

AMENDED IN SENATE MAY 3, 2011  
AMENDED IN SENATE APRIL 11, 2011  
AMENDED IN SENATE MARCH 24, 2011

**SENATE BILL**

**No. 923**

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**Introduced by Senator De León**

February 18, 2011

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An act to amend Section 5307.1 of the Labor Code, relating to workers' compensation.

LEGISLATIVE COUNSEL'S DIGEST

SB 923, as amended, De León. Workers' compensation: official medical fee schedule: physician services.

Existing law establishes a workers' compensation system, administered by the Administrative Director of the Division of Workers' Compensation, to compensate an employee for injuries sustained in the course of his or her employment.

Existing law requires the administrative director, after public hearings, to adopt and revise periodically an official medical fee schedule that establishes reasonable maximum fees paid for medical services, other than physician services, and other prescribed goods and services, in accordance with specified requirements.

Existing law, notwithstanding the above provisions, further authorizes the administrative director, after public hearings, to adopt and revise, no less frequently than biennially, an official medical fee schedule for physician services, in accordance with specified requirements.

This bill would instead require the administrative director, *by July 1, 2012*, to adopt ~~and revise, no less frequently than biennially beginning January 1, 2012,~~ an official medical fee schedule for physician services

based on the resource-based relative value scale, as defined, would ~~prohibit the administrative director from adopting an~~ *require the administrative director, on and after January 1, 2013, and no less frequently than biennially, to revise the* official medical fee schedule for physician services ~~using conversion factors, as defined, that are less than prescribed conversion factors,~~ and would delete obsolete provisions relating to the adoption of a medical fee schedule for inpatient facility fees for burn cases.

Vote: majority. Appropriation: no. Fiscal committee: yes.  
State-mandated local program: no.

*The people of the State of California do enact as follows:*

1 SECTION 1. This act shall be known and may be cited as the  
2 Fair Fee Schedule for Workers' Compensation Physicians Act.  
3 SEC. 2. The Legislature finds and declares all of the following:  
4 (a) The amount payers are required to pay to physicians  
5 providing primary care to injured workers in California is wholly  
6 dependent on the statewide official medical fee schedule for  
7 physician services as determined from time to time by the  
8 Administrative Director of the Division of Workers' Compensation.  
9 (b) California's official medical fee schedule for primary care  
10 workers' compensation physician services is currently the second  
11 lowest in the nation, even while California providers have the  
12 highest cost of providing medical services to injured workers. The  
13 current reimbursement rates for workers' compensation physicians  
14 in California are nearly 50 percent lower than those in the nearby  
15 states of Oregon and Washington.  
16 (c) California's primary care workers' compensation physicians  
17 have not had a meaningful fee schedule increase in over 11 years,  
18 while the California Consumer Price Index has increased 33 percent  
19 over that period. This has resulted in a steady decrease in real  
20 income for the state's primary care workers' compensation  
21 physicians.  
22 (d) This inequity is causing physicians to abandon the practice  
23 of primary care occupational medicine, resulting in diminished  
24 access to low-cost, high-quality care for California's injured  
25 workers. Without fee schedule relief, primary care workers'  
26 compensation physicians will continue to leave the occupational  
27 medicine practice, resulting in increased use of far more costly

1 alternatives, including, but not limited to, hospital emergency  
2 rooms, and increased time away from work. Once primary care  
3 providers leave the occupational medicine practice, the damage  
4 to California's workers' compensation system will be irreparable.

5 (e) California's primary care workers' compensation physicians  
6 are the gatekeepers to the state's workers' compensation system,  
7 serving as case managers for injured workers and returning them  
8 to gainful employment as quickly as possible, thereby controlling  
9 total case costs. Without fee schedule relief, California will suffer  
10 higher total injury case costs that will result in increased insurance  
11 premiums to employers throughout California.

12 (f) Subdivision (l) of Section 5307.1 provides the Administrative  
13 Director of the Division of Workers' Compensation with authority  
14 to adopt and revise, no less frequently than biennially, an official  
15 medical fee schedule for physician services. Pursuant to this  
16 authority, the Division of Workers' Compensation has developed  
17 a new official medical fee schedule for physician services in  
18 California based on the resource-based relative value scale  
19 (RBRVS). The RBRVS is widely recognized as the best model  
20 for fair and proper allocation of resources for physician payment.  
21 It is currently used by the federal Centers for Medicare and  
22 Medicaid Services, and in 33 other states' workers' compensation  
23 physician services fee schedules.

24 (g) It is the intent of the Legislature to address these issues by  
25 adopting the Fair Fee Schedule for Workers' Compensation  
26 Physicians Act.

27 SEC. 3. Section 5307.1 of the Labor Code is amended to read:

28 5307.1. (a) The administrative director, after public hearings,  
29 shall adopt and revise periodically an official medical fee schedule  
30 that shall establish reasonable maximum fees paid for medical  
31 services other than physician services, drugs and pharmacy  
32 services, health care facility fees, home health care, and all other  
33 treatment, care, services, and goods described in Section 4600 and  
34 provided pursuant to this section. Except for physician services,  
35 all fees shall be in accordance with the fee-related structure and  
36 rules of the relevant Medicare and Medi-Cal payment systems,  
37 provided that employer liability for medical treatment, including  
38 issues of reasonableness, necessity, frequency, and duration, shall  
39 be determined in accordance with Section 4600. Commencing  
40 January 1, 2004, and continuing until the time the administrative

1 director has adopted an official medical fee schedule in accordance  
2 with the fee-related structure and rules of the relevant Medicare  
3 payment systems, except for the components listed in subdivision  
4 (j), maximum reasonable fees shall be 120 percent of the estimated  
5 aggregate fees prescribed in the relevant Medicare payment system  
6 for the same class of services before application of the inflation  
7 factors provided in subdivision (g), except that for pharmacy  
8 services and drugs that are not otherwise covered by a Medicare  
9 fee schedule payment for facility services, the maximum reasonable  
10 fees shall be 100 percent of fees prescribed in the relevant Medi-Cal  
11 payment system. Upon adoption by the administrative director of  
12 an official medical fee schedule pursuant to this section, the  
13 maximum reasonable fees paid shall not exceed 120 percent of  
14 estimated aggregate fees prescribed in the Medicare payment  
15 system for the same class of services before application of the  
16 inflation factors provided in subdivision (g). Pharmacy services  
17 and drugs shall be subject to the requirements of this section,  
18 whether furnished through a pharmacy or dispensed directly by  
19 the practitioner pursuant to subdivision (b) of Section 4024 of the  
20 Business and Professions Code.

21 (b) In order to comply with the standards specified in subdivision  
22 (f), the administrative director may adopt different conversion  
23 factors, diagnostic related group weights, and other factors affecting  
24 payment amounts from those used in the Medicare payment system,  
25 provided estimated aggregate fees do not exceed 120 percent of  
26 the estimated aggregate fees paid for the same class of services in  
27 the relevant Medicare payment system.

28 (c) Notwithstanding subdivisions (a) and (d), the maximum  
29 facility fee for services performed in an ambulatory surgical center,  
30 or in a hospital outpatient department, shall not exceed 120 percent  
31 of the fee paid by Medicare for the same services performed in a  
32 hospital outpatient department.

33 (d) If the administrative director determines that a medical  
34 treatment, facility use, product, or service is not covered by a  
35 Medicare payment system, the administrative director shall  
36 establish maximum fees for that item, provided that the maximum  
37 fee paid shall not exceed 120 percent of the fees paid by Medicare  
38 for services that require comparable resources. If the administrative  
39 director determines that a pharmacy service or drug is not covered  
40 by a Medi-Cal payment system, the administrative director shall

1 establish maximum fees for that item. However, the maximum fee  
2 paid shall not exceed 100 percent of the fees paid by Medi-Cal for  
3 pharmacy services or drugs that require comparable resources.

4 (e) Prior to the adoption by the administrative director of a  
5 medical fee schedule pursuant to this section, for any treatment,  
6 facility use, product, or service not covered by a Medicare payment  
7 system, including acupuncture services, or, with regard to  
8 pharmacy services and drugs, for a pharmacy service or drug that  
9 is not covered by a Medi-Cal payment system, the maximum  
10 reasonable fee paid shall not exceed the fee specified in the official  
11 medical fee schedule in effect on December 31, 2003.

12 (f) Within the limits provided by this section, the rates or fees  
13 established shall be adequate to ensure a reasonable standard of  
14 services and care for injured employees.

15 (g) (1) (A) Notwithstanding any other law, the official medical  
16 fee schedule shall be adjusted to conform to any relevant changes  
17 in the Medicare and Medi-Cal payment systems no later than 60  
18 days after the effective date of those changes, provided that both  
19 of the following conditions are met:

20 (i) The annual inflation adjustment for facility fees for inpatient  
21 hospital services provided by acute care hospitals and for hospital  
22 outpatient services shall be determined solely by the estimated  
23 increase in the hospital market basket for the 12 months beginning  
24 October 1 of the preceding calendar year.

25 (ii) The annual update in the operating standardized amount and  
26 capital standard rate for inpatient hospital services provided by  
27 hospitals excluded from the Medicare prospective payment system  
28 for acute care hospitals and the conversion factor for hospital  
29 outpatient services shall be determined solely by the estimated  
30 increase in the hospital market basket for excluded hospitals for  
31 the 12 months beginning October 1 of the preceding calendar year.

32 (B) The update factors contained in clauses (i) and (ii) of  
33 subparagraph (A) shall be applied beginning with the first update  
34 in the Medicare fee schedule payment amounts after December  
35 31, 2003.

36 (2) The administrative director shall determine the effective  
37 date of the changes, and shall issue an order, exempt from Sections  
38 5307.3 and 5307.4 and the rulemaking provisions of the  
39 Administrative Procedure Act (Chapter 3.5 (commencing with  
40 Section 11340) of Part 1 of Division 3 of Title 2 of the Government

1 Code), informing the public of the changes and their effective date.  
2 All orders issued pursuant to this paragraph shall be published on  
3 the Internet Web site of the Division of Workers' Compensation.

4 (3) For the purposes of this subdivision, the following definitions  
5 apply:

6 (A) "Medicare Economic Index" means the input price index  
7 used by the federal Centers for Medicare and Medicaid Services  
8 to measure changes in the costs of a providing physician and other  
9 services paid under the resource-based relative value scale.

10 (B) "Hospital market basket" means the input price index used  
11 by the federal Centers for Medicare and Medicaid Services to  
12 measure changes in the costs of providing inpatient hospital  
13 services provided by acute care hospitals that are included in the  
14 Medicare prospective payment system.

15 (C) "Hospital market basket for excluded hospitals" means the  
16 input price index used by the federal Centers for Medicare and  
17 Medicaid Services to measure changes in the costs of providing  
18 inpatient services by hospitals that are excluded from the Medicare  
19 prospective payment system.

20 (h) This section does not prohibit an employer or insurer from  
21 contracting with a medical provider for reimbursement rates  
22 different from those prescribed in the official medical fee schedule.

23 (i) Except as provided in Section 4626, the official medical fee  
24 schedule shall not apply to medical-legal expenses, as that term is  
25 defined by Section 4620.

26 (j) The following Medicare payment system components shall  
27 not become part of the official medical fee schedule until January  
28 1, 2005:

29 (1) Inpatient skilled nursing facility care.

30 (2) Home health agency services.

31 (3) Inpatient services furnished by hospitals that are exempt  
32 from the prospective payment system for general acute care  
33 hospitals.

34 (4) Outpatient renal dialysis services.

35 (k) Notwithstanding subdivision (a), for the calendar years 2004  
36 and 2005, the existing official medical fee schedule rates for  
37 physician services shall remain in effect, but these rates shall be  
38 reduced by 5 percent. The administrative director may reduce fees  
39 of individual procedures by different amounts, but shall not reduce

1 the fee for a procedure that is currently reimbursed at a rate at or  
2 below the Medicare rate for the same procedure.

3 (l) (1) Notwithstanding subdivision (a), the administrative  
4 director shall adopt and revise, no less frequently than biennially  
5 beginning January 1, 2012, an official medical fee schedule for  
6 physician services that is based on the resource-based relative  
7 value scale. The administrative director shall not adopt an official  
8 medical fee schedule for physician services using conversion  
9 factors that are less than the following:

10 (A) For physician services other than anesthesiology, the  
11 minimum conversion factors are as follows:

	Surgery	Radiology	All other physician services
14 2012	57	57.75	46.5
15 2013	58	58.5	51
16 2014	59	59.25	55.5
17 2015 and after	60	60	60

18  
19 (B) For anesthesiology services, the minimum conversion factor  
20 is 34. director shall, by July 1, 2012, adopt an official medical fee  
21 schedule for physician services that is based on the resource-based  
22 relative value scale. On and after January 1, 2013, the  
23 administrative director shall, no less frequently than biennially,  
24 revise the official medical fee schedule for physician services based  
25 on the resource-based relative value scale.

26 (2) The administrative director shall adjust the official medical  
27 fee schedule to conform to any relevant changes in the Medicare  
28 and Medi-Cal payment systems no later than 60 days after the  
29 effective date of those changes, provided that in no event shall a  
30 change in a payment system reduce the existing reimbursement  
31 rate payable to workers' compensation physicians.

32 (3) For purposes of this subdivision, the following definitions  
33 apply:

34 (A) "Conversion factor" means the number that is multiplied  
35 by the relative value to produce the reimbursement rate payable  
36 to workers' compensation physicians, except that for  
37 anesthesiology services, "conversion factor" means base units plus  
38 time units.

39 (B) "Resource-based relative value scale" means the relative  
40 "resource-based relative value scale" means the relative value

- 1 scale created by the federal Centers for Medicare and Medicaid
- 2 Services and set forth in the Federal Register for each calendar
- 3 year.

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