

GENERAL INFORMATION AND INSTRUCTIONS

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INTRODUCTION

AUTHORITY

Pursuant to the provisions of Labor Code Sections 4603.5 and 5307.1, the Administrative Director of the Division of Workers' Compensation has adopted the Official Medical Fee Schedule as the basis for billing and payment of medical services provided injured employees under the Workers' Compensation Laws of the State of California.

This revision to the Official Medical Fee Schedule sets forth changes to the procedures, procedure numbers, descriptions, instructions, ground rules and unit values adopted by the Administrative Director. The amendments to the Official Medical Fee Schedule contained in the 1998 revision are effective for services rendered on or after April 1, 1999.

Use this schedule for services rendered on or after April 1, 1999. You will need to consult the applicable prior schedule for services that were provided prior to April 1, 1999.

The text in this revision of the Official Medical Fee Schedule is formatted to identify its sources. Language from the American Medical Association's Current Procedural Terminology (CPT) is identified by non-italicized text (eg, "American Medical Association"). Relative values and California modifications to the CPT language are identified by italics (eg, "California Official Medical Fee Schedule"). Language which is new and changed in this revision is underlined (eg, "American Medical Association" identifies new text from the 1997 CPT and "Official Medical Fee Schedule" identifies new California language).

SERVICES COVERED

The Official Medical Fee Schedule applies to all covered medical services provided, referred or prescribed by physicians (as defined in Section 3209.3 of the Labor Code), regardless of the type of facility in which the medical services are performed, including clinic and hospital based physicians working on a contract basis. The Schedule shall not apply to inpatient medical services provided by employees of a health facility, medical-legal expenses authorized under Section 4621 of the Labor Code, and medical expenses payable pursuant to Section 9795 of the California Code of Regulations.

Nothing contained in this schedule shall preclude any hospital as defined in subdivisions (a), (b), or (f) of Section 1250 of the Health and Safety Code, or any surgical facility which is licensed under subdivision (b) of Section 1204 of the Health and Safety Code, or any ambulatory surgical center that is certified to participate in the Medicare program under Title XIX (42 U.S.C. Sec. 1395 et seq.) of the federal Social Security Act, or any

surgical clinic accredited an accrediting agency as approved by the Licensing Division of the Medical Board of California pursuant to Health and Safety Code Sections 1248.15 and 1248.4, from charging and collecting a facility fee for the use of the emergency room or operating room of the facility. Outpatient procedures and services which are included in this fee schedule and which are provided in the emergency room or operating room of a hospital or in a freestanding outpatient surgery facility shall be reimbursed in accordance with this fee schedule.

No facility except those specified in the immediately preceding paragraph may charge or collect a facility fee for services provided on an outpatient basis

Hospital treatment rooms used by physicians for providing outpatient non-emergency follow-up services are not separately reimbursable as they are included in the value of the Evaluation and Management service codes.

CODES, MODIFIERS and SYMBOLS

The coding in this edition of the Official Medical Fee Schedule primarily uses the procedure codes, descriptors, and modifiers of the American Medical Association's Physicians' Current Procedural Terminology (CPT) 1997, copyright 1996, American Medical Association.

The Schedule also includes codes, descriptors, and modifiers that are unique to California, or California changes to CPT codes. Unique California codes, and CPT codes modified for California, are designated in the schedule by the symbol "∞".

Codes that have been revised since the last edition of the Schedule are designated by the symbol "®".

Codes that are new are designated by the symbol "Δ".

The "Orthotics and Prosthetics" section of the schedule uses the identifiers listed in Title 22, California Code of Regulations, Section 51051 and Section 51515.

FORMAT

The Official Medical Fee Schedule consists of seven major sections. Within each section are subsections with anatomic, procedural, condition, or descriptor subheadings.

The section numbers and their sequence are as follows:

EVALUATION and MANAGEMENT	99201 to 99499
ANESTHESIOLOGY	00100 to 01999
	99100 to 99140
SURGERY	10040 to 69979

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GENERAL INSTRUCTIONS

FEE COMPUTATION AND BILLING PROCEDURES

Except as otherwise provided in this Schedule, the fee amount is established by multiplying the listed unit value of the procedure by the applicable conversion factor set forth in Title 8, CCR Section 9792 (see Appendix B for the list of current conversion factors). The resultant fee establishes a reasonable maximum fee to be paid for the particular medical service provided (Labor Code Section 5307.1(a)).

A medical provider or a licensed health care facility may be paid by an employer or carrier fees in excess of those set forth in the Official Medical Fee Schedule, provided that the fee is: reasonable, accompanied by itemization, and justified by an explanation of extraordinary circumstances related to the unusual nature of the medical services rendered. In no event shall a physician charge in excess of his or her usual fee (Labor Code 5307.1(b)).

California law requires the employer (or insurer) to provide all medical care necessary to cure and relieve the effects of the employee's industrial or work related illness or injury.

Accordingly, under no circumstances shall the employee be billed for the treatment for which the employee has filed a workers' compensation claim unless the medical provider has received written notice that the claim has been rejected (Labor Code Section 3751(b)).

*Conversion factors to be applied to the unit values contained in the schedule are adjusted periodically after public hearings conducted by the Administrative Director, Division of Workers' Compensation. The conversion factors currently in use are included in appendix **C** of this schedule.*

Total reimbursement for the professional and technical components of procedures shall not exceed the listed value for the total procedure.

Billings must include each provider's professional designation and, if applicable, the license or certification number of the person providing the service and shall be limited to services allowed by the provider's authorized scope of practice.

Practitioners who are not physicians as defined by California workers' compensation law, including orthotists; prosthetists; nurse practitioners; physician assistants; marriage, family and child counselors; and licensed clinical social workers, who are

acting within the scope of their license, certification or education and who have received authorization from the payer to treat an injured worker, may be reimbursed in accordance with this Schedule.

Nonphysicians billing under this fee schedule shall use the appropriate modifier. (See the appropriate specialty section for nonphysician modifiers).

Claims administrators shall make determinations regarding authorization for payment of medical bills in accordance with all relevant statutes and regulations, including but not limited to Labor Code Sections 4600 and 4062; Title 8, California Code of Regulations Section 9792.6; and this Official Medical Fee Schedule.

CONFIRMATION OF VERBAL AUTHORIZATION FOR PAYMENT

This policy applies only to those services listed in the Official Medical Fee Schedule which require prior authorization or to services for which the provider voluntarily seeks confirmation of authorization.

When verbal authorization for payment is given for this purpose, the claims administrator shall provide to the provider (1) a confirmation number that the provider shall place on the bill when billing for the service, or (2) a written confirmation of the verbal authorization. Confirmation shall be placed in the mail to the provider by the claims administrator within five working days of the verbal authorization.

When authorization is given either verbally or through a written authorization, the claims administrator is obligated to pay for the services authorized in accordance with the Official Medical Fee Schedule or other contractual payment arrangements previously agreed.

In the event the claims administrator subsequently determines that authorization for payment should be terminated, the claims administrator shall notify the provider in writing of this change.

SUPPLIES AND MATERIALS

Supplies and/or materials normally necessary to perform the service are not separately reimbursable. Supplies and materials provided over and above those usually included with the office or other services rendered may be charged for separately.

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Examples of supplies that are usually not separately reimbursable include:
applied hot or cold packs
eye patches
injections or debridement trays
steristrips

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needles
needles
syringes
eye/ear trays
drapes
sterile gloves
applied eye wash or drops
creams (massage)
fluorescein
ultrasound pads and gel
tissues
urine collection kits
gauze
cotton balls/fluff
sterile water
bandaids and dressings for simple wound occlusion
head sheet
aspiration trays
tape for dressing

Exceptions to this rule include:
cast and strapping materials
sterile trays for laceration repair and more complex
surgeries

applied dressings beyond simple wound occlusion
taping supplies for sprains
iontophoresis electrodes
reusable patient specific electrodes
dispensed items such as, but not limited to, the following:

<u>canes</u>	<u>crutches</u>
<u>braces</u>	<u>splints</u>
<u>slings</u>	<u>back supports</u>
<u>ace wraps</u>	<u>dressings</u>
<u>TENS electrodes</u>	<u>hot or cold packs*</u>

* The application of hot or cold packs is not reimbursable (i.e., code 97010 has a relative value of 0.0 and is not reimbursable).

The following formulas only apply to health care providers such as physicians, physical therapists, Physician Assistants and Nurse Practitioners, dispensing items from their office or outpatient surgery facility.

Code 99070 is used to bill for separately reimbursable supplies and materials "By Report" (BR). The provider must identify the supplies and/or materials provided. Documentation of actual cost may be required.

The formulas for establishing fair and reasonable fees and charges for separately reimbursable supplies and materials are:

(1) Supplies and materials other than dispensed durable medical equipment:
cost (purchase price plus sales tax) plus 20% of cost up to a maximum of cost plus \$15.00 **not to exceed the provider's usual and customary charge for the item.**

(2) Dispensed durable medical equipment:
cost (purchase price plus sales tax plus shipping and handling) plus 50% of cost up to a maximum of cost plus \$25.00 **not to exceed the provider's usual and customary charge for the item.**

Patient instruction booklets, pamphlets, videos, or tapes are separately reimbursable using code 99071. Documentation of actual cost may be required.

Total rental cost of durable medical equipment cannot exceed the purchase cost. Prior authorization of the payer is required for rental or purchase. Prior authorization of the payer does not apply to emergency situations; such as, emergency room facility dispensing crutches. Documentation of actual cost may be required.

PHARMACEUTICALS

Reimbursement of pharmaceuticals (99070) shall be the lesser of: (1) the provider's usual charge, or (2) the fees established by the formulas for brand-name and generic pharmaceuticals as described. This provision applies to the dispensing of all pharmaceuticals including those dispensed by a medical provider, regardless of the point of service. "Dispense" means the furnishing of drugs upon a legal prescription from a physician, dentist or podiatrist. Over-the-counter pharmaceuticals do not warrant reimbursement of a dispensing fee.

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.

The formulas for establishing fair and reasonable fees and charges for brand-name and generic pharmaceuticals are:

(1) Brand-name Pharmaceutical Formula:
average wholesale price (AWP) times 1.10
plus a \$4.00 dispensing fee.

(2) Generic Pharmaceutical Formula:
average wholesale price (AWP) times 1.40
plus a \$7.50 dispensing fee.

When a generic pharmaceutical costs more than a brand-name pharmaceutical, according to the formulas described in this section, the fair and reasonable price

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medical opinion on the necessity or appropriateness of previously recommended medical treatment or a surgical procedure. A confirmatory consultation (CPT codes 99271-99275) may also be charged by the consulting physician.

professionals, the CPT code 99358 may be charged in addition to the basic charge for the appropriate Evaluation and Management code.

CPT code 99358 may also be used where the physician is required to spend 15 or more minutes reviewing records or tests, a job analysis, an evaluation of ergonomic status, work limitations, or work capacity when there is no direct (face-to-face) contact; however, in this case, the physician is not entitled to charge an Evaluation and Management code. For example, if subsequent to an examination of the employee, a consulting physician is asked to prepare a supplemental report based on a review of additional medical records, and the physician spends 15 minutes in this review, CPT code 99358 may be charged along with CPT code 99080 for a report, but no Evaluation and Management code may be charged.

DIETARY SUPPLEMENTS

Dietary supplements such as minerals and vitamins shall not be reimbursable unless a specific dietary deficiency has been clinically established in the injured employee as a result of the industrial injury or illness.

PROCEDURES WITHOUT UNIT VALUES ("BY REPORT")

Unit values are not shown for some procedures listed in the Schedule. Fees for such procedures need to be justified by report, although a detailed clinical record is not necessary.

By Report (BR): Procedures coded BR (By Report) are services which are unusual or variable.

An unlisted service or one that is rarely provided, unusual or variable may require a report demonstrating the medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort and equipment necessary to provide the service. Additional items which may be included are:

- complexity of symptoms;
- final diagnosis;
- pertinent physical findings;
- diagnostic and therapeutic procedures;
- concurrent problems;
- follow-up care.

In some instances, the values of BR procedures may be determined using the value assigned to a comparable procedure. The comparable procedure should reflect the same amount of time.

- A report by a consulting physician, where consultation was requested on one or more medical issues by a party, the Administrative Director, or the Workers' Compensation Appeals Board. Reports included under this section are those reports that are admissible and reimbursable in accordance with Labor Code Section 4064(c). An office consultation (CPT codes 99241-99245) may also be charged by the consulting physician.
- A report by the treating physician, where medical information other than that required to be reported under the treatment report section above was requested by a party, the Administrative Director, or the Workers' Compensation Appeals Board. An office consultation (CPT codes 99241-99245) may also be charged by the treating physician in this circumstance.
- **A report by a consulting physician where the claim does not meet the criteria of a "contested claim" as set forth in 8 CCR § 9793(b).**
- **A consultation code may not be billed when care or any part of care has been clearly transferred by the primary treating physician to another physician. (See definition of Referral under the Evaluation and Management Section page 11.)**

PROLONGED SERVICE CODES

Where appropriate, a treating or consulting physician may be paid for service which extends beyond the usual service time for a particular Evaluation and Management code. The prolonged service codes are of two types in the outpatient setting: direct (face-to-face) patient contact (CPT codes 99354 and 99355), and without direct (face-to-face) patient contact (CPT code 99358).

Where the physician is required to spend at least 30 minutes or more of direct (face-to-face) time in addition to the time set forth in the appropriate CPT code (eg, at least 90 minutes in an office consultation under CPT code 99244), then CPT codes 99354 and, where appropriate, 99355 may be charged in addition to the basic charge for the appropriate Evaluation and Management code.

Where the physician is required to spend 15 or more minutes before and/or after direct (face-to-face) patient contact in reviewing extensive records, tests or in communication with other

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complexity, expertise, etc., as required for the procedure performed.

SEPARATE PROCEDURES

Some of the listed procedures are commonly carried out as an integral part of a total service, and as such do not warrant a separate reimbursement. When however, such a procedure is

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performed independent of and is not immediately related to other services, it may be listed as a "separate procedure." Thus, when a procedure is performed alone for a specific purpose it may be considered to be a separate procedure.

STARRED PROCEDURES

The star "*" is used to identify certain surgical procedures. A description of this reporting mechanism is found in the Surgery ground rules.

SPECIAL SERVICES AND REPORTS

The procedures with code numbers 99000 through 99090 provide the reporting physician or health care provider with the means of identifying the completion of special reports and services that are an adjunct to the basic services rendered. The specific number assigned indicates the special circumstances under which a basic procedure is performed. Charges for services generally provided as an adjunct to common medical services should be billed only when circumstances clearly warrant an additional charge over and above the scheduled charges for the basic services.

CHART NOTES

Requests for chart notes shall be in writing and shall be separately reimbursable at \$10.00 for up to the first 15 pages. Pages in excess of 15 shall be reimbursable at \$0.25 per page. Chart note requests shall be made only by the claims administrator. Code 99086 is used to bill for chart notes "By Report", using these guidelines.

DUPLICATE REPORTS

A primary treating physician has fulfilled his or her reporting duties by sending one copy of a required report to the claims administrator or to a person designated by the claims administrator to be the recipient of the required report. Requests for duplicate reports related to billings shall be in writing. Duplicate reports shall be separately reimbursable. Where the payer requests an additional copy of the reports, the payer shall reimburse for the duplicate report at \$10.00 for up to the first 15 pages. Pages in excess of 15 pages shall be reimbursed at \$0.25 per page. Charges for duplicate reports shall be billed using code 99087. Requests for duplicate reports shall be made only by the claims administrator.

MISSED APPOINTMENTS

Code 99049 may be used to indicate missed appointments on a By-Report (BR) basis. This code is designed for communication purposes only. It does not imply that compensation is necessarily owed.

This code applies to both treatment and consultation appointments. For Medical-Legal missed appointments use the appropriate code from the Medical-Legal Fee Schedule - CCR 9795 (see Appendix C).

MODIFIERS

A modifier provides the means by which the reporting physician or health care provider can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. The judicious application of modifiers obviates the necessity for separate procedure listings that may describe the modifying circumstance. Modifiers may be used to indicate to the recipient of a report that:

- A service or procedure has both a professional and technical component.
- A service or procedure was performed by more than one physician and/or in more than one location.
- A service or procedure has been increased or reduced.
- Only part of service was performed.
- An adjunctive service was performed.
- A bilateral procedure was performed.
- A service or procedure was provided more than once.
- Unusual events occurred.

A listing of modifiers pertinent to Evaluation and Management, Anesthesia, Surgery, Radiology, Pathology, and Medicine is located in the Ground Rules of each section. A complete listing of modifiers is found in Appendix A.

GLOBAL SERVICE PROFESSIONAL COMPONENT AND TECHNICAL COMPONENT REIMBURSEMENT

Certain procedures are a combination of both a physician (professional) and a technical component. The listed values are total values that include both the professional and technical components. Total reimbursement for the professional and technical components combined shall not exceed the listed value for the total procedure, regardless of the site(s) where services are rendered. When both the professional and technical components of such procedures are performed by the same provider, a global service has been rendered. When the professional or technical

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component of a procedure is billed separately it shall be valued according to the percent of the total value indicated in the "PC/TC" column of the fee schedule. When reporting a procedure for which there is a professional/technical component split listed in this schedule use the modifier which appropriately describes the service rendered (i.e., '-26', '-27').

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EVALUATION AND MANAGEMENT

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case management codes.

The final component, Time, is discussed in detail *in this section*.

The actual performance and/or interpretation of diagnostic tests/studies ordered during a patient encounter are not included in the levels of E/M services. Physician performance of diagnostic tests/studies for which specific CPT codes are available *should be* reported separately, in addition to the appropriate E/M code. The physician's interpretation of the results of diagnostic tests/studies (i.e., professional component) with preparation of either a separate distinctly identifiable signed written report or a separate distinctly identifiable section of an overall report (i.e. PR-2, PR-3, Narrative Report or Doctor's First Report of Injury) may also be reported separately, using the appropriate CPT code with the modifier -26 appended.

Nature Of Presenting Problem

A presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for the encounter, with or without a diagnosis being established at the time of the encounter. The E/M codes recognize five types of presenting problems that are defined as follows:

- **Minimal**--A problem that may not require the presence of the physician, but service is provided under the physician's supervision.
- **Self-limited or Minor**--A problem that runs a definite and prescribed course, is transient in nature and is not likely to permanently alter health status OR has a good prognosis with management/compliance.
- **Low severity**--A problem where the risk of morbidity without treatment is low; there is little to no risk of mortality without treatment; full recovery without functional impairment is expected.
- **Moderate severity**--A problem where the risk of morbidity without treatment is moderate; there is moderate risk of mortality without treatment; uncertain prognosis OR increased probability of prolonged functional impairment.
- **High severity**--A problem where the risk of morbidity

without treatment is high to extreme; there is a moderate to high risk of mortality without treatment OR high probability of severe, prolonged functional impairment.

Past History

A review of the patient's past experiences with illnesses, injuries, and treatments that includes significant information about:

- prior major illnesses and injuries;
- prior operations;
- prior hospitalizations;
- current medications;
- allergies (e.g., drug, food);
- age appropriate immunization status;
- age appropriate feeding/dietary status.

Social History

An age appropriate review of past and current activities that includes significant information about:

- marital status and/or living arrangements;
- current employment;
- occupational history;
- use of drugs, alcohol, and tobacco;
- level of education;
- sexual history;
- other relevant social factors.

System Review (Review of Systems)

An inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced. For the purposes of CPT the following elements of a system review have been identified:

- Constitutional symptoms (fever, weight loss, etc.)
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine

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- Hematologic/Lymphatic
- Allergic/Immunologic

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ANESTHESIA

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Anesthetist (CRNA) and is involved in medical direction of the patient, including pre- and post-operative evaluation and care, but is not personally administering the anesthesia. The reimbursement for the supervising physician shall be for the basic value of the procedure plus one unit per hour or fraction thereof for the duration of the anesthesia. In order to be reimbursable the anesthesiologist shall remain within visual and auditory range of the operating rooms under medical direction and shall extend medical direction to no more than two rooms. Medical direction excludes simultaneous administration of anesthesia by the anesthesiologist. Total reimbursement to the nurse anesthetist and the supervising anesthesiologist shall not exceed the listed value of this service if performed by an anesthesiologist. Identify by adding modifier -48 to the appropriate anesthesia procedure code and anesthesia time code.

hypothermia. 5

99135 Anesthesia complicated by utilization of controlled hypotension. 5

99140 Anesthesia complicated by emergency conditions (specify). 2

These services are reimbursed using the Anesthesia Conversion Factor.

An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part. Use 99140.

∞ - 75 Concurrent Care, Services Rendered by More Than One Physician:

When the patient's condition requires the additional services of more than one physician, each physician may identify his or her services by adding the modifier -75 to the basic service performed.

11. QUALIFYING CIRCUMSTANCES

(More Than One May Be Selected.)

Many anesthesia services are provided under particularly difficult circumstances depending on factors such as extraordinary condition of patient, notable operative conditions or the unusual risk factors. This section includes a list of important qualifying circumstances that significantly impact on the character of the anesthesia service provided. These procedures would not be reported alone but would be reported as additional procedure numbers qualifying an anesthesia procedure or service. *These modifying units may be added to the basic unit value.*

CPT

RVs

99100 Anesthesia for patient of extreme age, under one year and over seventy. 1

99116 Anesthesia complicated by utilization of total body

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Radiology and Nuclear Medicine

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are reviewed in conjunction with a visit, consultation, record review, or other evaluation, no separate charge is warranted for the review by the medical practitioner or other medical personnel. Neither the professional component value modifier '-26' nor the radiologic consultation code (76140) is reimbursable under this circumstance. The review of diagnostic tests is included in the Evaluation and Management codes.

X-ray Consultation: Code 76140 is reimbursable only when the advice or expert opinion of a physician is requested regarding a specific diagnostic problem. Value at 100% of the listed value of the Professional Component of the x-ray study for which the consultation is made. Code 76140 is not reimbursable for routine confirmatory readings of x-ray films.

When radiology films or scans are duplicated for medical purposes, reimburse using code(s) 76175 and/or 76176, at \$5.00 per x-ray and \$10.00 per scan sheet as appropriate. Requests for duplication of films and scans shall be in writing.

9. MODIFIERS

Listed services and procedures may be modified under certain circumstances. When applicable, the modifying circumstances should be identified by the addition of the appropriate modifier code, which is reported by a two-digit number placed after the usual procedure number from which it is separated by a hyphen. If more than one modifier is used, place the Multiple Modifiers code '-99' immediately after the procedure code. This indicates that one or more additional modifier codes will follow. Modifiers commonly used in **Radiology (including Nuclear Medicine and Diagnostic Ultrasound)** are listed below.

Modifier - 29 for global procedures (those procedures where one provider is responsible for both the professional and technical component) has been deleted. If a provider is billing for a global service, no modifier is necessary.

®-22 Unusual Procedural Services:

When the service(s) provided is greater than that usually required for the listed procedure, it is identified by adding modifier '-22' to the usual procedure number. *Documentation is required.*

Note: Modifier '-22' may be utilized with computerized tomography numbers when additional

slices are required or a more detailed examination is necessary.

®-26 Professional Component:

Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service is identified by adding the modifier '-26' to the usual procedure number.

¥-27 Technical component:

Under certain circumstances, a charge may be made for the technical component alone (see definition of technical component under Radiology and Pathology sections, General Information and Ground Rules). Identify the technical component charge by adding modifier '-27' to the usual procedure code, and value in accordance with the ground rules for the section.

D¥-30 Consultation Service During Medical-legal

Evaluation:

Services or procedures performed by a consultant in the context of a medical-legal evaluation are identified by adding the modifier '-30' to the basic service or procedure code.

®-32 Mandated Services:

Services related to mandated consultation and/or related services (eg, PRO, 3rd party payer) is identified by adding the modifier '-32' to the basic procedure.

D-51 Multiple Procedures:

When multiple procedures, other than Evaluation and Management Services, are performed on the same day or at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) are identified by appending the modifier '-51' to the additional procedure or service code(s).

Note: This modifier should not be appended to designated "add-on" codes (eg, 22612, 22614).

-52 Reduced Services:

Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's election. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier '-52'

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signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.

component split listed in this schedule use the modifier which appropriate describes the service rendered (i.e., '-26', '-27').

Pathology and Laboratory

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Note: Modifier '-52' may be utilized with computerized tomography numbers for a limited study or a follow-up study.

to provide the service. Additional items which may be included are:

- complexity of symptoms;
- final diagnosis;
- pertinent physical findings;
- diagnostic and therapeutic procedures;
- concurrent problems;
- follow-up care.

In some instances, the values of BR procedures may be determined using the value assigned to a comparable procedure. The comparable procedure should reflect the same amount of time, complexity, expertise, etc., as required for the procedure performed.

6. SPECIFIC BILLING INSTRUCTIONS: GLOBAL SERVICE, PROFESSIONAL COMPONENT AND TECHNICAL COMPONENT REIMBURSEMENT

The relativities listed in this section include recording of the specimen, performance of the test, and reporting of the result. They do not include specimen collection, transfer, or individual patient administrative services. (For reporting collection and handling, see the 99000 series.)

Certain procedures are a combination of both a physician (professional) and a technical component. The listed values are total values that include both the professional and technical components. Total reimbursement for the professional and technical components combined shall not exceed the listed value for the total procedure, regardless of the site(s) where services are rendered. When both the professional and technical components of such procedures are performed by the same provider, a global service has been rendered. When the professional or technical component of a procedure is billed separately it shall be valued according to the percent of the total value indicated in the "PC/TC" column of the fee schedule. When reporting a procedure for which there is a professional/technical

The listed values apply to physicians, physician-owned laboratories, commercial laboratories, and hospital laboratories.

Global Service: Certain procedures are a combination of both a physician (professional) and a technical component. When both the professional and technical components of such procedures are performed by the same provider, a global service has been rendered.

Professional Component: The professional component represents the value of the professional pathology services or of the physician. This includes examination of the patient, when indicated, performance and/or supervision of the procedure, interpretation and written report of the laboratory procedure, and consultation with the referring physician. (Report using modifier '-26'.)

Technical Component: The technical component includes the charges for personnel, materials, space, equipment, and other facilities. (Report using modifier '-27'.)

The column designated PC/TC indicates the percent of the global fee (RV) for the technical and professional components of the procedure.

7. MODIFIERS

Listed services and procedures may be modified under certain circumstances. When applicable, the modifying circumstances should be identified by the addition of the appropriate modifier code. The modifier is reported by a two digit number placed after the usual procedure number from which it is separated by a hyphen. If more than one modifier is used, place the "Multiple Modifiers" code '-99' immediately after the procedure code. This indicates that one or more additional modifier codes will follow. Modifiers commonly used in **Pathology and Laboratory** are as follows:

Modifier - 29 for global procedures (those procedures where one provider is responsible for both the professional and technical component)

has been deleted. If a provider is billing for a global service, no modifier is necessary.

®-22 Unusual Procedural Services

When the service(s) provided is greater than that usually required for the listed procedure, it is identified by adding the modifier '-22' to the usual procedure number. *Documentation is required.*

®-26 Professional Component

Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service is identified by adding the modifier '-26' to the usual procedure number.

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5. UNLISTED SERVICE OR PROCEDURE

A service or procedure may be provided that is not listed in this edition of *this Schedule*. When reporting such a service, the appropriate "Unlisted Procedure" code may be used to indicate the service, identifying it By Report as discussed in *Item 6 below*. The "Unlisted Procedures" and accompanying codes for **Medicine** are as follows:

90749	<u>Unlisted Immunization procedure</u>
90799	<u>Unlisted therapeutic or diagnostic injection</u>
90899	<u>Unlisted psychiatric service or procedure</u>
90915	<u>Unlisted biofeedback procedure</u>
90999	<u>Unlisted dialysis procedure, inpatient or outpatient</u>
91299	<u>Unlisted diagnostic gastroenterology procedure</u>
92499	<u>Unlisted ophthalmological service or procedure</u>
92599	<u>Unlisted otorhinolaryngological service or procedure</u>
93799	<u>Unlisted cardiovascular service or procedure</u>
94799	<u>Unlisted pulmonary service or procedure</u>
95199	<u>Unlisted allergy/clinical immunologic service or procedure</u>
95999	<u>Unlisted neurological or neuromuscular diagnostic procedure</u>
96549	<u>Unlisted chemotherapy procedure</u>
96999	<u>Unlisted special dermatological service or procedure</u>
97039	<u>Unlisted physical medicine modality</u>
97139	<u>Unlisted physical medicine therapeutic procedure</u>
97799	<u>Unlisted physical medicine service or procedure</u>
99199	<u>Unlisted special service or report</u>

6. PROCEDURES WITHOUT UNIT VALUE ("BY REPORT")

Unit values are not shown for some procedures listed in the Schedule. Fees for such procedures need to be justified by report, although a detailed clinical record is not necessary.

By Report (BR): Procedures coded BR (By Report) are services which are unusual or variable.

An unlisted service or one that is rarely provided, unusual or variable may require a report demonstrating the medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the

procedure, and the time, effort and equipment necessary to provide the service. Additional items which may be included are:

- complexity of symptoms;
- final diagnosis;
- pertinent physical findings;
- diagnostic and therapeutic procedures;
- concurrent problems;
- follow-up care.

In some instances, the values of BR procedures may be determined using the value assigned to a comparable procedure. The comparable procedure should reflect the same amount of time, complexity, expertise, etc., as required for the procedure performed.

7. MODIFIERS

Listed services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance should be identified by the addition of the appropriate modifier code. The modifier is reported by a two digit number placed after the usual procedure number from which it is separated by a hyphen. If more than one modifier is used, place the Multiple Modifiers code '-99' immediately after the procedure code. This indicates that one or more additional modifier codes will follow. Modifiers commonly used in Medicine are listed below.

Modifier - 29 for global procedures (those procedures where one provider is responsible for both the professional and technical component) has been deleted. If a provider is billing for a global service, no modifier is necessary.

®-22 Unusual Procedural Services

When the service(s) provided is greater than that usually required for the listed procedure, it is identified by adding the modifier '-22' to the usual procedure number. *Documentation is required.*

®-25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of a Procedure or Other Service

The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or

*beyond the usual preoperative and postoperative
care associated*

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CPT CODE	Rel Value	Descriptor	CPT CODE	Rel Value	Descriptor
		(For development of cognitive skills, see 97799)	® <u>96111</u>	<u>21.8</u>	<u>extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments, eg, Bayley Scales of Infant Development) with interpretation and report, per hour</u>
		<u>Marriage, family and child counselors and licensed clinical social workers billing under this fee schedule shall use modifier '- 88'. (See item 7, "Modifiers", in the Medicine Section.)</u>			
<u>96100</u>	<u>17.1</u>	Psychological testing (includes psycho-diagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, eg, WAIS-R, Rorschach, MMPI) with interpretation and report, per hour	<u>96115</u>	<u>22.8</u>	<u>80/20</u> Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, memory, visual spatial abilities, language functions, planning) with interpretation and report, per hour
<u>96105</u>	<u>35.9</u>	<u>100/0</u> Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour	<u>96117</u>	<u>17.1</u>	Neuropsychological testing battery (eg, Halstead-Reitan, Luria, WAIS-R) with interpretation and report, per hour
® <u>96110</u>	<u>19.6</u>	<u>80/20</u> Developmental testing; <u>limited: Developmental Screening Test II, Early Language Milestone Screen) with interpretation and report</u>			

CHEMOTHERAPY ADMINISTRATION

Procedures 96400-96549 are independent of the patient's visit.

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If significant separately identifiable Evaluation and Management service is performed, the appropriate E/M service code should be reported in addition to 96400-96549.

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Physical Medicine

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reimbursed at 100% of listed value)

Additional time codes are not subject to the multiple procedures calculation (97145, 97221, 97241, 97501, 97521, 97531, 97541, 97631).

Physical therapist Assessment and Evaluation codes and test and measurement procedures are not included in the multiple procedures calculation or in the "no more than four in one visit." Additional time procedures (97145, 97721, 97241, 97501, 97521, 97531, 97541, 97631) shall not be included in multiple procedures and modalities calculation for reimbursement, but they are included in the "no more than four in one visit" ground rule. Codes 97660, 97670, 97690-97752 and 98770-98778 are reimbursable only once in a 30-day period of time and may not be combined with another procedure code which provides similar data unless prior authorization is received.

f. The reimbursement for follow-up evaluation and management services for the routine reassessment of an established patient is included in the value of the treatment codes in the Physical Medicine Section of the schedule. Follow-up Evaluation and Management services for the re-examination of an established patient may be reimbursed in addition to physical medicine, manipulation, starred procedures and acupuncture only when any of the following applies:

- There is a definite measurable change in the patient's condition requiring a significant change in the treatment plan
- The patient fails to respond to treatment requiring a change in the treatment plan
- The patient's condition becomes permanent and stationary, or the patient is ready for discharge
- It is medically necessary to provide evaluation services over and above those normally provided during the therapeutic services and included in the reimbursement for physical medicine treatment (Documentation may be required)
- It is necessary to provide evaluation services to meet

the reporting requirements set forth in Title 8, California Code of Regulations Section 9785(f).

g. Values for Physical Medicine codes and acupuncture codes include routine follow-up assessment for evaluation and management purposes and the value of an office visit. When an Evaluation and Management service, test and measurement service (codes 97660, 97670, 97690, 97700-97752, 98770-98778), or Physical therapist Assessment and Evaluation service is provided on the same day by the same licensed medical provider of service, 2.4 units of value using the Medicine conversion factor shall be deducted from the combined value of the treatment codes to account for the follow-up assessment for evaluation and management purposes and the office visit inherent in the treatment codes. This applies when the physician is the same provider giving physical medicine service or when the physical therapist is employed by a physician. When physical therapy is provided at a separate facility or when the physical therapy department has separate and distinct overhead costs of getting the patient in and out of the office, the full value for both codes shall be allowed.

h. Test and Measurement codes (97700-97752) shall not be reimbursed when billed with an Evaluation and Management (E/M) code or a Physical therapist Assessment and Evaluation (A/E) code unless justified by documentation.

i. Treatment using computer-assisted equipment is reimbursable under 97110 for less than 30 minutes. For treatments of 30 minutes or more, use 97620.

j. Patients who have progressed from individual exercise programs requiring a one-to-one interaction with the provider to an individualized exercise program supervised by the provider within a treatment facility, should be billed using 97630. Although some time may still be spent with the provider on a one-to-one basis, it is less than 50% of the visit. The group size is limited to a ratio of five patients to one provider.

k. Patient education programs (97650) must be clearly defined in terms of numbers of sessions and number of

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participants in the group. The sessions must be spaced over time.

2. WORK HARDENING

Work Hardening (97545) is a highly structured, goal-oriented, individualized treatment program designed to return the person to work. Work Hardening programs,

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CPT CODE	Rel Value	Descriptor	CPT CODE	Rel Value	Descriptor
			97028	3.0	ultraviolet
		PHYSICAL MEDICINE	97039	BR	unlisted modality (specify)
		(For muscle testing, range of joint motion, electromyography, see 95831 et seq)			PROCEDURES
		(For biofeedback training by EMG, see 90900)			(Physician or therapist is required to be in constant attendance)
		(For transcutaneous nerve stimulation (TNS), see 64550. <i>This code should only be used by physicians.</i>)			<i>(Except where otherwise specified, for additional procedure time beyond initial 30 minutes, use code 97145)</i>
		<u>(The appropriate physical medicine code for the use of a transcutaneous electrical nerve stimulator (TENS unit) is 97014.)</u>	97110	5.4	Physical medicine treatment to one area, initial 30 minutes, each visit; therapeutic exercises
		MODALITIES	97112	5.4	neuromuscular reeducation
		<i>(Physician or therapist is required to be in constant attendance)</i>	97114	5.4	functional activities
97010	<u>0.0</u>	Physical medicine treatment to one area; hot or cold packs	97116	4.4	gait training
97012	3.0	traction, mechanical	97118	3.8	electrical stimulation (manual)
97014	3.0	electrical stimulation (unattended)	97120	4.9	iontophoresis
97016	3.0	vasopneumatic devices	97122	3.3	traction, manual
97018	3.0	paraffin bath	97124	3.6	massage
97020	3.0	microwave	97126	3.3	contrast baths
97022	3.0	whirlpool	97128	3.4	ultrasound
97024	3.0	diathermy	97139	BR	unlisted procedure (specify)
97026	3.0	infrared	97145	2.2	Physical medicine treatment to one area, each additional 15 minutes
			97220	6.0	Hubbard tank; initial 30 minutes, each visit

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97221	2.9	each additional 15 minutes, up to one hour
97240	8.2	Pool therapy or Hubbard tank with therapeutic exercises; initial 30 minutes, each visit

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Manipulative Treatment

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**OSTEOPATHIC
MANIPULATIVE TREATMENT**

Codes 98925-98929 may be used only by licensed Doctors of Osteopathy (D.O.s) and licensed Doctors of Medicine (M.D.s)

Note: also see Physical Medicine and Rehabilitation ground rules which apply to osteopathic manipulative treatment codes.

Osteopathic manipulative treatment is a form of manual treatment applied by a physician to eliminate or alleviate somatic dysfunction and related disorders. This treatment may be accomplished by a variety of techniques.

Evaluation and Management services may be reported separately if, and only if, the patient's condition requires a significant separately identifiable E/M service, above and beyond the usual preservice and postservice work associated with the procedure

Body regions referred to are: head region; cervical region; thoracic region; lumbar region, sacral region; pelvic region; lower extremities; upper extremities; rib cage region; abdomen and viscera region.

	98928	<u>12.8</u>	seven to eight body regions involved
	98929	<u>13.9</u>	nine to ten body regions involved
98925	<u>6.2</u>		Osteopathic manipulative treatment (OMT) one to two body regions involved
98926	<u>9.3</u>		three to four body regions involved
98927	<u>11.0</u>		five to six body regions involved

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