

# From the CEO

## A Decade of Attempts to Convert the Workers' Compensation Fee Schedule to RBRVS

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Ten years ago, the Division of Workers' Compensation (DWC) announced the intent to transition the existing Official Medical Fee Schedule (OMFS) codes and unit values to Resource-Based Relative Value Scale (RBRVS). The conversion to RBRVS has been stalled for several years, due partly to opposition by those who treat workers' compensation patients as well as to political considerations. Another influence was the call for sweeping reform in other areas of the WC system, which put other changes before the fee schedule. After releasing three iterations of an RBRVS conversion, the DWC seems committed to moving ahead with fee schedule reform.

The Lewin Group, a research think tank, was contracted in 2002 to develop a transition plan to standardize the fee schedule coding, taking into account the unique aspects of the OMFS. Overseen by Allan Dobson, one of the architects of the Medicare RBRVS, they spent several months crunching numbers and developing a model for transition. Public hearings held in mid 2003 drew criticism of many aspects of the study, from questioning the validity of the data used for modeling to using Medicare rates as a benchmark for physician payments.

Concurrently, in 2002 demands for reform and cost containment by employers and insurers were heeded, and many significant changes occurred in 2003 and 2004. The changes that were related to medical benefits included limits on the number of physical therapy, occupational therapy, and chiropractic services; expansion of the OMFS to include hospital and ASC payments; a revised pharmacy schedule; and the elimination of the patient choice to switch to his own personal physician after 30 days if the patient is in a Medical Provider Network (an HMO-like network). In 2004, physician payments were reduced by 5 percent, leaving the anesthesiology conversion factor at \$32.78, slightly lower than the \$34.50 conversion factor (CF) set in the mid 1980s.

In 2008 an amendment to the original Lewin report was issued, again drawing stinging criticism from stakeholders. It examined the possibility of using geographic adjustments to payments in the way Medicare applies geographic

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practice cost indices. In addition, it incorporated a 10 percent increase for services provided in Health Professional Shortage Areas. It also projected a sizeable increase for evaluation and management services, with substantial decreases in payment for surgical services and modest decreases for radiology and pathology services. It proposed no change in payments for anesthesiology services. A significant complaint by physicians was that physical therapy services would receive an increase of over 10 percent.

In March 2010, the DWC released a third amendment to The Lewin Group study with a proposed fee schedule, and it invited the public and interested stakeholders to participate in an online discussion forum on the DWC Website. The report laid out, for the first time, a detailed budget-neutral option with a transition schedule to a single CF for all services except anesthesiology. Most who responded on the forum were individual practitioners who expressed outrage at the budget-neutral methodology, which shifts a portion of the funds paid for surgery to primary care services. This iteration of the proposal set the anesthesiology CF at \$33.98 and all other services would transition over three years to a single CF of \$45.15 in year four. Under that scenario, the surgery CF would drop from the initial rate of \$53.12, and the radiology CF would decrease from an initial CF of \$59.53. All other services, mostly office services, will increase from the starting point of \$40.70.

Concurrently, DWC announced reductions in the facility fees paid to ambulatory surgery centers. The intended payment is set at 120 percent of Medicare. This drew fire from ASC owners, who argued that the site of service should not affect the facility rate and that access to care may be decreased. Because Medicare and other payers have separate fee schedules for hospitals and ASCs, the DWC will likely prevail in that debate.

On May 24, another amendment was released that detailed a four-year transition to RBRVS, also culminating in a single CF for all services, plus a separate anesthesiology CF. The new proposed fee schedule is significantly more appealing than its predecessor to all specialties *except anesthesiology*. It calculates increases in CFs to most specialties except radiology and anesthesiology. The increases will be funded by savings derived from reduced payments for spinal hardware and ambulatory surgical center fees, along with system savings gained through requiring electronic billing. Under the new proposal, the conversion factor for all services *except anesthesiology* will increase to \$60 in 2013, with the anesthesia CF fixed at \$34.

### Title 8 CCR section 9789.12.4, conversion factors:

*For services other than anesthesiology, the proposal includes the initial use of three conversion factors—surgery, radiology, and “all other.” The regulations include a transition period of four years during which the three conversion factors converge to a single conversion factor in year five.*

Other features of the March proposal include application of the Correct Coding Initiative edits and most Medicare ground rules.

The DWC removed the draft regulations from its website on May 25, citing the possibility of an error in the content. On July 6, the regulations were reposted with an informal comment period until July 20. A 45-day notice of public hearings will occur after the comment period.

Assuming that the corrections will not affect anesthesiology services, here is the future for anesthesia that the DWC proposes:

1. The CF for anesthesiology services will be set at \$34, with no increase during the four-year transition.
2. Physical status and qualifying circumstances modifiers are reimbursed.
3. Most Medicare ground rules will be incorporated.

When the corrected regulation is released, detailed examination of the effects on payment for anesthesiology services will take place under the auspices of the CSA Legislative and Practice Affairs Division. The CSA will vigorously oppose the discriminatory tactic of freezing the anesthesiology conversion factor at 1980s levels and any other proposal that disadvantages anesthesiologists.

### **CSA Bulletin Cover for Volume 59, Number 3 “Historic Union Station Los Angeles”**

This photograph was taken of Union Station in Los Angeles in August 2009. This is the original ticket lobby. A Canon digital SLR was used to obtain a RAW image that was processed using Lightroom and Photoshop.

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