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Fee Schedule FAQs – California Workers' Compensation

REV 6.13.2025

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What is the most recent effective date?

The California Division of Workers' Compensation (DWC) Official Medical Fee Schedule (OMFS) is comprised of several sections and different effective dates:

Fee Schedule	Effective
OMFS Conversion Factors & GAFs	02/15/2024
OMFS Relative Value Units	Updated quarterly
Pathology & Clinical Laboratory	Updated quarterly
Ambulance	01/01/2025
DMEPOS	Updated quarterly
Physician-administered drugs, Biologicals, Vaccines, Blood Products	Updated monthly
Outpatient Hospital & ASC	03/01/2025 & quarterly
Inpatient Hospital	12/01/2024
Pharmaceuticals	Updated monthly
Med-Legal	04/01/2021
Copy Services	07/15/2022

What is the fee schedule based on?

The fee schedule incorporates many of the Medicare and Medi-Cal payment methodologies with workers' compensation-specific adjustments:

- Medicare Physician Fee Schedule Relative Value Units and flags
- DWC-specific statewide Geographic Adjustment Factors*

  *Effective 1/1/2019, these are replaced with Medicare Geographic Practice Cost Indices (GPCIs)
- DWC-specific Conversion Factors
- Medical Clinical Laboratory Fee Schedule with a 120% markup
- Medicare Ambulance Fee Schedule with a 120% markup
- DMEPOS Fee Schedule with a 120% markup
- Medi-Cal Fee Schedule for J-Codes, minus the $4.46 injection administration fee
- Medicare Outpatient Prospective Payment System (OPPS) Addendum B
- Medicare Inpatient Prospective Payment System (IPPS) data
- Medi-Cal pharmacy database

Where can the fee schedule rates be found?

The OMFS rates are not published by the DWC. Instead, fee schedule rates are calculated using the following factors, as updated by order of the Administrative Director:

Effective 1/1/2019:

- Medicare Physician Fee Schedule (MPFS) Relative Unit Values (RVUs)
- Medicare Geographic Practice Cost Indices (GPCIs)
- DWC-specific Conversion Factors

Rate Calculation for Services Performed in a NON-FACILITY setting:

[(Work RVU * Work GPCI) +
(Non-Facility Practice Expense RVU * Practice Expense GPCI) +
(Malpractice RVU * Malpractice GPCI)] * Conversion Factor (CF) = **Base Maximum Fee**

Rate Calculation for Services Performed in a FACILITY setting:

[(Work RVU * Work GPCI) +
(Facility Practice Expense RVU * Practice Expense GPCI) +
(Malpractice RVU * Malpractice GPCI)] * Conversion Factor (CF) = **Base Maximum Fee**

Effective 1/1/2014-12/31/2018:

- Medicare Physician Fee Schedule (MPFS) Relative Unit Values (RVUs)
- DWC-specific Average Statewide Geographic Adjustment Factors (GAFs)
- DWC-specific Conversion Factors

Rate Calculation for Services Performed in a NON-FACILITY setting:

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

Rate Calculation for Services Performed in a FACILITY setting:

[(Work RVU * Statewide Work GAF) +
(Facility Practice Expense RVU * Statewide Practice Expense GAF) +
(Malpractice RVU * Statewide Malpractice GAF)] * Conversion Factor (CF) = **Base Maximum Fee**

Does the state adopt NCCI?

Yes, the National Correct Coding Initiative and Medically Unlikely Edits (MUEs) for practitioners are adopted by the DWC.

Does the state allow payment greater than billed charge?

No, the fee schedule payment is the lesser of the provider's billed amount or the fee schedule allowance.

Is balance billing allowed?

No, California Labor Code § 3751(b) prohibits a medical provider from attempting to collect payment from the injured worker for medical treatment.

Does the state have any state reporting requirements?

Yes.

"California's workers' compensation information system (WCIS) uses electronic data interchange (EDI) to collect comprehensive information from claims administrators to help the Department of Industrial Relations oversee the state's workers' compensation system. This information helps facilitate evaluation of the system and measure adequacy of benefits for injured workers and their dependents, and also provides statistical data for research. After initial development with input from affected groups, the first phase of WCIS became operational in September of 1999. Electronic transmission of first reports of injury was required beginning March 1, 2000 and electronic versions of benefit notices were mandated as of July 1, 2000. Electronic reporting of medical billing data is required for any medical service that occurs on or after Sept. 22, 2006."
http://www.dir.ca.gov/dwc/WCIS.htm

Does the state have any EOR requirements?

Claims administrators/payers may use any format for the EOR but the EOR must include all required data elements set forth in Appendix B of the *California Division of Workers' Compensation Medical Billing and Payment Guide.*
(http://www.dir.ca.gov/dwc/EBilling/StandardizePaperBilling.html)

Does the state have any bill certification requirements?

The DWC does not have any bill certification requirements.

Does the state have any statute of limitations for submitting a medical bill?

Effective for services on or after January 1, 2017, requests for payment (with an itemization of services provided and the charge for each service) must be submitted to the employer within 12 months of the date of service or within 12 months of the date of discharge for inpatient facility services. Bills submitted outside of this timeframe are disallowed with RC XE.

Effective for services provided on or after January 1, 2017, all bills for medical-legal evaluation or medical-legal expense must be submitted to the employer within 12 months of the date of service. Bills submitted outside of this timeframe are disallowed with RC XE.

For dates of injury on or after January 1, 2018, bills for emergency care must be submitted to the employer or its insurer within 180 days of the date the service was provided. Bills submitted outside of this timeframe are disallowed with RC XE.

Does the state have any payment time limits?

When a complete bill is received in a non-electronic format, claims administrators/payers must pay uncontested medical treatment within 45 days of receipt of the bill. If the employer is a governmental agency, uncontested service must be paid within 60 days of receipt of the bill.

Complete bills submitted in an electronic form must be paid within 15 days of receipt.

How are unlisted codes and/or "by report" codes to be paid?

When a practitioner bills unlisted codes, a report must be included that adequately describes the procedure/service and the necessity of the treatment. Claims administrators/payers shall pay "by report" services based on comparable procedures or analogous codes.

What should be done if the provider bills an incorrect code?

If a payer contests any portion of a bill, the claims administrator/payer must notify the provider within 30 days of receipt of the bill. The notification must include the reason for the objection and any available remedies for the provider.

Does the state guidelines allow down-coding?

The DWC does not provide guidance for changing a provider's billed procedures/services.

Does the state accept/recommend any usual and customary databases?

The DWC does not regulate or recommend any specific usual and customary database.

What are the rules for out-of-state provider reimbursement?

The DWC does not provide instruction for out-of-state physician services. Physician services provided outside of California will be reviewed and paid according to DWC payment guidelines for medical treatment.

Outpatient hospital, ASC and inpatient hospital services rendered outside of the state of California are exempt from the fee schedule guidelines.

In CORE, outpatient hospital services that are provided in a facility outside of California will be paid at 120% of the Medicare OPPS amount for that facility. Medata applies this methodology as reasonable payment for out-of-state outpatient services since the DWC outpatient fee schedule utilizes Medicare OPPS data (with a 120% markup) to produce in-state rates for outpatient service.

Inpatient hospital bills that are provided in a facility outside of California will be allowed at the billed amount.

Has the state adopted a medical treatment guideline?

Yes, the DWC adopts a Medical Treatment Utilization Schedule (MTUS) to ensure doctors in California's workers' compensation system are providing evidence-based medical treatment that has been scientifically proven to cure or relieve work-related injuries and illnesses.

The MTUS can be found in the California Code of Regulations, Title 8, Section 9792.20 and on the DWC website.

ANESTHESIA

Effective 1/1/2019:

Reimbursement for anesthesia services is calculated as:

[Base Unit + Time Unit] * Adjusted Anesthesia CF by Locality = Base Maximum Fee

Effective 1/1/2014-12/31/2018:

Reimbursement for anesthesia services is calculated as:

[Base Unit + Time Unit] * CF * Statewide Anesthesia GAF = Base Maximum Fee

Anesthesia services must be reported with the appropriate modifiers to indicate if the service was personally performed, medically directed or medically supervised.

Modifier	Description	Payment
AA	Anesthesia Services performed personally by the anesthesiologist	100%
AD	Medical Supervision by a physician; more than 4 concurrent anesthesia procedures	3 Base Units per procedure
G8	Monitored anesthesia care for deep complex complicated, or markedly invasive surgical procedures	Informational only
G9	Monitored anesthesia care for patient who has a history of severe cardio-pulmonary condition	Informational only
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals	50%
QS	Monitored anesthesia care service	Informational only
QX	CRNA service; with medical direction by a physician	50%
QY	Medical direction of one certified registered nurse anesthetist by an anesthesiologist	50%
QZ	CRNA service: without medical direction by a physician	100%
GC	Services have been performed by a resident under the direction of a teaching physician. The GC modifier is reported by the teaching physician to indicate he/she rendered the service in compliance with the teaching physician requirements in section 9789.18.2. One of the payment modifiers must be used in conjunction with the GC modifier.	Informational only

The application is automated to calculate reimbursement for anesthesia services when the anesthesia code and modifier are entered into the system. In CORE, anesthesia time is entered as minutes in the **Time** field. Time units are computed by dividing the reported anesthesia time by 15 minutes. Round to one decimal place.

There are no additional units allowed for the Physical Status Modifiers P1-P6 or Qualifying Circumstances (99100, 99116, 99135, 99140).

SURGERY

Multiple Procedure Reductions

Multiple surgical procedures performed on the same day, by the same practitioners, may be subject to multiple surgery reductions and are based on the **Multiple Procedure flags** in the RBRVS:

Mult Proc	Description	Payment
0	No payment adjustment for multiple procedures	100%
1	No longer used	N/A
2	Payment reductions for multiple procedures	100%, 50%, 50%, 50%, 50% and by report
3	Endoscopic procedures	See Multiple Endoscopy rule
9	Concept does not apply	N/A

Multiple Endoscopic Procedures

Endoscopic surgical procedures are grouped by "family." Each family has a "parent" code, or base procedure, that represents the most basic version of the endoscopic service. A multiple endoscopic procedure rule will be applied if more than one procedure with the same **Endo Base** is performed on the same day:

- **Two codes in the same family are billed** - If an endoscopic procedure is only billed with its base procedure, the base procedure is not separately payable as it is included in the payment amount of the other endoscopy.
- **Three codes or more in the same family are billed** - Pay the highest valued endoscopic procedure, plus the difference between the next highest and the base procedure.

Assistant Surgery

Assistant surgery ***by a physician***:

- Shall be billed with modifiers 80, 81 or 82.
- If payable, reimbursement is 16% of the fee schedule amount.

Assistant surgery ***by a non-physician practitioner*** (physician assistant, nurse practitioner or clinical nurse specialist):

- Shall be billed with modifier AS.
- If payable, reimbursement is 13.6% (85% of 16%) of the fee schedule amount.

Eligibility for payment is determined by the RBRVS **Assistant Surgery flags**:

Asst Surg	Description	CORE Processing
0	Documentation of Medical Necessity required	Deny with **RC 2M** (Documentation required)
1	Assist-at-surgery services are not payable	Deny with **RC 91** (Service Not Allowed)
2	Assist-at-surgery services may be paid	Recommends Assistant Surgery Payment
9	Concept does not apply	Deny with **RC 91** (Service Not Allowed)

Bilateral Procedures

Bilateral procedures may be reported as a single code with modifier 50 or reported twice on the same date with modifiers LT and RT. Bilateral adjustments may be applied based on the **Bilateral flags** in the RBRVS:

Bilat Surg	Description	Payment
0	Non-bilateral procedure. No bilateral adjustment.	100% of fee schedule
1	Conditional bilateral. Bilateral reductions are applied.	150% of fee schedule
2	Inherent bilateral. No bilateral adjustment.	100% of fee schedule
3	Independent bilateral. No bilateral adjustment.	100% of fee schedule
9	Non-bilateral procedure. No bilateral adjustment.	100% of fee schedule

Co-Surgery

When two surgeons work together to perform a specific procedure, each surgeon will report the surgical procedure with modifier 62 to indicate co-surgery. Eligibility for payment is initially determined based on the **Co-Surgery flags** in the RBRVS. If documentation of medical necessity is substantiated, each surgeon is reimbursed 62.5% of fee schedule amount for the surgical procedure.

Co-Surg	Description	CORE Processing
0	Co-surgeons not permitted	Deny with **RC 4W** (Service Not Allowed)
1	Co-surgeons may be paid based on supporting documentation	Deny with **RC J3** (Documentation required) Override of RC J3 allows 62.5%.
2	Co-surgeons permitted. No documentation required.	Deny with **RC J3** (Documentation required) Override of RC J3 allows 62.5%.
9	Concept does not apply	N/A

Team Surgery

When a team of surgeons (three or more) work together to complete a complex surgical procedure, each surgeon will report the surgical procedure with modifier 66. Eligibility for payment is initially determined based on the **Team Surgery flags** in the RBRVS. If documentation of medical necessity is substantiated, each surgeon's services should be paid "by report."

Team Surg	Description	CORE Processing
0	Team surgeons not permitted	Deny with **RC 4X** (Service Not Allowed)
1	Team surgeons may be paid based on supporting documentation	Deny with **RC J4** (Documentation required) Override of RC J4 allows 100% of fee schedule.
2	Team surgeons permitted. No documentation required.	Deny with **RC J4** (Documentation required) Override of RC J4 allows 100% of fee schedule.
9	Concept does not apply	N/A

Follow Up Days

The fee schedule utilizes the RBRVS payment guideline for **Global Days**:

Glob Days	Surgical Package
000	E/M services on the day of surgery are generally not payable
010	E/M services on the day of surgery and during the 10-day post-operative are generally not payable
090	E/M services 1-day preoperative and within the 90-days post-operative are generally not payable
ZZZ	Add-on code. Global days are based on the primary procedure
YYY	Not used for workers' compensation

RADIOLOGY

Where applicable, the fee schedule has separate rates for the whole component, technical component and professional component of radiology procedures.

The fee schedule also incorporates the CMS Multiple Procedure Payment Reduction (MPPR) rules for certain diagnostic radiological procedures. The rules are applied based on the **Multiple Procedure flags** in the RBRVS:

Mult Proc	Description	Payment
4	Multiple Diagnostic Imaging procedures	**Primary Procedure (Highest value):** 100% of both components **Secondary/Subsequent Procedures:** 50% of the technical component, 75% of the PC (01/01/2014-02/28/2017) *or* 95% of the PC (effective 03/01/2017)
6	Multiple Diagnostic Cardiovascular procedures	**Primary Procedure (Highest Value):** 100% of both components **Secondary/Subsequent Procedures:** 75% of the technical component 100% of the professional component
7	Multiple Diagnostic Ophthalmology procedures	**Primary Procedure (Highest value):** 100% of both components **Secondary/Subsequent Procedures:** 80% of the technical component 100% of the professional component

OPPS Cap

Section 5102(b) of the Deficit Reduction Act of 2005 requires that the technical component of diagnostic imaging procedures be capped at the payment amount from the Outpatient Prospective Payment System (OPPS).

Modifier -FX

Effective 01/01/2017, CMS added a new rule for x-ray imaging using film. Providers must report **modifier -FX** when an x-ray is taken with film. Payment for the **technical component** is reduced by **20%**.

Modifier -FY

Effective 01/01/2018, CMS added a new rule for x-ray using computed radiography. Providers must report **modifier -FY** when an x-ray is taken using computed radiography. Payment for the **technical component** is reduced by **7%**.

LABORATORY AND PATHOLOGY

The DWC adopts the CMS Clinical Laboratory fee schedule for pathology and laboratory tests. Providers must follow Medicare coding practices to obtain accurate reimbursement of these services.

Physician laboratory services will have RVU data in the RBRVS.

MEDICINE

Physical Medicine

The following treatment limitations should be followed per visit, unless prior authorization has been obtained:

- Modalities only - No more than two codes on the same visit
- Modalities, Physical medicine procedures or acupuncture - No more than 60 minutes at the same visit
- Modalities and Physical medicine procedures - No more than 4 codes total on the same visit

The fee schedule also adopts the CMS Multiple Procedure Payment Reduction (MPPR) rule for "Always Therapy" codes. The rule is applicable to procedure codes that have the following **Multiple Procedure flag**, plus 97810, 97811, 97813, 97814, 98940-98943.

Mult Proc	Description	Payment
5	Multiple Therapy Services	**Primary Procedure (Highest Practice Expense RUV):** 100% of the Practice Expense component **Secondary/Subsequent Procedures:** 50% of the Practice Expense component

24-VISIT CAP

Per Labor Code section 4604.5(c)(i), "for injuries occurring on and after January 1, 2004, an employee shall be entitled to no more than 24 chiropractic, 24 occupational therapy, and 24 physical therapy visits per industrial injury." The cap does not apply where the provider has received written prior-authorization for additional visits.

In CORE, visits exceeding the limit are disallowed with **RC CQ** (The limitation of twenty-four (24) chiropractic, physical therapy, and/or occupational therapy visits during the life of the claim has been exceeded).

EVALUATION AND MANAGEMENT

The fee schedule does not allow the use of CPT consultation codes 99241-99245 or 99251-99255.

NON-PHYSICIAN PRACTITIONERS (NPPS)

Physician assistants, nurse practitioners and clinical nurse specialists are reimbursed at 85% of the fee schedule amount for their services. Clinical social workers are paid at 75% of the fee schedule amount.

Please reference the **Surgery section** for assist-at-surgery services by non-physician practitioners.

HPSA BONUS PAYMENTS

Medicare provides a 10% bonus payment to **physicians** that provide a professional service in a Health Professional Shortage Area (HPSA). The Health Resources and Services Administration (HRSA) annually publishes a list of ZIP codes designates as primary care HPSAs and a list of ZIP codes designated as mental health HPSAs.

PC/TC Indicator	Description
0	Pay bonus.
1	Billed globally: Pay bonus on professional component only. Billed with modifier -26: Pay bonus. Billed with modifier -TC: Do not pay bonus.
2	Professional component only. Pay bonus.
3	Technical component only. Do not pay bonus.
4	Billed globally: Pay bonus on professional component only. Billed with modifier -26: Pay bonus. Billed with modifier -TC: Do not pay bonus.
5	Incident to codes. Do not pay bonus.
6	Laboratory physician interpretation codes. Pay bonus.
7	Physical therapy. Do not pay bonus.
8	Physician interpretation codes. Pay bonus.
9	Concept does not apply. Do not pay bonus.

Procedure codes billed with **Provider Type** **01** (Medical Doctor), **02** (Osteopathic Physician), **03** (Chiropractic Physician), **05** (Podiastrist) or **22** (Optometrist) *or* with **modifier -AQ** (Physician providing a service in an unlisted Health Professional Shortage Area) that qualify for the HPSA bonus will be increased by 10% and RC **2H** is applied to the line item.

AMBULANCE

Ground ambulance services are payable at 120% of the CMS Ambulance fee schedule. Air ambulance services are exempt from the fee schedule. Payment for air services is either negotiated or at charges.

DENTAL

The state does not provide fee schedule rates for dental services. Dental services are payable "by report."

DURABLE MEDICAL EQUIPMENT/PROSTHETICS, ORTHOTICS, SUPPLIES (DMEPOS)

DMEPOS are payable at 120% of the Medicare DMEPOS fee schedule.

J-CODES

Physician-administered drugs are payable at the Medi-Cal fee schedule (minus the Medi-Cal administration fee of $4.46).

INPATIENT HOSPITAL (ACUTE-CARE)

Inpatient admissions in an acute-care hospital are reimbursed under a DRG methodology. The fee schedule is comprised of Facility-Specific Composite Factors and CMS DRG weights. The formula for payment is:

[(Facility Composite Factor x DRG Weight) x 1.20] = Inpatient Hospital Payment Amount

Outliers

The bill may qualify for an additional outlier payment if the hospital's costs exceed the outlier threshold.

Implants

Effective 1/1/2014, there is no separate payment for implantable hardware or devices provided during an inpatient stay.

Trauma

The DWC does not have special payment provisions for trauma admissions or trauma facilities.

Critical Access Hospitals

Critical access hospitals are exempt from the fee schedule. Payment is made at the facility's charges.

Out-of-State Inpatient Stays

Hospitals outside the state of California are exempt from the CA Inpatient schedule guidelines.

Since the CAWC Inpatient Hospital Fee Schedule is DRG-based and utilizes data factors from Medicare, a recommendation of 120% of the Medicare Inpatient Hospital Prospective Payment System allowance may be used as a "usual and customary" payment for the stay, or as a starting point for negotiating a payment agreement with the facility. Links to the Medicare IPPS Pricer Tool and data entry instructions can be found in the Medicare FAQs.

Data Entry Requirements

The following guidelines identify the key fields required for accurate inpatient pricing in CORE.

On the **Provider Record** screen:

- **Prov Type** = 10

On the **Data Entry** screen:

- **UB04** = Y

On the **Additional Info** screen:

- **Date Admit** - Enter the Admission Date (FL12 on the UB-04)
- **Bill Type** - Enter the Type of Bill (FL4 on the UB-04)
- **B.O.S. Date** - Enter the Beginning date (FL6 on the UB-04)
- **E.O.S. Date** - Enter the Ending date (FL6 on the UB-04)
- **Facility Type** = A (Acute Care Facility) or O (use for all other facility types)
- **Billed DRG** - Enter the DRG (FL71 on the UB-04)

On the **DRG Header Input** screen:

- **DRG Y/N** = Y (Acute Care Facility) or N (use for CAH, Rehab, Psych, LTCH)
- **Pat Status** - Enter the Discharge Status (FL17 on the UB-04)
- **Medicare ID** - Enter the facility's Medicare Provider Number (MPN)
- **DRG Code** - Auto-populates per the DRG Grouper output. User may manually override.

When entering the revenue codes and charges:

- Key all lines presented on the bill
- **POS** = 21

CORE will calculate payment according to the fee schedule and RC ZE is applied to the lines.

DRG Grouper Requirements

CORE contains a MS-DRG Grouper program. The grouper program requires the following data elements in order to accurately compute a MS-DRG in the **DRG Code** field on the **DRG Header Input s**creen:

1) Patient **Date of Birth** (in Claim Record)
2) Patient **Gender** (in Claim Record and in DRG Header Input screen)
3) Patient **Discharge Status** (in the DRG Header Input screen)
4) ICD **Diagnosis Codes** and POA Indicators (from FL67 A-Q on the UB-04)
5) ICD **Procedure Codes** (from FL 74 A-E on the UB-04)

NOTE: If any of these requirements are not met, the grouper will apply DRG 999. User may manually override.

OUTPATIENT HOSPITAL & AMBULATORY SURGERY CENTER

Outpatient hospital and ASC services are reimbursed per an Ambulatory Payment Classification (APC) model specifically developed for California Workers' Compensation claims.

Outpatient Hospital

Generally, emergency room visits, surgical procedures and other outpatient services are reimbursed as follows:

(Medicare OPPS APC weight * Facility-specific conversion factor) * WC Outpatient Markup = Facility Fee

Separately payable outpatient services that do not have APC amounts may be reimbursed according to the medical fee schedule (Clinical Laboratory, DMEPOS, etc).

Ambulatory Surgery Center

Generally, surgical procedures are reimbursed as follows:

(Medicare OPPS APC weight * County-specific conversion factor) * WC ASC Markup = Facility Fee

The surgical facility fee includes all ancillary services provided by the ASC.

Implants

The APC weights for surgical procedures are developed to include the cost of associated implants and required supplies. Therefore, there is no separate payment for implantable hardware or devices used during a surgical procedure.

SPECIALTY FACILITY/SERVICES

Rehabilitation, Psychiatric, Long Term Care Hospitals

Reimbursement for these facility types is not regulated by the DWC.

Skilled Nursing Facility (SNF)

Reimbursement for SNF services is not regulated by the DWC.

Home Health Agency

Reimbursement for Home Health services is not regulated by the DWC.

Reimbursement for prescription drugs is **100%** of the payable amount in the **Medi-Cal** pharmacy database, including the Medi-Cal **dispensing fees ($7.25** for patients not in a nursing home and **$8.00** for patients in a nursing home).

If the NDC is not found in the Medi-Cal database, then reimbursement is based on the NDC of the underlying drug product. If the NDC of the underlying drug product is not in the Medi-Cal database, reimbursement shall be 83% of the average wholesale price of the lowest priced therapeutic equivalent drug.

MTUS Drug Formulary

The DWC adopts a Medical Treatment Utilization Schedule (MTUS) Drug Formulary effective **January 1, 2018**. Key formulary rules include:

- The formulary is applicable to any drug dispensed on or after 1/1/2018, regardless of date of injury.

  Exception:
  Existing drug therapy plans. The claims administrator and the prescribing medical doctor must work together to transition the patient to an "Exempt" drug, where appropriate.

- When a physician prescribes a **brand name drug** and orders no substitutions, the physician must obtain pre-authorization through prospective review.

- All **Physician-dispensed drugs** require prospective review.

  Exception:
  "Exempt" drugs provided at an initial visit, within 7 days of the date of injury, and up to a 7 day supply.

- All **compounded drugs** require prospective review.

- **"Exempt"** drugs are identified on the MTUS Drug List. "Exempt" drugs, when prescribed in accordance with the MTUS Treatment guidelines, can be dispensed and paid without prospective review unless, a) the brand name is ordered, or b) it is physician-dispensed, or c) it is a compounded drug.

- **"Non-Exempt"** drugs are identified on the MTUS Drug List. "Non-Exempt" drugs always require prior authorization through prospective review.

  Exception:
  "Non-Exempt" medications where the "Special Fill" or "Perioperative Fill" eligibility guidelines are met.

NOTE: "**Prospective review**" means that the drug must be **pre-authorized *PRIOR*** to dispensing it to the injured worker.

CORE Processing

The Drug Formulary can be configured in **Review Options**.

- **W** - Drug formulary is active. If an infraction occurs, allowance is recommended with a warning message.
- **C** (Default setting) - Drug formulary is active. If an infraction occurs, charge is denied with a message.
- **N -** Drug formulary is disabled.

Automated Rules (Using default setting of 'C')

1) Physician - Dispensed Drugs:

   If a medical/professional bill (CORE Provider Type is ***not*** 20-Pharmacy) has an NDC with a DOS > 12/31/2017, the charge is disallowed with **RC EG** unless the Prior Auth # field is populated ***or*** all of the following conditions are met:

   - No provider history; ***and***
   - Drug is listed as "Exempt" on the MTUS Drug List; ***and***
   - DOS is within 7 days of the Claimant's DOI; ***and***
   - Days Supply < 8

2) Brand-name drugs:

   On any bill type (professional/pharmacy/facility), if an NDC with a DOS > 12/31/2017 is a brand name (and is not an OTC drug) and the DAW = 1, 3 or 7, the charge is disallowed with **RC EH** unless the Prior Auth # field is populated.

3) "Non-Exempt" drugs and "Special Fill" exceptions:

   On any bill type (professional/pharmacy/facility), if an NDC with a DOS > 12/31/2017 is a non-exempt drug (and is not an OTC drug), the charge is disallowed with **RC EI** unless the Prior Auth # field is populated ***or*** all of the following conditions are met:

   - DOS is within 7 days of the Claimant's DOI; ***and***
   - Days Supply =< Special Fill days

4) Existing drug plans for DOI < 1/1/2018:

   On any bill type (professional/pharmacy/facility), if an NDC with a DOS > 12/31/2017 is a non-exempt drug (and is not an OTC drug) and the same NDC is found in Claimant history with an allowance > $0.00, the charge is allowed with **RC EJ**.

RC EG = Drugs dispensed by a physician require pre-authorization.
RC EH = A brand name drug where substitution is not allowed requires pre-authorization.
RC EI = The drug prescribed contains an active ingredient that is Non-Exempt on the MTUS Drug List. Prior authorization is required.
RC EJ = The drug prescribed contains an active ingredient that is Non-Exempt on the MTUS Drug List and is part of an existing treatment plan.

Repackaged Drugs

Repackaged drugs are reimbursed based on the NDC of the original drug product used by the repackager in producing the repackaged product.

Compound Drugs

Effective 1/1/2018, all compound drugs require pre-authorization before the drug can be dispensed to the injured workers. Reimbursement of compound drugs is not yet automated in CORE.

The following instructions for paying compound drugs are derived from the following webpage:
http://www.dir.ca.gov/dwc/pharmfeesched/PFScompound.asp

For compound prescription pricing, the **compound dispensing fee (CDF)** is dependent on route of administration, dosage form, and date of service.

For all dates of service, the **compound dispensing fee (CDF)** is the sum of the **dispensing fee (DF)** plus the **compounding fee (CF)** plus the **sterility fee (SF)**:
CDF = DF + CF + SF

For all dates of service, the **number of containers (NC)** is multiplied by the **compound dispensing fee** only for routes of administration **4 – injection** and **14 - perfusion**. Otherwise the **number of containers (NC)** is considered to be **one** (1).

For all dates of service, the **sterility fee (SF)** is the lesser of the usual and customary sterility fee and the maximum sterility fee allowed for that route of administration (see table 2024).

For all dates of service, the **compounding fee (CF)** is the fee allowed for that route of administration and dosage metric decimal units, or, if that amount is zero, then the compounding fee allowed for the applicable dosage form and range of dosage metric decimal units (see table 2024).

For compound prescription pricing, the **Medi-Cal price (MP)** is the sum, for each **ingredient (i)** in the compound prescription, of the **unit price (UP)** times the number of **metric decimal units (MDU)** of that ingredient (without rounding), plus the **compound dispensing fee (CDF)** times the **number of containers (NC)**. The total number of ingredients is the **ingredient count (IC)**:
$$\mathbf{MP = [S}_{i=1 \text{ to IC}} \mathbf{(UP_i \times MDU_i)] + (NC \times CDF)}$$

The **usual and customary price (CP)** is the actual usual and customary price, including all dispensing or compounding fees.

The **payment price (PP)** is the lower of the Medi-Cal price or the usual and customary price, minus the discount:
PP = (lesser of(MP,CP)) – D

INDEPENDENT MEDICAL EXAMINATIONS (IME) – Medical-Legal Fee Schedule

The CA Division of Workers' Compensation adopts regulations for medical-legal expenses incurred by or on behalf of any party for the purposes of establishing evidence for a contested claim.

X-rays, laboratory services and other diagnostic tests are billed and reimbursed in accordance with the OMFS fee schedules. For evaluations and other QME services, the physician must bill using the following state-specific codes.

Effective 04/01/2021:

Code	Description
ML200	Missed Appointment for a Comprehensive or Follow-up Med-Legal Evaluation
ML201	Comprehensive Med-Legal Evaluation
ML202	Follow-Up Med-Legal Evaluation (within 18 months of prior evaluation)
ML203	Supplemental Med-Legal Evaluation
ML204	Fees for Medical-Legal Testimony
ML205	Fees for Review of Sub Rosa Recordings
MLPRR	Records Review of Additional Pages

Modifiers

The following modifiers may be reported with ML201 through ML203 to identify the following circumstances:

- 92 – Performed by primary treating physician (informational only)
- 93 – Interpreter for ML201 or ML202 (110%)
- 94 – Evaluation and medical testimony by an Agreed Medical Evaluator (135%)
- 95 – Evaluation by a panel selected QME (informational only)
- 96 – Evaluation by a Psychiatrist or Psychologist (200%)
- 97 – Evaluation by a physician who is board certified in Toxicology (150%)
- 98 – Evaluation by a physician who is board certified in Medical Oncology (150%)

Prior to 04/01/2021:

Code	Description
ML100	Missed Appointment for a Comprehensive or Follow-Up Medical-Legal Evaluation
ML101	Follow-Up Medical-Legal Evaluation
ML102	Basic Comprehensive Medical-Legal Evaluation
ML103	Complex Comprehensive Medical-Legal Evaluation
ML104	Comprehensive Medical-Legal Evaluation Involving Extraordinary Circumstances
ML105	Fees for Medical-Legal Testimony
ML106	Fees for Supplemental Medical-Legal Evaluations

Modifiers

The following modifiers may be reported with ML101 through ML106 to identify the following circumstances:

- 92 – Performed by primary treating physician (informational only)
- 93 – Interpreter for **ML102 or ML103** only (110%)
- 94 – Evaluation and medical testimony by an Agreed Medical Evaluator (135%)
- 95 – Evaluation by a panel selected QME (informational only)

REPORTS

Practitioners must use the California-specific codes when billing for reports:

Code	Description
WC001	Doctor's First Report of Occupational Illness or Injury (Form 5021)
WC002	Treating Physician's Progress Report (PR-2 or narrative equivalent in accordance with § 9785)
WC003	Primary Treating Physician's Permanent and Stationary Report (Form PR-3)
WC004	Primary Treating Physician's Permanent and Stationary Report (Form PR-4)
WC005	Psychiatric Report requested by the WCAB or the Administrative Director
WC006	[Reserved]
WC007	Consultation Reports Requested by the WC Appeals Board or the AD (Use modifier 32) or Consultation Reports requested by the QME or AME in the context of a medical-legal evaluation
WC008	Chart Notes
WC009	Duplicate Reports
WC010	Duplication of X-Ray
WC011	Duplication of Scan
WC012	Missed Appointment

COPY SERVICE FEE SCHEDULE

Effective 07/15/2022, the DWC adopts the following state-specific codes for copy services:

Code	Description
WC019	Copy Service, Flat Rate
WC021	Copy Service, Cancelled
WC022	Certificate of No Record
WC023	Copy Service, Per Page over 500 Pages
WC028	Duplication of X-Ray or Scan
WC029	CD of X-Ray or Scan
WC030	Requested Services
WC031	Contract Rate, Additional Sets
WC032	Contracted Services
WC033	Additional Set
WC034	Surgcharge, Late Payment

Effective 07/15/2015, the DWC adopted the following state-specific codes for copy services:

Code	Description
WC020	Copy Service
WC021	Copy Service, Cancelled
WC022	Certificate of No Record
WC023	Copy Service, Per Page over 500 Pages
WC024	Records from EDD
WC025	Records from WCIRB
WC026	Additional Electronic Set within 30 Days
WC027	Additional Electronic Set beyond 30 Days
WC028	Duplication of X-Ray or Scan
WC029	CD of X-Ray or Scan

INTERPRETER SERVICES

Fees for Interpreter services are found in §9795.3 of the CA DWC Administrative Rules. The DWC does not have state-specific coding requirements; however, interpreter services may be billed with HCPCS T1013.

Services by a **certified** or **provisionally certified interpreter** billed with T1013 will be reimbursed at the rate of $11.25 per quarter hour, or portion thereof, with a **minimum payment of two hours** ($90.00) when provided during the following circumstances:

- Physician exam per request of the claims administrator, the administrative director, or the appeals board
- A medical treatment appointment
- A medical-legal evaluation

Interpreter fees for an appeals board hearing, arbitration, or deposition are paid at the greater of:

a) at the rate for one-half day or one full day as set forth in the Superior Court fee schedule for interpreters in the county where the service was provided, or

b) at the market rate.

The Superior Court Interpreter Fees can be found at: https://www.courts.ca.gov/programs-interpreters.htm

Since the regulations allow for the interpreter to establish and be reimbursed at a market rate, if a dollar amount is entered in the Invoice field in CORE, that amount will be recommended as payment.