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Consultations Under RBRVS

As the workers' compensation community prepares for the shift to the new RBRVS-based fee system, which goes into effect 1/1/14, one of the most common questions concerns consultation codes.

The new Physician Fee Schedule eliminates the use of office consultation CPT codes for work comp reimbursement. Instead, office consultation visits must be billed using the appropriate "new patient" or "established patient" evaluation and management (E/M) CPT codes.

These codes fall within the range of 99201-99205 or 99211-99215. It is important to note that for workers' compensation the definitions for "new" and "established" patients differ from those of the Center for Medicare and Medicaid Services (CMS). Rather than defining the *patient* as "new" or "established," workers' comp defines the presenting industrial *injury* as "new" or "established." Please see the relevant definitions below.

Although consultation CPT codes are no longer payable, the new RBRVS reimbursement rates for E&M codes for new patients are more or less comparable to the current OMFS consultation reimbursement rates.

Procedure Code	Description	OMFS Table A Current Fee	CMS E&M Code	RBRVS Reimbursement as of 1/1/2014	Payment Change in Fee as of 1/1/2014	% Change in Fee as of 1/1/2014
99241	Office consultation	$79.14	99201	$51.89	-$27.25	-34%
99242	Office consultation	$104.98	99202	$87.54	-$17.44	-17%
99243	Office consultation	$131.62	99203	$126.00	-$5.62	-4%
99244	Office consultation	$184.86	99204	$190.22	$5.36	3%
99245	Office consultation	$238.79	99205	$234.99	-$3.80	-2%
99241	Office consultation	$79.14	99211	24.51	-$54.63	-69%
99242	Office consultation	$104.98	99212	51.89	-$53.09	-51%
99243	Office consultation	$131.62	99213	85.23	-$46.39	-35%
99244	Office consultation	$184.86	99214	124.78	-$60.08	-33%
99245	Office consultation	$238.79	99215	166.31	-$72.48	-30%

For example, the current OMFS Table A reimburses a 99244 code at a rate of $184.86.

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Under the new RBRVS fee schedule, the RBRVS-equivalent code for a new patient is 99204 and pays $190.22 in a non-facility setting, which is a $5.36 reimbursement increase. (Note that these codes are used solely for example purposes and that proper coding procedures should be utilized as described by section 9789.12.11 of the new regulations.)

However, the reimbursement rates are quite different if a claims administrator requests an examination of a patient who has previously been seen by a provider who is a member of the same medical group. In this case, the RBRVS-equivalent reimbursements that are applicable are those for an established patient. Reimbursement for established patients are drastically reduced compared to the current reimbursement for comparable consultation codes listed in OMFS Table A.

For example, the current OMFS Table A reimburses a 99245 at a rate of $238.79. Under the new RBRVS fee schedule, the RBRVS-equivalent code for an established patient is 99215 and pays $166.31, a $72.48 reimbursement reduction.

Remember that Labor code 5307.11 allows healthcare providers and claims administrators to "contract for reimbursement rates different from those in the fee schedule adopted."

See related articles:

- Contracts Under Labor Code 5307.11
- Record Review Under RBRVS
- Consultation Reports
- Supplemental and Requested Reports or Forms
- Second Review Under RBRVS

§ 9789.12.11 Evaluation and Management: Coding – New Patient; Documentation
(a) For purposes of workers' compensation billing, the following definitions of "new patient" and "established patient" will be used instead of the CPT definitions:
(1) A "new patient" is one who is new to the physician or medical group or an established patient with a new industrial injury or illness. Only one new patient visit is reimbursable to a single physician or medical group per specialty for evaluation of the same patient relating to the same incident, injury or illness.
(2) An "established patient" is a patient who has been seen previously for the same industrial injury or illness by the physician or medical group.

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Consultation Reports

The new Physician Fee Schedule effective 1/1/14 eliminates reimbursement for CPT 99080 - Special reports or forms. On 1/1/14, CPT 99080 has a status code of "B" which, according the DWC rules for status codes, means CPT 99080 is no longer a payable service.

With the elimination of 99080 as a payable CPT code, consultation reports provided to the claims administrator or to an injured worker's primary treating physician will no longer be reimbursable. These accompanying reports are considered to be bundled into the underlying evaluation and management (E/M) code.

Per § 9789.12.12, there are two situations when a consultation report is reimbursable and both require the use of new California-specific billing codes:

1. If the Workers' Compensation Appeals Board or the Administrative Director requests a consultation report, it is reimbursable and should be billed with the new California specific code WC007 with a modifier -32. Reimbursement for WC007 is $38.68 for the first page and $23.80 for each additional page. A six page maximum is allowable, absent mutual agreement (for a total maximum reimbursement of $157.68).
2. If the Qualified Medical Evaluator (QME) or the Agreed Medical Evaluator (AME) requests the consultation and an accompanying consultation report. Under these circumstances the modifier -30 should be appended to the code WC007.

Remember that Labor code 5307.11 allows healthcare providers and claims administrators to "contract for reimbursement rates different from those in the fee schedule adopted."

See related articles:

- Contracts Under Labor Code 5307.11
- Record Review Under RBRVS
- Consultations under RBRVS
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§ 9789.12.12 Consultation Services Coding – use of visit codes
(b) Consultation reports are bundled into the underlying evaluation and management visit code, and are not separately payable, except as specified in subdivision (c).
(c) The following consultation reports are separately reimbursable:
(1) Consultation reports requested by the Workers' Compensation Appeals Board or the Administrative Director. Use WC007, modifier -32.
(2) Consultation reports requested by the Qualified Medical Evaluator ("QME") or Agreed Medical Evaluator ("AME") in the context of a medical-legal evaluation. Use WC007, modifier -30.

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Record Review Under RBRVS

The new Physician Fee Schedule effective 1/1/14 eliminates reimbursement for CPT 99358 - Prolong service without contact. As of 1/1/2014, CPT 99358 has a status code of "B" which, according the DWC rules for status codes, means CPT 99358 is no longer a payable service.

Per section 9789.12.11 Evaluation and Management: Coding – New Patient; Documentation, the DWC instructs health care providers to use one of two guidelines to determine the appropriate level of evaluation and management (E/M) services for an injured worker. To establish the appropriate level of evaluation and management, both guidelines incorporate the amount and/or complexity of data to be reviewed as a component of the complexity of the medical decision making.

However, situations arise when a claims administrator requests a health care provider to review either:

1. A large quantity of past records for an injured worker, or
2. Past records without face to face contact with the injured worker

Under these circumstances, Labor Code 5307.11 allows a health care provider and a claims administrator to "contract for reimbursement rates different from those in the fee schedule adopted."

Please see related articles:

- Contracts Under Labor Code 5307.11
- Consultations under RBRVS
- Consultation Reports
- Supplemental and Requested Reports or Forms
- Second Review Under RBRVS

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Supplemental and Requested Reports or Forms Under RBRVS

The new Physician Fee Schedule effective 1/1/14 eliminates reimbursement for CPT 99080 - Special reports or forms. As of 1/1/2014, CPT 99080 has a status code of "B" which, according the DWC rules for status codes, means CPT 99080 is no longer a payable service.

With the exception of Physician's Return-to-Work & Voucher Report (considered bundled into payment for PR-3 or PR-4), in the event a claims administrator requests that a health care provider furnish a supplemental or requested report or complete a form, the healthcare provider and the claims administrator can agree upon a contracted rate for these services per Labor Code 5307.11.

Please see related articles:

- Contracts Under Labor Code 5307.11
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Contracts Under Labor Code Section 5307.11

As of 1/1/14, the new Physician Fee Schedule eliminates or reduces many workers' compensation fees for services rendered by health care providers. Labor Code section 5307.11 permits providers and claims administrators to contract reimbursement rates different from the fees allowed by the Physician Fee Schedule.

To contract for a fee that is different from the amount allowed by the Physician Fee Schedule, the provider must memorialize in writing a pre-negotiated fee and pre-authorized agreement with an authorized agent of the claims administrator. This must be done **prior** to performing services requested by a claims administrator.

See below for an example of a "Contract Pursuant to LC Section 5307.11 Pre-Authorization and Pre-Negotiated Fee Arrangement." To guarantee payment at the pre-negotiated rates it is extremely important that a copy of the signed contract accompany the bill submission.

Contracting per 5307.11 for reimbursement rates different from those in the fee schedule is a separate, but parallel, process to submitting a Request for Authorization for Medical Treatment (DWC Form RFA).

To obtain authorization for treatment to an injured worker, a health care provider must submit an RFA to a claims administrator along with Primary Treating Physician's Progress Report, DWC Form PR-2, or narrative report substantiating the requested treatment.

When submitting an RFA requesting authorization for treatment, if the provider wants reimbursement at rates different from the fees allowed by the Physician Fee Schedule, the provider needs to request that the claims administrator agree to and sign an accompanying "Contract Pursuant to LC Section 5307.11 Pre-Authorization and Pre-Negotiated Fee Arrangement," to memorialize the different rates for the authorized treatment.

See related articles:

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Contract Pursuant to Labor Code section 5307.11
Pre-Authorization and Pre-Negotiated Fee Arrangement

Provider Name:
Provider Tax ID:
Injured Worker's Name:
Claims Administrator:
Workers' Compensation Claim Number:
Name of Authorized Agent of Claims Administrator:

Pursuant to Labor Code 5307.11, provider and claims administrator agree to a one time agreement for payment of the following service(s) for the above named patient:

Service	Billing Code	Fee	Initial box of service to be provided
Record Review	99358	$xx per 15 minute increment	
Record Review	99358	Fixed fee $XX	
Special report or forms	99080	$xx per page a maximum of xx pages	
Special report or forms	99080	Fixed fee $	

Additional details of services to be renderend pursuant to this agreement:

_____

_____

_____

By signing below, the authorized agent of the claims administrator pre-authorizes the above-noted services at the rates indicated.

_____ _____
Name of Authorized Agent of Claims Administrator Title

_____ _____
Date Signature

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§ 9792.5.5. Second Review of Medical Treatment Bill or Medical-Legal Bill

As of 1/1/2014, under the new Physician Fee Schedule, reimbursement rates are changing for virtually all HCPCS, including CPT codes. Incorrect payments by claims administrators are inevitable. An understanding of the details of submitting a second review is critical to obtaining reimbursement for incorrectly paid bills.

The following "Table A Reimbursement vs RBRVS 1/1/2014 Reimbursement" illustrates the increased reimbursement for every evaluation and management CPT code as of 1/1/2014.

Table A Reimbursement vs RBRVS 1/1/2014 Reimbursement

Procedure Code	Description	OMFS Table A Current Fee	RBRVS Reimbursement as of 1/1/2014	Payment Change in Fee as of 1/1/2014	% Change in Fee as of 1/1/2014
99201	Office/outpatient visit new	39.9	51.89	$11.99	30%
99202	Office/outpatient visit new	70.19	87.54	$17.35	25%
99203	Office/outpatient visit new	103.86	126	$22.14	21%
99204	Office/outpatient visit new	146.12	190.22	$44.10	30%
99205	Office/outpatient visit new	186.73	234.99	$48.26	26%
99211	Office/outpatient visit est	23.81	24.51	$0.70	3%
99212	Office/outpatient visit est	42.02	51.89	$9.87	23%
99213	Office/outpatient visit est	56.93	85.23	$28.30	50%
99214	Office/outpatient visit est	89.57	124.78	$35.21	39%
99215	Office/outpatient visit est	129.41	166.31	$36.90	29%

In the event that the claims administrator incorrectly reimburses a bill, a compliant second review requesting additional payment must be sent by the provider within ninety (90) days from the receipt of the explanation of review. If the second review is not filed within ninety (90) days the provider loses his or her right to collect any additional reimbursement.

The ninety (90) day deadline to send a second review only applies when a provider disputes the calculation of the amount of the reimbursement. For example, as of 1/1/2014 if the claims administrator incorrectly pays the Table A reimbursement rate of $56.93 for CPT code 99213 instead of the new RBRVS rate of $85.23, a second review requesting additional payment

must be submitted with 90 days of receipt of the EOR. On the other hand, if the reimbursement is for an issue other than payment amount, the ninety day time limit does not apply. For example, submitting denials questioning authorization are not subject to the ninety day timeframe.

See related articles:

- Contracts Under Labor Code 5307.11
- Record Review Under RBRVS
- Consultations under RBRVS
- Consultation Reports
- Supplemental and Requested Reports or Forms

Feel free to contact DaisyBill (347.676.1548) with further questions about consultations, the transition to the RBRVS fee schedule, or for information about e-Billing.