Working Paper

Fee Schedule Options for Services Furnished by Hospitals to Outpatients under the California Workers' Compensation Program

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WR-1016-DIR
February 2014
Prepared for the California Department of Industrial Relations

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Preface

The Official Medical Fee Schedule (OMFS) establishes the maximum allowable amounts for medical services under the California workers' compensation system. California Senate Bill 863 requires that the administrative director of the Division of Workers' Compensation implement a resource-based relative value scale (RBRVS) fee schedule for physician and other practitioner services, similar to the fee schedule utilized in the federal Medicare program. The Department of Industrial Relations asked the RAND Corporation to provide technical assistance in implementing the fee schedule. RAND issued a technical report that modeled the impact of implementing the RBRVS fee schedule for physician and other practitioner services.[1] The final regulations adopting a RBRVS fee schedule as the OMFS for services furnished by physicians and other practitioners are effective January 1, 2014.[2]

However, the pre-2014 OMFS for physician services also applies to certain services furnished by hospitals to outpatients− largely diagnostic procedures and clinic visits. The administrative director is addressing through a separate rulemaking process what allowances should apply to these services after the RBRVS for physician services is implemented. Our technical report provided preliminary policy options for establishing the allowances for these services. Because additional analyses are required on this topic, we have removed the preliminary analyses from the initial report and are issuing this working paper, which consolidates into a single document our analyses of the policy options for paying for the hospital services provided to outpatients. The paper should be of interest to the California provider and payer communities and to policymakers in California and in other states that are considering implementing Medicare-based fee schedules for medical services provided to injured workers.

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[1] Barbara O. Wynn, Hangsheng Liu, et al., *Implementing a Resource-based Relative Value Scale for Physician Services: An Assessment of Policy Options for the California Workers' Compensation Program*, RAND: Santa Monica, CA, February 2014, RR-395-1.

[2] California Department of Industrial Relations, Division of Workers' Compensation, "Physician Fee Schedule Regulations, Title 8, California Code of Regulations Division 1, Chapter 4.5, Subchapter 1 Administrative Director – Administrative Rules, Article 5.3 Official Medical Fee Schedule (Effective January 1, 2014).

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

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Summary

The Official Medical Fee Schedule (OMFS) establishes the maximum allowable amounts (MAAs) for medical services under the California workers' compensation system. California Senate Bill 863 requires that the administrative director of the Division of Workers' Compensation implement a resource-based relative value scale (RBRVS) fee schedule for physician and other practitioner services. The final rule implementing the RBRVS for physician services were filed with the secretary of state September 24, 2013 and will be effective January 1, 2014.[3] The RBRVS fee schedule is similar to the fee schedule utilized in the federal Medicare program except that the allowances are 120 percent of what Medicare would pay for comparable services (i.e., a 1.2 multiplier is applied to the Medicare rate).

Senate Bill 863 did not address how the allowances for certain services furnished by hospitals to outpatients−mostly diagnostic procedures and clinic visits−that are paid under the pre-2014 OMFS for physician services should be established after the RBRVS is implemented for physician services. These services represent approximately seven percent of total expenditures for outpatient services provided by hospitals to workers' compensation patients. The last major update to the pre-2014 OMFS physician fee schedule occurred in 1999. Given its outdated nature and the implementation of the RBRVS for physician services, it is not appropriate to continue to use the pre-2014 OMFS physician fee schedule to set allowances for hospital services to outpatients. Two basic OMFS alternatives build on Medicare-based fee schedules that are already used to determine OMFS allowances for some services: 1) the RBRVS fee schedule that was implemented for physician and other practitioner services effective January 1, 2014 and/or 2) the fee schedule based on the Medicare outpatient prospective payment system (OPPS) that currently is used for the OMFS for hospital facility fees for outpatient surgery and emergency room visits. Both fee schedules apply a 1.2 multiplier to the Medicare payment rate; however, the administrative director has the flexibility to adopt different multipliers for selected services as long as aggregate payments do not exceed 120 percent of what would be payable under Medicare for comparable services.

Under the pre-2014 OMFS for physician services, the same payment is made for diagnostic procedures and clinic visits regardless of where they are provided. Basing the allowances on the RBRVS fee schedule would be most consistent with the pre-2014 OMFS policy. Medicare generally pays higher rates for services furnished in a hospital outpatient setting because hospitals incur costs for standby capacity for emergencies and have higher infrastructure and regulatory costs. Basing the allowances on the OPPS fee schedule would recognize these higher

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[3] The rules were subsequently updated to reflect Medicare 2014 RBRVS rates (see DIR, 2013d).

costs. A key policy question that should be considered in deciding whether the allowances should be based on the RBRVS or OPPS rates is whether workers' compensation should pay more to hospitals than community-based providers for services that could appropriately be provided in a less costly setting.

The labor code limits aggregate MAAs under the OMFS to 120 percent of the amounts that would be payable under Medicare for comparable services (which, in the case of the services furnished by hospitals that are subject to the pre-2014 OMFS would be 120 percent of the OPPS rate). Within this aggregate limitation, the administrative director has the authority to use different multipliers for selected services to preserve access and/or encourage the efficient delivery of medically appropriate care. We compared the MAAs for services furnished by hospitals that are covered under the pre-2014 OMFS for physician services with two potential policies that were chosen in consultation with DWC:

> Option 1: A separate facility fee based on the RBRVS PE RVUs.
> This would set the OMFS allowance for hospital outpatient facility services based on the PE component of the RBRVS for services furnished in a nonfacility setting with a 1.20 multiplier. For services that have separate technical and professional components, the allowances for each component (and for the full service) would be determined in accordance with the RBRVS (including the 1.2 multiplier). The outpatient facility service allowance for other services would be based on nonfacility setting PE RVUs only and a separate allowance for the related physician professional services based on the allowances for services furnished in a facility-setting. This approach is modeled on the Medicare payment methodology for office-based surgeries performed in ambulatory surgery centers, which sets the facility fees for the office-based surgeries at the PE component of the RBRVS fee schedule.
>
> Option 2: A separate facility fee based on the OPPS with no multiplier.
> This would set the OMFS allowance at the Medicare rate for the hospital outpatient facility services that are currently subject to the pre-2014 OMFS for physician services. There would be separate RBRVS-allowances for the related physician professional services based on the allowances for services furnished in a facility-setting.

Relative to pre-2014 OMFS allowances, aggregate MAAs would decrease 7.6 percent if the RBRVS fee schedule with a 1.2 multiplier were used (Table 1). These would be the same as allowances paid to physicians for their practice expenses when services are provided in office settings. Aggregate MAAs would increase 48-65 percent if the OPPS fee schedule were used without a multiplier. This represents an estimated 3-5 percent increase in overall expenditures for hospital services to outpatients. Both estimates include where applicable additional RBRVS allowances for related services provided by physicians in a facility setting.

Table 1 Summary of Impacts of Alternative Policies for Establishing Allowances for Services Provided by Hospitals to WC Outpatients

Option	Estimated percentage change in allowances for services paid under the pre-2014 OMFS for physician services		Estimated percentage change in total expenses for hospital services to outpatients	
	Low estimate	High estimate	Low estimate	High estimate
1. RBRVS with 1.2 multiplier	(7.6)	(7.6)	(0.5)	(0.5)
2. OPPS with no multiplier	48.4	65.2	3.4	4.6

Acknowledgments

We are deeply appreciative of the guidance and assistance that we received throughout this study from our project officers, Jackie Schauer and Jarvia Shu at the California Division of Workers' Compensation. Their thoughtful insights were invaluable in shaping the impact analysis and examination of alternative policies. We also extend our thanks to our RAND colleague Tom LaTourrette for his guidance and support during the preparation of this report for publication and to our RAND colleague, Ross Anthony, and A. Bruce Steinwald of Bruce Steinwald Consulting for their constructive comments on an earlier version of the report.

Abbreviations

APC	ambulatory payment classification
CMS	Centers for Medicare & Medicaid Services
CPT®	Current Procedural Terminology
CT	computerized tomography
MAA	maximum allowable amount
MedPAC	Medicare Payment Advisory Commission
MRI	magnetic resonance imaging
PC	professional component
PE	practice expense
OMFS	Official Medical Fee Schedule
OPPS	outpatient prospective payment system
RBRVS	resource-based relative value scale
RVU	relative value unit
SB	Senate bill
TC	technical component
WCIS	workers' compensation information system

Background

The California Division of Workers' Compensation maintains an Official Medical Fee Schedule (OMFS) for medical services provided under California's workers' compensation program. The OMFS establishes the maximum allowable amount (MAA) for services unless the payer and provider contract for a different payment amount.[4] Until January 1, 2014, the OMFS for physician services (referred to as the pre-2014 OMFS throughout this paper) applied to all covered medical services provided, referred, or prescribed by physicians, regardless of the type of facility in which the services are provided. With the exception of facility fees for the use of emergency rooms or ambulatory surgical suites and clinical laboratory diagnostic tests, the pre-2014 OMFS applies to services furnished to hospital outpatients, including clinic services and diagnostic procedures. As a result, regardless of whether a diagnostic procedure is provided in a physician's office or a freestanding diagnostic testing facility or to a hospital outpatient, the same allowances have applied.

As amended by Senate Bill (SB) 863, Labor Code §5307.1(a)(2) requires a four-year transition from the aggregate MAAs under the pre-2014 OMFS to MAAs based on the resource-based relative value scale (RBRVS). Labor Code §5307.1(a) (2) is silent on how the services furnished by hospitals that are currently payable under the pre-2014 physician fee schedule should be paid when the RBRVS is implemented. The provision specifies that the administrative director shall adopt the RBRVS-based fee schedule "for physician services and nonphysician practitioner services, as defined by the administrative director." Section 5307.2(a) (2)(C) provides for a default option that shall apply to the maximum reasonable fees "for physician services and nonphysician practitioner services, including, but not limited to, physician assistant, nurse practitioner, and physical therapist services." Section 5307.1(a) (1), which was not amended by SB 863, requires the administrative director to adopt fee schedules for items other than physician services, including health care facility fees. The labor code does not define health care facility fees, but, when the administrative director implemented Medicare-based fee schedules for nonphysician services in 2004, health care facility fees for outpatient services were defined by Common Procedural Terminology (CPT) code as including only surgical and emergency department visit codes. One rationale for this approach was that the pre-2014 OMFS for physician services did not differentiate allowances by setting. Because the costs of providing clinic services were already reflected in the pre-OMFS allowance for physician services, making a separate payment for facility costs would have resulted in a duplicate payment. This rationale does not apply to a RBRVS fee schedule. As discussed in greater detail below, the RBRVS

[4] For example, it is common for fee discounting to occur under medical provider networks.

establishes different allowances for services furnished in facility and nonfacility (office) settings on the assumption the facility rather than the physician bears the staffing and other costs associated with providing the services when a service is provided in a facility setting.

The final regulations adopting a RBRVS fee schedule as the OMFS for services furnished by physicians and other practitioners were filed with the secretary of state on September 24, 2013 and were effective January 1, 2014 (Department of Industrial Relations, 2013c). The final regulations do not address how allowances for hospital services to outpatients will be established for services that are currently covered by the pre-2014 OMFS for physician services. Instead, the administrative director is addressing this issue through separate rulemaking. Until this rulemaking activity is completed, the pre-2014 OMFS continues to apply to these hospital services. This working paper supports the rulemaking by outlining policy alternatives and modeling the impact of selected options. It builds on the data and methodologies used in the RAND technical report that modeled the impact of the RBRVS implementation on allowances for physician and other practitioner services (Wynn, Liu, Mulcahy et al., 2013). The technical report provides more in-depth explanations of data and methodology for the modeling and should be consulted if additional information is needed on how the estimates of current OMFS allowances and RBRVS allowances were made.

As used in this paper, the term “RBRVS” fee schedule refers to the OMFS fee schedule that is effective for physician services January 1, 2014.The term “OPPS” fee schedule refers to the OMFS fee schedule that currently applies to facility fees for ambulatory surgery and emergency room visits and could be expanded to include other services. Both fee schedules are Medicare-based and except for the conversion factor and certain ground rules, the RBRVS and OPPS terms can be used interchangeably to refer to the Medicare fee schedules. When it is important to distinguish between the Medicare and OMFS fee schedules, we do so by specifying which fee schedule we are describing.

Medicare-based Fee Schedule Alternatives

Overview of Fee Schedules

Given the outdated nature of the pre-2014 OMFS physician fee schedule (the last major update occurred in 1999) and the adoption of the RBRVS for physician services, it is not appropriate to continue to use the pre-2014 OMFS physician fee schedule to set allowances for hospital services to outpatients. Two basic alternatives build on Medicare-based fee schedules that are already used to determine OMFS allowances: 1) the RBRVS fee schedule that was implemented for physician and other practitioner services effective January 1, 2014 and/or 2) the OPPS fee schedule that is currently used to determine OMFS allowances for hospital facility fees for outpatient surgery and emergency room visits.

As adopted by the administrative director, the RBRVS fee schedule has the following elements:

- relative value units (RVUs) for each medical service based on the resources associated with the physician's work (the time and skill required for the procedure), practice expenses (the staff time and costs of maintaining an office), and malpractice expenses. For most services, the RVUs for practice expenses vary based on whether the service is performed in the physician's office or in a facility. The RVUs compare the resources required for one service with those required for other services. Relative to the pre-2014 OMFS for physician services, the RBRVS tends to provide lower relative values for procedures and higher relative values for evaluation and management services. The RBRVS bundles values for reports and most supplies into the RVUs for the primary procedure.
- a conversion factor that converts the RVUs into a maximum allowed amount for the service. The conversion factor determines overall fee-schedule payment levels. Under the transition framework established in Labor Code §5307.1(a)(2), the RBRVS will be phased in over a four-year period by transitioning from multiple conversion factors for anesthesia, surgery, radiology, and all other services combined in 2014 to a single conversion factor in 2017for all services other than anesthesia (which will continue to have its own conversion factor). The 2014 conversion factors are based on 75 percent of budget-neutral conversion factors and 25 percent of 1.2 times the Medicare 2012 conversion factor. The 2017 single conversion factor for all services other than anesthesia is based on 1.2 times the Medicare 2012 conversion factor.
- an annual adjustment in the conversion factor for inflation and changes in the RVUs. The inflation adjustment is based on the cumulative increase in the Medicare Economic Index (a measure of annual changes in the costs of maintaining a physician practice) between 2012 and the payment year. The adjustment for changes in the RVUs is the annual adjustment factor that Medicare applies to the conversion factor to make the RVU changes budget neutral.

- a geographic adjustment factor based on separate statewide geographic adjustments for work, practice expense (PE) and malpractice RVUs.

Under Medicare, the outpatient prospective payment system (OPPS) fee schedule covers the facility fees for services furnished to outpatients in hospitals.[5] The OMFS uses the Medicare OPPS fee schedule to establish facility fee allowances for outpatient surgery and emergency department visits. The OMFS fee schedule has the following elements:

- relative weights for each service based on its assignment to an Ambulatory Payment Classification (APC) grouping of clinically coherent procedures with similar costs. Each APC has a relative weight reflecting the costliness of the median procedure in the group relative to the median cost for a mid-level clinic visit. Composite APCs have a single relative weight for certain multiple procedures that are frequently provided together during the same encounter.
- a conversion factor based on the Medicare conversion factor that was in effect when the OMFS fee schedule for facility fees for ambulatory surgery and emergency department visits was adopted in 2004. The conversion factor is adjusted annually for inflation and is multiplied by 1.20. The OMFS conversion factor for services furnished on or after April 1, 2013 is 1.2 x $70.761.
- a geographic adjustment factor that takes into account differences in average hospital wages across geographic locations. The average statewide adjustment factor is 1.35. It is applied to 60 percent of the conversion factor.

In addition to its OPPS payment for facility services, Medicare makes a separate payment for any physician's services that are furnished in hospitals to outpatients. The RBRVS practice expense component is typically lower for comparable services provided in hospitals than for services provided in physician offices and other nonfacility settings. The lower rate accounts for Medicare's separate OPPS payment to the hospital for the costs of clinical staff, supplies, and equipment that would be incurred by the physician if the service were furnished in an office setting.

Most diagnostic procedures under the RBRVS fee schedule have a professional component (PC) that covers the physician's professional services related to supervising and interpreting the procedure results and a technical component (TC) that covers the staff and equipment costs associated with providing the actual procedure. CPT code modifiers are used to report the TC and PC components. When the complete service is performed, the payment equals the sum of the payments for these two components. Only the PC is payable to a physician under the RBRVS if

[5] The OPPS does not apply to outpatient rehabilitation services. The RBRVS fee schedule applies to services provided by hospitals and by therapists in community-based practices.

the service is furnished in a facility setting on the assumption the facility assumes the costs for the TC. [6]

Diagnostic and therapeutic services with separate TC/PC components account for 86 percent of the allowances for services furnished by hospitals to outpatients that are covered by the pre-2014 OMFS for physician services. The issue for these services is how the allowance for the TC should be established. The PC would be payable under the OMFS RBRVS fee schedule regardless of where the services are furnished. The basic choice is between a TC allowance based on the RBRVS and an allowance based on the OPPS.

Other services provided to workers' compensation outpatients by hospitals that are currently covered by the pre-2014 OMFS physician fee schedule (for example, clinic visits) account for 14 percent of total pre-OMFS allowances. The alternatives for these services are less straightforward. The pre-2014 OMFS established a single allowance regardless of where the service is provided. Medicare's RBRVS rates are consistent with its rules for how services are paid in a facility versus nonfacility setting and what is covered by the facility rate. The rate for services provided in a facility setting is lower than in a nonfacility setting because there is a separate outpatient hospital facility fee. To be consistent with how the RBRVS values are set, the OMFS should establish a separate facility fee for hospital outpatient facility services that complements the RBRVS allowance for professional services in a facility setting. This is Medicare's policy and is also the policy adopted by other workers' compensation fee schedules that use Medicare-based fee schedules for both outpatient and physician services.
The separate hospital outpatient facility fee could be based either on the RBRVS practice expenses (PE) applicable to services furnished in a nonfacility setting or the OPPS.

A key policy question in deciding whether hospital facility services to outpatients should be based on the RBRVS or OPPS fee schedule is whether workers' compensation should pay more to hospitals than community providers for services that would be clinically appropriate to provide in a less costly setting. The Medicare Payment Advisory Commission (MedPAC) has recommended that Medicare pay for clinic visits at the same rate as office visits (MedPAC, 2012) and is considering whether to extend the recommendation to other services (MedPAC, 2013). The principles that MedPAC has laid out to make this evaluation are as follows (Zabinski and Winter, 2013):

- Patients should have access to settings that provide an appropriate level of care.
- A prudent purchaser should not pay more for a service in one setting than another.

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[6] In the medicine section of the CPT codebook, different CPT codes are used instead of modifiers to describe the components of some diagnostic procedures. For example, three separate codes are used to report routine electrocardiograms: CPT 93000 (tracing and interpretation and report), CPT 93005 (tracing only) and CPT 93010 (interpretation and report only).

- Payment rates should be based on the resources needed to treat patients in the lowest-cost clinically appropriate setting.

Payment rates for hospital outpatient services are typically higher for three reasons: 1) hospitals incur standby capacity costs for emergencies and have higher infrastructure and regulatory costs, (2) patient severity might be greater in hospital outpatient departments than in office settings, and (3) the Medicare OPPS has broader bundling policies than the RBRVS fee schedule.[7]

In recommending that clinic visits be paid at the same rate as office visits, MedPAC concluded that these higher costs should not affect the costs of evaluation and management visits outside the emergency department. Moreover, MedPAC was concerned about the growing trend toward hospital purchases of physician practices. When a hospital purchases a physician practice, Medicare's fee schedule changes from the RBRVS to the OPPS despite no change in the nature of the actual services. Others have also highlighted the inappropriateness of the OPPS and Medicare physician fee schedule differentials for comparable services.[8]

The labor code limits aggregate allowances under the OMFS to 120 percent of the amounts that would be payable under Medicare for comparable services (which, in the case of the services furnished by hospitals that are subject to the pre-2014 OMFS would be 120 percent of the OPPS rate). Within this aggregate limitation, the administrative director has the authority to use different multipliers for selected services to preserve access and/or encourage the efficient delivery of medically appropriate care.

Specific Policy Alternatives for Outpatient Facility Fees

1. Pay for services using the RBRVS PE (or TC) RVUS.
   - Advantages
     - Consistent with the pre-2014 OMFS policy of paying the same amount across different ambulatory settings
     - Encourages provision of care in the least costly clinically appropriate setting
     - Levels the playing field across hospitals and community-based providers for comparable services
     - Consistent with the policy direction advocated by some for Medicare payment reform (MedPAC, 2013; National Commission on Physician Payment Reform, 2013)
     - Results in minimal changes in aggregate expenditures for hospital outpatient services

[7] Bundling refers to the package of services that are included in the allowance for a primary service. For example, stress agents, contrast material, and radionuclides are separately payable under the RBRVS but not the OPPS.

[8] See, for example, National Commission on Physician Payment Reform, 2013.

- Disadvantages
  - Fails to recognize that hospitals have higher infrastructure costs
  - Requires special policies to provide adequate allowances for services that are performed only in facility settings
  - Complicates bill processing by having different payment rules for different types of hospital services provided to outpatients

2. Pay for services using OPPS rates but with a lower multiplier.

- Advantages
  - Avoids large and arguably unjustifiable increases in OMFS allowances
  - Recognizes that workers' compensation patients are not likely to have higher costs than Medicare patients for diagnostic services
  - Consistent with following Medicare's lead in determining appropriate allowances payment rates
- Disadvantages
  - The same item may be paid at 120 percent of the OPPS rate when it is furnished as an integral and subordinate part of a surgical procedure or emergency department visit and at 100 percent of the OPPS rate when it is furnished in conjunction with other hospital outpatient services.
  - Creates incentives to provide emergency department rather than clinic visits

3. Pay for services under the OPPS with a 1.2 multiplier

- Advantages
  - Most straightforward reading of the labor code
  - Adopts a single payment system for hospital outpatient services consistent with Medicare rules and other payers
- Disadvantages
  - Increases expenditures unnecessarily when services could be provided in a less costly medically appropriate setting
  - Would be contrary to prudent buyer policy directions

4. Pay for related ancillary and diagnostic services furnished during an emergency department visits using OPPS rates and remaining services under the RBRVS.

- Advantages
  - Strikes a balance between prudent buyer objectives and recognizing when higher costs may be justified
- Disadvantages
  - Could result in unnecessary provision of emergency department services to obtain higher allowances for ancillary services
  - Complicates administration by having two different payment systems apply to hospital outpatient services

We compared the allowances for services furnished by hospitals that are covered under the pre-2014 OMFS with two potential policies that were chosen in consultation with DWC:

> Option 1: A separate facility fee based on the RBRVS PE (or TC) RVUs with a 1.2 multiplier.
>
> This would set the OMFS allowance for hospital outpatient facility services based on the same allowances as physicians would receive for their practice expenses when the services are provided in office settings. For services that have separate technical and professional components, the allowances for each component (and for the full service) would be determined in accordance with the RBRVS (including the 1.2 multiplier). For other services furnished to hospital outpatients, the PE RVUs in a nonfacility setting would be used for the outpatient facility service allowance and there would be a separate allowance for the related physician professional services based on the allowances for services provided in facility-settings. This approach is modeled on the Medicare payment methodology for office-based surgeries performed in ambulatory surgery centers, which sets the facility fees for the office-based surgeries at the PE component of the RBRVS fee schedule.
>
> Option 2: A separate facility fee based on the OPPS with no multiplier.
>
> This would set the OMFS allowance at the Medicare rate for the hospital outpatient facility services that are currently subject to the pre-2014 OMFS for physician services. There would be separate RBRVS-allowances for the related physician professional services based on the allowances for furnishing services in a facility-setting.

Because we were working with aggregate data, we did not model an option of paying for services provided in conjunction with emergency department visits at a higher rate than services provided in conjunction with clinic visits and/or referrals from the community. The impact of adopting this policy would depend on how the allowances were set for the emergency vs. non-emergency cases. Regardless of the specific policies, different allowance levels are likely to create incentives for unnecessary emergency department visits and increase the administrative burden of reviewing the medical necessity of any emergency visits. In lieu of setting the allowances on a retroactive case-by-case determination, an alternative would be to classify ancillary procedures according to the proportion of time they are furnished on an emergency basis, and to establish a lower payment for services that are typically furnished on a non-emergency basis than for services that are typically furnished in conjunction with an emergency department visit. This approach, which is along the lines that MedPAC is using to develop its policies on hospital outpatient payment differentials, would require considerable policy development before it could be implemented.

Comparison of Allowances for High Expenditure Procedures

Table 2 compares the MAAs for the procedures with the highest aggregate TC allowances under the pre-2014 OMFS with what would be allowed under the two options identified above.

The volumes and pre-2014 OMFS MMAs for any outdated CPT codes have been crosswalked to their 2014 equivalents.[9] The RBRVS rate is based on 2014 RVUs and the 2012 Medicare conversion factor x 1.2 adjusted for the statewide geographic adjustment factors and updated for inflation to 2014. Using this rate rather than the actual 2014 transition rate provides a better comparison of the amounts that will be payable after the transition to the RBRVS fee schedule is completed. The comparison does not account for discounting policies that apply when multiple diagnostic procedures are furnished during the same encounter or for differences in bundling policies. In general, the OPPS has broader bundling policies than the RBRVS, which means that the RBRVS allowance may be slightly understated relative to the OPPS payments.

With the exception of one code (CPT 72131 CT scan, lumbar spine, without contrast), the TC allowance is higher under the OPPS with no multiplier than under the RBRVS with a 1.2 multiplier. Generally, the OPPS differential is greater for less resource-intensive services (e.g., x-ray examinations) than for more resource-intensive services, such as magnetic resonance imaging (MRI) and computerized tomography (CT) scans.

Table 3 compares the allowances for other high-expenditure services furnished by hospitals to WC outpatients. Part A of the table provides information on the rates that were used to price services under the policy options. Part B compares the aggregate allowances under the two options for the facility fee. Unlike the pre-2014 physician fee schedule, the two options establish a separate facility fee in addition to the allowance for the professional services in a facility setting. Option 1 reports both facility and total allowances assuming the facility fee allowance is set using the PE RVUs. Option 2 reports allowances assuming the allowance for the facility fee is set at the OPPS rate with no multiplier. Under both options, the total allowances include any allowances that would be payable for related professional services in a facility setting. Some services such as the drug administration codes (for example, CPT 90471) are payable under the RBRVS only in a nonfacility setting. Because there is no physician work component for the service, the service has only a facility fee allowance (based on the nonfacility PE) and no additional allowance would be made for a physician service. In our estimates, the total allowances are the same as the facility allowances for these services. For evaluation and management services, Medicare pays a facility fee to cover the hospital's expenses in providing the services plus a separate amount for the related physician service (that is typically paid to the physician or physician's employer). The OPPS rates for clinic visits were modified effective January 1 so that the same rate applies for all visit levels and for established versus new patients; in contrast, the RBRVS allowances vary by type of clinic visit. For a CPT 99213 (Level 3 established patient clinic visit) visit provided in a nonfacility setting, the total allowance if the

[9] The pre-2014 OMFS uses 1997 CPT codes. To determine allowances using 2014 CPT codes and payment rules, we crosswalked the outdated codes into their 2014 equivalents. Because multiple OMFS codes may have been crosswalked to a single 2014 CPT code, the average OMFS allowance for the code computed by dividing the MAAs by the volume may not be the same as the allowance for the code under the pre-2014 OMFS fee schedule.

hospital's allowance were based on the PE RVUs would be $116.45 ($66.02 for the professional service and $50.43 for the facility service). If the Medicare OPPS rates were adopted, the total allowance for would be $111.74 for the facility fee (assuming no multiplier) plus an additional $66.02 for the physician's professional service (based on the allowance for furnishing the service in a facility setting). The total allowance for both components would be $177.76. As seen in Table 3, the facility allowances are consistently higher using the OPPS rates than the rates based on 120 percent of the PE RVUs.

Table 2 Comparison of MAAs for Highest-Expenditure TC Procedures Options 1 and 2 with Pre-2014 OMFS Allowances

				Option 1: RBRVS with 1.2 Multiplier			Option 2:Pay Based on OPPS with No Multiplier		
Code	Description	TC Volume A	OMFS TC Allowances B	RBRVS Rate with 1.2 multiplier[a] C	Total RBRVS allowances D= A x C	% change in allowances E = (D-B)/B	OPPS Rate ($) with No Multiplier[b] F	Total allowances at 1.0 x OPPS rate($) G=A x F	% change in allowances using 1.0 multiplier H=(G-B)/B
70450	CT scan, head/brain; w/out contrast	695	155,409	115.27	80,113	(48.45)	152.73	106,147	(31.7)
70553	MRI, brain with/without contrast	84	82,320	394.64	33,150	(59.73)	595.27	50,003	(39.3)
72050	Radiologic exam, spine, 4–5 views	1,845	78,874	46.68	86,125	9.19	109.76	202,507	156.7
72100	Radiologic exam, spine, lumbo-sacral; anteroposterior and lateral	6,387	200,232	34.58	220,862	10.30	69.25	442,300	120.9
72110	Radiologic exam spine lumbosacral; complete with oblique views	2,481	107,824	47.69	118,319	9.73	109.76	272,315	152.6
72131	CT scan, lumbar spine; without contrast	336	92,467	199.48	67,025	(27.51)	152.73	51,317	(44.5)
72141	MRI, spinal canal, cervical without contrast	768	396,902	238.82	183,414	(53.79)	355.99	273,400	(31.1)
72146	MRI, spinal canal, thoracic without contrast	157	80,384	238.82	37,495	(53.36)	355.99	55,890	(30.5)
72148	MRI, spinal canal and lumbar, without contrast	1,407	720,384	238.82	336,020	(53.36)	355.99	500,878	(30.5)
72158	MRI, spinal; with/without contrast, lumbar	268	192,156	392.63	105,225	(45.24)	595.27	159,532	(17.0)
73030	Radiologic exam, shoulder; complete, minimum 2 views	4,912	170,594	30.04	147,556	(13.50)	69.25	340,156	99.4

Code	Description	TC Volume	OMFS TC Allowances	Option 1: RBRVS with 1.2 Multiplier			Option 2:Pay Based on OPPS with No Multiplier		
				RBRVS Rate with 1.2 multiplier[a]	Total RBRVS allowances	% change in allowances	OPPS Rate ($) with No Multiplier[b]	Total allowances at 1.0 x OPPS rate($)	% change in allowances using 1.0 multiplier
73110	Radiologic exam, wrist; minimum 3 views	3,986	116,909	41.64	165,977	41.97	69.25	276,031	136.1
73130	Radiologic exam, hand; minimum 3 views	5,064	126,296	34.58	175,113	38.65	69.25	350,682	177.7
73221	MRI, any joint of lower extremity, without contrast	1,185	618,562	263.02	311,728	(49.60)	355.99	421,915	(31.8)
73564	Radiologic exam, knee; complete, 4+ views	2,637	88,313	45.17	119,113	34.88	69.25	182,612	106.8
73610	Radiologic exam, ankle; complete, minimum 3 views	4,307	119,692	35.59	153,286	28.07	69.25	298,260	149.2
73630	Radiologic exam, foot; minimum 3 views	3,885	110,956	33.07	128,477	15.79	69.25	269,036	142.5
73721	MRI, any joint of lower extremity	1,061	564,619	263.53	279,688	(50.46)	355.99	377,817	(33.1)
93005	ECG tracing[c]	11,961	419,546	11.38	136,115	(67.56)	32.75	391,719	(6.6)
93458	Angiography with left heart catheterization	39	162,810	1066.22	41,302	(74.63)	3124.13	121,019	(25.7)
93971	Duplex scan, extremity veins	998	120,315	128.88	128,622	6.90	162.51	162,185	34.8

[a] CY 2014 RVUs for technical component multiplied by 120 percent of the 2012 Medicare CF ($40.8451) and the statewide GPCI values and updated to 2014 by the estimated cumulative increase in the MEI and budget neutrality adjustment (1.0638).

[b] CY 2014 OPPS relative weights multiplied by the OMFS 2013 conversion factor ($70.761) adjusted by the estimated statewide wage index applicable to hospitals for outpatient services furnished to WC patients (1.35) and updated to 2014 by estimated increase in the hospital market basket (1.025 percent).

[c] Treated as technical component because no work value is associated with code.

Table 3 Comparison of MAAs for Other Outpatient Procedures Under Options 1 and 2 with Pre-2014 Allowances

A. Potential Allowances for High Expenditure Therapeutic Services

Code	Description	Outpatient Volume	Average Pre-2014 OMFS Allowance [a]	Total Pre-2014 OMFS Allowances	2014 Allowance Alternatives		
					RBRVS PE for nonfacility setting ($)[b]	OPPS rate ($) with no multiplier[c]	RBRVS facility-setting fee[d]
		A	B	C	D	E	F
90471	Immunization administration	2,778	45.30	125,844	26.22	52.87	Nonfacility setting only
90853	Group medical psychotherapy	895	50.60	45,285	6.05	83.73	32.57
93798	Outpatient cardiac rehab monitoring	982	41.85	41,092	20.17	124.74	17.98
96365	IV infusion therapy; initial, up to 1 hour	834	53.85	44,919	84.72	207.93	Nonfacility setting only
96372	Injection	4,878	9.79	47,770	26.22	52.87	Nonfacility setting only
96374	Injection; IV push, single or initial	3,171	21.29	67,508	68.58	127.89	Nonfacility setting only
96375	Each additional IV push of a new drug	898	89.87	80,656	25.72	52.87	Nonfacility setting only
99212[e]	Level 2 established patient visit	1,673	41.91	70,116	35.30	111.74	32.43
99213[e]	Level 3 established patient visit	2,267	56.73	128,616	50.43	111.74	66.02
99214[e]	Level 4 established patient visit	494	89.50	44,211	71.11	111.74	101.43

[a] Average allowance for codes crosswalked to 2014 equivalents and may not be the same as OMFS allowance for specific code.

[b] CY 2014 PE RVUs for nonfacility-setting multiplied by 120 percent of the 2012 Medicare CF ($40.8451) and the statewide GPCI values and updated to 2014 by the cumulative estimated increase in the MEI and budget neutrality adjustment factor (1.0638).Malpractice RVUs included if there are no physician RVUS.

[c] CY 2014 OPPS relative weights multiplied by the OMFS 2013 conversion factor ($70.761) adjusted by the estimated statewide wage index applicable to hospitals for outpatient services furnished to WC patients (1.35) and updated to 2014 by estimated increase in the hospital market basket (1.025 percent).

[d] CY 2014 total RVUs for facility-setting multiplied by 120 percent of the 2012 Medicare CF ($40.8451) and the statewide GPCI values and updated to 2014 by the cumulative estimated increase in the MEI and budget neutrality adjustment factor (1.0638).

[e] Codes crosswalked to G0463 for OPPS payment and assigned to APC 634 Clinic Visits.

B. Comparison of Facility and Total Allowances

Code	Description	Option 1: RBRVS PE x 1.2 multiplier			Option 2:Use OPPS with no multiplier		
		Facility allowance at 1.2x RBRVS PE ($)	Total (facility +physician allowance)	% change in total allowance	Facility allowances at 1.0 x OPPS rate($)	Total (facility +physician) allowance	% change in total allowances
		G=A x D	H=A(D+F)	I=(H-C)/C	J=AxE	K=A(E+F)	L=(K-C)/C
90471	Immunization administration	72,848	72,848	(42.11)	146,873	146,873	16.7
90853	Group medical psychotherapy	5,416	34,566	(23.67)	74,938	104,089	129.9
93798	Outpatient cardiac rehab monitoring	19,809	37,465	(8.83)	122,495	140,151	241.1
96365	IV infusion therapy; initial, up to 1 hour	70,674	70,674	57.34	173,455	173,455	286.1
96372	Injection	127,917	127,917	167.77	257,900	257,900	439.9
96374	Injection; IV push, single or initial	217,479	217,479	222.15	405,539	405,539	500.7
96375	Each additional IV push of a new drug	23,083	23,083	(71.38)	47,452	47,452	(41.2)
99212	Level 2 established patient visit	59,058	113,313	61.61	186,941	241,196	244.0
99213	Level 3 established patient visit	114,323	263,990	105.26	253,315	402,982	213.3
99214	Level 4 established patient visit	35,126	85,232	92.79	55,200	105,306	138.2

Impact Analysis

Tables 2 and 3 compare differences in allowances for high expenditure procedures under two options for setting the allowances for hospital facility services to outpatients. In the impact analysis, we expand the analysis to the full range of pre-2014 OMFS services and to the extent feasible account for differences in 2014 bundling policies and multiple procedure discounting under the RBRVS and OPPS fee schedules.

Methodology

Our impact analysis includes the full range of services provided to hospital outpatients that are subject to the pre-2014 OMFS physician fee schedule. Because our objective is to compare allowances using the RBRVS PE component with an allowance based on the OPPS fee schedule, we excluded services that are covered under the OMFS using another Medicare-based fee schedule (e.g., for diagnostic clinical laboratory tests and for durable medical equipment, prosthetics, orthotics and supplies) and services that are not subject to an OMFS fee schedule when they are furnished to hospital outpatients. An example of the latter is dialysis for chronic end-stage renal disease.

Option 1: RBRVS PE-based fee schedule

We first estimated what the outpatient facility allowance would be using the PE RVUs for the nonfacility setting. We applied a conversion factor based on 120 percent of the Medicare 2012 conversion factor updated for inflation to 2014 using the estimated cumulative increase in the Medicare Economic Index and budget neutrality adjustment factor. This estimates the allowances that will be payable after the transition to the RBRVS fee schedule rather than actual 2014 allowances. We used the statewide geographic adjustment factors in the estimate and further adjusted for health professional shortage area bonus payments.

For services with a TC, we used the same general methodology that we used for physician-furnished services in Wynn, Liu, Mulcahy et al. (2013), including the application of RBRVS policies for multiple procedure discounting and for bundling.[10] We assumed that supplies billed in conjunction with radiology procedures using contrast media would be passed-through under the RBRVS and included these amounts in the aggregate allowances. We note, however, that the

[10] Under the RB-RVS, certain codes, including supplies and reports, are bundled into the payment for other services. When multiple radiology procedures are furnished during the same encounter, the TC for the highest-value code is valued at 100% and additional codes are valued at 50%.

volume of supplies billed by hospitals in conjunction with radiology procedures is low. We identified 25 TC services with OMFS payments totaling $72,732 that are contractor-priced under the RBRVS. We assumed that these would also be contractor-priced if the facility fees were based on the RBRVS.

In addition to services with TC/PC components, hospitals provide other diagnostic and therapeutic services that are payable under the pre-2014 OMFS for physician services. We estimated an outpatient facility fee under the RBRVS using only the nonfacility setting PE RVUs. A subset of services does not have nonfacility setting PE RVUs because Medicare assumes the services are provided only in a facility setting. [11] Certain cardiovascular codes for electrophysiologic evaluation (CPT 93650-93656) and hospital observation services (CPT 99218-99220) fall into this category.[12] We used the OPPS rate (with no multiplier) for these services, which means that some hospital outpatient services would be paid under the RBRVS while others would be paid under the OPPS. Arguably, this creates no more complexity than the current system, which pays for some services to outpatients under the pre-2014 OMFS physician fee schedule and others under the OPPS.

Most services other than those with a TC modifier involve physician work. This means that in addition to the outpatient facility fee, there is a separate allowance for the professional service that is payable under the Medicare RBRVS physician fee schedule in a facility setting. To make the RBRVS comparison consistent to the pre-2014 OMFS allowances, we also estimated an RBRVS allowance for the related physician service in a facility setting. We summed the RBRVS PE-based facility fee and the RBRVS physician fee allowances to estimate total MAAs if the outpatient facility fee were based on the RBRVS PE. Under the pre-2014 OMFS, payments for the physician's professional services are flowing to the hospitals that are billing for these services. Even if physicians were to bill separately for these services instead of the hospital in the future, the amounts represent additional allowances that should be taken into consideration in estimating aggregate payments if a RBRVS PE-based facility fee schedule were adopted.

Option 2: OPPS-based facility fee

We then estimated what the facility fee allowances would be under an OPPS-based fee schedule with no multiplier. We used the 2013 OMFS conversion factor applicable to hospital ambulatory surgery and emergency department visits updated to 2014 using the estimated

[11] In Addendum B that is issued as part of the annual Medicare physician fee schedule rulemaking process, these are Status Code A procedures with NA shown for the nonfacility setting practice expense RVUs. In the National Provider Payment File that is issued subsequently, the practice expense RVUs for the facility-setting are assigned to the nonfacility setting.

[12] In the case of observation services, HCPCS Code G0378 and G0379 are used under the Medicare OPPS to establish the rates for facility services. HCPCS Code G0378 is bundled under the OPPS but G0379 Direct Referral for Observation is not.

increase in the hospital market basket. Other than no multiplier, the resulting facility fee allowances are comparable to that used to determine OMFS allowances for hospital outpatient surgery and emergency department facility services. Medicare assigns each procedure code a status code describing how it will be paid under the OPPS. We applied the OPPS bundling rules to procedures with status code N and used the discounted units of service to estimate allowances for procedures subject to multiple procedure discounting (status code T). Procedures with other status codes were not discounted. Because we were working with aggregate data rather than patient-level data to estimate the OPPS payments, we were unable to directly model the effect of status code Q1, Q2, and Q3 modifiers on the allowances. Instead, we performed some sensitivity analysis.

- Status code Q1 and Q2 apply to procedures that are not separately payable if a major primary procedure (Q1) or a minor primary procedure (Q2) is reported for the same encounter. We estimated allowances with and without allowances for the services with these status codes.
- When two or more imaging codes with Status Code Q3 are provided during the same encounter, the procedures are assigned to Imaging Composite APCs 8004-8008. We used the difference between the discounted and undiscounted RBRVS units for each procedure to estimate the number of imaging procedures that were furnished with another procedure. We multiplied the difference by two to estimate the total number of procedures that would be assigned to a composite APC. We subtracted these procedures from their original APC assignment and estimated new allowances based on APC assignments. We made two different assumptions regarding how many composite APC allowances would apply to the multiple procedures. Our high allowance estimate assumes two procedures occurred together. Our low allowance estimate assumed three procedures occurred together. For purposes of assigning the procedures to the composite APCs, we assumed that the procedures came from the same original APC.

Consistent with our method used to determine total MAAs under Option 1, we added an estimate of the allowances physician services in the facility setting to the estimate of OPPS-based facility fees. This provides an estimate of the total MAAs if the outpatient facility fee were OPPS-based that is comparable to the pre-2014 OMFS MAAs.

Results

Our analysis indicates that if the RBRVS PE (or TC) were used to pay for services furnished by hospitals that are currently paid under the pre-2014 OMFS for physician services, there would be a 7.6 percent reduction in allowances after multiple procedure discounting and bundling rules are applied under the RBRVS. Our RBRVS estimate is understated if contrast media used during radiology procedures that would qualify for separate payments are underreported in the workers' compensation information system data. Further, some services have no nonfacility setting RVUs. We priced the TC services with no PE RVUs using the OPPS rates with no multipliers and other services based on the amounts paid under the pre-2014 OMFS. If a different approach were taken

with respect to the services with no nonfacility PE RVUs, the RBRVS allowances would be slightly different.

Our impact estimate uses the Medicare 2012 rate updated to 2014 to gauge impacts by the end of the transition instead of the actual 2014 RBRVS transition rates that would apply under this option. Similar to the findings in Wynn et al. (2103), the impact of using the RBRVS to set the allowances is quite different for services with TC components (primarily radiology) than other hospital outpatient services. The TC allowances, which account for 86 percent of pre-2014 OMFS hospital allowances, would be reduced 21 percent. The allowances for other services would increase 31 percent if only the outpatient facility fee were considered and 80 percent considering the aggregate allowances for outpatient facility fees based on the RBRVS nonfacility setting PE RVUs and the allowances for associated physician services in nonfacility settings. These changes would be phased-in through the RBRVS transition conversion factors.[13] Using the 2014 transition CF for radiology ($53.1039), surgery ($55.2913) and all other services ($38.3542), total estimated allowances are $8.405 million for facility fees and $0.459 million for professional services provided to hospital outpatients (data not shown). The total ($8,874 million) indicates that in the first year under the RBRVS (2014) there would be a negligible difference in total allowances for the pre-2014 OMFS services.

We estimate that allowances to hospitals would increase 48-65 percent if allowances were determined using the OPPS rates with no multiplier. This includes the estimated allowances that would be made under the RBRVS for related physician professional services in addition to the separate facility allowances under the OPPS. The low estimate assumes that no allowances would be made for status code Q1 and Q2 procedures (i.e., it assumes that these procedures are always furnished in conjunction with other procedures) and assumes that three procedures are involved when multiple procedures with status code Q3 occur during the same encounter. The high estimate assumes that additional allowances would be made for all status code Q1 and Q2 procedures and that two procedures are involved when multiple procedures with status code Q3 occur during the same encounter. Even if our assumptions understate the frequency with which radiology procedures would be assigned to the composite APCs, the general pattern of significantly higher allowances under an OPPS-based fee schedule is unlikely to change.

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[13] As noted earlier, we used a single conversion factor to estimate impacts by the end of the transition. During the 4-year transition from budget neutral conversion factors to the single transition factor, the conversion factor for radiology will decline and the conversion factor for all other services than surgery and anesthesia will increase. Thus, the impacts shown in the table will be phased in over the transition.

Table 4 Comparison of Allowances under the OMFS, RBRVS, and OPPS for Hospital Services Paid Under the Pre-2014 OMFS for Physician Services

	OMFS MAAs ($ 000s)	Option 1 MAAs Using PE Component of RBRVS ($ 000s)	Option 2 MAAs Using OPPS with No Multiplier ($ 000s)
1. Facility Fees			
Services with TC components	7,488	5,891	11,476
Other services	1,270	1,660	3,103
Less estimated allowances for Q codes	----	----	-4,894
Estimated allowances net of OPPS Q codes	8,758	7,552	9,685
2. Estimated OPPS allowances for Q1+Q2 procedures			
a. Low estimate	----	-----	0
b. High estimate			1,404
3. Estimated allowances for composite APCs			
a. Low estimate	----	----	3,428
b. High estimate			3,512
4. Estimated allowances for physician professional services	----	617	617
5. Supplies	79	1	**0**
6.Total allowances			
a. Low estimate (1+2a+3a+4+5)	8,837	8,169	13,113
b. High estimate (1+2b+3b+4+5)	8,837	8,169	14,600
7. Percentage change in allowances for services paid under the pre-2014 OMFS physician fee schedule (Line 6 –OMFS line 6) ÷ OMFS line 6			
a. Low estimate		-7.6	48.4
b. High estimate		-7.6	65.2
8. Percentage change in total allowances for hospital services to outpatients			
a. Low estimate (.07 x (1+ 7a) +.93-1)		-0.5	3.4
b, High estimate (.07 x (1+ 7b) +.93-1)		-0.5	4.6

Summary and Discussion

The implementation of the RBRVS fee schedule for physician services raises the question of whether the allowances for facility services furnished by hospitals to outpatients that are currently subject to the pre-2014 OMFS for physician services should be subject to a fee schedule based on the RBRVS or the OPPS. These services represent approximately seven percent of payments to hospitals for services provided to workers' compensation patients on an outpatient basis. The remaining expenses are primarily for facility services for surgical procedures and emergency department visits that are currently paid under the Medicare-based OPPS fee schedule, laboratory tests that are paid under the clinical laboratory fee schedule, drugs and medical supplies, and physician professional services that will be paid under the RBRVS.

We compared the impact of establishing Medicare-based fee schedules using the RBRVS PE component for physician services furnished in nonfacility settings with a 1.2 multiplier to the impact of using the OPPS rates with no multiplier. Relative to allowances under the pre-2014 OMFS, MAAs to hospitals would decrease 7.6 percent if the allowances were based on the RBRVS. If the OPPS fee schedule were used with no multiplier, aggregate MAAs would increase 48-65 percent. This represents an estimated 3-5 percent increase in overall expenditures for hospital services to outpatients.

Aggregate MAAs using the OPPS-based rates with a 1.2 multiplier represent maximum allowances permissible under the labor code and would result in substantially higher increases than should be needed to provide reasonable payment for hospital care provided to workers' compensation outpatients. The administrative director has the flexibility to consider applying alternative OPPS-based multipliers within this aggregate limitation for all or selected hospital outpatient services or using a RB-RVS-based fee schedule. Even the OPPS-based rates with no multiplier represent a substantial increase in allowances relative to the pre-2014 OMFS physician fee schedule.

The RB-RVS-based fee schedule has conceptual appeal at least with respect to services that are clinically appropriate to provide in a lower cost setting. However, it would increase program complexity because not all facility services have PE RVUs in a nonfacility setting. It would also complicate program integrity activities relative to an OPPS-based fee schedule. This is because the same bundling policies would not be applied to all services furnished by the hospital to outpatients. OPPS facility fees are attractive because they would be consistent with Medicare policies for setting the RBRVS allowances and would price most outpatient services using one set of rules.

The aggregate financial impact of either option is significant relative to pre-OMFS allowances but in opposite directions. In particular, using the OPPS rates with no multiplier for the pre-2014 services would substantially increase OMFS aggregate expenditures without

evidence that the current rates are insufficient to provide access to necessary care. If the current aggregate expenditures for hospital outpatient services are generally appropriate, the impact of either option could be moderated through use of a different multiplier so that in the aggregate expenditures for hospital outpatient services would remain at current levels. For example, we estimate that adoption of RB-RVS- based facility fees could be made budget neutral by increasing the multiplier for the pre-2014 OMFS services from 1.2 to 1.31 using the Medicare 2012 CF updated for inflation (with the multiplier for related physician professional services remaining at 1.2). If the transition CF were used, the multiplier could be phased-in as the CF for radiology is reduced. No adjustment would be needed in 2014 to maintain aggregate expenditures for pre-2014 OMFS services at current levels.

If the OPPS rates were used for the facility fee, the 1.2 multiplier for surgical and emergency department visits could be reduced to offset the increased expenditures for the pre-2014 OMFS services. We estimate that reducing the multiplier to 1.14 for surgery and emergency department visits would make a 1.0 multiplier for pre-2014 OMFS services budget neutral. An across-the-board 1.115 multiplier applied to all services paid under the OPPS (including the pre-2014 OMFS services) would be budget neutral to current aggregate expenditures for these services. This would put the pre-OMFS services on the same fee schedule as other OPPS services with no change in estimated aggregate expenditures.

There are several limitations to our analysis. First, not all claims with medical expenditures are reported into the system although the data are generally representative (Wynn, Liu, Mulcahy et al., 2013). This means that the percentage estimates produced by the impact analysis are more important for interpreting systemwide impacts than the dollar estimates. Second, the estimates of the OPPS-based impacts draw on the encounter-level data for the RBRVS analyses; the OPPS ground rules were not applied to encounter-level data. We addressed this limitation through sensitivity analyses that provide an overall assessment of using an OPPS-based fee schedule. We recognize that an encounter-level assessment would be more accurate but did not have the time or resources to undertake such an assessment. However, it is unlikely that the overall results would change substantially. Finally, the impact analysis is based on Medicare's 2014 payment rules. CMS deferred until 2015 the creation of comprehensive APCs for certain device-intensive APCs that would expand services that are bundled into the payment for the primary procedure (CMS, 2013c). If these changes are adopted by CMS in 2015, the complexity of using two different payment systems will increase. Further, the impact of paying for the services under an OPPS-based system relative to an RBRVS-based system is likely to be somewhat different that the estimated impacts using the 2014 payment rules.

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