LEGISLATIVE RESEARCH SERVICES

Alaska State Legislature
Division of Legal and Research Services
State Capitol, Juneau, AK 99801

(907) 465-3991 phone
(907) 465-3908 fax
research@legis.state.ak.us

Research Brief

TO: Representative Kurt Olson
FROM: Susan Haymes, Legislative Analyst
DATE: February 27, 2014
RE: Workers' Compensation Medical Fee Schedules
LRS Report 14.270

You asked about workers' compensation medical fee schedules. Specifically, you asked how medical fee schedules are determined in California, Idaho, Oregon, and Washington. Additionally, you asked what criteria states use to update conversion factors. You also asked how many states have advisory committees that help set medical fee rates.

Forty-three states, including Alaska, use a medical fee schedule to reimburse physicians providing medical services to injured workers. Typically, workers' compensation programs use one of two types of fee schedules: the *resource-based relative value scale* (RBRVS) or the *usual, customary and reasonable* (UCR). A RBRVS fee schedule is based on the resources a physician uses to provide a medical service.[1] California, Idaho, Oregon, and Washington are among at least 32 states that have adopted the RBRVS fee schedule. The RBRVS approach may include three components:

- The relative value unit (RVU)—which includes a combination of the physician's work, practice expense, and malpractice insurance to provide the medical service.
- A geographic adjustment factor (GAF)—which measures the relative cost of producing a physician service in a local area.
- A conversion factor—which is a dollar amount that converts the relative value units into a payment amount for a service. Many states use multiple conversion factors.[2]

Most states that have adopted the RBRVS system use the relative value units developed by the Centers for Medicare and Medicaid Services (CMS).[3] The CMS assigns a relative value unit to each code in the American Medical Association's Current Procedural Terminology (CPT). The CMS updates the RVUs annually and publishes them in the *Medicare National Physician Fee Schedule Relative Value File*. States may then refer to this document to obtain the RVU for the specific medical service. Some states adjust the RVU by applying a geographic adjustment factor (GAF), which is used to correct for differences in the cost of operating in different states and urban versus rural areas. The adjusted RVU is then multiplied by the state's conversion factor(s) to calculate the maximum allowable fee for that service. Most states set their own conversion factor(s), which may be based on specific criteria outlined in statute or at the discretion of the Workers' Compensation Division. States that use multiple conversion factors typically use different factors for evaluation and management, radiology, lab and pathology, general medicine, and surgery.

---

[1] The states are Alabama, Arkansas, California, Colorado, Connecticut, Florida, Hawaii, Idaho, Kansas, Kentucky, Maine, Massachusetts, Maryland, Michigan, Minnesota, Mississippi, Montana, Nebraska, Nevada, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Vermont, Washington, and West Virginia.

[2] The conversion factor may also serve to adjust relative values units for inflation.

[3] Another source of ready-made relative values units is the *Relative Values for Physicians*, which is based upon five criteria: time, skill, severity of illness, the risk to the patient, and risk to the physician.

California, Idaho, Oregon, and Washington all use relative value units provided by the CMS. California and Washington's medical fee schedules are both calculated using a geographic adjustment factor, and beginning in 2017, both will use a single conversion factor. Neither Idaho nor Oregon uses a geographic adjustment factor, and both use multiple conversion factors. We briefly describe the method each state uses to set its medical fee schedule.

California

In 2013, California became the most recent state to adopt an RBRVS fee schedule for workers' compensation (SB 863).[4] California adopted the CMS or Medicare relative value scale.[5] In other words, the state's Division of Workers Compensation (DWC) will refer to the RVUs established by the CMS when calculating the maximum allowable fee for specific services. The Medicare RBRVS use different RVUs for physician services in a facility versus a non-facility. For example, in a non-facility setting such as the physician's office, the physician bears higher practice expenses than if the physician performed the service in a facility (California Labor Code § 5307.1).

The RBRVS system will be phased in over the next four years through changes in the conversion factors applicable to each type of service. California will transition from separate conversion factors for surgery, radiology, and "all other services" to a single conversion factor in 2017, for all services except anesthesia.[6] By 2017, the single conversion factor will be based on 120 percent of the Medicare 2012 payment levels, plus inflation adjustments and relative value scale adjustments adopted by Medicare, if any. Thereafter, the conversion factor will be updated based on the increase in the Medicare Economic Index (an inflation adjustment) and any relative values scale adjustment adopted by Medicare (Labor Code § 5307.1[b][2][A][iii], [g]).

California's RBRVS system also employs a geographic adjustment factor (GAF) that is a statewide average of Medicare's adjustment factors for the nine geographic areas in California. The workers' compensation RBRVS uses statewide average geographic adjustment factors for each RVU component—work, practice expense, and malpractice—to determine the adjusted RVU for the medical service. Once the adjusted RVU has been determined, that number is multiplied by the conversion factor to calculate the maximum allowable fee. For example, after identifying the CPT code for the medical service and appropriate RVUs from the 2014 Medicare relative value scale, the fee formula for an injured worker who is examined in the physician's office looks something like this:

> [(Work RVU x Statewide Work GAF) + (Non-Facility Practice Expense RVU x Statewide practice expense GAF) + malpractice RVU x State wide malpractice GAF)] x conversion factor = Base Maximum Fee

Idaho

The Idaho Industrial Commission also uses the RBRVS, published by the Centers for Medicare and Medicaid Services (CMS) as the standard to be used for determining the RVUs for each medical service (IDAPA 17.02.09).[7] Idaho does not apply a geographic cost adjustment, but uses eight different conversion factors, including four for different categories of surgeries,

---

[4] More information on SB 863, including the text of the bill and more details about the changes, can be accessed at *http://www.dir.ca.gov/dwc/SB863/SB863.htm*. The Rand Corporation prepared a report for California on implementing a RBRVS fee schedule, which may be of interest. The 227-page report, "Implementing a Resource-Based Relative Value Scale Fee Schedule for Physician Services," 2013, can be accessed at *http://www.rand.org/pubs/research_reports/RR395.html*.

[5] The 2014 California medical fee schedule can be accessed at *http://www.dir.ca.gov/dwc/OMFS9904.htm#4*. We include a fact sheet on the Resource Based Relative Value Scale Fee Schedule prepared by the California DWC as Attachment A

[6] Most states price anesthesia under a different scale that uses base units and times with a separate conversion factor.

[7] More information on Idaho's medical fee schedule can be accessed at *http://www.iic.idaho.gov/medical/medical.html#feeschedule*.

one for radiology, one for pathology and laboratory, and two for general medicine (Idaho Statute § 72-803). The Commission is required to adjust the conversion factors each fiscal year to reflect change in inflation or market conditions (IDAPA 17.02.09 § 031.06).

Using the same example as we did for California, Idaho's formula is as follows:

> (Work RVU + Non-Facility Practice Expense RVU + malpractice RVU) x conversion factor = Base Maximum Fee

Oregon

The Oregon Workers' Compensation Division primarily uses the Medicare RBRVS to determine the RVU for a medical service. Oregon has also developed its own state-specific codes for certain services that are used in addition to the Current Procedural Terminology (CPT) coding.[8] Similar to the system in Idaho, Oregon does not apply a geographic adjustment to the RVU and also uses multiple conversion factors. Oregon uses different conversion factors for evaluation and management, radiology, lab and pathology, medicine, physical medicine and rehabilitation, surgery and state-specific codes. Under Oregon law, the Division must update the fee schedule including the conversion factors annually and may base the update upon a statistically valid survey of medical service fees or markups, medical service fee information, information provided by providers of health insurance, or the annual percentage increase or decrease in the physician's services component of the national Consumer Price Index (Oregon Statute § 656.248). Oregon's fee schedule formula is the same as Idaho's.

Washington State

Washington adopted the RBRVS system in 1993. Like the California system, Washington's RBRVS fee schedule is based on relative value units, geographic adjustment factors for Washington State, and a single conversion factor. Washington uses the RVUs as determined by the CMS, including the site of service payment differential.[9] Like California, Washington uses a single conversion factor for all services. The current conversion factor is $55.34 (WAC § 296-20-135). The Washington Department of Labor and Industries may adjust the conversion factor annually based on the estimated increase or decrease in the state's average wage for the current year and "on other factors as determined by department policy" (WAC § 296-20-132).

The maximum fee for a procedure is obtained by multiplying the adjusted RVUs by the conversion factor. Washington's maximum fees for facility and nonfacility settings are published in the Professional Services Fee Schedule.[10] Washington's formula would be the same as the one for California: each RVU component is adjusted by the geographic adjustment and the total is multiplied by the conversion factor.

---

[8] More information on Oregon's medical fee schedule is available at ***http://www.cbs.state.or.us/wcd/rdrs/mru/mpindex.html***.

[9] More information on Washington's medical fee schedule can be accessed at ***http://www.lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched/2012/MARFS/Chapter31/default.asp#CalcRBRVS***.

[10] Washington State's 2013 Professional Services fee Schedule can be accessed at ***http://www.lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched/2013/default.asp***.

Conversion Factors

As discussed above, within the RBRVS system, the conversion factor is a dollar amount that is used to convert the adjusted RVU to the maximum allowable fee for physician services. Some states—such as California, Texas, and Washington—use a single conversion factor, and others—such as, Arkansas, Idaho, Kansas, Minnesota, Oklahoma, Oregon, and Montana—use multiple conversion factors.

Many states require that the workers' compensation fee schedule be updated annually, and of those, some also specify the basis for adjusting the conversion factor(s). We identified a number of bases that states use to adjust the conversion factor(s) including the Consumer Price Index; the statewide average weekly wage; measures of inflation such as the Medicare economic index, and year-over-year inflation; and changes in levels of reimbursement. The most common bases specified are changes in the Consumer Price Index and the statewide average weekly wage. For example, Minnesota, Montana, and Washington, consider adjustments based on changes in the statewide average weekly wage. Idaho, Nevada, and Oklahoma consider changes in inflationary measures. Oregon may consider a variety of factors including changes in the Consumer Price Index.[11]

Workers' Compensation Medical Fee Advisory Committees

We identified three states—Illinois, Kansas, and Utah—that have Workers' Compensation Medical Fee Advisory Boards that are specifically charged with advising their state's Workers' Compensation Division on the establishment of fees for medical services.[12] The nine-member Illinois Workers' Compensation Medical Fee Advisory Board advises is comprised of representatives of medical providers, employers, and employees.[13] The Utah Medical Fee Advisory Board is comprised of individuals representing physicians, nurses, physical therapists, employers, insurance, and the Workers' Compensation Division.

At least 15 states have created Workers' Compensation Advisory Councils or Boards to offer advice on general policy, programmatic, and budget matters relating to workers' compensation.[14] No doubt, some of these Councils may also offer advice on setting fees.

We hope this is helpful. If you have questions or need additional information, please let us know.

[11] As examples, we include relevant regulations or statutes from Idaho, Minnesota, Oregon, and Washington as Attachment B.

[12] This is by no means a comprehensive list. There are likely other states with medical fee advisory committees that we did not identify under the current time restraints.

[13] More information on the Illinois medical fee advisory board can be accessed at ***http://www.iwcc.il.gov/boards.htm#WCMFAB***.

[14] The states are Connecticut, Illinois, Louisiana, Maryland, Massachusetts, Minnesota, New Hampshire, New Mexico, Oklahoma, Oregon, South Dakota, Tennessee, Utah, Washington, and Wisconsin.

Fact Sheet on the Resource Based Relative Value Scale (RBRVS) Fee Schedule Effective January 1, 2014

1. ***When did the new RBRVS-based fee schedule become effective?***
   1.1. The RBRVS-based physician and non-physician practitioner fee schedule is effective for *services rendered* on or after January 1, 2014.
   1.2. The rule as initially adopted through rulemaking was based upon Medicare's 2013 policies and RVUs. After reviewing Medicare's Physician Fee Schedule 2014 Final Rule (issued November 27, 2013), the Division updated the workers' compensation Physician Fee Schedule regulations in accordance with Labor Code §5307.1 by issuing and posting an Administrative Director update Order adopting relevant changes from the 2014 Medicare Physician Fee Schedule. Although the Medicare Physician Fee Schedule Final Rule is usually issued approximately November 1st, it was delayed in 2013 due to the federal government shutdown.
   1.3. The Update Order and regulations are posted on the Division's Official Medical Fee Schedule (OMFS) web page: http://www.dir.ca.gov/dwc/OMFS9904.htm#7 .
      1.3.1. As part of that Order, the Administrative Director updates the links and documents incorporated by reference into title 8, Cal. Code Regs. §9789.19. The Order also updates the conversion factors to account for inflation in accordance with the Medicare Economic Index and the relative value scale adjustment, if any.
      1.3.2. The Physician Fee Schedule uses the Medicare 2014 relative value units and 2014 CPT codes.
      1.3.3. The posted regulations include provisions adopted in the initial rulemaking action, in the "clean up" rulemaking (to eliminate use of federal Office of Workers' Compensation Program values), and in the Administrative Director's Update Order.

2. **How does the RBRVS fee schedule work?**
   2.1. The fee schedule has three components:
      2.1.1. *Relative Value Units (RVUs)* for each medical service measure the relative resources associated with the physician's work (the time and skill required for the procedure), practice expenses (the staff time and costs of maintaining an office), and malpractice expenses. The RVUs compare the resources required for one service to those required for other services. Relative to the pre-2014 OMFS, the RBRVS tends to provide lower relative values for surgical and other technical procedures and higher relative values for E&M services. Most RVUs will be based on Medicare's RVUs. If Medicare has not established RVUs for a reimbursable procedure code the services will be priced By Report.
         2.1.1.1. The pre-2014 OMFS set one RVU for each procedure, and did not list separate RVUs for physician work, practice expense and malpractice. The RBRVS-based fee schedule adopts the Medicare relative value scale file which sets forth separate RVUs for work, practice expense and malpractice.
         2.1.1.2. The pre-2014 OMFS set the same fee for a physician service regardless of where the service was rendered, e.g. the physician received the same fee if the procedure was performed in a physician office or at an inpatient facility. The RBRVS-based fee

Table 1. Transition Conversion Factors Before Adjustments for Inflation/RV Scale Adjustment

Type of Service	RAND Budget-Neutral CF	120% 2012 Medicare[a]	2014 CF 75/25 Blend	2015 CF 50/50 Blend	2016 CF 25/75 Blend	2017 CF 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

[a] The Medicare 2012 CFs for anesthesia and all other services are $21.408 and $34.042, respectively.

2.2.2. The Conversion Factors for each year will be updated with the published inflation factor and the Medicare relative value scale adjustment, if any. The updated conversion factors will be adopted by use of an Administrative Director Order posted on the DWC website as specified in Labor Code section 5307.1 subdivision (g). For 2014, the updated conversion factors (set forth in 8 CCR §9789.19) are shown in Table 2.

Table 2. 2014 Conversion Factors, Adjusted for Inflation and Relative Value Scale Budget Neutrality Adjustments

Type of Service	2014 CF
Anesthesia	33.8190
Surgery	55.2913
Radiology	53.1039
All other services	38.3542

2.3. The maximum fee for a workers' compensation medical service performed in 2014 is calculated by applying the appropriate formula and ground rules.

Example: Injured worker is a new patient who is examined in the physician's office.
Physician bills CPT® 99205 Office or other outpatient visit for evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; comprehensive examination; medical decision making of high complexity.

Step 1: Determine if place of service is "facility" or "non-facility" (§9789.12.2(d).)
Physician's Office is Place of Service code 11 Office, a "non-facility" setting.

Step 2: Select formula for non-facility site of service calculation (§9789.12.2(a)).

Step 6: Apply the formula for non-facility site of service calculation (§9789.12.2(a)).

[(Work RVU * Statewide Work GAF) +
(Non-Facility PE RVU * Statewide PE GAF) +
(MP RVU * Statewide MP GAF)] * Conversion Factor (CF) = Base Maximum Fee

[(3.17 * 1.040) +
(2.35 * 1.1606) +
(0.26 * 0.6636)] * $38.3542 = $237.67

Step 7: Apply relevant ground rules, if any, to the Base Maximum Fee to determine the payable fee (e.g., the Health Professional Shortage Area 10% bonus payment.) Note, however, that certain ground rules are applied during the initial calculations rather than being applied at the end of the formula. For example, the Physical Therapy Multiple Procedure Payment Reduction is applied to reduce the practice expense RVU component of multiple procedures during the initial calculations using the formula; the Physical Therapy MPPR is not applied at the end of the calculations as that would result in an incorrect reduction.

3. What are the biggest changes in ground rules?

3.1. The ground rules adopted in the RBRVS-based fee schedule adopt Medicare ground rules, with some exceptions. The exceptions address WC-specific programmatic needs such as WC-required reports. Unless there was a compelling policy reason for retaining a pre-2014 OMFS rule, the Division adopted Medicare payment rules.

3.1.1. Adopting the Medicare rules simplifies the administration of the fee schedule and brings WC policies in conformance to how the RBRVS rates are set.

3.1.2. Aggregate payments under the RBRVS are limited to 120 percent of Medicare aggregate payments. If different policies were adopted for Medicare-covered services that increase aggregate payments, an offsetting adjustment would be required.

3.2. *Coding.* The RBRVS-based fee schedule regulation adopts the American Medical Association's *Current Procedural Terminology®* and incorporates it by reference into the regulations. The new edition of the CPT will be adopted each year through an Administrative Director update Order. The regulations specify certain CPT codes that are not to be used.

3.3. *Supplies and reports.* The pre-2014 OMFS provided separate allowances for certain reports and supplies. The RBRVS-based fee schedule generally bundles payment for reports and supplies into the payment for E&M and other services. Certain WC-required reports that are separately reimbursable continue to be paid separately, including progress reports, permanent and stationary PR-4 reports, consultation reports requested by the QME or AME in the context of a medical-legal evaluation and consultation reports requested by the WCAB or Administrative Director.

3.4. *Consultations.* The pre-2014 OMFS utilized consultation codes. The RBRVS-based fee schedule does not use consultation codes, but follows the Medicare rule which uses visit codes to report consultation services.

3.6.2. The pre-2014 OMFS limits on the number of procedures and time billed during an encounter will continue as "presumed reasonable limits on reimbursement." Medically necessary procedures above the limits must be preauthorized and subject to a pre-negotiated fee agreement in order to be paid.

3.7. *Non-physician practitioners.* The pre-2014 OMFS does not differentiate between physicians and non-physician practitioners acting within their scope of practice for purposes of determining the maximum allowable fee for a procedure. The RBRVS-based fee schedule adopts the Medicare rules relating to non-physician practitioner fees.

3.7.1. Unless their services are billed "incident to" a physician's service, the RBRVS-based fee schedule: a) pays services furnished by nurse practitioners and physician assistants at 85 percent of the allowed amount for physician services; b) pays clinical social workers at 75 percent of the allowed amount. The rule follows the Medicare ground rules and pays for non-physician practitioners at the discounted rate when they bill directly for their services (rather than a physician billing for their services "incident to" the physician's service).

3.8. *Physician-administered vaccines and drugs.* The pre-2014 OMFS contains outdated allowances for physician-administered vaccines and drugs that are injected or infused during an E&M visit or other procedure.

3.8.1. The new rule follows the MediCal fee schedule for drug ingredients because it provides broader drug coverage than Medicare. The fee schedule is contained in the Medi-Cal Rates file.

3.8.2. The MediCal Rates file follows Medicare for most drugs, which sets the maximum rate at the Average Sales Price (ASP) plus 6 percent. If a drug does not have a Medicare ASP price, MediCal's pharmacy pricing methodology for outpatient prescription drugs applies.

3.8.3. The "Basic Rate" price listed on the Medi-Cal rates page includes an injection administration fee of $4.46. This injection administration fee should be subtracted from the published rate because payment for the injection administration will be determined under the RBRVS.

3.8.4. The Medi-Cal Rates file applies to the *physician-administered* drugs, not to *physician-dispensed* drugs (which are governed by Labor Code section 5307.1 and title 8, Cal. Code Regs. §9789.40.)

3.9. *Health Professional Shortage Area (HPSA) Bonus.* The RBRVS-based fee schedule adopts the Medicare HPSA bonus payments. Physicians who provide professional services in a Primary Care or Mental Health HPSA are eligible for a 10-percent bonus payment.

3.9.1. Only psychiatrists are eligible for the Mental Health HPSA, and if the service is performed in a zip code that is both a primary and mental health HPSA, only one 10-percent bonus is payable.

3.9.2. Eligibility for the HPSA bonus is determined by the location services were rendered, not where the physician maintains his/her office.

3.9.3. The rule provides that the claims administrator must automatically pay the 10% bonus along with the underlying payment for the service, if the service is performed in a zip code that fully falls within the HPSA. For services rendered in a zip code that does not fall within

6.4. Because most providers furnish a range of services, most impacts by provider specialty are less than the impacts by type of service. Table 2 compares the estimated impacts by type of service and selected specialties at the end of the transition period in 2017 when allowances will be based on 120 percent of the Medicare 2012 rate updated for inflation.

Table 3: Summary of Impacts by Type of Service and By Specialty in 2017 Relative to Pre-2014 OMFS

	By Type of Service	By Specialty
Surgery	-20.1 percent	-8.7 percent
Radiology	-15.9 percent	-23.3 percent
Pathology	-29.0 percent	-6.9 percent
E&M	+39.5 percent	
Anesthesiology	-19.6 percent	-15.3 percent
Medicine	+17.3 percent	
Chiropractic		+22.3 percent
Family and general medicine	---	+12.0 percent
Physical therapy	---	+64.7 percent
Physical medicine and rehab	---	+51.7 percent
Psychiatry	---	+2.6 percent
Occupational medicine	---	+29.2 percent

IDAPA 17.02.09.031

IDAHO ADMINISTRATIVE CODE

*** THIS DOCUMENT IS CURRENT THROUGH JULY 10, 2013 ***

IDAPA 17: INDUSTRIAL COMMISSION
TITLE 02
CHAPTER 09: MEDICAL FEES

IDAPA 17.02.09.031 (2013)

031. ACCEPTABLE CHARGES FOR MEDICAL SERVICES PROVIDED BY PHYSICIANS UNDER THE IDAHO WORKERS' COMPENSATION LAW.

Pursuant to Section 72-508 and Section 72-803, Idaho Code, the Industrial Commission (hereinafter "the Commission") hereby adopts the following rule for determining acceptable charges for medical services provided by physicians under the Idaho Workers' Compensation Law. Effective Date (4-7-11)

01. Acceptable Charge. Payors shall pay providers the acceptable charge for medical services provided by physicians. Effective Date (4-7-11)

02. Adoption of Standard for Physicians. The Commission hereby adopts the Resource-Based Relative Value Scale (RBRVS), published by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services, as amended, as the standard to be used for determining the acceptable charge for medical services provided under the Idaho Workers' Compensation Law by physicians. Effective Date (4-7-11)

03. Conversion Factors. The following conversion factors shall be applied to the fully-implemented facility or non-facility Relative Value Unit (RVU) as determined by place of service found in the latest RBRVS, as amended, that was published before December 31 of the previous calendar year for a medical service identified by a code assigned to that service in the latest edition of the Physicians' Current Procedural Terminology (CPT), published by the American Medical Association, as amended:

MEDICAL FEE SCHEDULE

SERVICE CONVERSION
CODE RANGE(S) DESCRIPTION
CATEGORY FACTOR

Anesthesia 00000 - 09999 Anesthesia $ **60.33**
22000 - 22999 Spine
23000 - 24999 Shoulder, Upper Arm, & Elbow
25000 - 27299 Forearm, Wrist, Hand, Pelvis & Hip
Surgery - 27300 - 27999 Leg, Knee, & Ankle
$ 140.00
Group One 29800 - 29999 Endoscopy & Arthroscopy
61000 - 61999 Skull, Meninges & Brain
62000 - 62259 Repair, Neuroendoscopy & Shunts

63000 - 63999 Spine & Spinal Cord
Surgery - 28000 - 28999 Foot & Toes
$ 129.00
Group Two 64550 - 64999 Nerves & Nervous System
Surgery - 13000 - 19999 Integumentary System
$ 113.52
Group Three 20650 - 21999 Musculoskeletal System
10000 - 12999 Integumentary System
20000 - 20615 Musculoskeletal System
29000 - 29799 Casts & Strapping
30000 - 39999 Respiratory & Cardiovascular
Surgery - 40000 - 49999 Digestive System
$ 87.72
Group Four 50000 - 59999 Urinary System
60000 - 60999 Endocrine System
62260 - 62999 Spine & Spinal Cord
64000 - 64549 Nerves & Nervous System
65000 - 69999 Eye & Ear
Radiology 70000 - 79999 Radiology $ 88.54
Pathology &
80000 - 89999 Pathology & Laboratory To Be Determined
Laboratory
90000 - 90799 Immunization, Injections, & Infusions
Medicine - 94000 - 94999 Pulmonary / Pulse Oximetry
$ 47.00
Group One 97000 - 97799 Physical Medicine & Rehabilitation
97800 - 98999 Acupuncture, Osteopathy, & Chiropractic
90800 - 92999 Psychiatry & Medicine
93000 - 93999 Cardiography, Catheterization, & Vascular
Medicine - Studies
$ 68.50
Group Two 95000 - 96020 Allergy / Neuromuscular Procedures
96040 - 96999 Assessments & Special Procedures
99000 - 99607 E / M & Miscellaneous Services Effective Date (7-1-12)

04. Anesthesiology. The Conversion Factor for the Anesthesiology CPT Codes shall be multiplied by the Anesthesia Base Units assigned to that CPT Code by the Centers for Medicare and Medicaid Services of the U.S.
Department of Health and Human Services as of December 31 of the previous calendar year, plus the allowable time units reported for the procedure. Time units are computed by dividing reported time by fifteen (15) minutes. Time

units will not be used for CPT Code 01996. Effective Date (4-7-11)

05. Adjustment of Conversion Factors. The conversion factors set out in this rule shall be adjusted each fiscal year (FY) by the Commission to reflect changes in inflation or market conditions in accordance with Section 72-803, Idaho Code. Effective Date (4-7-11)

06. Services Without CPT Code, RVU or Conversion Factor. The acceptable charge for medical services that do not have a current CPT code, a currently assigned

RVU, or a conversion factor will be the reasonable charge for that service, based upon the usual and customary charge and other relevant evidence, as determined by the Commission. Where a service with a CPT Code, RVU, and conversion factor is, nonetheless, claimed to be exceptional or unusual, the Commission may, notwithstanding the conversion factor for that service set out in Subsection 031.03, above, determine the acceptable charge for that service, based on all relevant evidence in accordance with the procedures set out in Section 034, below. Effective Date (4-7-11)

07. Coding. The Commission will generally follow the coding guidelines published by the Centers for Medicare and Medicaid Services and by the American Medical Association, including the use of modifiers. The procedure with the largest RVU will be the primary procedure and will be listed first on the claim form. Modifiers will be reimbursed as follows: Effective Date (4-7-11)

a. Modifier 50: Additional fifty percent (50%) for bilateral procedure. Effective Date (4-7-11)

b. Modifier 51: Fifty percent (50%) of secondary procedure. This modifier will be applied to each medical or surgical procedure rendered during the same session as the primary procedure. Effective Date (4-7-11)

c. Modifier 80: Twenty-five percent (25%) of coded procedure. Effective Date (4-7-11)

d. Modifier 81: Fifteen percent (15%) of coded procedure. This modifier applies to MD and non-MD assistants. Effective Date (4-7-11)

Minn. Stat. § 176.136

*** This document is current through Chapter 144, Regular Session ***
*** Annotations are current through January 13, 2014 ***

LABOR, INDUSTRY
CHAPTER 176. WORKERS' COMPENSATION
FEES FOR SERVICES

Minn. Stat. § 176.136 (2013)

176.136 **MEDICAL FEE** REVIEW

Subdivision 1. *Schedule.*

(a) The commissioner shall by rule establish procedures for determining whether or not the charge for a health service is excessive. In order to accomplish this purpose, the commissioner shall consult with insurers, associations and organizations representing the **medical** and other providers of treatment services and other appropriate groups.

(b) The procedures established by the commissioner must limit, in accordance with subdivisions 1a, 1b, and 1c, the charges allowable for **medical,** chiropractic, podiatric, surgical, hospital and other health care provider treatment or services, as defined and compensable under section 176.135. The procedures established by the commissioner for determining whether or not the charge for a health service is excessive must be structured to encourage providers to develop and deliver services for rehabilitation of injured workers. The procedures must incorporate the provisions of sections 144.701, 144.702, and 144.703 to the extent that the commissioner finds that these provisions effectively accomplish the intent of this section or are otherwise necessary to ensure that quality hospital care is available to injured employees.

Subd. 1a. *Relative value **fee** schedule.*

(a) The liability of an employer for services included in the **medical fee** schedule is limited to the maximum **fee** allowed by the schedule in effect on the date of the **medical** service, or the provider's actual **fee,** whichever is lower. The commissioner shall adopt permanent rules regulating **fees** allowable for **medical,** chiropractic, podiatric, surgical, and other health care provider treatment or service, including those provided to hospital outpatients, by implementing a relative value **fee** schedule. The commissioner may adopt by reference, according to the procedures in paragraph (h), clause (2), the relative value **fee** schedule tables adopted for the federal Medicare program. The relative value **fee** schedule must contain reasonable classifications including, but not limited to, classifications that differentiate among health care provider disciplines. The **conversion** factors for the original relative value **fee** schedule must reasonably reflect a 15 percent overall reduction from the

(2) Each time the workers' compensation relative value **fee** schedule tables are updated under paragraph (h), the commissioner shall adjust the **conversion** factors so that, for services in both **fee** schedules, there is no difference between the overall payment in each category of service listed in paragraph (b) under the new schedule and the overall payment for that category under the workers' compensation **fee** schedule most recently in effect. This adjustment must be made before making any additional adjustment under clause (1).

(h) The commissioner shall give notice of the adjusted **conversion** factors and updates to the relative value **fee** schedule as follows:

(1) The commissioner shall annually give notice in the State Register of the adjusted **conversion** factors and any amendments to rules to implement Medicare relative value tables incorporated by reference under this subdivision. The notices of the adjusted **conversion** factors and amended rules to implement the relative value tables are subject to the requirements of section 14.386, paragraph (a). The annual adjustments to the **conversion** factors and the **medical fee** schedules adopted under this section, including all previous **fee** schedules, are not subject to expiration under section 14.386, paragraph (b).

(2) The commissioner shall periodically, but at least once every three years, update the workers' compensation relative value tables by incorporating by reference the relative value tables in the national physician **fee** schedule relative value file established by the Centers for Medicare and Medicaid Services. The commissioner shall publish the notices of the incorporation by reference in the State Register at least 60 days before the tables are to become effective for purposes of payment under this section. Each notice of incorporation must state the date the incorporated tables will become effective and must include information on how the Medicare relative value tables may be obtained. The published notices of incorporation by reference and the incorporated tables are not rules subject to section 14.386 or other provisions of chapter 14, but have the force and effect of law as of the date specified in the notices.

Subd. 1b. *Limitation of liability.*

(a) The liability of the employer for treatment, articles, and supplies provided to an employee while an inpatient or outpatient at a small hospital shall be the hospital's usual and customary charge, unless the charge is determined by the commissioner or a compensation judge to be unreasonably excessive. A "small hospital," for purposes of this paragraph, is a hospital which has 100 or fewer licensed beds.

(b) The liability of the employer for the treatment, articles, and supplies that are not limited by subdivision 1a or 1c or paragraph (a) shall be limited to 85 percent of the provider's usual and customary charge, or 85 percent of the prevailing charges for similar treatment, articles, and supplies furnished to an injured person when paid for by the injured person, whichever is lower. On this basis, the commissioner or compensation judge may determine the reasonable value of all treatment, services, and supplies, and the liability of the employer is limited to that amount. The commissioner may by rule establish the reasonable value of a service, article, or supply in lieu of the 85 percent limitation in this paragraph. A

The commissioner shall also conduct a study of the qualifications and background of rehabilitation consultants and vendors providing services under section 176.102 for the purpose of determining whether there are adequate professional standards provided, including safeguards to protect against conflicts of interest.

Subd. 4. [Repealed, 1987 c 332 s 117]

Subd. 5. [Repealed, 1992 c 510 art 4 s 26]

History:

Ex1979 c 3 s 45; 1981 c 346 s 87; 1982 c 424 s 130; 1983 c 289 s 114 subd 1; 1983 c 290 s 108; 1984 c 432 art 2 s 25; 1984 c 640 s 32; 1984 c 655 art 1 s 92; 1985 c 234 s 11; 1987 c 332 s 39; 1989 c 282 art 2 s 51,52; 1992 c 510 art 4 s 14-18; 1993 c 194 s 6; 1995 c 231 art 2 s 64-66; 1996 c 374 s 4; 1997 c 187 art 5 s 26; 1Sp2005 c 1 art 4 s 40; 2008 c 250 s 7,8; 2013 c 70 art 2 s 9

NOTES:

EDITOR'S NOTE
Laws 2013 article 2, § 14 of chapter 70 provides, "Section 9 is effective on October 1, 2013, and shall be used to establish prevailing charges on or after that date."

EFFECTIVE NOTE
The 2013 amendment is effective October 1, 2013.

AMENDMENT NOTE
The 2013 amendment added the last sentence of 1b.(b).

*** Current through the 2012 Regular Session and 2012 Special Session ***
*** Annotations current through November 16, 2011 ***

ORS § 656.248 (2012)

656.248 Medical service fee schedules; basis of fees; application to service provided by managed care organization; resolution of fee disputes; rules.

(1) The Director of the Department of Consumer and Business Services, in compliance with ORS 656.794 and ORS chapter 183, shall promulgate rules for developing and publishing fee schedules for medical services provided under this chapter. These schedules shall represent the reimbursement generally received for the services provided. Where applicable, and to the extent the director determines practicable, these fee schedules shall be based upon any one or all of the following:

(a) The current procedural codes and relative value units of the Department of Health and Human Services Medicare Fee Schedules for all medical service provider services included therein;

(b) The average rates of fee schedules of the Oregon health insurance industry;

(c) A reasonable rate of markup for the sale of medical devices or other medical services;

(d) A commonly used and accepted medical service fee schedule; or

(e) The actual cost of providing medical services.

(2) Medical fees equal to or less than the fee schedules published under this section shall be paid when the vendor submits a billing for medical services. In no event shall that portion of a medical fee be paid that exceeds the schedules.

(3) In no event shall a provider charge more than the provider charges to the general public.

(4) If no fee has been established for a given service or procedure the director may, in compliance with ORS 656.794 and ORS chapter 183, promulgate a reasonable rate, which shall be the same within any given area for all primary health care providers to be paid for that service or procedure.

(5) At the request of the director and in the method and manner prescribed by rule, all providers of health insurance, as defined by ORS 731.162, shall cooperate and consult with the director in providing information reasonably necessary and available to develop the fee schedules prescribed under subsection (1) of this section. A provider shall not be required to provide information or data that the provider deems proprietary or confidential. However, the information provided shall be considered proprietary and shall not be released by the director. The director shall not require such information from a health insurance provider more than once per year and shall reimburse the provider's costs for providing the required information.

(6) Notwithstanding subsection (1) or (2) of this section, such rates or fees provided in subsections (1) and (2) of this section shall be adequate to insure at all times to the injured workers the standard of services and care intended by this chapter.

(7) The director shall update the schedule required by subsection (1) of this section annually. As appropriate and applicable, the update shall be based upon:

(a) A statistically valid survey by the director of medical service fees or markups;

(b) That information provided to the director by any person or state agency having access to medical service fee information;

(c) That information provided to the director pursuant to subsection (5) of this section; or

(d) The annual percentage increase or decrease in the physician's services component of the national Consumer Price Index published by the Bureau of Labor Statistics of the United States Department of Labor.

(8) The director is prohibited from adopting or administering rules which treat manipulation, when performed by an osteopathic physician, as anything other than a separate therapeutic procedure which is paid in addition to other services or office visits.

(9) The director may, by rule, establish a fee schedule for reimbursement for specific hospital services based upon the actual cost of providing the services.

(10) A medical service provider is not authorized to charge a fee for preparing or submitting a medical report form required by the director under this chapter.

(11) Notwithstanding any other provision of this section, fee schedules for medical services and hospital services shall apply to those services performed by a managed care organization certified pursuant to ORS 656.260, unless otherwise provided in the managed care contract.

(12) When a dispute exists between an injured worker, insurer or self-insured employer and a medical service provider regarding either the amount of the fee or nonpayment of

bills for compensable medical services, notwithstanding any other provision of this chapter, the injured worker, insurer, self-insured employer or medical service provider may request administrative review by the director. The decision of the director is subject to review under ORS 656.704.

(13) The director may excludehospitals defined in ORS 442.470 from imposition of a fee schedule authorized by this section upon a determination of economic necessity.

History:

Amended by 1965 c.285 § 26; 1969 c.611 § 1; 1971 c.329 § 1; 1981 c.535 § 5; 1983 c.816 § 6; 1985 c.107 § 1; 1985 c.739 § 5; 1987 c.884 § 42; 1990 c.2 § 14; 1995 c.332 § 26; 1999 c.233 § 1; 2005 c.26 § 6; 2009 c.36 § 2.

NOTES:

Note: See notes under 656.202.

WAC § 296-20-132

*** This file includes all rules adopted and filed through the ***
*** 14-01 Washington State Register dated December 18, 2013 ***

TITLE 296. LABOR AND INDUSTRIES, DEPARTMENT OF
CHAPTER 20. MEDICAL AID RULES
BILLING

WAC § 296-20-132 (2013)

WAC 296-20-132. Determination of conversion factor adjustments.

Adjustments to the conversion factors for providers and services covered by the fee schedules and by department policy may occur annually following prior public hearings.

Such adjustments will be based on the estimated increase/decrease in the state's average wage for the current year and on other factors as determined by department policy. The following calendar year's estimate, of the average state wage will be adjusted to reflect the actual increase/decrease in the state's average wage for the preceding year.

The total percentage change for any one calendar year for the conversion factors may not exceed the total of the estimated increase/decrease in the current year, plus or minus the actual adjustment for the preceding calendar year.

Statutory Authority: RCW 51.04.020(4) and 51.04.030. 96-10-086, § 296-20-132, filed 5/1/96, effective 7/1/96. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159. 93-16-072, § 296-20-132, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 88-24-011 (Order 88-28), § 296-20-132, filed 12/1/88, effective 1/1/89; 82-24-050 (Order 82-39), § 296-20-132, filed 11/29/82, effective 1/1/84.