17100	17000	Lewin
15420	15275	RAND	17100	17003	Lewin
15420	15276	RAND	17100	17004	Lewin
15421	15277	RAND	17101	17000	Lewin
15421	15278	RAND	17101	17003	Lewin
15430	15271	RAND	17101	17004	Lewin
15430	15272	RAND	17102	17000	Lewin
15430	15275	RAND	17102	17003	Lewin
15430	15276	RAND	17102	17004	Lewin
15431	15273	RAND	17104	17000	Lewin
15431	15274	RAND	17104	17003	Lewin
15431	15277	RAND	17104	17004	Lewin
15431	15278	RAND	17105	17000	Lewin
15580	15574	Lewin	17105	17003	Lewin
15625	15620	Lewin	17105	17004	Lewin
15810	NONE	Lewin	17110	17110	Lewin
15811	NONE	Lewin	17110	17111	Lewin
15831	15830	Lewin	17200	11200	Lewin
15831	15847	Lewin	17200	11201	Lewin
15831	17999	Lewin	17201	11200	Lewin
16010	16020	Lewin	17201	11201	Lewin
16015	16025	Lewin	17304	17311	Lewin
16015	16030	Lewin	17305	17312	Lewin
16035	16035	Lewin	17305	17314	Lewin
16035	16036	Lewin	17306	17312	Lewin
16040	15002	Lewin	17306	17314	Lewin
16040	15004	Lewin	17307	17312	Lewin
16041	15002	Lewin	17307	17314	Lewin
16041	15004	Lewin	17310	17315	Lewin
16042	15002	Lewin	19100	19100	Lewin
16042	15004	Lewin	19100	19101	Lewin

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
19100	19102	Lewin	21557	21558	RAND
19100	19103	Lewin	21740	21740	Lewin
19101	19100	Lewin	21740	21742	Lewin
19101	19101	Lewin	21740	21743	Lewin
19101	19102	Lewin	21930	21930	RAND
19101	19103	Lewin	21930	21931	RAND
19140	19300	Lewin	21930	21932	RAND
19160	19301	Lewin	21930	21933	RAND
19162	19302	Lewin	21935	21935	RAND
19180	19303	Lewin	21935	21936	RAND
19182	19304	Lewin	22900	22900	RAND
19200	19305	Lewin	22900	22901	RAND
19220	19306	Lewin	22900	22902	RAND
19240	19307	Lewin	22900	22903	RAND
20000	10060	RAND	22900	22904	RAND
20000	10061	RAND	22900	22905	RAND
20986	0054T	RAND	23075	23071	RAND
20986	0055T	RAND	23075	23075	RAND
20987	0054T	RAND	23076	23073	RAND
20987	0055T	RAND	23076	23076	RAND
21015	21015	RAND	23077	23077	RAND
21015	21016	RAND	23077	23078	RAND
21040	21040	Lewin	23221	23220	RAND
21040	21046	Lewin	23222	23220	RAND
21040	21047	Lewin	24075	24071	RAND
21041	21040	Lewin	24075	24075	RAND
21041	21046	Lewin	24076	24073	RAND
21041	21047	Lewin	24076	24076	RAND
21300	NONE	Lewin	24077	24077	RAND
21493	NONE	Lewin	24077	24079	RAND
21494	NONE	Lewin	24151	24150	RAND
21555	21552	RAND	24153	24152	RAND
21555	21555	RAND	24350	24357	Lewin
21556	21554	RAND	24350	24358	Lewin
21556	21556	RAND	24350	24359	Lewin
21557	21557	RAND	24351	24357	Lewin

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
24351	24358	Lewin	27048	27048	RAND
24351	24359	Lewin	27049	27049	RAND
24352	24357	Lewin	27049	27059	RAND
24352	24358	Lewin	27079	27078	RAND
24352	24359	Lewin	27315	27325	Lewin
24354	24357	Lewin	27320	27326	Lewin
24354	24358	Lewin	27327	27327	RAND
24354	24359	Lewin	27327	27337	RAND
24356	24357	Lewin	27328	27328	RAND
24356	24358	Lewin	27328	27339	RAND
24356	24359	Lewin	27329	27329	RAND
25075	25071	RAND	27329	27364	RAND
25075	25075	RAND	27615	27615	RAND
25076	25073	RAND	27615	27616	RAND
25076	25076	RAND	27618	27618	RAND
25077	25077	RAND	27618	27632	RAND
25077	25078	RAND	27619	27619	RAND
25274	25274	Lewin	27619	27634	RAND
25274	25275	Lewin	28030	28055	Lewin
25611	25606	Lewin	28043	28039	RAND
25620	25607	Lewin	28043	28043	RAND
25620	25608	Lewin	28045	28041	RAND
25620	25609	Lewin	28045	28045	RAND
26115	26111	RAND	28046	28046	RAND
26115	26115	RAND	28046	28047	RAND
26116	26113	RAND	29220	29799	RAND
26116	26116	RAND	29590	NONE	RAND
26117	26117	RAND	29815	29805	Lewin
26117	26118	RAND	29909	29999	Lewin
26255	26250	RAND	31585	NONE	Lewin
26261	26260	RAND	31586	NONE	Lewin
26504	26390	Lewin	31622	31622	Lewin
26585	26587	Lewin	31622	31623	Lewin
27047	27043	RAND	31622	31624	Lewin
27047	27047	RAND	31628	31628	Lewin
27048	27045	RAND	31628	31632	Lewin

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
31629	31629	Lewin	32850	32856	Lewin
31629	31633	Lewin	33200	NONE	Lewin
31656	31899	RAND	33201	NONE	Lewin
31700	NONE	Lewin	33242	33218	Lewin
31708	NONE	Lewin	33242	33220	Lewin
31710	NONE	Lewin	33245	NONE	Lewin
31715	31899	RAND	33246	NONE	Lewin
32000	32554	Lewin <sup>a</sup>	33247	33216	Lewin
32000	32555	Lewin <sup>a</sup>	33253	33254	Lewin
32002	32554	Lewin <sup>a</sup>	33253	33255	Lewin
32002	32555	Lewin <sup>a</sup>	33253	33256	Lewin
32005	32560	Lewin	33861	33864	RAND
32019	32550	RAND	33918	33925	Lewin
32020	32551	Lewin	33918	33926	Lewin
32095	32096	RAND	33919	33925	Lewin
32095	32097	RAND	33919	33926	Lewin
32095	32098	RAND	33930	33930	Lewin
32402	32098	RAND	33930	33933	Lewin
32420	32405	RAND	33940	33940	Lewin
32421	32554	RAND	33940	33944	Lewin
32421	32555	RAND	35161	37799	Lewin
32422	32554	RAND	35162	37799	Lewin
32422	32555	RAND	35301	35301	Lewin
32500	32505	RAND	35301	35302	Lewin
32500	32506	RAND	35301	35303	Lewin
32500	32507	RAND	35301	35304	Lewin
32520	NONE	Lewin	35301	35305	Lewin
32522	NONE	Lewin	35301	35306	Lewin
32525	NONE	Lewin	35381	35302	Lewin
32602	32607	RAND	35381	35303	Lewin
32602	32608	RAND	35381	35304	Lewin
32602	32609	RAND	35381	35305	Lewin
32603	32601	RAND	35381	35306	Lewin
32605	32601	RAND	35454	37220	RAND
32850	32850	Lewin	35454	37221	RAND
32850	32855	Lewin	35454	37222	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
35454	37223	RAND	35485	37229	RAND
35456	37224	RAND	35485	37231	RAND
35456	37225	RAND	35485	37233	RAND
35456	37226	RAND	35485	37235	RAND
35456	37227	RAND	35490	0234T	RAND
35459	37228	RAND	35490	0235T	RAND
35459	37229	RAND	35491	0236T	RAND
35459	37230	RAND	35492	0238T	RAND
35459	37231	RAND	35493	37225	RAND
35459	37232	RAND	35493	37227	RAND
35459	37233	RAND	35494	0237T	RAND
35459	37234	RAND	35495	37229	RAND
35459	37235	RAND	35495	37231	RAND
35470	37228	RAND	35495	37233	RAND
35470	37229	RAND	35495	37235	RAND
35470	37230	RAND	35507	35506	Lewin
35470	37231	RAND	35541	35537	Lewin
35470	37232	RAND	35541	35538	Lewin
35470	37233	RAND	35546	35539	Lewin
35470	37234	RAND	35546	35540	Lewin
35470	37235	RAND	35548	35537	RAND
35473	37220	RAND	35548	35539	RAND
35473	37221	RAND	35548	35565	RAND
35473	37222	RAND	35549	35537	RAND
35473	37223	RAND	35549	35538	RAND
35474	37224	RAND	35549	35539	RAND
35474	37225	RAND	35549	35540	RAND
35474	37226	RAND	35549	35565	RAND
35474	37227	RAND	35551	35539	RAND
35480	0234T	RAND	35551	35540	RAND
35480	0235T	RAND	35551	35556	RAND
35481	0236T	RAND	35551	35583	RAND
35482	0238T	RAND	35582	NONE	Lewin
35483	37225	RAND	35601	35601	Lewin
35483	37227	RAND	35601	35637	Lewin
35484	0237T	RAND	35601	35638	Lewin

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
35641	35637	Lewin	36530	36563	Lewin
35641	35638	Lewin	36531	36575	Lewin
35646	35646	Lewin	36531	36576	Lewin
35646	35647	Lewin	36531	36578	Lewin
35681	35681	Lewin	36531	36581	Lewin
35681	35682	Lewin	36531	36582	Lewin
35681	35683	Lewin	36531	36584	Lewin
36145	36147	RAND	36531	36585	Lewin
36145	36148	RAND	36532	36590	Lewin
36488	36555	Lewin	36533	36557	Lewin
36488	36556	Lewin	36533	36558	Lewin
36488	36568	Lewin	36533	36560	Lewin
36488	36569	Lewin	36533	36561	Lewin
36488	36580	Lewin	36533	36565	Lewin
36488	36584	Lewin	36533	36566	Lewin
36489	36555	Lewin	36533	36570	Lewin
36489	36556	Lewin	36533	36571	Lewin
36489	36568	Lewin	36534	36575	Lewin
36489	36569	Lewin	36534	36576	Lewin
36489	36580	Lewin	36534	36578	Lewin
36489	36584	Lewin	36534	36581	Lewin
36490	36555	Lewin	36534	36582	Lewin
36490	36556	Lewin	36534	36583	Lewin
36490	36568	Lewin	36534	36585	Lewin
36490	36569	Lewin	36535	36589	Lewin
36490	36580	Lewin	36540	36591	RAND
36490	36584	Lewin	36550	36593	RAND
36491	36555	Lewin	36821	36819	Lewin
36491	36556	Lewin	36821	36820	Lewin
36491	36568	Lewin	36821	36821	Lewin
36491	36569	Lewin	36832	36832	Lewin
36491	36580	Lewin	36832	36833	Lewin
36491	36584	Lewin	37201	37211	RAND
36493	36597	Lewin	37201	37212	RAND
36520	36511	Lewin	37201	37213	RAND
36520	36512	Lewin	37201	37214	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
37203	37197	RAND	44152	44799	Lewin
37209	37211	RAND	44153	44799	Lewin
37209	37212	RAND	44625	44625	Lewin
37209	37213	RAND	44625	44626	Lewin
37209	37214	RAND	44900	44900	Lewin
37620	37191	RAND	44900	44901	Lewin
37620	37619	RAND	45170	45171	RAND
37720	37718	Lewin	45170	45172	RAND
37720	37722	Lewin	46210	46999	RAND
37730	37718	Lewin	46211	46999	RAND
37730	37722	Lewin	46934	46930	RAND
38231	38205	Lewin	46935	46930	RAND
38231	38206	Lewin	46936	46930	RAND
39502	43332	RAND	46937	45190	RAND
39502	43333	RAND	46938	45190	RAND
39520	43334	RAND	47010	47010	Lewin
39520	43335	RAND	47010	47011	Lewin
39530	43336	RAND	47134	47140	Lewin
39530	43337	RAND	47716	NONE	Lewin <sup>a</sup>
39531	43336	RAND	47719	NONE	RAND
39531	43337	RAND	48005	48105	Lewin
42325	NONE	Lewin	48180	48548	Lewin
42326	NONE	Lewin	48510	48510	Lewin
43234	43235	RAND	48510	48511	Lewin
43259	43237	Lewin	48550	48550	Lewin
43259	43259	Lewin	48550	48551	Lewin
43324	43327	RAND	48550	48552	Lewin
43324	43328	RAND	49040	49040	Lewin
43326	43327	RAND	49040	49041	Lewin
43326	43328	RAND	49060	49060	Lewin
43600	43605	RAND	49060	49061	Lewin
43638	NONE	Lewin	49080	49082	RAND
43639	NONE	Lewin	49080	49083	RAND
43750	43246	Lewin	49080	49084	RAND
43846	43845	Lewin	49081	49082	RAND
43846	43846	Lewin	49081	49083	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
49081	49084	RAND	52338	52354	Lewin
49085	49402	Lewin	52339	52355	Lewin
49200	49203	Lewin	52340	52400	Lewin
49200	49204	Lewin	52510	NONE	Lewin
49200	49205	Lewin	52606	52214	RAND
49200	58957	Lewin	52612	52601	RAND
49200	58958	Lewin	52614	52601	RAND
49201	49203	Lewin	52620	52630	RAND
49201	49204	Lewin	53443	53431	Lewin
49201	49205	Lewin	53447	53447	Lewin
49201	58957	Lewin	53447	53448	Lewin
49201	58958	Lewin	53670	51701	Lewin
49420	49418	RAND	53670	51702	Lewin
49420	49421	RAND	53675	51703	Lewin
49421	49418	RAND	53853	55899	RAND
49421	49421	RAND	54152	54150	Lewin
50020	50020	Lewin	54402	54415	Lewin
50020	50021	Lewin	54402	54416	Lewin
50300	50300	Lewin	54407	54406	Lewin
50300	50323	Lewin	54407	54408	Lewin
50320	50320	Lewin	54407	54410	Lewin
50320	50325	Lewin	54409	54408	Lewin
50559	NONE	Lewin	54510	54512	Lewin
50578	NONE	Lewin	54820	54865	Lewin
50959	NONE	Lewin	55859	55875	Lewin
50978	NONE	Lewin	56300	49320	Lewin
51000	51100	Lewin	56301	58670	Lewin
51005	51101	Lewin	56302	58671	Lewin
51010	51102	Lewin	56303	58662	Lewin
51726	51726	RAND	56304	58660	Lewin
51726	51727	RAND	56305	49321	Lewin
51726	51728	RAND	56306	49322	Lewin
51726	51729	RAND	56307	58661	Lewin
52335	52351	Lewin	56308	58550	Lewin
52336	52352	Lewin	56308	58552	Lewin
52337	52353	Lewin	56309	58545	Lewin

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
56309	58546	Lewin	57452	57454	Lewin
56311	38570	Lewin	57452	57455	Lewin
56312	38571	Lewin	57452	57456	Lewin
56313	38572	Lewin	57452	57460	Lewin
56315	44970	Lewin	57452	57461	Lewin
56316	49650	Lewin	57454	57452	Lewin
56317	49651	Lewin	57454	57454	Lewin
56320	55550	Lewin	57454	57455	Lewin
56322	43651	Lewin	57454	57456	Lewin
56323	43652	Lewin	57454	57460	Lewin
56324	47570	Lewin	57454	57461	Lewin
56340	47562	Lewin	57460	57452	Lewin
56341	47563	Lewin	57460	57454	Lewin
56342	47564	Lewin	57460	57455	Lewin
56343	58673	Lewin	57460	57456	Lewin
56344	58672	Lewin	57460	57460	Lewin
56350	58555	Lewin	57460	57461	Lewin
56351	58558	Lewin	57820	57558	Lewin
56352	58559	Lewin	58140	58140	Lewin
56353	58560	Lewin	58140	58146	Lewin
56354	58561	Lewin	59000	59000	Lewin
56355	58562	Lewin	59000	59001	Lewin
56356	58563	Lewin	60001	60300	Lewin
56362	47560	Lewin	61106	NONE	Lewin
56363	47561	Lewin	61130	NONE	Lewin
56399	NONE	Lewin	61538	61537	Lewin
56720	56442	Lewin	61538	61538	Lewin
57108	57106	Lewin	61538	61539	Lewin
57110	57110	Lewin	61538	61540	Lewin
57110	57111	Lewin	61539	61537	Lewin
57110	57112	Lewin	61539	61538	Lewin
57282	57282	Lewin	61539	61539	Lewin
57282	57283	Lewin	61539	61540	Lewin
57284	57284	Lewin	61712	69990	Lewin
57284	57285	Lewin	61793	61796	RAND
57452	57452	Lewin	61793	61797	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
61793	61798	RAND	63691	95970	Lewin
61793	61799	RAND	63691	95971	Lewin
61793	61800	RAND	64415	64415	Lewin
61793	63620	RAND	64415	64416	Lewin
61793	63621	RAND	64440	64479	Lewin
61795	61781	RAND	64440	64483	Lewin
61795	61782	RAND	64441	64480	Lewin
61795	61783	RAND	64441	64484	Lewin
61855	61867	Lewin	64442	64493	Lewin <sup>a</sup>
61855	61868	Lewin	64443	64494	Lewin <sup>a</sup>
61865	61867	Lewin	64443	64495	Lewin <sup>a</sup>
61865	61868	Lewin	64445	64445	Lewin
61885	61885	Lewin	64445	64446	Lewin
61885	61886	Lewin	64470	64490	RAND
62274	62310	Lewin	64472	64491	RAND
62274	62311	Lewin	64472	64492	RAND
62275	62310	Lewin	64475	64493	RAND
62276	62318	Lewin	64476	64494	RAND
62276	62319	Lewin	64476	64495	RAND
62277	62318	Lewin	64555	64555	Lewin
62277	62319	Lewin	64555	64561	Lewin
62278	62311	Lewin	64560	NONE	RAND
62279	62319	Lewin	64573	NONE	RAND
62288	62310	Lewin	64575	64575	Lewin
62288	62311	Lewin	64575	64581	Lewin
62289	62311	Lewin	64577	NONE	RAND
62298	62310	Lewin	64622	64635	Lewin <sup>a</sup>
63040	63040	Lewin	64623	64636	Lewin <sup>a</sup>
63040	63043	Lewin	64626	64633	RAND
63040	63044	Lewin	64627	64634	RAND
63660	63661	RAND	64680	64680	Lewin
63660	63662	RAND	64680	64681	Lewin
63660	63663	RAND	64830	69990	Lewin
63660	63664	RAND	65805	65800	RAND
63690	95970	Lewin	66710	66710	Lewin
63690	95971	Lewin	66710	66711	Lewin

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
67038	67041	Lewin	73720	73718	Lewin
67038	67042	Lewin	73720	73719	Lewin
67038	67043	Lewin	73720	73720	Lewin
67228	67228	Lewin	73721	73721	Lewin
67228	67229	Lewin	73721	73722	Lewin
67350	67346	Lewin	73721	73723	Lewin
69410	NONE	Lewin	74181	74181	Lewin
69802	NONE	RAND	74181	74182	Lewin
70540	70540	Lewin	74181	74183	Lewin
70540	70542	Lewin	74350	49440	Lewin
70540	70543	Lewin	74405	74400	Lewin
70541	70544	Lewin	74405	74410	Lewin
70541	70545	Lewin	74405	74415	Lewin
70541	70546	Lewin	75552	75557	Lewin <sup>a</sup>
70541	70547	Lewin	75552	75559	Lewin <sup>a</sup>
70541	70548	Lewin	75553	75561	Lewin <sup>a</sup>
70541	70549	Lewin	75553	75563	Lewin <sup>a</sup>
71036	77002	Lewin	75554	75557	Lewin <sup>a</sup>
71038	31628	Lewin	75554	75559	Lewin <sup>a</sup>
71038	31632	Lewin	75554	75561	Lewin <sup>a</sup>
71040	76499	RAND	75554	75563	Lewin <sup>a</sup>
71060	76499	RAND	75555	75557	Lewin <sup>a</sup>
71090	NONE	RAND	75555	75559	Lewin <sup>a</sup>
71550	71550	Lewin	75555	75561	Lewin <sup>a</sup>
71550	71551	Lewin	75555	75563	Lewin <sup>a</sup>
71550	71552	Lewin	75556	75565	Lewin <sup>a</sup>
72196	72195	Lewin	75558	75565	RAND
72196	72196	Lewin	75560	75565	RAND
72196	72197	Lewin	75562	75565	RAND
73220	73218	Lewin	75564	75565	RAND
73220	73219	Lewin	75650	36221	RAND
73220	73220	Lewin	75650	36222	RAND
73221	73221	Lewin	75650	36223	RAND
73221	73222	Lewin	75650	36224	RAND
73221	73223	Lewin	75650	36225	RAND
73542	27096	RAND	75650	36226	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
75660	36227	RAND	75996	0235T	RAND
75662	36227	RAND	75998	77001	RAND
75665	36223	RAND	76003	77002	Lewin
75665	36224	RAND	76005	77003	RAND
75671	36223	RAND	76006	77071	RAND
75671	36224	RAND	76012	72291	RAND
75676	36222	RAND	76013	72292	RAND
75676	36223	RAND	76020	77072	Lewin
75676	36224	RAND	76040	77073	Lewin
75680	36222	RAND	76061	77074	Lewin
75680	36223	RAND	76062	77075	Lewin
75680	36224	RAND	76065	77076	Lewin
75685	36225	RAND	76066	77077	Lewin
75685	36226	RAND	76070	77078	Lewin <sup>a</sup>
75722	36251	RAND	76071	NONE	RAND
75722	36253	RAND	76075	77080	Lewin
75724	36252	RAND	76076	77081	RAND
75724	36254	RAND	76077	77082	RAND
75790	36147	RAND	76078	NONE	RAND
75790	75791	RAND	76082	77051	RAND
75900	37211	RAND	76083	77052	RAND
75900	37212	RAND	76086	77053	Lewin
75900	37213	RAND	76088	77054	Lewin
75900	37214	RAND	76090	77055	Lewin
75940	37191	RAND	76091	77056	Lewin
75961	37197	RAND	76092	77057	Lewin
75992	0238T	RAND	76093	77058	Lewin
75992	37225	RAND	76094	77059	Lewin
75992	37227	RAND	76095	77031	Lewin
75992	37229	RAND	76096	77032	Lewin
75992	37231	RAND	76150	NONE	RAND
75993	0238T	RAND	76350	NONE	RAND
75993	37233	RAND	76355	77011	Lewin
75993	37235	RAND	76360	77012	Lewin
75994	0234T	RAND	76362	77013	RAND
75995	0235T	RAND	76365	77012	Lewin

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
76370	77014	Lewin	77781	77785	RAND
76375	76376	Lewin <sup>a</sup>	77781	77786	RAND
76375	76377	Lewin <sup>a</sup>	77782	77785	RAND
76393	77021	RAND	77782	77786	RAND
76394	77022	RAND	77782	77787	RAND
76400	77084	Lewin	77783	77785	RAND
76511	76510	Lewin	77783	77786	RAND
76511	76511	Lewin	77783	77787	RAND
76511	76512	Lewin	77784	77785	RAND
76512	76510	Lewin	77784	77786	RAND
76512	76511	Lewin	77784	77787	RAND
76512	76512	Lewin	78000	78012	RAND
76778	76775	Lewin	78001	78012	RAND
76778	76776	Lewin	78003	78012	RAND
76805	76801	Lewin	78006	78013	RAND
76805	76802	Lewin	78006	78014	RAND
76805	76805	Lewin	78007	78013	RAND
76805	76810	Lewin	78007	78014	RAND
76810	76801	Lewin	78010	78013	RAND
76810	76802	Lewin	78010	78014	RAND
76810	76805	Lewin	78011	78013	RAND
76810	76810	Lewin	78011	78014	RAND
76818	76818	Lewin	78017	78018	Lewin
76818	76819	Lewin	78160	NONE	Lewin
76880	76881	RAND	78162	NONE	Lewin
76880	76882	RAND	78170	NONE	Lewin
76934	76942	Lewin <sup>a</sup>	78172	NONE	Lewin
76938	76942	Lewin	78220	NONE	RAND
76960	76950	Lewin	78223	78226	RAND
76986	76998	Lewin	78223	78227	RAND
77079	NONE	RAND	78455	NONE	Lewin
77083	NONE	RAND	78460	78451	RAND
77419	77427	Lewin	78460	78453	RAND
77420	77427	Lewin	78461	78452	RAND
77425	77427	Lewin	78461	78454	RAND
77430	77427	Lewin	78464	78451	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
78465	78452	RAND	78802	78802	Lewin
78478	78453	RAND	78802	78804	Lewin
78478	78454	RAND	78810	78811	Lewin
78480	78453	RAND	78810	78812	Lewin
78480	78454	RAND	78810	78813	Lewin
78584	78582	RAND	78890	NONE	RAND
78585	78582	RAND	78891	NONE	RAND
78586	78579	RAND	78990	NONE	Lewin
78587	78579	RAND	79000	79005	Lewin
78588	78582	RAND	79001	79005	Lewin
78591	78579	RAND	79020	79005	Lewin
78593	78579	RAND	79030	79005	Lewin
78594	78579	RAND	79035	79005	Lewin
78596	78597	RAND	79100	79101	Lewin
78596	78598	RAND	79400	79101	Lewin
78615	78610	Lewin	79420	79445	Lewin
78704	78707	Lewin	79900	NONE	Lewin
78704	78708	Lewin	82307	82306	RAND
78704	78709	Lewin	82926	82930	RAND
78707	78707	Lewin	82928	82930	RAND
78707	78708	Lewin	83890	81200	RAND
78707	78709	Lewin	83890	81201	RAND
78715	78707	Lewin	83890	81202	RAND
78715	78708	Lewin	83890	81203	RAND
78715	78709	Lewin	83890	81205	RAND
78726	78799	Lewin	83890	81206	RAND
78727	78700	Lewin	83890	81207	RAND
78727	78701	Lewin	83890	81208	RAND
78727	78707	Lewin	83890	81209	RAND
78727	78708	Lewin	83890	81210	RAND
78727	78709	Lewin	83890	81211	RAND
78760	78761	Lewin	83890	81212	RAND
78800	78800	Lewin	83890	81213	RAND
78800	78802	Lewin	83890	81214	RAND
78800	78804	Lewin	83890	81215	RAND
78802	78800	Lewin	83890	81216	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
83890	81217	RAND	83890	81275	RAND
83890	81220	RAND	83890	81280	RAND
83890	81221	RAND	83890	81281	RAND
83890	81222	RAND	83890	81282	RAND
83890	81223	RAND	83890	81290	RAND
83890	81224	RAND	83890	81291	RAND
83890	81225	RAND	83890	81292	RAND
83890	81226	RAND	83890	81293	RAND
83890	81227	RAND	83890	81294	RAND
83890	81228	RAND	83890	81295	RAND
83890	81229	RAND	83890	81296	RAND
83890	81235	RAND	83890	81297	RAND
83890	81240	RAND	83890	81298	RAND
83890	81241	RAND	83890	81299	RAND
83890	81242	RAND	83890	81300	RAND
83890	81243	RAND	83890	81301	RAND
83890	81244	RAND	83890	81302	RAND
83890	81245	RAND	83890	81303	RAND
83890	81250	RAND	83890	81304	RAND
83890	81251	RAND	83890	81310	RAND
83890	81252	RAND	83890	81315	RAND
83890	81253	RAND	83890	81316	RAND
83890	81254	RAND	83890	81317	RAND
83890	81255	RAND	83890	81318	RAND
83890	81256	RAND	83890	81319	RAND
83890	81257	RAND	83890	81321	RAND
83890	81260	RAND	83890	81322	RAND
83890	81261	RAND	83890	81323	RAND
83890	81262	RAND	83890	81324	RAND
83890	81263	RAND	83890	81325	RAND
83890	81264	RAND	83890	81326	RAND
83890	81265	RAND	83890	81330	RAND
83890	81266	RAND	83890	81331	RAND
83890	81267	RAND	83890	81332	RAND
83890	81268	RAND	83890	81340	RAND
83890	81270	RAND	83890	81341	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
83890	81342	RAND	83891	81210	RAND
83890	81350	RAND	83891	81211	RAND
83890	81355	RAND	83891	81212	RAND
83890	81370	RAND	83891	81213	RAND
83890	81371	RAND	83891	81214	RAND
83890	81372	RAND	83891	81215	RAND
83890	81373	RAND	83891	81216	RAND
83890	81374	RAND	83891	81217	RAND
83890	81375	RAND	83891	81220	RAND
83890	81376	RAND	83891	81221	RAND
83890	81377	RAND	83891	81222	RAND
83890	81378	RAND	83891	81223	RAND
83890	81379	RAND	83891	81224	RAND
83890	81380	RAND	83891	81225	RAND
83890	81381	RAND	83891	81226	RAND
83890	81382	RAND	83891	81227	RAND
83890	81383	RAND	83891	81228	RAND
83890	81400	RAND	83891	81229	RAND
83890	81401	RAND	83891	81235	RAND
83890	81402	RAND	83891	81240	RAND
83890	81403	RAND	83891	81241	RAND
83890	81404	RAND	83891	81242	RAND
83890	81405	RAND	83891	81243	RAND
83890	81406	RAND	83891	81244	RAND
83890	81407	RAND	83891	81245	RAND
83890	81408	RAND	83891	81250	RAND
83890	81479	RAND	83891	81251	RAND
83891	81200	RAND	83891	81252	RAND
83891	81201	RAND	83891	81253	RAND
83891	81202	RAND	83891	81254	RAND
83891	81203	RAND	83891	81255	RAND
83891	81205	RAND	83891	81256	RAND
83891	81206	RAND	83891	81257	RAND
83891	81207	RAND	83891	81260	RAND
83891	81208	RAND	83891	81261	RAND
83891	81209	RAND	83891	81262	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
83891	81263	RAND	83891	81325	RAND
83891	81264	RAND	83891	81326	RAND
83891	81265	RAND	83891	81330	RAND
83891	81266	RAND	83891	81331	RAND
83891	81267	RAND	83891	81332	RAND
83891	81268	RAND	83891	81340	RAND
83891	81270	RAND	83891	81341	RAND
83891	81275	RAND	83891	81342	RAND
83891	81280	RAND	83891	81350	RAND
83891	81281	RAND	83891	81355	RAND
83891	81282	RAND	83891	81370	RAND
83891	81290	RAND	83891	81371	RAND
83891	81291	RAND	83891	81372	RAND
83891	81292	RAND	83891	81373	RAND
83891	81293	RAND	83891	81374	RAND
83891	81294	RAND	83891	81375	RAND
83891	81295	RAND	83891	81376	RAND
83891	81296	RAND	83891	81377	RAND
83891	81297	RAND	83891	81378	RAND
83891	81298	RAND	83891	81379	RAND
83891	81299	RAND	83891	81380	RAND
83891	81300	RAND	83891	81381	RAND
83891	81301	RAND	83891	81382	RAND
83891	81302	RAND	83891	81383	RAND
83891	81303	RAND	83891	81400	RAND
83891	81304	RAND	83891	81401	RAND
83891	81310	RAND	83891	81402	RAND
83891	81315	RAND	83891	81403	RAND
83891	81316	RAND	83891	81404	RAND
83891	81317	RAND	83891	81405	RAND
83891	81318	RAND	83891	81406	RAND
83891	81319	RAND	83891	81407	RAND
83891	81321	RAND	83891	81408	RAND
83891	81322	RAND	83891	81479	RAND
83891	81323	RAND	83892	81200	RAND
83891	81324	RAND	83892	81201	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
83892	81202	RAND	83892	81254	RAND
83892	81203	RAND	83892	81255	RAND
83892	81205	RAND	83892	81256	RAND
83892	81206	RAND	83892	81257	RAND
83892	81207	RAND	83892	81260	RAND
83892	81208	RAND	83892	81261	RAND
83892	81209	RAND	83892	81262	RAND
83892	81210	RAND	83892	81263	RAND
83892	81211	RAND	83892	81264	RAND
83892	81212	RAND	83892	81265	RAND
83892	81213	RAND	83892	81266	RAND
83892	81214	RAND	83892	81267	RAND
83892	81215	RAND	83892	81268	RAND
83892	81216	RAND	83892	81270	RAND
83892	81217	RAND	83892	81275	RAND
83892	81220	RAND	83892	81280	RAND
83892	81221	RAND	83892	81281	RAND
83892	81222	RAND	83892	81282	RAND
83892	81223	RAND	83892	81290	RAND
83892	81224	RAND	83892	81291	RAND
83892	81225	RAND	83892	81292	RAND
83892	81226	RAND	83892	81293	RAND
83892	81227	RAND	83892	81294	RAND
83892	81228	RAND	83892	81295	RAND
83892	81229	RAND	83892	81296	RAND
83892	81235	RAND	83892	81297	RAND
83892	81240	RAND	83892	81298	RAND
83892	81241	RAND	83892	81299	RAND
83892	81242	RAND	83892	81300	RAND
83892	81243	RAND	83892	81301	RAND
83892	81244	RAND	83892	81302	RAND
83892	81245	RAND	83892	81303	RAND
83892	81250	RAND	83892	81304	RAND
83892	81251	RAND	83892	81310	RAND
83892	81252	RAND	83892	81315	RAND
83892	81253	RAND	83892	81316	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
83892	81317	RAND	83892	81405	RAND
83892	81318	RAND	83892	81406	RAND
83892	81319	RAND	83892	81407	RAND
83892	81321	RAND	83892	81408	RAND
83892	81322	RAND	83892	81479	RAND
83892	81323	RAND	83893	81200	RAND
83892	81324	RAND	83893	81201	RAND
83892	81325	RAND	83893	81202	RAND
83892	81326	RAND	83893	81203	RAND
83892	81330	RAND	83893	81205	RAND
83892	81331	RAND	83893	81206	RAND
83892	81332	RAND	83893	81207	RAND
83892	81340	RAND	83893	81208	RAND
83892	81341	RAND	83893	81209	RAND
83892	81342	RAND	83893	81210	RAND
83892	81350	RAND	83893	81211	RAND
83892	81355	RAND	83893	81212	RAND
83892	81370	RAND	83893	81213	RAND
83892	81371	RAND	83893	81214	RAND
83892	81372	RAND	83893	81215	RAND
83892	81373	RAND	83893	81216	RAND
83892	81374	RAND	83893	81217	RAND
83892	81375	RAND	83893	81220	RAND
83892	81376	RAND	83893	81221	RAND
83892	81377	RAND	83893	81222	RAND
83892	81378	RAND	83893	81223	RAND
83892	81379	RAND	83893	81224	RAND
83892	81380	RAND	83893	81225	RAND
83892	81381	RAND	83893	81226	RAND
83892	81382	RAND	83893	81227	RAND
83892	81383	RAND	83893	81228	RAND
83892	81400	RAND	83893	81229	RAND
83892	81401	RAND	83893	81235	RAND
83892	81402	RAND	83893	81240	RAND
83892	81403	RAND	83893	81241	RAND
83892	81404	RAND	83893	81242	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
83893	81243	RAND	83893	81301	RAND
83893	81244	RAND	83893	81302	RAND
83893	81245	RAND	83893	81303	RAND
83893	81250	RAND	83893	81304	RAND
83893	81251	RAND	83893	81310	RAND
83893	81252	RAND	83893	81315	RAND
83893	81253	RAND	83893	81316	RAND
83893	81254	RAND	83893	81317	RAND
83893	81255	RAND	83893	81318	RAND
83893	81256	RAND	83893	81319	RAND
83893	81257	RAND	83893	81321	RAND
83893	81260	RAND	83893	81322	RAND
83893	81261	RAND	83893	81323	RAND
83893	81262	RAND	83893	81324	RAND
83893	81263	RAND	83893	81325	RAND
83893	81264	RAND	83893	81326	RAND
83893	81265	RAND	83893	81330	RAND
83893	81266	RAND	83893	81331	RAND
83893	81267	RAND	83893	81332	RAND
83893	81268	RAND	83893	81340	RAND
83893	81270	RAND	83893	81341	RAND
83893	81275	RAND	83893	81342	RAND
83893	81280	RAND	83893	81350	RAND
83893	81281	RAND	83893	81355	RAND
83893	81282	RAND	83893	81370	RAND
83893	81290	RAND	83893	81371	RAND
83893	81291	RAND	83893	81372	RAND
83893	81292	RAND	83893	81373	RAND
83893	81293	RAND	83893	81374	RAND
83893	81294	RAND	83893	81375	RAND
83893	81295	RAND	83893	81376	RAND
83893	81296	RAND	83893	81377	RAND
83893	81297	RAND	83893	81378	RAND
83893	81298	RAND	83893	81379	RAND
83893	81299	RAND	83893	81380	RAND
83893	81300	RAND	83893	81381	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
83893	81382	RAND	83894	81227	RAND
83893	81383	RAND	83894	81228	RAND
83893	81400	RAND	83894	81229	RAND
83893	81401	RAND	83894	81235	RAND
83893	81402	RAND	83894	81240	RAND
83893	81403	RAND	83894	81241	RAND
83893	81404	RAND	83894	81242	RAND
83893	81405	RAND	83894	81243	RAND
83893	81406	RAND	83894	81244	RAND
83893	81407	RAND	83894	81245	RAND
83893	81408	RAND	83894	81250	RAND
83893	81479	RAND	83894	81251	RAND
83894	81200	RAND	83894	81252	RAND
83894	81201	RAND	83894	81253	RAND
83894	81202	RAND	83894	81254	RAND
83894	81203	RAND	83894	81255	RAND
83894	81205	RAND	83894	81256	RAND
83894	81206	RAND	83894	81257	RAND
83894	81207	RAND	83894	81260	RAND
83894	81208	RAND	83894	81261	RAND
83894	81209	RAND	83894	81262	RAND
83894	81210	RAND	83894	81263	RAND
83894	81211	RAND	83894	81264	RAND
83894	81212	RAND	83894	81265	RAND
83894	81213	RAND	83894	81266	RAND
83894	81214	RAND	83894	81267	RAND
83894	81215	RAND	83894	81268	RAND
83894	81216	RAND	83894	81270	RAND
83894	81217	RAND	83894	81275	RAND
83894	81220	RAND	83894	81280	RAND
83894	81221	RAND	83894	81281	RAND
83894	81222	RAND	83894	81282	RAND
83894	81223	RAND	83894	81290	RAND
83894	81224	RAND	83894	81291	RAND
83894	81225	RAND	83894	81292	RAND
83894	81226	RAND	83894	81293	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
83894	81294	RAND	83894	81375	RAND
83894	81295	RAND	83894	81376	RAND
83894	81296	RAND	83894	81377	RAND
83894	81297	RAND	83894	81378	RAND
83894	81298	RAND	83894	81379	RAND
83894	81299	RAND	83894	81380	RAND
83894	81300	RAND	83894	81381	RAND
83894	81301	RAND	83894	81382	RAND
83894	81302	RAND	83894	81383	RAND
83894	81303	RAND	83894	81400	RAND
83894	81304	RAND	83894	81401	RAND
83894	81310	RAND	83894	81402	RAND
83894	81315	RAND	83894	81403	RAND
83894	81316	RAND	83894	81404	RAND
83894	81317	RAND	83894	81405	RAND
83894	81318	RAND	83894	81406	RAND
83894	81319	RAND	83894	81407	RAND
83894	81321	RAND	83894	81408	RAND
83894	81322	RAND	83894	81479	RAND
83894	81323	RAND	83896	81200	RAND
83894	81324	RAND	83896	81201	RAND
83894	81325	RAND	83896	81202	RAND
83894	81326	RAND	83896	81203	RAND
83894	81330	RAND	83896	81205	RAND
83894	81331	RAND	83896	81206	RAND
83894	81332	RAND	83896	81207	RAND
83894	81340	RAND	83896	81208	RAND
83894	81341	RAND	83896	81209	RAND
83894	81342	RAND	83896	81210	RAND
83894	81350	RAND	83896	81211	RAND
83894	81355	RAND	83896	81212	RAND
83894	81370	RAND	83896	81213	RAND
83894	81371	RAND	83896	81214	RAND
83894	81372	RAND	83896	81215	RAND
83894	81373	RAND	83896	81216	RAND
83894	81374	RAND	83896	81217	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
83896	81220	RAND	83896	81280	RAND
83896	81221	RAND	83896	81281	RAND
83896	81222	RAND	83896	81282	RAND
83896	81223	RAND	83896	81290	RAND
83896	81224	RAND	83896	81291	RAND
83896	81225	RAND	83896	81292	RAND
83896	81226	RAND	83896	81293	RAND
83896	81227	RAND	83896	81294	RAND
83896	81228	RAND	83896	81295	RAND
83896	81229	RAND	83896	81296	RAND
83896	81235	RAND	83896	81297	RAND
83896	81240	RAND	83896	81298	RAND
83896	81241	RAND	83896	81299	RAND
83896	81242	RAND	83896	81300	RAND
83896	81243	RAND	83896	81301	RAND
83896	81244	RAND	83896	81302	RAND
83896	81245	RAND	83896	81303	RAND
83896	81250	RAND	83896	81304	RAND
83896	81251	RAND	83896	81310	RAND
83896	81252	RAND	83896	81315	RAND
83896	81253	RAND	83896	81316	RAND
83896	81254	RAND	83896	81317	RAND
83896	81255	RAND	83896	81318	RAND
83896	81256	RAND	83896	81319	RAND
83896	81257	RAND	83896	81321	RAND
83896	81260	RAND	83896	81322	RAND
83896	81261	RAND	83896	81323	RAND
83896	81262	RAND	83896	81324	RAND
83896	81263	RAND	83896	81325	RAND
83896	81264	RAND	83896	81326	RAND
83896	81265	RAND	83896	81330	RAND
83896	81266	RAND	83896	81331	RAND
83896	81267	RAND	83896	81332	RAND
83896	81268	RAND	83896	81340	RAND
83896	81270	RAND	83896	81341	RAND
83896	81275	RAND	83896	81342	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
83896	81350	RAND	83897	81211	RAND
83896	81355	RAND	83897	81212	RAND
83896	81370	RAND	83897	81213	RAND
83896	81371	RAND	83897	81214	RAND
83896	81372	RAND	83897	81215	RAND
83896	81373	RAND	83897	81216	RAND
83896	81374	RAND	83897	81217	RAND
83896	81375	RAND	83897	81220	RAND
83896	81376	RAND	83897	81221	RAND
83896	81377	RAND	83897	81222	RAND
83896	81378	RAND	83897	81223	RAND
83896	81379	RAND	83897	81224	RAND
83896	81380	RAND	83897	81225	RAND
83896	81381	RAND	83897	81226	RAND
83896	81382	RAND	83897	81227	RAND
83896	81383	RAND	83897	81228	RAND
83896	81400	RAND	83897	81229	RAND
83896	81401	RAND	83897	81235	RAND
83896	81402	RAND	83897	81240	RAND
83896	81403	RAND	83897	81241	RAND
83896	81404	RAND	83897	81242	RAND
83896	81405	RAND	83897	81243	RAND
83896	81406	RAND	83897	81244	RAND
83896	81407	RAND	83897	81245	RAND
83896	81408	RAND	83897	81250	RAND
83896	81479	RAND	83897	81251	RAND
83897	81200	RAND	83897	81252	RAND
83897	81201	RAND	83897	81253	RAND
83897	81202	RAND	83897	81254	RAND
83897	81203	RAND	83897	81255	RAND
83897	81205	RAND	83897	81256	RAND
83897	81206	RAND	83897	81257	RAND
83897	81207	RAND	83897	81260	RAND
83897	81208	RAND	83897	81261	RAND
83897	81209	RAND	83897	81262	RAND
83897	81210	RAND	83897	81263	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
83897	81264	RAND	83897	81326	RAND
83897	81265	RAND	83897	81330	RAND
83897	81266	RAND	83897	81331	RAND
83897	81267	RAND	83897	81332	RAND
83897	81268	RAND	83897	81340	RAND
83897	81270	RAND	83897	81341	RAND
83897	81275	RAND	83897	81342	RAND
83897	81280	RAND	83897	81350	RAND
83897	81281	RAND	83897	81355	RAND
83897	81282	RAND	83897	81370	RAND
83897	81290	RAND	83897	81371	RAND
83897	81291	RAND	83897	81372	RAND
83897	81292	RAND	83897	81373	RAND
83897	81293	RAND	83897	81374	RAND
83897	81294	RAND	83897	81375	RAND
83897	81295	RAND	83897	81376	RAND
83897	81296	RAND	83897	81377	RAND
83897	81297	RAND	83897	81378	RAND
83897	81298	RAND	83897	81379	RAND
83897	81299	RAND	83897	81380	RAND
83897	81300	RAND	83897	81381	RAND
83897	81301	RAND	83897	81382	RAND
83897	81302	RAND	83897	81383	RAND
83897	81303	RAND	83897	81400	RAND
83897	81304	RAND	83897	81401	RAND
83897	81310	RAND	83897	81402	RAND
83897	81315	RAND	83897	81403	RAND
83897	81316	RAND	83897	81404	RAND
83897	81317	RAND	83897	81405	RAND
83897	81318	RAND	83897	81406	RAND
83897	81319	RAND	83897	81407	RAND
83897	81321	RAND	83897	81408	RAND
83897	81322	RAND	83897	81479	RAND
83897	81323	RAND	83898	81200	RAND
83897	81324	RAND	83898	81201	RAND
83897	81325	RAND	83898	81202	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
83898	81203	RAND	83898	81255	RAND
83898	81205	RAND	83898	81256	RAND
83898	81206	RAND	83898	81257	RAND
83898	81207	RAND	83898	81260	RAND
83898	81208	RAND	83898	81261	RAND
83898	81209	RAND	83898	81262	RAND
83898	81210	RAND	83898	81263	RAND
83898	81211	RAND	83898	81264	RAND
83898	81212	RAND	83898	81265	RAND
83898	81213	RAND	83898	81266	RAND
83898	81214	RAND	83898	81267	RAND
83898	81215	RAND	83898	81268	RAND
83898	81216	RAND	83898	81270	RAND
83898	81217	RAND	83898	81275	RAND
83898	81220	RAND	83898	81280	RAND
83898	81221	RAND	83898	81281	RAND
83898	81222	RAND	83898	81282	RAND
83898	81223	RAND	83898	81290	RAND
83898	81224	RAND	83898	81291	RAND
83898	81225	RAND	83898	81292	RAND
83898	81226	RAND	83898	81293	RAND
83898	81227	RAND	83898	81294	RAND
83898	81228	RAND	83898	81295	RAND
83898	81229	RAND	83898	81296	RAND
83898	81235	RAND	83898	81297	RAND
83898	81240	RAND	83898	81298	RAND
83898	81241	RAND	83898	81299	RAND
83898	81242	RAND	83898	81300	RAND
83898	81243	RAND	83898	81301	RAND
83898	81244	RAND	83898	81302	RAND
83898	81245	RAND	83898	81303	RAND
83898	81250	RAND	83898	81304	RAND
83898	81251	RAND	83898	81310	RAND
83898	81252	RAND	83898	81315	RAND
83898	81253	RAND	83898	81316	RAND
83898	81254	RAND	83898	81317	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
83898	81318	RAND	83898	81406	RAND
83898	81319	RAND	83898	81407	RAND
83898	81321	RAND	83898	81408	RAND
83898	81322	RAND	83898	81479	RAND
83898	81323	RAND	83900	81200	RAND
83898	81324	RAND	83900	81201	RAND
83898	81325	RAND	83900	81202	RAND
83898	81326	RAND	83900	81203	RAND
83898	81330	RAND	83900	81205	RAND
83898	81331	RAND	83900	81206	RAND
83898	81332	RAND	83900	81207	RAND
83898	81340	RAND	83900	81208	RAND
83898	81341	RAND	83900	81209	RAND
83898	81342	RAND	83900	81210	RAND
83898	81350	RAND	83900	81211	RAND
83898	81355	RAND	83900	81212	RAND
83898	81370	RAND	83900	81213	RAND
83898	81371	RAND	83900	81214	RAND
83898	81372	RAND	83900	81215	RAND
83898	81373	RAND	83900	81216	RAND
83898	81374	RAND	83900	81217	RAND
83898	81375	RAND	83900	81220	RAND
83898	81376	RAND	83900	81221	RAND
83898	81377	RAND	83900	81222	RAND
83898	81378	RAND	83900	81223	RAND
83898	81379	RAND	83900	81224	RAND
83898	81380	RAND	83900	81225	RAND
83898	81381	RAND	83900	81226	RAND
83898	81382	RAND	83900	81227	RAND
83898	81383	RAND	83900	81228	RAND
83898	81400	RAND	83900	81229	RAND
83898	81401	RAND	83900	81235	RAND
83898	81402	RAND	83900	81240	RAND
83898	81403	RAND	83900	81241	RAND
83898	81404	RAND	83900	81242	RAND
83898	81405	RAND	83900	81243	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
83900	81244	RAND	83900	81302	RAND
83900	81245	RAND	83900	81303	RAND
83900	81250	RAND	83900	81304	RAND
83900	81251	RAND	83900	81310	RAND
83900	81252	RAND	83900	81315	RAND
83900	81253	RAND	83900	81316	RAND
83900	81254	RAND	83900	81317	RAND
83900	81255	RAND	83900	81318	RAND
83900	81256	RAND	83900	81319	RAND
83900	81257	RAND	83900	81321	RAND
83900	81260	RAND	83900	81322	RAND
83900	81261	RAND	83900	81323	RAND
83900	81262	RAND	83900	81324	RAND
83900	81263	RAND	83900	81325	RAND
83900	81264	RAND	83900	81326	RAND
83900	81265	RAND	83900	81330	RAND
83900	81266	RAND	83900	81331	RAND
83900	81267	RAND	83900	81332	RAND
83900	81268	RAND	83900	81340	RAND
83900	81270	RAND	83900	81341	RAND
83900	81275	RAND	83900	81342	RAND
83900	81280	RAND	83900	81350	RAND
83900	81281	RAND	83900	81355	RAND
83900	81282	RAND	83900	81370	RAND
83900	81290	RAND	83900	81371	RAND
83900	81291	RAND	83900	81372	RAND
83900	81292	RAND	83900	81373	RAND
83900	81293	RAND	83900	81374	RAND
83900	81294	RAND	83900	81375	RAND
83900	81295	RAND	83900	81376	RAND
83900	81296	RAND	83900	81377	RAND
83900	81297	RAND	83900	81378	RAND
83900	81298	RAND	83900	81379	RAND
83900	81299	RAND	83900	81380	RAND
83900	81300	RAND	83900	81381	RAND
83900	81301	RAND	83900	81382	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
83900	81383	RAND	83901	81228	RAND
83900	81400	RAND	83901	81229	RAND
83900	81401	RAND	83901	81235	RAND
83900	81402	RAND	83901	81240	RAND
83900	81403	RAND	83901	81241	RAND
83900	81404	RAND	83901	81242	RAND
83900	81405	RAND	83901	81243	RAND
83900	81406	RAND	83901	81244	RAND
83900	81407	RAND	83901	81245	RAND
83900	81408	RAND	83901	81250	RAND
83900	81479	RAND	83901	81251	RAND
83901	81200	RAND	83901	81252	RAND
83901	81201	RAND	83901	81253	RAND
83901	81202	RAND	83901	81254	RAND
83901	81203	RAND	83901	81255	RAND
83901	81205	RAND	83901	81256	RAND
83901	81206	RAND	83901	81257	RAND
83901	81207	RAND	83901	81260	RAND
83901	81208	RAND	83901	81261	RAND
83901	81209	RAND	83901	81262	RAND
83901	81210	RAND	83901	81263	RAND
83901	81211	RAND	83901	81264	RAND
83901	81212	RAND	83901	81265	RAND
83901	81213	RAND	83901	81266	RAND
83901	81214	RAND	83901	81267	RAND
83901	81215	RAND	83901	81268	RAND
83901	81216	RAND	83901	81270	RAND
83901	81217	RAND	83901	81275	RAND
83901	81220	RAND	83901	81280	RAND
83901	81221	RAND	83901	81281	RAND
83901	81222	RAND	83901	81282	RAND
83901	81223	RAND	83901	81290	RAND
83901	81224	RAND	83901	81291	RAND
83901	81225	RAND	83901	81292	RAND
83901	81226	RAND	83901	81293	RAND
83901	81227	RAND	83901	81294	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
83901	81295	RAND	83901	81376	RAND
83901	81296	RAND	83901	81377	RAND
83901	81297	RAND	83901	81378	RAND
83901	81298	RAND	83901	81379	RAND
83901	81299	RAND	83901	81380	RAND
83901	81300	RAND	83901	81381	RAND
83901	81301	RAND	83901	81382	RAND
83901	81302	RAND	83901	81383	RAND
83901	81303	RAND	83901	81400	RAND
83901	81304	RAND	83901	81401	RAND
83901	81310	RAND	83901	81402	RAND
83901	81315	RAND	83901	81403	RAND
83901	81316	RAND	83901	81404	RAND
83901	81317	RAND	83901	81405	RAND
83901	81318	RAND	83901	81406	RAND
83901	81319	RAND	83901	81407	RAND
83901	81321	RAND	83901	81408	RAND
83901	81322	RAND	83901	81479	RAND
83901	81323	RAND	83902	81200	RAND
83901	81324	RAND	83902	81201	RAND
83901	81325	RAND	83902	81202	RAND
83901	81326	RAND	83902	81203	RAND
83901	81330	RAND	83902	81205	RAND
83901	81331	RAND	83902	81206	RAND
83901	81332	RAND	83902	81207	RAND
83901	81340	RAND	83902	81208	RAND
83901	81341	RAND	83902	81209	RAND
83901	81342	RAND	83902	81210	RAND
83901	81350	RAND	83902	81211	RAND
83901	81355	RAND	83902	81212	RAND
83901	81370	RAND	83902	81213	RAND
83901	81371	RAND	83902	81214	RAND
83901	81372	RAND	83902	81215	RAND
83901	81373	RAND	83902	81216	RAND
83901	81374	RAND	83902	81217	RAND
83901	81375	RAND	83902	81220	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
83902	81221	RAND	83902	81281	RAND
83902	81222	RAND	83902	81282	RAND
83902	81223	RAND	83902	81290	RAND
83902	81224	RAND	83902	81291	RAND
83902	81225	RAND	83902	81292	RAND
83902	81226	RAND	83902	81293	RAND
83902	81227	RAND	83902	81294	RAND
83902	81228	RAND	83902	81295	RAND
83902	81229	RAND	83902	81296	RAND
83902	81235	RAND	83902	81297	RAND
83902	81240	RAND	83902	81298	RAND
83902	81241	RAND	83902	81299	RAND
83902	81242	RAND	83902	81300	RAND
83902	81243	RAND	83902	81301	RAND
83902	81244	RAND	83902	81302	RAND
83902	81245	RAND	83902	81303	RAND
83902	81250	RAND	83902	81304	RAND
83902	81251	RAND	83902	81310	RAND
83902	81252	RAND	83902	81315	RAND
83902	81253	RAND	83902	81316	RAND
83902	81254	RAND	83902	81317	RAND
83902	81255	RAND	83902	81318	RAND
83902	81256	RAND	83902	81319	RAND
83902	81257	RAND	83902	81321	RAND
83902	81260	RAND	83902	81322	RAND
83902	81261	RAND	83902	81323	RAND
83902	81262	RAND	83902	81324	RAND
83902	81263	RAND	83902	81325	RAND
83902	81264	RAND	83902	81326	RAND
83902	81265	RAND	83902	81330	RAND
83902	81266	RAND	83902	81331	RAND
83902	81267	RAND	83902	81332	RAND
83902	81268	RAND	83902	81340	RAND
83902	81270	RAND	83902	81341	RAND
83902	81275	RAND	83902	81342	RAND
83902	81280	RAND	83902	81350	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
83902	81355	RAND	83903	81212	RAND
83902	81370	RAND	83903	81213	RAND
83902	81371	RAND	83903	81214	RAND
83902	81372	RAND	83903	81215	RAND
83902	81373	RAND	83903	81216	RAND
83902	81374	RAND	83903	81217	RAND
83902	81375	RAND	83903	81220	RAND
83902	81376	RAND	83903	81221	RAND
83902	81377	RAND	83903	81222	RAND
83902	81378	RAND	83903	81223	RAND
83902	81379	RAND	83903	81224	RAND
83902	81380	RAND	83903	81225	RAND
83902	81381	RAND	83903	81226	RAND
83902	81382	RAND	83903	81227	RAND
83902	81383	RAND	83903	81228	RAND
83902	81400	RAND	83903	81229	RAND
83902	81401	RAND	83903	81235	RAND
83902	81402	RAND	83903	81240	RAND
83902	81403	RAND	83903	81241	RAND
83902	81404	RAND	83903	81242	RAND
83902	81405	RAND	83903	81243	RAND
83902	81406	RAND	83903	81244	RAND
83902	81407	RAND	83903	81245	RAND
83902	81408	RAND	83903	81250	RAND
83902	81479	RAND	83903	81251	RAND
83903	81200	RAND	83903	81252	RAND
83903	81201	RAND	83903	81253	RAND
83903	81202	RAND	83903	81254	RAND
83903	81203	RAND	83903	81255	RAND
83903	81205	RAND	83903	81256	RAND
83903	81206	RAND	83903	81257	RAND
83903	81207	RAND	83903	81260	RAND
83903	81208	RAND	83903	81261	RAND
83903	81209	RAND	83903	81262	RAND
83903	81210	RAND	83903	81263	RAND
83903	81211	RAND	83903	81264	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
83903	81265	RAND	83903	81330	RAND
83903	81266	RAND	83903	81331	RAND
83903	81267	RAND	83903	81332	RAND
83903	81268	RAND	83903	81340	RAND
83903	81270	RAND	83903	81341	RAND
83903	81275	RAND	83903	81342	RAND
83903	81280	RAND	83903	81350	RAND
83903	81281	RAND	83903	81355	RAND
83903	81282	RAND	83903	81370	RAND
83903	81290	RAND	83903	81371	RAND
83903	81291	RAND	83903	81372	RAND
83903	81292	RAND	83903	81373	RAND
83903	81293	RAND	83903	81374	RAND
83903	81294	RAND	83903	81375	RAND
83903	81295	RAND	83903	81376	RAND
83903	81296	RAND	83903	81377	RAND
83903	81297	RAND	83903	81378	RAND
83903	81298	RAND	83903	81379	RAND
83903	81299	RAND	83903	81380	RAND
83903	81300	RAND	83903	81381	RAND
83903	81301	RAND	83903	81382	RAND
83903	81302	RAND	83903	81383	RAND
83903	81303	RAND	83903	81400	RAND
83903	81304	RAND	83903	81401	RAND
83903	81310	RAND	83903	81402	RAND
83903	81315	RAND	83903	81403	RAND
83903	81316	RAND	83903	81404	RAND
83903	81317	RAND	83903	81405	RAND
83903	81318	RAND	83903	81406	RAND
83903	81319	RAND	83903	81407	RAND
83903	81321	RAND	83903	81408	RAND
83903	81322	RAND	83903	81479	RAND
83903	81323	RAND	83904	81200	RAND
83903	81324	RAND	83904	81201	RAND
83903	81325	RAND	83904	81202	RAND
83903	81326	RAND	83904	81203	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
83904	81205	RAND	83904	81256	RAND
83904	81206	RAND	83904	81257	RAND
83904	81207	RAND	83904	81260	RAND
83904	81208	RAND	83904	81261	RAND
83904	81209	RAND	83904	81262	RAND
83904	81210	RAND	83904	81263	RAND
83904	81211	RAND	83904	81264	RAND
83904	81212	RAND	83904	81265	RAND
83904	81213	RAND	83904	81266	RAND
83904	81214	RAND	83904	81267	RAND
83904	81215	RAND	83904	81268	RAND
83904	81216	RAND	83904	81270	RAND
83904	81217	RAND	83904	81275	RAND
83904	81220	RAND	83904	81280	RAND
83904	81221	RAND	83904	81281	RAND
83904	81222	RAND	83904	81282	RAND
83904	81223	RAND	83904	81290	RAND
83904	81224	RAND	83904	81291	RAND
83904	81225	RAND	83904	81292	RAND
83904	81226	RAND	83904	81293	RAND
83904	81227	RAND	83904	81294	RAND
83904	81228	RAND	83904	81295	RAND
83904	81229	RAND	83904	81296	RAND
83904	81235	RAND	83904	81297	RAND
83904	81240	RAND	83904	81298	RAND
83904	81241	RAND	83904	81299	RAND
83904	81242	RAND	83904	81300	RAND
83904	81243	RAND	83904	81301	RAND
83904	81244	RAND	83904	81302	RAND
83904	81245	RAND	83904	81303	RAND
83904	81250	RAND	83904	81304	RAND
83904	81251	RAND	83904	81310	RAND
83904	81252	RAND	83904	81315	RAND
83904	81253	RAND	83904	81316	RAND
83904	81254	RAND	83904	81317	RAND
83904	81255	RAND	83904	81318	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
83904	81319	RAND	83904	81407	RAND
83904	81321	RAND	83904	81408	RAND
83904	81322	RAND	83904	81479	RAND
83904	81323	RAND	83905	81200	RAND
83904	81324	RAND	83905	81201	RAND
83904	81325	RAND	83905	81202	RAND
83904	81326	RAND	83905	81203	RAND
83904	81330	RAND	83905	81205	RAND
83904	81331	RAND	83905	81206	RAND
83904	81332	RAND	83905	81207	RAND
83904	81340	RAND	83905	81208	RAND
83904	81341	RAND	83905	81209	RAND
83904	81342	RAND	83905	81210	RAND
83904	81350	RAND	83905	81211	RAND
83904	81355	RAND	83905	81212	RAND
83904	81370	RAND	83905	81213	RAND
83904	81371	RAND	83905	81214	RAND
83904	81372	RAND	83905	81215	RAND
83904	81373	RAND	83905	81216	RAND
83904	81374	RAND	83905	81217	RAND
83904	81375	RAND	83905	81220	RAND
83904	81376	RAND	83905	81221	RAND
83904	81377	RAND	83905	81222	RAND
83904	81378	RAND	83905	81223	RAND
83904	81379	RAND	83905	81224	RAND
83904	81380	RAND	83905	81225	RAND
83904	81381	RAND	83905	81226	RAND
83904	81382	RAND	83905	81227	RAND
83904	81383	RAND	83905	81228	RAND
83904	81400	RAND	83905	81229	RAND
83904	81401	RAND	83905	81235	RAND
83904	81402	RAND	83905	81240	RAND
83904	81403	RAND	83905	81241	RAND
83904	81404	RAND	83905	81242	RAND
83904	81405	RAND	83905	81243	RAND
83904	81406	RAND	83905	81244	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
83905	81245	RAND	83905	81303	RAND
83905	81250	RAND	83905	81304	RAND
83905	81251	RAND	83905	81310	RAND
83905	81252	RAND	83905	81315	RAND
83905	81253	RAND	83905	81316	RAND
83905	81254	RAND	83905	81317	RAND
83905	81255	RAND	83905	81318	RAND
83905	81256	RAND	83905	81319	RAND
83905	81257	RAND	83905	81321	RAND
83905	81260	RAND	83905	81322	RAND
83905	81261	RAND	83905	81323	RAND
83905	81262	RAND	83905	81324	RAND
83905	81263	RAND	83905	81325	RAND
83905	81264	RAND	83905	81326	RAND
83905	81265	RAND	83905	81330	RAND
83905	81266	RAND	83905	81331	RAND
83905	81267	RAND	83905	81332	RAND
83905	81268	RAND	83905	81340	RAND
83905	81270	RAND	83905	81341	RAND
83905	81275	RAND	83905	81342	RAND
83905	81280	RAND	83905	81350	RAND
83905	81281	RAND	83905	81355	RAND
83905	81282	RAND	83905	81370	RAND
83905	81290	RAND	83905	81371	RAND
83905	81291	RAND	83905	81372	RAND
83905	81292	RAND	83905	81373	RAND
83905	81293	RAND	83905	81374	RAND
83905	81294	RAND	83905	81375	RAND
83905	81295	RAND	83905	81376	RAND
83905	81296	RAND	83905	81377	RAND
83905	81297	RAND	83905	81378	RAND
83905	81298	RAND	83905	81379	RAND
83905	81299	RAND	83905	81380	RAND
83905	81300	RAND	83905	81381	RAND
83905	81301	RAND	83905	81382	RAND
83905	81302	RAND	83905	81383	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
83905	81400	RAND	83906	81229	RAND
83905	81401	RAND	83906	81235	RAND
83905	81402	RAND	83906	81240	RAND
83905	81403	RAND	83906	81241	RAND
83905	81404	RAND	83906	81242	RAND
83905	81405	RAND	83906	81243	RAND
83905	81406	RAND	83906	81244	RAND
83905	81407	RAND	83906	81245	RAND
83905	81408	RAND	83906	81250	RAND
83905	81479	RAND	83906	81251	RAND
83906	81200	RAND	83906	81252	RAND
83906	81201	RAND	83906	81253	RAND
83906	81202	RAND	83906	81254	RAND
83906	81203	RAND	83906	81255	RAND
83906	81205	RAND	83906	81256	RAND
83906	81206	RAND	83906	81257	RAND
83906	81207	RAND	83906	81260	RAND
83906	81208	RAND	83906	81261	RAND
83906	81209	RAND	83906	81262	RAND
83906	81210	RAND	83906	81263	RAND
83906	81211	RAND	83906	81264	RAND
83906	81212	RAND	83906	81265	RAND
83906	81213	RAND	83906	81266	RAND
83906	81214	RAND	83906	81267	RAND
83906	81215	RAND	83906	81268	RAND
83906	81216	RAND	83906	81270	RAND
83906	81217	RAND	83906	81275	RAND
83906	81220	RAND	83906	81280	RAND
83906	81221	RAND	83906	81281	RAND
83906	81222	RAND	83906	81282	RAND
83906	81223	RAND	83906	81290	RAND
83906	81224	RAND	83906	81291	RAND
83906	81225	RAND	83906	81292	RAND
83906	81226	RAND	83906	81293	RAND
83906	81227	RAND	83906	81294	RAND
83906	81228	RAND	83906	81295	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
83906	81296	RAND	83906	81377	RAND
83906	81297	RAND	83906	81378	RAND
83906	81298	RAND	83906	81379	RAND
83906	81299	RAND	83906	81380	RAND
83906	81300	RAND	83906	81381	RAND
83906	81301	RAND	83906	81382	RAND
83906	81302	RAND	83906	81383	RAND
83906	81303	RAND	83906	81400	RAND
83906	81304	RAND	83906	81401	RAND
83906	81310	RAND	83906	81402	RAND
83906	81315	RAND	83906	81403	RAND
83906	81316	RAND	83906	81404	RAND
83906	81317	RAND	83906	81405	RAND
83906	81318	RAND	83906	81406	RAND
83906	81319	RAND	83906	81407	RAND
83906	81321	RAND	83906	81408	RAND
83906	81322	RAND	83906	81479	RAND
83906	81323	RAND	83907	81200	RAND
83906	81324	RAND	83907	81201	RAND
83906	81325	RAND	83907	81202	RAND
83906	81326	RAND	83907	81203	RAND
83906	81330	RAND	83907	81205	RAND
83906	81331	RAND	83907	81206	RAND
83906	81332	RAND	83907	81207	RAND
83906	81340	RAND	83907	81208	RAND
83906	81341	RAND	83907	81209	RAND
83906	81342	RAND	83907	81210	RAND
83906	81350	RAND	83907	81211	RAND
83906	81355	RAND	83907	81212	RAND
83906	81370	RAND	83907	81213	RAND
83906	81371	RAND	83907	81214	RAND
83906	81372	RAND	83907	81215	RAND
83906	81373	RAND	83907	81216	RAND
83906	81374	RAND	83907	81217	RAND
83906	81375	RAND	83907	81220	RAND
83906	81376	RAND	83907	81221	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
83907	81222	RAND	83907	81282	RAND
83907	81223	RAND	83907	81290	RAND
83907	81224	RAND	83907	81291	RAND
83907	81225	RAND	83907	81292	RAND
83907	81226	RAND	83907	81293	RAND
83907	81227	RAND	83907	81294	RAND
83907	81228	RAND	83907	81295	RAND
83907	81229	RAND	83907	81296	RAND
83907	81235	RAND	83907	81297	RAND
83907	81240	RAND	83907	81298	RAND
83907	81241	RAND	83907	81299	RAND
83907	81242	RAND	83907	81300	RAND
83907	81243	RAND	83907	81301	RAND
83907	81244	RAND	83907	81302	RAND
83907	81245	RAND	83907	81303	RAND
83907	81250	RAND	83907	81304	RAND
83907	81251	RAND	83907	81310	RAND
83907	81252	RAND	83907	81315	RAND
83907	81253	RAND	83907	81316	RAND
83907	81254	RAND	83907	81317	RAND
83907	81255	RAND	83907	81318	RAND
83907	81256	RAND	83907	81319	RAND
83907	81257	RAND	83907	81321	RAND
83907	81260	RAND	83907	81322	RAND
83907	81261	RAND	83907	81323	RAND
83907	81262	RAND	83907	81324	RAND
83907	81263	RAND	83907	81325	RAND
83907	81264	RAND	83907	81326	RAND
83907	81265	RAND	83907	81330	RAND
83907	81266	RAND	83907	81331	RAND
83907	81267	RAND	83907	81332	RAND
83907	81268	RAND	83907	81340	RAND
83907	81270	RAND	83907	81341	RAND
83907	81275	RAND	83907	81342	RAND
83907	81280	RAND	83907	81350	RAND
83907	81281	RAND	83907	81355	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
83907	81370	RAND	83908	81213	RAND
83907	81371	RAND	83908	81214	RAND
83907	81372	RAND	83908	81215	RAND
83907	81373	RAND	83908	81216	RAND
83907	81374	RAND	83908	81217	RAND
83907	81375	RAND	83908	81220	RAND
83907	81376	RAND	83908	81221	RAND
83907	81377	RAND	83908	81222	RAND
83907	81378	RAND	83908	81223	RAND
83907	81379	RAND	83908	81224	RAND
83907	81380	RAND	83908	81225	RAND
83907	81381	RAND	83908	81226	RAND
83907	81382	RAND	83908	81227	RAND
83907	81383	RAND	83908	81228	RAND
83907	81400	RAND	83908	81229	RAND
83907	81401	RAND	83908	81235	RAND
83907	81402	RAND	83908	81240	RAND
83907	81403	RAND	83908	81241	RAND
83907	81404	RAND	83908	81242	RAND
83907	81405	RAND	83908	81243	RAND
83907	81406	RAND	83908	81244	RAND
83907	81407	RAND	83908	81245	RAND
83907	81408	RAND	83908	81250	RAND
83907	81479	RAND	83908	81251	RAND
83908	81200	RAND	83908	81252	RAND
83908	81201	RAND	83908	81253	RAND
83908	81202	RAND	83908	81254	RAND
83908	81203	RAND	83908	81255	RAND
83908	81205	RAND	83908	81256	RAND
83908	81206	RAND	83908	81257	RAND
83908	81207	RAND	83908	81260	RAND
83908	81208	RAND	83908	81261	RAND
83908	81209	RAND	83908	81262	RAND
83908	81210	RAND	83908	81263	RAND
83908	81211	RAND	83908	81264	RAND
83908	81212	RAND	83908	81265	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
83908	81266	RAND	83908	81331	RAND
83908	81267	RAND	83908	81332	RAND
83908	81268	RAND	83908	81340	RAND
83908	81270	RAND	83908	81341	RAND
83908	81275	RAND	83908	81342	RAND
83908	81280	RAND	83908	81350	RAND
83908	81281	RAND	83908	81355	RAND
83908	81282	RAND	83908	81370	RAND
83908	81290	RAND	83908	81371	RAND
83908	81291	RAND	83908	81372	RAND
83908	81292	RAND	83908	81373	RAND
83908	81293	RAND	83908	81374	RAND
83908	81294	RAND	83908	81375	RAND
83908	81295	RAND	83908	81376	RAND
83908	81296	RAND	83908	81377	RAND
83908	81297	RAND	83908	81378	RAND
83908	81298	RAND	83908	81379	RAND
83908	81299	RAND	83908	81380	RAND
83908	81300	RAND	83908	81381	RAND
83908	81301	RAND	83908	81382	RAND
83908	81302	RAND	83908	81383	RAND
83908	81303	RAND	83908	81400	RAND
83908	81304	RAND	83908	81401	RAND
83908	81310	RAND	83908	81402	RAND
83908	81315	RAND	83908	81403	RAND
83908	81316	RAND	83908	81404	RAND
83908	81317	RAND	83908	81405	RAND
83908	81318	RAND	83908	81406	RAND
83908	81319	RAND	83908	81407	RAND
83908	81321	RAND	83908	81408	RAND
83908	81322	RAND	83908	81479	RAND
83908	81323	RAND	83909	81200	RAND
83908	81324	RAND	83909	81201	RAND
83908	81325	RAND	83909	81202	RAND
83908	81326	RAND	83909	81203	RAND
83908	81330	RAND	83909	81205	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
83909	81206	RAND	83909	81257	RAND
83909	81207	RAND	83909	81260	RAND
83909	81208	RAND	83909	81261	RAND
83909	81209	RAND	83909	81262	RAND
83909	81210	RAND	83909	81263	RAND
83909	81211	RAND	83909	81264	RAND
83909	81212	RAND	83909	81265	RAND
83909	81213	RAND	83909	81266	RAND
83909	81214	RAND	83909	81267	RAND
83909	81215	RAND	83909	81268	RAND
83909	81216	RAND	83909	81270	RAND
83909	81217	RAND	83909	81275	RAND
83909	81220	RAND	83909	81280	RAND
83909	81221	RAND	83909	81281	RAND
83909	81222	RAND	83909	81282	RAND
83909	81223	RAND	83909	81290	RAND
83909	81224	RAND	83909	81291	RAND
83909	81225	RAND	83909	81292	RAND
83909	81226	RAND	83909	81293	RAND
83909	81227	RAND	83909	81294	RAND
83909	81228	RAND	83909	81295	RAND
83909	81229	RAND	83909	81296	RAND
83909	81235	RAND	83909	81297	RAND
83909	81240	RAND	83909	81298	RAND
83909	81241	RAND	83909	81299	RAND
83909	81242	RAND	83909	81300	RAND
83909	81243	RAND	83909	81301	RAND
83909	81244	RAND	83909	81302	RAND
83909	81245	RAND	83909	81303	RAND
83909	81250	RAND	83909	81304	RAND
83909	81251	RAND	83909	81310	RAND
83909	81252	RAND	83909	81315	RAND
83909	81253	RAND	83909	81316	RAND
83909	81254	RAND	83909	81317	RAND
83909	81255	RAND	83909	81318	RAND
83909	81256	RAND	83909	81319	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
83909	81321	RAND	83909	81408	RAND
83909	81322	RAND	83909	81479	RAND
83909	81323	RAND	83912	81200	RAND
83909	81324	RAND	83912	81201	RAND
83909	81325	RAND	83912	81202	RAND
83909	81326	RAND	83912	81203	RAND
83909	81330	RAND	83912	81205	RAND
83909	81331	RAND	83912	81206	RAND
83909	81332	RAND	83912	81207	RAND
83909	81340	RAND	83912	81208	RAND
83909	81341	RAND	83912	81209	RAND
83909	81342	RAND	83912	81210	RAND
83909	81350	RAND	83912	81211	RAND
83909	81355	RAND	83912	81212	RAND
83909	81370	RAND	83912	81213	RAND
83909	81371	RAND	83912	81214	RAND
83909	81372	RAND	83912	81215	RAND
83909	81373	RAND	83912	81216	RAND
83909	81374	RAND	83912	81217	RAND
83909	81375	RAND	83912	81220	RAND
83909	81376	RAND	83912	81221	RAND
83909	81377	RAND	83912	81222	RAND
83909	81378	RAND	83912	81223	RAND
83909	81379	RAND	83912	81224	RAND
83909	81380	RAND	83912	81225	RAND
83909	81381	RAND	83912	81226	RAND
83909	81382	RAND	83912	81227	RAND
83909	81383	RAND	83912	81228	RAND
83909	81400	RAND	83912	81229	RAND
83909	81401	RAND	83912	81235	RAND
83909	81402	RAND	83912	81240	RAND
83909	81403	RAND	83912	81241	RAND
83909	81404	RAND	83912	81242	RAND
83909	81405	RAND	83912	81243	RAND
83909	81406	RAND	83912	81244	RAND
83909	81407	RAND	83912	81245	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
83912	81250	RAND	83912	81304	RAND
83912	81251	RAND	83912	81310	RAND
83912	81252	RAND	83912	81315	RAND
83912	81253	RAND	83912	81316	RAND
83912	81254	RAND	83912	81317	RAND
83912	81255	RAND	83912	81318	RAND
83912	81256	RAND	83912	81319	RAND
83912	81257	RAND	83912	81321	RAND
83912	81260	RAND	83912	81322	RAND
83912	81261	RAND	83912	81323	RAND
83912	81262	RAND	83912	81324	RAND
83912	81263	RAND	83912	81325	RAND
83912	81264	RAND	83912	81326	RAND
83912	81265	RAND	83912	81330	RAND
83912	81266	RAND	83912	81331	RAND
83912	81267	RAND	83912	81332	RAND
83912	81268	RAND	83912	81340	RAND
83912	81270	RAND	83912	81341	RAND
83912	81275	RAND	83912	81342	RAND
83912	81280	RAND	83912	81350	RAND
83912	81281	RAND	83912	81355	RAND
83912	81282	RAND	83912	81370	RAND
83912	81290	RAND	83912	81371	RAND
83912	81291	RAND	83912	81372	RAND
83912	81292	RAND	83912	81373	RAND
83912	81293	RAND	83912	81374	RAND
83912	81294	RAND	83912	81375	RAND
83912	81295	RAND	83912	81376	RAND
83912	81296	RAND	83912	81377	RAND
83912	81297	RAND	83912	81378	RAND
83912	81298	RAND	83912	81379	RAND
83912	81299	RAND	83912	81380	RAND
83912	81300	RAND	83912	81381	RAND
83912	81301	RAND	83912	81382	RAND
83912	81302	RAND	83912	81383	RAND
83912	81303	RAND	83912	81400	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
83912	81401	RAND	83913	81235	RAND
83912	81402	RAND	83913	81240	RAND
83912	81403	RAND	83913	81241	RAND
83912	81404	RAND	83913	81242	RAND
83912	81405	RAND	83913	81243	RAND
83912	81406	RAND	83913	81244	RAND
83912	81407	RAND	83913	81245	RAND
83912	81408	RAND	83913	81250	RAND
83912	81479	RAND	83913	81251	RAND
83913	81200	RAND	83913	81252	RAND
83913	81201	RAND	83913	81253	RAND
83913	81202	RAND	83913	81254	RAND
83913	81203	RAND	83913	81255	RAND
83913	81205	RAND	83913	81256	RAND
83913	81206	RAND	83913	81257	RAND
83913	81207	RAND	83913	81260	RAND
83913	81208	RAND	83913	81261	RAND
83913	81209	RAND	83913	81262	RAND
83913	81210	RAND	83913	81263	RAND
83913	81211	RAND	83913	81264	RAND
83913	81212	RAND	83913	81265	RAND
83913	81213	RAND	83913	81266	RAND
83913	81214	RAND	83913	81267	RAND
83913	81215	RAND	83913	81268	RAND
83913	81216	RAND	83913	81270	RAND
83913	81217	RAND	83913	81275	RAND
83913	81220	RAND	83913	81280	RAND
83913	81221	RAND	83913	81281	RAND
83913	81222	RAND	83913	81282	RAND
83913	81223	RAND	83913	81290	RAND
83913	81224	RAND	83913	81291	RAND
83913	81225	RAND	83913	81292	RAND
83913	81226	RAND	83913	81293	RAND
83913	81227	RAND	83913	81294	RAND
83913	81228	RAND	83913	81295	RAND
83913	81229	RAND	83913	81296	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
83913	81297	RAND	83913	81378	RAND
83913	81298	RAND	83913	81379	RAND
83913	81299	RAND	83913	81380	RAND
83913	81300	RAND	83913	81381	RAND
83913	81301	RAND	83913	81382	RAND
83913	81302	RAND	83913	81383	RAND
83913	81303	RAND	83913	81400	RAND
83913	81304	RAND	83913	81401	RAND
83913	81310	RAND	83913	81402	RAND
83913	81315	RAND	83913	81403	RAND
83913	81316	RAND	83913	81404	RAND
83913	81317	RAND	83913	81405	RAND
83913	81318	RAND	83913	81406	RAND
83913	81319	RAND	83913	81407	RAND
83913	81321	RAND	83913	81408	RAND
83913	81322	RAND	83913	81479	RAND
83913	81323	RAND	83914	81200	RAND
83913	81324	RAND	83914	81201	RAND
83913	81325	RAND	83914	81202	RAND
83913	81326	RAND	83914	81203	RAND
83913	81330	RAND	83914	81205	RAND
83913	81331	RAND	83914	81206	RAND
83913	81332	RAND	83914	81207	RAND
83913	81340	RAND	83914	81208	RAND
83913	81341	RAND	83914	81209	RAND
83913	81342	RAND	83914	81210	RAND
83913	81350	RAND	83914	81211	RAND
83913	81355	RAND	83914	81212	RAND
83913	81370	RAND	83914	81213	RAND
83913	81371	RAND	83914	81214	RAND
83913	81372	RAND	83914	81215	RAND
83913	81373	RAND	83914	81216	RAND
83913	81374	RAND	83914	81217	RAND
83913	81375	RAND	83914	81220	RAND
83913	81376	RAND	83914	81221	RAND
83913	81377	RAND	83914	81222	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
83914	81223	RAND	83914	81290	RAND
83914	81224	RAND	83914	81291	RAND
83914	81225	RAND	83914	81292	RAND
83914	81226	RAND	83914	81293	RAND
83914	81227	RAND	83914	81294	RAND
83914	81228	RAND	83914	81295	RAND
83914	81229	RAND	83914	81296	RAND
83914	81235	RAND	83914	81297	RAND
83914	81240	RAND	83914	81298	RAND
83914	81241	RAND	83914	81299	RAND
83914	81242	RAND	83914	81300	RAND
83914	81243	RAND	83914	81301	RAND
83914	81244	RAND	83914	81302	RAND
83914	81245	RAND	83914	81303	RAND
83914	81250	RAND	83914	81304	RAND
83914	81251	RAND	83914	81310	RAND
83914	81252	RAND	83914	81315	RAND
83914	81253	RAND	83914	81316	RAND
83914	81254	RAND	83914	81317	RAND
83914	81255	RAND	83914	81318	RAND
83914	81256	RAND	83914	81319	RAND
83914	81257	RAND	83914	81321	RAND
83914	81260	RAND	83914	81322	RAND
83914	81261	RAND	83914	81323	RAND
83914	81262	RAND	83914	81324	RAND
83914	81263	RAND	83914	81325	RAND
83914	81264	RAND	83914	81326	RAND
83914	81265	RAND	83914	81330	RAND
83914	81266	RAND	83914	81331	RAND
83914	81267	RAND	83914	81332	RAND
83914	81268	RAND	83914	81340	RAND
83914	81270	RAND	83914	81341	RAND
83914	81275	RAND	83914	81342	RAND
83914	81280	RAND	83914	81350	RAND
83914	81281	RAND	83914	81355	RAND
83914	81282	RAND	83914	81370	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
83914	81371	RAND	88180	88182	Lewin
83914	81372	RAND	88180	88189	Lewin
83914	81373	RAND	88318	88313	RAND
83914	81374	RAND	88384	81200	RAND
83914	81375	RAND	88384	81201	RAND
83914	81376	RAND	88384	81202	RAND
83914	81377	RAND	88384	81203	RAND
83914	81378	RAND	88384	81205	RAND
83914	81379	RAND	88384	81206	RAND
83914	81380	RAND	88384	81207	RAND
83914	81381	RAND	88384	81208	RAND
83914	81382	RAND	88384	81209	RAND
83914	81383	RAND	88384	81210	RAND
83914	81400	RAND	88384	81211	RAND
83914	81401	RAND	88384	81212	RAND
83914	81402	RAND	88384	81213	RAND
83914	81403	RAND	88384	81214	RAND
83914	81404	RAND	88384	81215	RAND
83914	81405	RAND	88384	81216	RAND
83914	81406	RAND	88384	81217	RAND
83914	81407	RAND	88384	81220	RAND
83914	81408	RAND	88384	81221	RAND
83914	81479	RAND	88384	81222	RAND
85095	38220	Lewin	88384	81223	RAND
85102	38221	Lewin	88384	81224	RAND
86586	86356	RAND	88384	81225	RAND
86586	86486	RAND	88384	81226	RAND
86781	86780	RAND	88384	81227	RAND
86903	86902	RAND	88384	81228	RAND
88150	88150	Lewin	88384	81229	RAND
88150	88152	Lewin	88384	81235	RAND
88150	88153	Lewin	88384	81240	RAND
88150	88154	Lewin	88384	81241	RAND
88151	88141	Lewin	88384	81242	RAND
88170	10021	Lewin	88384	81243	RAND
88171	10022	Lewin	88384	81244	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
88384	81245	RAND	88384	81303	RAND
88384	81250	RAND	88384	81304	RAND
88384	81251	RAND	88384	81310	RAND
88384	81252	RAND	88384	81315	RAND
88384	81253	RAND	88384	81316	RAND
88384	81254	RAND	88384	81317	RAND
88384	81255	RAND	88384	81318	RAND
88384	81256	RAND	88384	81319	RAND
88384	81257	RAND	88384	81321	RAND
88384	81260	RAND	88384	81322	RAND
88384	81261	RAND	88384	81323	RAND
88384	81262	RAND	88384	81324	RAND
88384	81263	RAND	88384	81325	RAND
88384	81264	RAND	88384	81326	RAND
88384	81265	RAND	88384	81330	RAND
88384	81266	RAND	88384	81331	RAND
88384	81267	RAND	88384	81332	RAND
88384	81268	RAND	88384	81340	RAND
88384	81270	RAND	88384	81341	RAND
88384	81275	RAND	88384	81342	RAND
88384	81280	RAND	88384	81350	RAND
88384	81281	RAND	88384	81355	RAND
88384	81282	RAND	88384	81370	RAND
88384	81290	RAND	88384	81371	RAND
88384	81291	RAND	88384	81372	RAND
88384	81292	RAND	88384	81373	RAND
88384	81293	RAND	88384	81374	RAND
88384	81294	RAND	88384	81375	RAND
88384	81295	RAND	88384	81376	RAND
88384	81296	RAND	88384	81377	RAND
88384	81297	RAND	88384	81378	RAND
88384	81298	RAND	88384	81379	RAND
88384	81299	RAND	88384	81380	RAND
88384	81300	RAND	88384	81381	RAND
88384	81301	RAND	88384	81382	RAND
88384	81302	RAND	88384	81383	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
88384	81400	RAND	88385	81229	RAND
88384	81401	RAND	88385	81235	RAND
88384	81402	RAND	88385	81240	RAND
88384	81403	RAND	88385	81241	RAND
88384	81404	RAND	88385	81242	RAND
88384	81405	RAND	88385	81243	RAND
88384	81406	RAND	88385	81244	RAND
88384	81407	RAND	88385	81245	RAND
88384	81408	RAND	88385	81250	RAND
88384	81479	RAND	88385	81251	RAND
88385	81200	RAND	88385	81252	RAND
88385	81201	RAND	88385	81253	RAND
88385	81202	RAND	88385	81254	RAND
88385	81203	RAND	88385	81255	RAND
88385	81205	RAND	88385	81256	RAND
88385	81206	RAND	88385	81257	RAND
88385	81207	RAND	88385	81260	RAND
88385	81208	RAND	88385	81261	RAND
88385	81209	RAND	88385	81262	RAND
88385	81210	RAND	88385	81263	RAND
88385	81211	RAND	88385	81264	RAND
88385	81212	RAND	88385	81265	RAND
88385	81213	RAND	88385	81266	RAND
88385	81214	RAND	88385	81267	RAND
88385	81215	RAND	88385	81268	RAND
88385	81216	RAND	88385	81270	RAND
88385	81217	RAND	88385	81275	RAND
88385	81220	RAND	88385	81280	RAND
88385	81221	RAND	88385	81281	RAND
88385	81222	RAND	88385	81282	RAND
88385	81223	RAND	88385	81290	RAND
88385	81224	RAND	88385	81291	RAND
88385	81225	RAND	88385	81292	RAND
88385	81226	RAND	88385	81293	RAND
88385	81227	RAND	88385	81294	RAND
88385	81228	RAND	88385	81295	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
88385	81296	RAND	88385	81377	RAND
88385	81297	RAND	88385	81378	RAND
88385	81298	RAND	88385	81379	RAND
88385	81299	RAND	88385	81380	RAND
88385	81300	RAND	88385	81381	RAND
88385	81301	RAND	88385	81382	RAND
88385	81302	RAND	88385	81383	RAND
88385	81303	RAND	88385	81400	RAND
88385	81304	RAND	88385	81401	RAND
88385	81310	RAND	88385	81402	RAND
88385	81315	RAND	88385	81403	RAND
88385	81316	RAND	88385	81404	RAND
88385	81317	RAND	88385	81405	RAND
88385	81318	RAND	88385	81406	RAND
88385	81319	RAND	88385	81407	RAND
88385	81321	RAND	88385	81408	RAND
88385	81322	RAND	88385	81479	RAND
88385	81323	RAND	88386	81200	RAND
88385	81324	RAND	88386	81201	RAND
88385	81325	RAND	88386	81202	RAND
88385	81326	RAND	88386	81203	RAND
88385	81330	RAND	88386	81205	RAND
88385	81331	RAND	88386	81206	RAND
88385	81332	RAND	88386	81207	RAND
88385	81340	RAND	88386	81208	RAND
88385	81341	RAND	88386	81209	RAND
88385	81342	RAND	88386	81210	RAND
88385	81350	RAND	88386	81211	RAND
88385	81355	RAND	88386	81212	RAND
88385	81370	RAND	88386	81213	RAND
88385	81371	RAND	88386	81214	RAND
88385	81372	RAND	88386	81215	RAND
88385	81373	RAND	88386	81216	RAND
88385	81374	RAND	88386	81217	RAND
88385	81375	RAND	88386	81220	RAND
88385	81376	RAND	88386	81221	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
88386	81222	RAND	88386	81282	RAND
88386	81223	RAND	88386	81290	RAND
88386	81224	RAND	88386	81291	RAND
88386	81225	RAND	88386	81292	RAND
88386	81226	RAND	88386	81293	RAND
88386	81227	RAND	88386	81294	RAND
88386	81228	RAND	88386	81295	RAND
88386	81229	RAND	88386	81296	RAND
88386	81235	RAND	88386	81297	RAND
88386	81240	RAND	88386	81298	RAND
88386	81241	RAND	88386	81299	RAND
88386	81242	RAND	88386	81300	RAND
88386	81243	RAND	88386	81301	RAND
88386	81244	RAND	88386	81302	RAND
88386	81245	RAND	88386	81303	RAND
88386	81250	RAND	88386	81304	RAND
88386	81251	RAND	88386	81310	RAND
88386	81252	RAND	88386	81315	RAND
88386	81253	RAND	88386	81316	RAND
88386	81254	RAND	88386	81317	RAND
88386	81255	RAND	88386	81318	RAND
88386	81256	RAND	88386	81319	RAND
88386	81257	RAND	88386	81321	RAND
88386	81260	RAND	88386	81322	RAND
88386	81261	RAND	88386	81323	RAND
88386	81262	RAND	88386	81324	RAND
88386	81263	RAND	88386	81325	RAND
88386	81264	RAND	88386	81326	RAND
88386	81265	RAND	88386	81330	RAND
88386	81266	RAND	88386	81331	RAND
88386	81267	RAND	88386	81332	RAND
88386	81268	RAND	88386	81340	RAND
88386	81270	RAND	88386	81341	RAND
88386	81275	RAND	88386	81342	RAND
88386	81280	RAND	88386	81350	RAND
88386	81281	RAND	88386	81355	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
88386	81370	RAND	89134	43755	RAND
88386	81371	RAND	89135	43754	RAND
88386	81372	RAND	89135	43755	RAND
88386	81373	RAND	89136	43754	RAND
88386	81374	RAND	89136	43755	RAND
88386	81375	RAND	89137	43754	RAND
88386	81376	RAND	89137	43755	RAND
88386	81377	RAND	89138	43754	RAND
88386	81378	RAND	89138	43755	RAND
88386	81379	RAND	89139	43754	RAND
88386	81380	RAND	89139	43755	RAND
88386	81381	RAND	89140	43754	RAND
88386	81382	RAND	89140	43755	RAND
88386	81383	RAND	89141	43754	RAND
88386	81400	RAND	89141	43755	RAND
88386	81401	RAND	89225	NONE	RAND
88386	81402	RAND	89235	NONE	RAND
88386	81403	RAND	90379	90378	RAND
88386	81404	RAND	90465	90460	RAND
88386	81405	RAND	90465	90471	RAND
88386	81406	RAND	90465	90473	RAND
88386	81407	RAND	90466	90461	RAND
88386	81408	RAND	90466	90472	RAND
88386	81479	RAND	90466	90474	RAND
88400	88720	RAND	90467	90460	RAND
89100	43756	RAND	90467	90471	RAND
89105	43757	RAND	90467	90473	RAND
89130	43754	RAND	90468	90461	RAND
89130	43755	RAND	90468	90472	RAND
89131	43754	RAND	90468	90474	RAND
89131	43755	RAND	90470	NONE	RAND
89132	43754	RAND	90663	90664	RAND
89132	43755	RAND	90665	NONE	RAND
89133	43754	RAND	90701	NONE	RAND
89133	43755	RAND	90709	NONE	Lewin
89134	43754	RAND	90711	NONE	Lewin

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
90714	90690	Lewin	90742	90396	Lewin <sup>a</sup>
90714	90691	Lewin	90742	90399	Lewin <sup>a</sup>
90714	90692	Lewin	90745	90743	Lewin <sup>a</sup>
90714	90693	Lewin	90745	90744	Lewin <sup>a</sup>
90718	90714	RAND	90746	90739	RAND
90724	90655	Lewin	90746	90746	RAND
90724	90657	Lewin	90760	96360	RAND
90724	90658	Lewin	90761	96361	RAND
90724	90660	Lewin	90765	96365	RAND
90726	90675	Lewin	90766	96366	RAND
90726	90676	Lewin	90767	96367	RAND
90728	90585	Lewin	90768	96368	RAND
90728	90586	Lewin	90769	96369	RAND
90730	90632	Lewin	90770	96370	RAND
90730	90633	Lewin	90771	96371	RAND
90730	90634	Lewin	90772	96372	RAND
90737	90645	Lewin	90773	96373	RAND
90737	90646	Lewin	90774	96374	RAND
90737	90647	Lewin	90775	96375	RAND
90737	90648	Lewin	90776	96376	RAND
90741	90281	Lewin <sup>a</sup>	90779	96379	RAND
90741	90283	Lewin <sup>a</sup>	90780	96360	Lewin <sup>a</sup>
90741	90284	Lewin <sup>a</sup>	90780	96361	Lewin <sup>a</sup>
90742	90287	Lewin <sup>a</sup>	90780	96365	Lewin <sup>a</sup>
90742	90288	Lewin <sup>a</sup>	90780	96366	Lewin <sup>a</sup>
90742	90291	Lewin <sup>a</sup>	90780	96367	Lewin <sup>a</sup>
90742	90296	Lewin <sup>a</sup>	90780	96368	Lewin <sup>a</sup>
90742	90371	Lewin <sup>a</sup>	90781	96360	Lewin <sup>a</sup>
90742	90375	Lewin <sup>a</sup>	90781	96361	Lewin <sup>a</sup>
90742	90376	Lewin <sup>a</sup>	90781	96365	Lewin <sup>a</sup>
90742	90378	Lewin <sup>a</sup>	90781	96366	Lewin <sup>a</sup>
90742	90384	Lewin <sup>a</sup>	90781	96367	Lewin <sup>a</sup>
90742	90385	Lewin <sup>a</sup>	90781	96368	Lewin <sup>a</sup>
90742	90386	Lewin <sup>a</sup>	90782	96372	Lewin <sup>a</sup>
90742	90389	Lewin <sup>a</sup>	90783	96373	Lewin <sup>a</sup>
90742	90393	Lewin <sup>a</sup>	90784	96374	Lewin <sup>a</sup>

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
90788	96372	Lewin <sup>a</sup>	90843	90832	Lewin <sup>a</sup>
90799	96379	Lewin <sup>a</sup>	90843	90833	Lewin <sup>a</sup>
90801	90791	RAND	90844	90834	Lewin <sup>a</sup>
90801	90792	RAND	90844	90836	Lewin <sup>a</sup>
90802	90791	RAND	90855	90832	Lewin <sup>a</sup>
90802	90792	RAND	90855	90833	Lewin <sup>a</sup>
90804	90832	RAND	90855	90834	Lewin <sup>a</sup>
90805	90833	RAND	90855	90836	Lewin <sup>a</sup>
90806	90834	RAND	90855	90837	Lewin <sup>a</sup>
90807	90836	RAND	90855	90838	Lewin <sup>a</sup>
90808	90837	RAND	90857	90853	RAND
90809	90838	RAND	90862	90863	RAND
90810	90832	RAND	90871	90870	Lewin
90811	90833	RAND	90918	90951	RAND
90812	90834	RAND	90918	90952	RAND
90813	90836	RAND	90918	90953	RAND
90814	90837	RAND	90918	90963	RAND
90815	90838	RAND	90918	90967	RAND
90816	90832	RAND	90919	90954	RAND
90817	90833	RAND	90919	90955	RAND
90818	90834	RAND	90919	90956	RAND
90819	90836	RAND	90919	90964	RAND
90821	90837	RAND	90919	90968	RAND
90822	90838	RAND	90920	90957	RAND
90823	90832	RAND	90920	90958	RAND
90824	90833	RAND	90920	90959	RAND
90826	90834	RAND	90920	90965	RAND
90827	90836	RAND	90920	90969	RAND
90828	90837	RAND	90921	90960	RAND
90829	90838	RAND	90921	90961	RAND
90835	90865	Lewin	90921	90962	RAND
90841	90832	Lewin <sup>a</sup>	90921	90966	RAND
90841	90834	Lewin <sup>a</sup>	90921	90970	RAND
90841	90837	Lewin <sup>a</sup>	90922	90951	RAND
90842	90837	Lewin <sup>a</sup>	90922	90952	RAND
90842	90838	Lewin <sup>a</sup>	90922	90953	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
90922	90963	RAND	92135	92133	RAND
90922	90967	RAND	92135	92134	RAND
90923	90954	RAND	92330	NONE	Lewin
90923	90955	RAND	92335	NONE	Lewin
90923	90956	RAND	92390	NONE	Lewin
90923	90964	RAND	92391	NONE	Lewin
90923	90968	RAND	92392	NONE	Lewin
90924	90957	RAND	92393	NONE	Lewin
90924	90958	RAND	92395	NONE	Lewin
90924	90959	RAND	92396	NONE	Lewin
90924	90965	RAND	92510	NONE	Lewin
90924	90969	RAND	92525	92610	Lewin
90925	90960	RAND	92525	92611	Lewin
90925	90961	RAND	92569	92570	RAND
90925	90962	RAND	92573	92700	Lewin
90925	90966	RAND	92589	NONE	Lewin
90925	90970	RAND	92598	NONE	Lewin
91000	43200	RAND	92599	92700	Lewin
91011	91013	RAND	92980	92928	RAND
91012	91013	RAND	92980	92933	RAND
91032	91034	Lewin	92980	92937	RAND
91032	91035	Lewin	92980	92941	RAND
91033	91034	Lewin	92980	92943	RAND
91033	91035	Lewin	92981	92929	RAND
91052	43754	RAND	92981	92934	RAND
91052	43755	RAND	92981	92938	RAND
91055	43754	RAND	92981	92944	RAND
91055	43755	RAND	92982	92920	RAND
91060	NONE	Lewin	92982	92937	RAND
91100	NONE	RAND	92982	92941	RAND
91105	43753	RAND	92982	92943	RAND
91123	NONE	RAND	92984	92921	RAND
92070	92071	RAND	92984	92938	RAND
92070	92072	RAND	92984	92944	RAND
92120	NONE	RAND	92995	92924	RAND
92130	NONE	RAND	92995	92933	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
92995	92937	RAND	93536	33967	Lewin
92995	92941	RAND	93539	93563	RAND
92995	92943	RAND	93540	93564	RAND
92996	92925	RAND	93541	93568	RAND
92996	92934	RAND	93542	93566	RAND
92996	92938	RAND	93543	93565	RAND
92996	92944	RAND	93544	93567	RAND
93012	93268	RAND	93545	NONE	RAND
93012	93270	RAND	93555	NONE	RAND
93012	93271	RAND	93556	NONE	RAND
93014	93272	RAND	93607	93622	Lewin
93230	93224	RAND	93651	93653	RAND
93231	93225	RAND	93651	93654	RAND
93232	93226	RAND	93651	93655	RAND
93233	93227	RAND	93651	93656	RAND
93235	93224	RAND	93651	93657	RAND
93236	93225	RAND	93652	93653	RAND
93236	93226	RAND	93652	93654	RAND
93237	93227	RAND	93652	93655	RAND
93501	93451	RAND	93652	93656	RAND
93508	93454	RAND	93652	93657	RAND
93508	93455	RAND	93720	94726	RAND
93508	93456	RAND	93721	94726	RAND
93508	93457	RAND	93722	94726	RAND
93508	93458	RAND	93727	93285	RAND
93508	93459	RAND	93727	93291	RAND
93508	93460	RAND	93727	93298	RAND
93508	93461	RAND	93731	93280	RAND
93510	93452	RAND	93731	93288	RAND
93511	93452	RAND	93731	93294	RAND
93514	93452	RAND	93732	93280	RAND
93524	93453	RAND	93732	93288	RAND
93526	93453	RAND	93732	93294	RAND
93527	93453	RAND	93733	93293	RAND
93528	93453	RAND	93734	93279	RAND
93529	93453	RAND	93734	93288	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
93734	93294	RAND	94350	94726	RAND
93735	93279	RAND	94350	94727	RAND
93735	93288	RAND	94360	94726	RAND
93735	93294	RAND	94360	94728	RAND
93736	93293	RAND	94370	94726	RAND
93737	93282	Lewin <sup>a</sup>	94370	94727	RAND
93737	93283	Lewin <sup>a</sup>	94620	94620	Lewin
93737	93289	Lewin <sup>a</sup>	94620	94621	Lewin
93737	93292	Lewin <sup>a</sup>	94650	NONE	Lewin
93737	93295	Lewin <sup>a</sup>	94651	NONE	Lewin
93738	93282	Lewin <sup>a</sup>	94652	NONE	Lewin
93738	93283	Lewin <sup>a</sup>	94656	94002	Lewin
93738	93289	Lewin <sup>a</sup>	94656	94004	Lewin
93738	93292	Lewin <sup>a</sup>	94657	94003	Lewin
93738	93295	Lewin <sup>a</sup>	94657	94004	Lewin
93741	93282	RAND	94665	NONE	Lewin
93741	93289	RAND	94720	94729	RAND
93741	93292	RAND	94725	94729	RAND
93741	93295	RAND	95010	95017	RAND
93742	93282	RAND	95010	95018	RAND
93742	93289	RAND	95015	95017	RAND
93742	93292	RAND	95015	95018	RAND
93742	93295	RAND	95075	95076	RAND
93743	93283	RAND	95075	95079	RAND
93743	93289	RAND	95078	NONE	Lewin
93743	93295	RAND	95858	NONE	Lewin
93744	93283	RAND	95900	95907	RAND
93744	93289	RAND	95900	95908	RAND
93744	93295	RAND	95900	95909	RAND
93760	NONE	RAND	95900	95910	RAND
93762	NONE	RAND	95900	95911	RAND
93875	93880	RAND	95900	95912	RAND
94240	94726	RAND	95900	95913	RAND
94240	94727	RAND	95903	95907	RAND
94260	94726	RAND	95903	95908	RAND
94260	94727	RAND	95903	95909	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
95903	95910	RAND	96408	96409	Lewin
95903	95911	RAND	96410	96413	Lewin
95903	95912	RAND	96412	96415	Lewin
95903	95913	RAND	96414	96416	Lewin
95904	95907	RAND	96445	96446	RAND
95904	95908	RAND	96520	96521	Lewin
95904	95909	RAND	96530	96522	Lewin
95904	95910	RAND	96545	NONE	Lewin
95904	95911	RAND	97020	97024	Lewin
95904	95912	RAND	97110	97110	Lewin
95904	95913	RAND	97110	97112	Lewin
95920	95940	RAND	97110	97113	Lewin
95920	95941	RAND	97110	97124	Lewin
95934	95907	RAND	97110	97139	Lewin
95934	95908	RAND	97112	97110	Lewin
95934	95909	RAND	97112	97112	Lewin
95934	95910	RAND	97112	97113	Lewin
95934	95911	RAND	97112	97124	Lewin
95934	95912	RAND	97112	97139	Lewin
95934	95913	RAND	97114	97530	Lewin
95936	95907	RAND	97118	97032	Lewin
95936	95908	RAND	97120	97033	Lewin
95936	95909	RAND	97122	97140	Lewin
95936	95910	RAND	97124	97110	Lewin
95936	95911	RAND	97124	97112	Lewin
95936	95912	RAND	97124	97113	Lewin
95936	95913	RAND	97124	97124	Lewin
96100	96101	Lewin	97124	97139	Lewin
96100	96102	Lewin	97126	97034	Lewin
96100	96103	Lewin	97128	97035	Lewin
96115	96116	Lewin	97139	97110	Lewin
96117	96118	Lewin	97139	97112	Lewin
96117	96119	Lewin	97139	97113	Lewin
96117	96120	Lewin	97139	97124	Lewin
96400	96401	Lewin	97139	97139	Lewin
96400	96402	Lewin	97145	97110	Lewin

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
97145	97112	Lewin	97752	97750	Lewin
97145	97113	Lewin	98770	97001	Lewin
97145	97116	Lewin	98771	97001	Lewin
97145	97124	Lewin	98772	97001	Lewin
97145	97139	Lewin	98773	97001	Lewin
97145	97140	Lewin	98774	97001	Lewin
97220	97036	Lewin	98775	97002	Lewin
97221	97036	Lewin	98776	97002	Lewin
97240	97036	Lewin	98777	97002	Lewin
97240	97113	Lewin	98778	97002	Lewin
97241	97036	Lewin	99025	99201	Lewin <sup>a</sup>
97241	97113	Lewin	99025	99202	Lewin <sup>a</sup>
97250	97140	Lewin	99025	99203	Lewin <sup>a</sup>
97260	97140	Lewin	99025	99204	Lewin <sup>a</sup>
97261	97140	Lewin	99025	99205	Lewin <sup>a</sup>
97500	97760	Lewin	99050	99050	Lewin
97501	97760	Lewin	99050	99051	Lewin
97520	97761	Lewin	99050	99053	Lewin
97521	97761	Lewin	99052	99050	Lewin <sup>a</sup>
97531	97530	Lewin	99052	99051	Lewin <sup>a</sup>
97540	97535	Lewin	99052	99053	Lewin <sup>a</sup>
97540	97537	Lewin	99054	99050	Lewin <sup>a</sup>
97541	97535	Lewin	99054	99051	Lewin <sup>a</sup>
97541	97537	Lewin	99058	99058	Lewin <sup>a</sup>
97610	97140	Lewin	99058	99060	Lewin <sup>a</sup>
97616	97140	Lewin	99071	99071	Lewin
97630	97150	Lewin	99075	99075	Lewin
97631	97150	Lewin	99078	99078	Lewin
97660	97750	Lewin	99080	99080	Lewin
97670	97750	Lewin	99185	99116	RAND
97690	97750	Lewin	99186	99116	RAND
97691	97750	Lewin	99190	99190	Lewin
97700	97762	Lewin	99195	99195	Lewin
97701	97762	Lewin	99261	99231	Lewin
97720	97750	Lewin	99261	99232	Lewin
97721	97750	Lewin	99261	99233	Lewin

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
99261	99307	Lewin	99272	99254	Lewin
99261	99308	Lewin	99272	99255	Lewin
99261	99309	Lewin	99273	99241	Lewin
99261	99310	Lewin	99273	99242	Lewin
99262	99231	Lewin	99273	99243	Lewin
99262	99232	Lewin	99273	99244	Lewin
99262	99233	Lewin	99273	99245	Lewin
99262	99307	Lewin	99273	99251	Lewin
99262	99308	Lewin	99273	99252	Lewin
99262	99309	Lewin	99273	99253	Lewin
99262	99310	Lewin	99273	99254	Lewin
99263	99231	Lewin	99273	99255	Lewin
99263	99232	Lewin	99274	99241	Lewin
99263	99233	Lewin	99274	99242	Lewin
99263	99307	Lewin	99274	99243	Lewin
99263	99308	Lewin	99274	99244	Lewin
99263	99309	Lewin	99274	99245	Lewin
99263	99310	Lewin	99274	99251	Lewin
99271	99241	Lewin	99274	99252	Lewin
99271	99242	Lewin	99274	99253	Lewin
99271	99243	Lewin	99274	99254	Lewin
99271	99244	Lewin	99274	99255	Lewin
99271	99245	Lewin	99275	99241	Lewin
99271	99251	Lewin	99275	99242	Lewin
99271	99252	Lewin	99275	99243	Lewin
99271	99253	Lewin	99275	99244	Lewin
99271	99254	Lewin	99275	99245	Lewin
99271	99255	Lewin	99275	99251	Lewin
99272	99241	Lewin	99275	99252	Lewin
99272	99242	Lewin	99275	99253	Lewin
99272	99243	Lewin	99275	99254	Lewin
99272	99244	Lewin	99275	99255	Lewin
99272	99245	Lewin	99289	99466	RAND
99272	99251	Lewin	99290	99467	RAND
99272	99252	Lewin	99293	99471	RAND
99272	99253	Lewin	99294	99472	RAND

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
99295	99468	RAND	99311	99310	Lewin
99296	99469	RAND	99311	99318	Lewin
99297	99469	Lewin <sup>a</sup>	99312	99304	Lewin
99298	99478	RAND	99312	99305	Lewin
99299	99479	RAND	99312	99306	Lewin
99300	99480	RAND	99312	99307	Lewin
99301	99304	Lewin	99312	99308	Lewin
99301	99305	Lewin	99312	99309	Lewin
99301	99306	Lewin	99312	99310	Lewin
99301	99307	Lewin	99312	99318	Lewin
99301	99308	Lewin	99313	99304	Lewin
99301	99309	Lewin	99313	99305	Lewin
99301	99310	Lewin	99313	99306	Lewin
99301	99318	Lewin	99313	99307	Lewin
99302	99304	Lewin	99313	99308	Lewin
99302	99305	Lewin	99313	99309	Lewin
99302	99306	Lewin	99313	99310	Lewin
99302	99307	Lewin	99313	99318	Lewin
99302	99308	Lewin	99321	99324	Lewin
99302	99309	Lewin	99321	99325	Lewin
99302	99310	Lewin	99321	99326	Lewin
99302	99318	Lewin	99321	99327	Lewin
99303	99304	Lewin	99321	99328	Lewin
99303	99305	Lewin	99321	99334	Lewin
99303	99306	Lewin	99321	99335	Lewin
99303	99307	Lewin	99321	99336	Lewin
99303	99308	Lewin	99322	99324	Lewin
99303	99309	Lewin	99322	99325	Lewin
99303	99310	Lewin	99322	99326	Lewin
99303	99318	Lewin	99322	99327	Lewin
99311	99304	Lewin	99322	99328	Lewin
99311	99305	Lewin	99322	99334	Lewin
99311	99306	Lewin	99322	99335	Lewin
99311	99307	Lewin	99322	99336	Lewin
99311	99308	Lewin	99323	99324	Lewin
99311	99309	Lewin	99323	99325	Lewin

OMFS Code	2013 CPT	Crosswalk	OMFS Code	2013 CPT	Crosswalk
99323	99326	Lewin	99342	99342	Lewin
99323	99327	Lewin	99342	99343	Lewin
99323	99328	Lewin	99342	99344	Lewin
99323	99334	Lewin	99342	99345	Lewin
99323	99335	Lewin	99343	99341	Lewin
99323	99336	Lewin	99343	99342	Lewin
99331	99324	Lewin	99343	99343	Lewin
99331	99325	Lewin	99343	99344	Lewin
99331	99326	Lewin	99343	99345	Lewin
99331	99327	Lewin	99351	99347	Lewin
99331	99328	Lewin	99352	99348	Lewin
99331	99334	Lewin	99353	99349	Lewin
99331	99335	Lewin	99358	99358	Lewin
99331	99336	Lewin	99358	99359	Lewin
99332	99324	Lewin	99361	99367	Lewin
99332	99325	Lewin	99362	99366	Lewin
99332	99326	Lewin	99362	99367	Lewin
99332	99327	Lewin	99362	99368	Lewin
99332	99328	Lewin	99371	99441	Lewin
99332	99334	Lewin	99371	99442	Lewin
99332	99335	Lewin	99371	99443	Lewin
99332	99336	Lewin	99372	99441	Lewin
99333	99324	Lewin	99372	99442	Lewin
99333	99325	Lewin	99372	99443	Lewin
99333	99326	Lewin	99373	99441	Lewin
99333	99327	Lewin	99373	99442	Lewin
99333	99328	Lewin	99373	99443	Lewin
99333	99334	Lewin	99375	99374	Lewin
99333	99335	Lewin	99375	99375	Lewin
99333	99336	Lewin	99376	99375	Lewin
99341	99341	Lewin	99376	99378	Lewin
99341	99342	Lewin	99376	99380	Lewin
99341	99343	Lewin	99431	99460	RAND
99341	99344	Lewin	99432	99461	RAND
99341	99345	Lewin	99433	99462	RAND
99342	99341	Lewin	99435	99463	RAND

<b>OMFS Code</b>	<b>2013 CPT</b>	<b>Crosswalk</b>
99436	99464	RAND
99440	99465	RAND

<sup>a</sup> Indicates codes originally cross-walked by The Lewin Group but updated by the authors.

## Appendix C Official Medical Fee Schedule Codes with No 2013 Equivalent Codes in the Current Procedural Terminology

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This appendix contains two categories of OMFS codes that we did not cross-walk into 2013 CPT codes. Table C.1 shows codes that DWC proposes to continue to recognize using either a WC-specific code or an unlisted code. The paid amounts for these codes were carried over as paid amounts under the RBRVS in the impact analysis. Table C.2 shows codes that DWC proposes to delete. The paid amounts for these codes are in the OMFS allowances but are not included in the RBRVS allowances. The services described by several of these codes would typically be bundled under Medicare ground rules or have been replaced by other codes that are likely to be used to describe the services in the future.

**Table C.1 Official Medical Fee Schedule Codes with No 2013 Counterpart in the Current Procedural Terminology That Were Priced Under the Resource-Based Relative Value Scale at Official Medical Fee Schedule Allowances**

OMFS Code	OMFS Description	Total Payments	OMFS Allowance	Treatment Under RBRVS
76175	Duplication of x-ray	1,858	\$4.75 each	Continue at OMFS allowance
76176	Duplication of scan	775	\$9.50 per scan	Continue at OMFS allowance
97680	Job site visit/assessment	28,808	BR	Pay BR under 97999
99048	Telephone calls by provider	25,741	BR	Pay using CPT 99442 and 99443 values
99049	Missed appointment	230,884	BR with optional payment	Continue BR with optional payment
99060	Environmental intervention	18,156	BR	Pay BR under 99199
99086	Reproduction of chart notes	272,092	0.95 × (\$10 first 15 pages + \$0.25 each additional page)	Continue at OMFS prices
99087	Reproduction of duplicate reports	38,176	\$10 first 15 pages; \$0.25 each additional page	Continue at OMFS prices

**Table C.2 Official Medical Fee Schedule Special Services with No 2013 Counterpart in the Current Procedural Terminology That Were Priced with No Payment Under the Resource-Based Relative Value Scale**

<b>OMFS Code</b>	<b>OMFS Description</b>	<b>Units Billed</b>	<b>Total Payments (\$)</b>	<b>Disposition</b>
99017	Preparation of specimen for transfer	—	—	Delete
99019	Single venous/capillary puncture, referral to other lab	8	80	Delete
99020	Multiple venous or capillary puncture	—	—	Delete
99025	Initial visit when a starred (*) surgical procedure is the major service during visit	3,600	82,967	Delete
99026	Mileage within 7 miles	83	376	Delete; code has been recycled
99027	Mileage charge, more than 7 miles	9	377	Delete; code has been recycled
99028	Apportioned mileage	—	—	Delete
99030	Mileage > 7 miles	219	740	Delete
99031	Travel add-on for large urban area	65	4,690	Delete
99052	Service request between 6 p.m. and 7 a.m. in addition to basic service	2,355	53,932	Delete; replaced by 99050 and 99053
99054	Service requested Sunday or holiday	2,490	48,207	Delete; replaced by 99050
99065	Outside office hours, payment for technologist	363	2,518	Delete; replaced by 99050
99085	External medical photography	747	4,198	Delete

## Appendix D Analysis of Alternative Pricing Policies for Physician-Administered Drugs

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We identified several data-constancy issues when analyzing 2011 WC drug data. First, despite OMFS instructions to report NDC when billing for any drug, providers use both NDC codes and HCPCS J-codes to bill for PAD ingredients. Providers are currently paid for PADs regardless of whether they are billed as an NDC or as an HCPCS J-code. Second, quantities were inconsistently reported across three separate variables, including units, days of drug dispensed, and amount of drug dispensed. For PADs billed by NDC, the variables for days of drug dispensed and amount of drug dispensed often did not correspond to one another. For PADs billed by HCPCS code, providers often billed in number of drug units, e.g., milliliters, when the HCPCS code indicates that the PADs should be billed per injection (or vice versa). Finally, service dates were missing for many drug claims in the WC data.

We identified PADs in 2011 WC data to the extent possible given these limitations. First, we isolated all bill lines with either an HCPCS J-code (210,000 lines) or an NDC (3.6 million lines). Many lines billed by NDC are for outpatient drugs rather than PADs. We used the crosswalk for CMS NDC to HCPCS (maintained by Noridian Healthcare Solutions) to identify drugs billed by NDC that were likely to be PADs. Of the 3.6 million lines, only 150,000 lines matched to the CMS crosswalk. We eliminated 24,000 records with a procedure code other than a J-code. The final drug analysis file included roughly 340,000 lines.

We aggregated WC 2011 paid amounts, volume, the product of volume and CMS price, and the product of volume and Medi-Cal price by HCPCS code. We imputed volume using the number-of-units variable first and filling in, as feasible, with the other two drug-volume variables. All lines paid zero were excluded from the analysis.

Table 7.2 in Chapter Seven compares MAAs from the CMS PAD fee schedule and from the Medi-Cal fee schedule. Allowed fees are, for the most part, similar across the two fee schedules, which reflects Medi-Cal's recent transition to ASP-plus-6-percent pricing.

We also estimated ingredient-plus-administration MAAs under the current OMFS approach (pay administration codes separately), the CMS approach (pay administration codes only when they occur outside the context of an E&M visit), and the Medi-Cal approach (pay a flat administration fee for most drugs). We simulated the payment of an administration code 90780 for all lines to approximate the current OMFS approach. For the CMS approach, we assumed that injection fees would be bundled in payment for an E&M visit when the injection is included on the same bill as an E&M visit. In a separate analysis, we found that more than 90 percent of PADs were billed with an E&M code. We therefore simulated the payment of 90780 for 10 percent of lines to approximate the CMS approach. Finally, we added a \$4.46 administration fee to all lines with a Medi-Cal 030 modifier to simulate the Medi-Cal approach. Table 7.3

compares the total ingredient-plus-administration MAAs using these three approaches. Either the CMS or Medi-Cal approach results in significantly lower MAAs than the current OMFS approach because administration is bundled in E&M services.

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