A REPORT TO THE INDUSTRY

The Impact of Medical Inflation on California Workers' Compensation Fee Schedules

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BACKGROUND

As the U.S. economy experienced sharp increases in consumer prices in 2021 and 2022, inflation became a major national health care cost concern, including in California's workers' compensation system. The 12-month change in the Consumer Price Index (CPI) reached a 40-year high of 9.1% in June 2022 and has since slowed.[1] This report explores how medical inflation impacts California's Official Medical Fee Schedule (OMFS). Although there are many available price indices to measure medical inflation,[2] this analysis will focus on the price indices used to adjust fee schedule rates in the California workers' compensation OMFS.

In the California workers' compensation system, payments for medical services provided to injured workers are regulated by the OMFS, which is promulgated by the Administrative Director of the Division of Workers' Compensation (DWC).

The OMFS sections include:

- physician services and non-physician practitioner services
- inpatient hospital services
- hospital outpatient departments and ambulatory surgical centers
- pharmacy
- pathology and laboratory
- durable medical equipment, prosthetics, orthotics and supplies (DMEPOS)
- ambulance services
- skilled nursing facility
- home health care, and
- outpatient renal dialysis

Currently, the fee schedule regulations for skilled nursing facilities, home health care, and outpatient renal dialysis are pending.

California specific services including medical-legal, interpreter, and copy service are also reimbursed according to fee schedules adopted by the DWC. However, these fee schedules do not contain an inflation adjustment component.

Each of the OMFS sections uses distinct rules for fee schedule calculations and different inflation factors to update prices. The OMFS incorporates many of the Medicare and Medi-Cal payment methodologies with California workers' compensation-specific adjustments. For ambulance ground services, DMEPOS, and laboratory/pathology, the fee schedule is set at 120% of the Medicare fee schedule, meaning year-to-year increases are driven by the same updating process as Medicare to account for inflation.

[1] The CPI is published by the U.S. Bureau of Labor Statistics (BLS) and measures the average change over time in the prices paid by urban consumers for a market basket of consumer goods and services.

[2] For example, the medical care subindex of the CPI tracks out-of-pocket consumer payments for medical services and commodities. The healthcare services in the Producer Price Index (PPI) measure the average change over time in prices received by domestic health care providers, including Medicare Part A, Medicaid, and other third-party payers.

Exhibit 1 summarizes the payment scheme for each section of the California workers' compensation OMFS and indicates the inflationary factors used to update payments.

Exhibit 1: Summary of California Workers' Compensation Official Medical Fee Schedule and Inflationary Adjustments

Section	Payment System / Fee Schedule	Inflationary Factor	Percent of Med Treatment Payments[a]
Physician Services and Non-Physician Practitioner Services	Based on Medicare's Resource-Based Relative Value Scale (RBRVS); formula to update conversion factors is different from Medicare	Medicare Economic Index Congressional Adjustments adopted by DWC	53.3%
Inpatient Hospital Services	Reimbursed on a Diagnosis-Related Group (DRG) basis	Hospital market basket for operating costs and the capital market basket for capital costs	17.5%
Outpatient Hospital & Ambulatory Surgery Center	Reimbursed by an Ambulatory Payment Classification (APC)	Hospital market basket	11.7%
Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS)	Payable at 120% of CMS' DMEPOS Fee Schedule	Consumer Price Index for all Urban Consumers (CPI-U)[b]	5.5%
Ambulance (only for ground transportation)	Payable at 120% of CMS' Ambulance Fee Schedule	Ambulance Inflation Factor	2.2%
Laboratory and Pathology	Payable at 120% of the CMS' Clinical Laboratory Fee Schedule (CLFS)	As of 2018, CMS' CLFS payment rates are not updated annually based on inflation	0.5%
Pharmaceuticals	Payable at 100% of the reimbursement specified by the Medi-Cal fixed fee schedule, including the Medi-Cal professional dispensing fee	No auto increase	2.6%
Other	Fee schedules with pending regulations (home health, etc.), miscellaneous codes, etc.	No auto increase	6.7%

[a] Note: Based on CWCI's IRIS data for the second half of the service year 2022. Population: Insured only. Total medical cost excludes payments to med-legal, copy-service, and procedures with no fee schedule. [b] Since 2011, for certain DMEPOS the percentage increase in the CPI-U is reduced by a productivity adjustment.

In the following sections, we examine in detail the inflationary adjustments used in each section of the OMFS.[3]

Physician and Non-Physician Practitioners Fee Schedule

For payment purposes, the OMFS distinguishes between all physician and non-physician services (non-anesthesia) and anesthesia. Anesthesia services accounted for 2.4% of the 53.3% of total medical payments for this category (see Exhibit 1).

[3] A glossary of terms used in this report can be found at the end of the report for quick reference.

Payments for professional services, excluding anesthesia, are based on Medicare's Resource-Based Relative Value Scale (RBRVS), which assigns relative value units (RVUs) to each procedure. These national units reflect physician work, practice expenses (PE), and malpractice costs, and are adjusted by Geographic Practice Cost Indices (GPCIs) to reflect the variation in practice costs from area to area.[4] The fee schedule rate is calculated by summing the geographically adjusted RVUs and multiplying by a conversion factor to convert the units into dollar amounts.[5]

Anesthesia services are paid using a different formula based on allowable base and time units and an anesthesia conversion factor adjusted by the anesthesia shares (proxies for the work, PE, and malpractice RVUs for anesthesia services) and GPCIs specific to the locality where the service was provided.[6]

When analyzing what drives the year-to-year price increases in the California workers' compensation fee schedule, a key element to consider is the conversion factor. This variable is updated annually by the DWC to account for inflation and relevant Medicare adjustment factors.[7] Exhibit 2 shows the primary adjustment factors considered in updating the OMFS conversion factor between 2018 and 2024.

Exhibit 2: OMFS Adjustment Factors for All Services Other Than Anesthesia

Service Year	RVU Budget Neutrality	Medicare Economic Index	Temporary Increases
2018	-0.10%	1.4%	N/A
2019	-0.14%	1.5%	N/A
2020	0.14%	1.9%	N/A
2021	-6.81%	1.4%	3.75%
2022	-0.10%	2.1%	3.0%
2023	-1.60%	3.8%	2.5%
2024[a]	-2.18%	4.6%	1.25%
2024[b]	-2.18%	4.6%	2.93%

Note: [a] For services between 2/15/2024 to 3/31/2024. [b] For services provided on or after 4/1/2024. Temporary Medicare increases for 2021, 2023-2024 were mandated by Consolidation Appropriation Acts, while the increase in 2022 was enacted by the Protecting Medicare and American Farmers from Sequester Cuts Act, Public Law. Source: CCR §9789.19. Update Table.

The Administrative Director of the DWC oversees annual updates to the conversion factor to account for inflation by applying the annual percentage change in the Medicare Economic Index (MEI). The MEI is a fixed-weight input price index calculated by the Centers for Medicare & Medicaid Services (CMS) on a quarterly basis. The

[4] A Geographic Practice Cost Index (GPCI) is assigned to each Medicare payment locality for the three RVU components. In California, there are 29 designated Medicare payment localities.

[5] The general formula for calculating the maximum fee is: Base Maximum Fee = [(Work RVU × Work GPCI) + (PE RVU × PE GPCI) + (MP RVU × MP GPCI)] × Conversion Factor. Practice expense RVUs differ between facility and non-facility.

[6] The formula for anesthesia services is: Base Maximum Fee = [Base Unit + Time Unit] × Adjusted CF by locality. The adjusted conversion factor for the locality corresponding to the county where the service is provided, is calculated as: [(Work GPCI by locality × Anesthesia Work Share) + (Practice Expense GPCI by locality × Anesthesia Practice Expense Share) + (Malpractice GPCI by locality × Anesthesia Malpractice Share)] × Anesthesia Conversion Factor].

[7] The Administrative Director of the DWC updates the conversion factors in accordance with the Labor Code and the California Code of Regulations (CCR). Labor Code section 5307.1, subdivision (g)(1)(A) states in part as follows:

(g) (1) (A) Notwithstanding any other law, the official medical fee schedule *shall be adjusted to conform to any relevant changes in the Medicare and Medi-Cal payment systems* no later than 60 days after the effective date of those changes, subject to the following provisions:

***

(iii) The annual adjustment factor for physician services shall be based on the product of *one plus the percentage change in the Medicare Economic Index and any relative value scale adjustment factor*. [Emphasis added.]

Title 8, CCR, section 9789.12.5, subdivision (c) states that "For calendar year 2018, and annually thereafter, the Anesthesia conversion factor and the Other Services conversion factor in effect in the prior calendar year shall be updated by the Medicare Economic Index inflation rate and by the Relative Value Scale Adjustment Factor, if any."

MEI measures the average annual price change for various inputs involved in furnishing physicians' services, including compensation and practice expenses. To construct the MEI, CMS uses data from the U.S. Census Bureau's Services Annual Survey, the Employment Cost Index, and other price indices published by BLS.

Additionally, as specified in the California Labor Code and the Code of Regulations, the Administrative Director must consider the Relative Value Scale Adjustment Factor, also known as the Medicare RVU budget neutrality adjustment factor. Medicare uses this adjustment to maintain budget neutrality when changes in RVUs would otherwise result in a significant increase in payments.

Furthermore, Section 1848(c)(2)(B)(ii)(II) of the Social Security Act requires that, when calculating the Medicare Physician Fee Schedule conversion factor for a year, increases or decreases in RVUs may not cause the expenditures for the year to differ more than $20 million from what expenditures would have been in the absence of these changes. If this threshold is exceeded, CMS must adjust the conversion factor to preserve budget neutrality. CMS calculates the RVU budget neutrality based on Medicare's utilization and mix of services. A future research question is whether this adjustment factor is budget neutral for California workers' compensation given the differences in service mix and utilization compared to Medicare.

Between 2018 and 2024, the RVU budget neutrality adjustment has been in the direction of decreasing the conversion factor, except for 2020 (Exhibit 2). For 2021, CMS finalized an RVU budget neutrality adjustment of -6.81% to offset increases in valuation of the Evaluation and Management (E&M) office visit codes.[8] This budget neutrality adjustment resulted in a decrease to the conversion factor for that calendar year for both Medicare and California's workers' compensation.

Between 2021 and 2024, Congress mandated additional temporary adjustments for Medicare, which the DWC also chose to incorporate into the OMFS. The Consolidated Appropriations Act (CAA) of 2021 introduced several provisions impacting Medicare, particularly addressing issues related to the COVID-19 pandemic. CAA 2021 included a temporary 3.75% increase for CY 2021. To offset the expiration of the 3.75% increase from CY 2021, the Protecting Medicare and American Farmers from Sequester Cuts Act established a 3% increase for CY 2022. CAA 2023 mandated temporary increases of 2.5% for CY 2023 and 1.25% for CY 2024, and later, an additional CAA set a 2.93% increase for services between March 9 and December 31, 2024.[9] These increases were designated as temporary adjustments, as the acts specified that they should not influence payment rates in future years. For example, the 2022 increase was applied to an adjusted 2021 conversion factor, calculated as though the temporary 3.75% increase from 2021 had not been applied.[10]

While the California OMFS adopts Medicare's RVUs and GPCIs, the formula to update the conversion factor in the physician fee schedule differs from that of the Medicare Physician Fee Schedule. Exhibit 3 compares the adjustment factors used in updating conversion factors for Medicare and for the California OMFS.

[8] For example, from 2020 to 2021, the work RVU increased 46% for CPT code 99212, 34% for 99213, and 28% for 99214.

[9] CAA 2024 replaced the CY 2024 1.25% update with a 2.93% increase for services between March 9 and December 31, 2024. Therefore, the earlier 1.25% increase for CY 2024 only applied for services between January 1 and March 8, 2024.

[10] The formula to update the conversion factor (CF) in the OMFS has varied between 2014 and 2024. For 2020 and 2021, the updated CF was equal to the product of all adjustment factors for the year and the CF of previous year. Starting in 2022, the formula has been adapted and instead of applying the adjustments to the previous year conversion factor, the formula uses a counterfactual CF instead. For more details see the *OMFS Update for Physician and Non-Physician Practitioner Services- Explanation of Changes*, published in the DWC website for each service year.

Exhibit 3: Adjustment Factors Considered in Updating Conversion Factors as of CY 2024

Adjustment Factor	Medicare	California WC OMFS
Medicare Economic Index (MEI)		✓
RVU Budget Neutrality	✓	✓
Statutory Update Factor mandated by MACRA	✓	
Other Temporary Medicare increases mandated by Congress	✓	✓

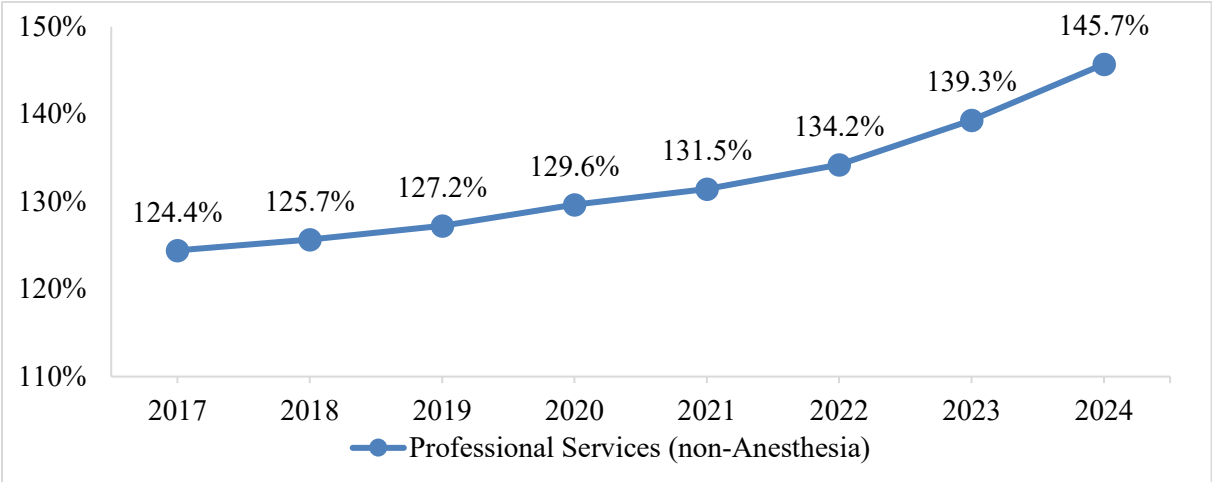
Note: Other temporary increases mandated by Congress are those from Consolidation Appropriation Acts (2021, 2023, and 2024), and the Protecting Medicare and American Farmers from Sequester Cuts Act, Public Law (2022).

The key difference in the formula used to update the conversion factor between Medicare and the OMFS lies in the use of the MEI and statutory update factors mandated by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). MACRA replaced the Medicare update formula based on the MEI and the Sustainable Growth Rate, which tied payment updates to past spending and gross domestic product growth, so Medicare ceased using the MEI to update its conversion factor in 2015. Instead, MACRA set statutory updates: 0.5% annual increases from July 1, 2015 to 2019, and 0% updates from 2020 to 2025.

The DWC chose not to adopt the statutory update factors mandated by MACRA. For example, DWC's *2018 OMFS Update for Physician and Non-Physician Practitioner Services - Explanation of Changes* stated: "The "Update Factor" of 0.50 percent and the CY 2018 Target Recapture Amount of -0.09 percent in Table 48 and Table 49 of CY 2018 Medicare Physician Fee Schedule Final Rule, CMS-1676-F are not applicable because Labor Code §5307.1(g)(1)(A)(iii) specifies that the physician fee schedule annual updates are to be based upon the Medicare Economic Index and the relative value scale adjustment factors." However, they did choose to adopt other congressional increases made from 2021 to 2024.

The differences in updating factors explain the increasing California workers' compensation differential relative to Medicare's conversion factor. Exhibit 4 shows the California workers' compensation conversion factor as a percentage of Medicare rose from 124.4% in 2017 to a maximum of 145.7% in 2024. A similar increasing trend was observed for the anesthesia conversion factor.

Exhibit 4: Workers' Compensation Conversion Factor as a Percentage of Medicare



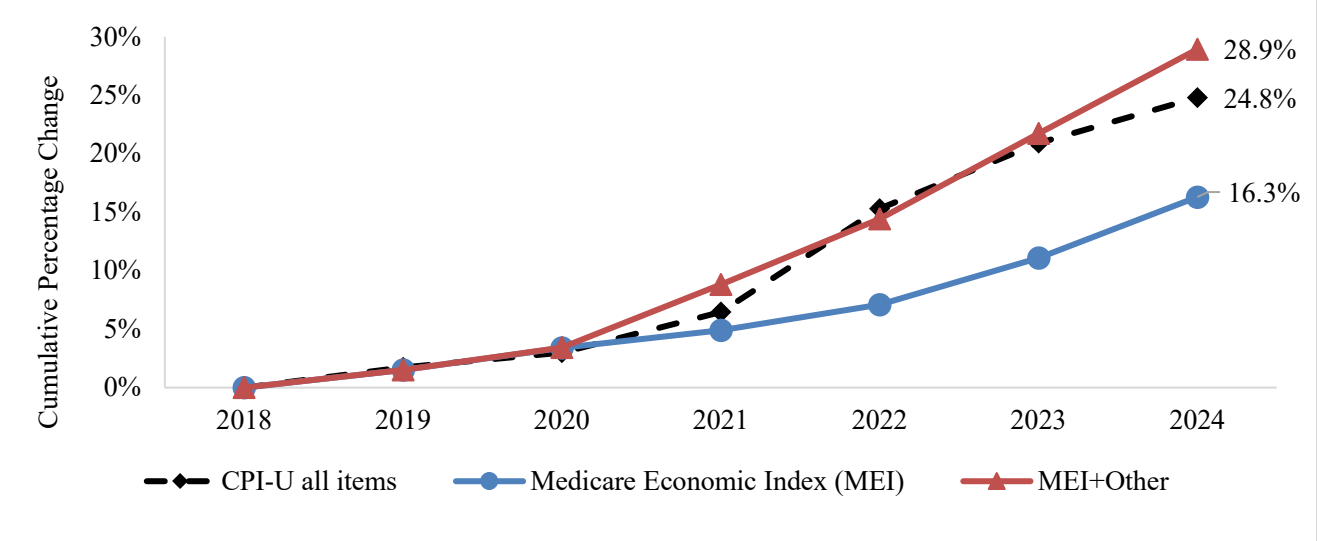
Note: For 2023, the graph shows conversion factors for service dates between February 15 and December 31, 2023. For 2024, the graph shows conversion factors for service dates between April 1 and December 31, 2024.

Similarly, an estimation of the workers' compensation differential over Medicare, calculated by the Workers Compensation Research Institute (WCRI) using aggregate fee schedule rates, showed a 34% premium for 2022.[11] This aligns with the finding in this report which calculated the differential based on the conversion factor. For procedures paid under the RBRVS system, the only difference in the formula used to calculate fee schedule rates is the conversion factor as the RVUs and GPCIs in California workers' compensation and Medicare are the same.

Exhibit 5 compares the cumulative percentage changes since 2018 for the physician Medicare Economic Index (MEI), economy-wide inflation, and the MEI combined with the temporary Medicare increases adopted by the DWC in updating the conversion factor for professional services. Economy-wide inflation is measured by the 12-month average percentage change in the Consumer Price Index (CPI-U) for all urban consumers, based on data from the first half of the year.

Between 2018 and 2024, the physician MEI increased by 16.3% while economy-wide inflation rose by 24.8%. Before 2021, the MEI's cumulative percentage change closely tracked general inflation. However, in 2021-2022, the U.S. economy saw high inflation rates, largely driven by sharp price increases in food, housing, and gasoline. For California workers' compensation, the cumulative increase in inflationary factors (MEI plus the temporary increases mandated by Congress for Medicare) was 28.9% during this period, higher than general inflation.

Exhibit 5: Cumulative Inflation Factors for Professional Services OMFS vs. CPI



Note: To calculate the cumulative percentage change for the CPI-U for all items we used the 12-month percentage change average for the first half of the year.

In summary, the fee schedule rate (*e.g.,* price level) is impacted by different factors, including inflationary updates. In the OMFS professional fee schedule the formula to calculate rates considers three elements: 1) the conversion factor, 2) the relative value units (RVUs), and 3) the Geographic Practice Cost Indices (GPCIs). Thus, any changes to these elements will impact fee schedule rates for procedures paid under the RBRVS system. While physician practice inflation is only passed through the conversion factor, changes in coding rules affect the conversion factor through the RVU budget neutrality adjustment and the RVUs directly. Finally, in addition to inflation, average payments for physician services are also influenced by changes in utilization, service mix, and discounting practices.

[11] Fomenko, O., and T. Liu. Designing Worker's Compensation Medical Fee Schedules. WCRI. 2022.

Inpatient Hospital, Hospital Outpatient Departments and Ambulatory Surgical Centers

In the OMFS, inpatient discharges are reimbursed using a Diagnosis-Related Group (DRG) basis, and rates are updated as in the Medicare's Acute Inpatient Prospective Payment System (IPPS). The facility component of services provided in a hospital outpatient department or ambulatory surgical center under the OMFS is reimbursed by using an Ambulatory Payment Classification. These outpatient services are paid under a separate fee schedule based on Medicare's Outpatient Prospective Payment System and the Ambulatory Surgical Center Payment System. Services paid using these fee schedules accounted for 29.2% of the total medical payments in the California workers' compensation system in 2022 (Exhibit 1).

As in Medicare's IPPS, under the OMFS, hospitals are paid a standard rate for inpatient discharges with two components: operating and capital-related costs (known as the standardized payment amounts).[12] These uniform rates are further adjusted for various factors such as the area wage index to reflect differences in local labor market prices, case mix (DRG weight), and qualifying hospitals' policy adjustments to account for local costs and patient needs.

Inpatient hospital base rates under the OMFS are updated annually using the hospital market basket for the operating rate and the capital market basket for the capital rate. The inpatient hospital market basket measures input price changes related to operating costs, including labor, supply costs, and professional liability insurance. While the capital market basket measures input price changes for capital costs, like depreciation, interest, and rent.[13] These "market baskets" are input price indexes that CMS uses to account for inflation in its Prospective Payment Systems.[14] A market basket measures the price change over time for the same mix of inputs used by Medicare providers to deliver patient care. The Office of the Actuary within CMS constructs the market baskets for each of Medicare's Prospective Payment Systems by estimating cost weights for spending categories in a base period using data from hospital cost reports, matching each category to a relevant price index, and calculating a composite index by multiplying weights by their corresponding price proxies.[15]

Payment rates for services reimbursed under the Hospital Outpatient and Ambulatory Surgical Center Fee Schedule are calculated using Ambulatory Payment Classification weights, a conversion factor, and a wage index. The conversion factor in this fee schedule is updated annually by the inpatient hospital market basket to account for inflation. Every year, the percentage increase in the OMFS rate for inpatient and outpatient services is higher than Medicare updates because the OMFS does not include the productivity adjustments that Medicare applies.[16]

Exhibit 6 compares cumulative percentage changes since 2018 for the inpatient hospital market basket, capital market basket, and the CPI. Between 2018 and 2024, economy-wide inflation, as measured by the urban CPI for all items, rose the most, accumulating a 24.8% increase, followed by a 19.9% increase for the inpatient market basket, and an 11% increase for the capital market basket. The graph also shows that prices for hospital capital inputs have increased at a lower rate compared to labor inputs.

[12] Operating costs cover labor and supplies, while capital-related costs cover depreciation, interest, rent, and property-related insurance and taxes.

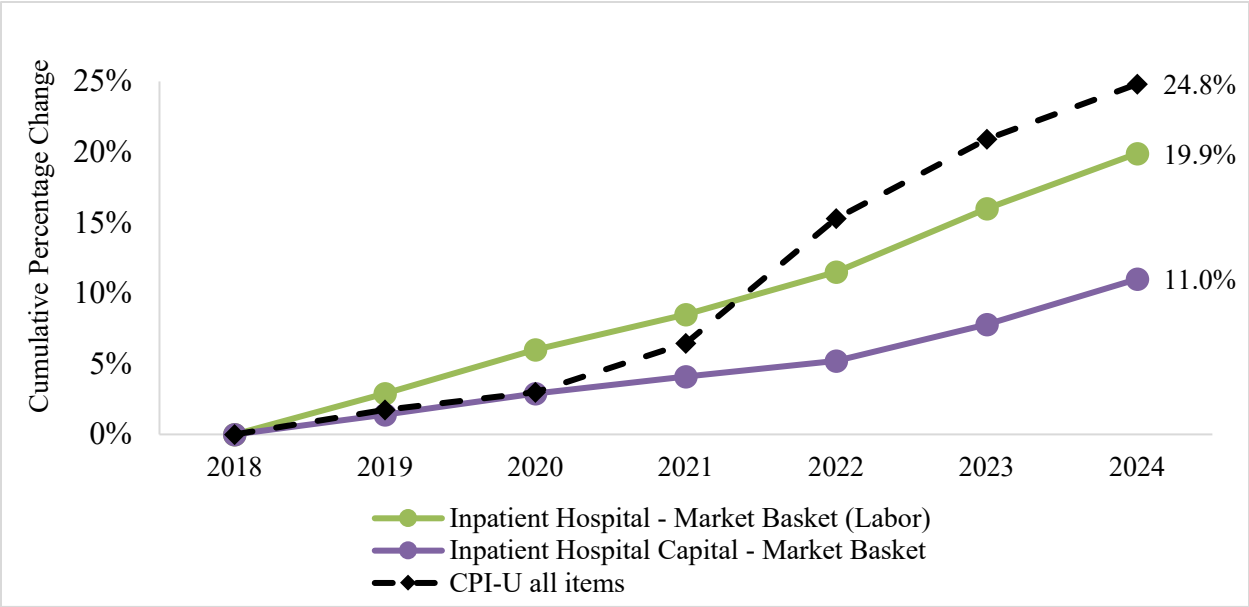
[13] Medicare's IPPS uses the hospital market basket to update payment rates for operating costs and the capital market basket for capital costs. Both market basket increases are adjusted by a productivity adjustment, as mandated by law, to reflect gains in efficiency.

[14] For more information on the CMS's market baskets see: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/medicareprogramratesstats/downloads/info.pdf

[15] Major cost categories for the hospital inpatient market basket include wages and salaries (41.2%), employee benefits (11.7%), and pharmaceuticals (7.1%). For the capital market basket, the major cost categories are depreciation (76.8%) and interest (16.6%).

[16] This is because L.C. §5307.1(g)(1)(A)(i) provides that the annual inflation adjustment for inpatient hospital facility fees shall be determined solely by the estimated increase in the hospital market basket.

Exhibit 6: Cumulative Inflation Factors for Hospital Inpatient and Outpatient OMFS vs. CPI



Note: The Hospital Outpatient Fee Schedule does not have a capital component. To calculate the cumulative percentage change for the CPI-U for all items we used the 12-month percentage change average for the first half of the year.

Besides the inflationary adjustments, other annual updates that can affect prices in the Inpatient Hospital Fee Schedule include changes to base rates, wage indexes, DRG definitions and weights, and the outlier fixed-loss amount. Similarly, changes in the Ambulatory Payment Classification weights or wage indexes could also impact prices in the Hospital Outpatient and Ambulatory Surgical Center Fee Schedule.

Ambulance

California's OMFS establishes that ground ambulance services are payable at 120% of the Medicare Ambulance Fee Schedule (AFS). The Medicare AFS, however, includes air services[17] that are exempt from the OMFS, so payments for those services are either negotiated or based on charges.[18]

The Medicare AFS payment for ground ambulance services equals a base rate for the level of service, plus payment for mileage and applicable adjustment factors.[19] The base payment is the product of three variables: the Relative Value Unit, which refers to the relative intensity or service level of the ambulance transport; a conversion factor, which is used to convert the Relative Value Unit into dollars; and a geographic adjustment factor to account for the geographic differences in the cost of providing ambulance services. In the OMFS for ambulance services the conversion factor is called the "base rate."

The payment for the mileage component of the AFS reflects the costs attributable to the use of the ambulance vehicle and is the product of miles traveled with the patient and a mileage rate determined by CMS.

CMS uses the Ambulance Inflation Factor to annually update both the base rate and the mileage rate. The Ambulance Inflation Factor is equal to the percentage increase in the Consumer Price Index for all Urban

[17] For air ambulance services, the Medicare fee schedule amount includes: 1) A nationally uniform base rate for fixed wing and a nationally uniform base rate for rotary wing; 2) GPCI; 3) a nationally uniform loaded mileage rate for each type of air service; and 4) a rural adjustment to the base rate and mileage for services furnished for a rural point-of-pickup. See: Medicare Claims Processing Manual Chapter 15 – Ambulance.

[18] Fee Schedule FAQs – California Workers' Compensation. Medata 2023.

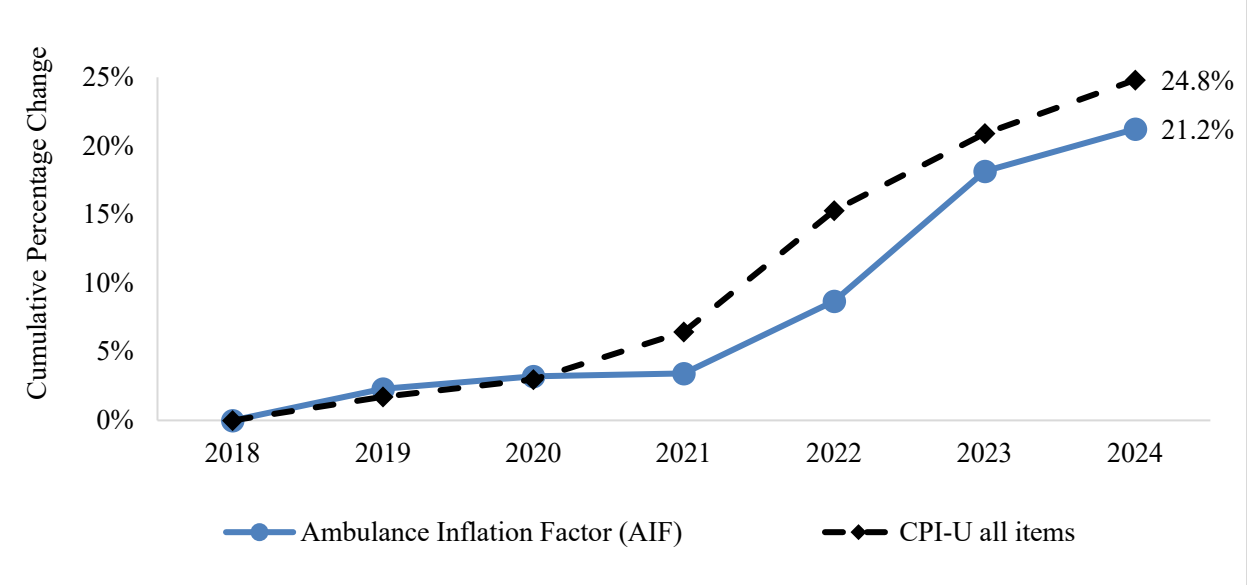
[19] 42 CFR §414.61 Basis of payment.

Consumers for the 12-month period ending with June of the previous year, minus the 10-year moving average of changes in economy-wide private nonfarm business multi-factor productivity.[20]

Multifactor productivity, recently renamed "total factor productivity", is a statistic published annually by the BLS. It measures how efficiently the U.S. converts inputs, such as labor and capital, into outputs of goods and services. The BLS defines total factor productivity as the change in output levels relative to the change in input levels.

Exhibit 7 compares the cumulative percentage changes since 2018 for the Ambulance Inflation Factor and the CPI-U for all items. Since the Ambulance Inflation Factor is based on the one-year lagged CPI-U, its trend closely follows the general inflation rate. As a result, fluctuations in this factor are influenced by price changes in volatile items like food and gasoline. From 2018 to 2024, the cumulative percentage increase in the Ambulance Inflation Factor was 21.2%, which was slightly below the economy-wide inflation rate because of the productivity adjustment.

Exhibit 7: Cumulative Inflation Factors for Ambulance OMFS vs CPI



Note: To calculate the cumulative percentage change for the CPI-U for all items we used the 12-month percentage change average for the first half of the year.

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

Maximum fees for DMEPOS under the OMFS are capped at 120% of the applicable fees in the Medicare DMEPOS fee schedule.

Medicare sets payment rates for DMEPOS using a competitive bidding program (CBP) and a fee schedule. Beginning in 2011, CMS paid for certain types of products in large urban areas under CBP. These areas are referred to as competitive bidding areas.[21] In 2016, CMS began using pricing information from the CBP to adjust the fee schedule rates in non-competitive bidding areas for DMEPOS items included in the CBP.[22] DMEPOS

[20] Section 1834(l)(3)(B) of the Social Security Act (the Act) provides the basis for an update to the payment limits for ambulance services. Section 3401 of the Affordable Care Act amended Section 1834(l)(3) of the Act to apply a productivity adjustment starting January 1, 2011.

[21] The CBP began in 2011 in nine Metropolitan Statistical Areas and covered the highest cost and highest volume items. Over time, the CBP has added products and expanded geographically. For more details on the history of the CBP refer to: MedPAC. 2018. *Report to the Congress: Medicare and the Health Care Delivery System*." Medicare Payment Advisory Commission. Chapter 6.

[22] Non-competitive bidding areas include rural areas, non-rural areas, and non-contiguous areas.

items excluded from the CBP are paid based on a historical fee schedule updated for inflation, regardless of whether the beneficiary resides in a competitive or non-competitive bidding area.

CMS periodically updates the DMEPOS Fee Schedule in April, July, or October to add new items, to make corrections, or to implement statutory or regulatory changes.[23] Furthermore, as specified in section 1834(a)(14)(L) of the Social Security Act, CMS updates certain DMEPOS Fee Schedule rates by the percentage increase in the CPI-U for the 12-month period ending June 30 of the previous year, reduced by a multifactor productivity adjustment. This inflationary adjustment is the same as the Ambulance Inflation Factor discussed in the previous section.

Pathology and Clinical Laboratory

Maximum fees for pathology and clinical laboratory services under the OMFS are capped at 120% of the applicable fees in the Medicare Clinical Laboratory Fee Schedule.

Through December 31, 2017, CMS paid for outpatient clinical laboratory services based on a fee schedule, where payment was the lesser of the amount billed, the local fee for geographic area, or a national limit. CMS sets the national limits at a percentage of the median of all local fee schedule amounts for each laboratory test code. Each year, CMS updated the fees for inflation based on the percentage change in the CPI–U and reduced by a multi-factor productivity adjustment.[24]

Starting in 2018, CMS adopted a new Clinical Laboratory Fee Schedule, where the payment amount for most tests equals the weighted median of private payor rates. Under this new system, payment rates are not updated annually based on inflation. Instead, for most tests, payment rates will be in effect for three years, after which CMS will institute revised payment rates based on new data collected from laboratories.[25]

Pharmacy

The OMFS allows reimbursement for prescription drugs at 100% of the payable amount in the Medi-Cal pharmacy database, including the Medi-Cal dispensing fees. The fee schedule is set by the California Department of Health Care Services, which considers the National Average Drug Acquisition Cost of the drug, the Wholesale Acquisition Cost, the Federal Upper Limit, or the Maximum Allowable Ingredient Cost in calculating drug costs. The Medi-Cal fixed fee schedule does not include automatic updates for inflation.

Other Fee Schedules

California's OMFS regulations for skilled nursing facilities, home health care, and outpatient renal dialysis services are pending. Medicare uses separate Prospective Payment Systems to determine reimbursements for these services, with annual updates based on specific market baskets and a productivity adjustment.[26]

State-specific services including medical-legal, interpreter, and copy services are also reimbursed under fee schedules. However, rates under these fee schedules are not frequently updated to account for inflation. For

[23] This process is outlined in Section 60 of the Medicare Claims Processing Manual, Chapter 23.

[24] https://www.cms.gov/medicare/payment/fee-schedules/clinical-laboratory-fee-schedule/clfs-history

[25] Medicare Payment Advisory Commission. (2023). Clinical Laboratory Services Payment System. Washington, DC: MedPAC.

[26] There are separate market baskets for SNFs, home health agencies, and End-Stage Renal Disease (ESRD).

example, fees for medical-legal services in the California workers' compensation system had not been updated in more than 15 years until the new Medical-Legal Fee Schedule (MLFS) was implemented in April 2021.[27]

Fees for interpreter services (Appeals Board hearings, arbitration, or depositions) are paid either at the Superior Court fee rate for the county where the service was provided or at the market rate, whichever is higher. For interpretation during the provision of medical services, fees are $11.25 per quarter hour, with a minimum of two hours, or the market rate, whichever is higher.[28]

SUMMARY

In California, maximum fees for medical services provided to injured workers are regulated by the Official Medical Fee Schedule (OMFS). Each of the OMFS sections uses distinct rules for payment calculation, as well as different inflation factors to update payment rates. For inpatient, outpatient facility, ambulatory surgical center, ambulance services, and DMEPOS, the California workers' compensation fee schedule adopts the same inflationary factors as Medicare. Overall, the cumulative percentage increase in the OMFS inflationary factors for these fee schedules has been lower than economy-wide inflation.

Since 2015, inflationary adjustments for the OMFS conversion factor in professional services have not aligned with Medicare, as Medicare stopped using the Medicare Economic Index (MEI) and shifted to statutory changes set by the U.S. Congress. In contrast, in California workers' compensation the use of MEI remains mandated by statute. From 2015 to 2019, statutory adjustments to the Medicare conversion factor were minimal (0.5%), and the DWC did not adopt them. However, from 2021 to 2024, Congress mandated increases of 1.25% to 3.75% annually for Medicare, which the DWC incorporated in addition to the MEI adjustments. As a result, the OMFS conversion factor as a percentage of Medicare for professional services rose from 124.4% in 2017 to 145.7% in 2024.

In addition to inflation adjustments, fee schedules rates (*e.g.,* price levels) are affected each year by changes in factors such as Relative Value Units, DRG and APC weights, and geographic adjustment variables (like GPCIs and wage indexes). While a fee schedule rate sets the maximum reimbursable price for each service, in addition to inflation, average payments for physician services are also influenced by changes in utilization, service mix, and discounting practices.

[27] David, R., Bullis, R, and Widener-Brightwell, S. Increased Medical-Legal Costs and Current QME Supply-Impact of the 2021 Medical-Legal Fee Schedule. CWCI Research Update. June 2024.

[28] According to Reg §9795.3. Fees for Interpreter Services.

GLOSSARY

Ambulance Inflation Factor (AIF): A yearly adjustment factor applied to the Medicare Ambulance Fee Schedule to account for inflation.

Ambulatory Payment Classification (APC): Centers for Medicare & Medicaid Services' (CMS) list of ambulatory payment classifications of hospital outpatient services. CMS assigns individual services (HCPCS codes) to APC groups based on similar clinical characteristics and similar costs.

Ambulatory Surgical Center (ASC): Any surgical clinic as defined in the California Health and Safety Code Section 1204, subdivision (b)(1), any ambulatory surgical center that is certified to participate in the Medicare program, or any surgical clinic accredited by an accrediting agency as approved by the Licensing Division of the Medical Board of California pursuant to Health and Safety Code Sections 1248.15 and 1248.4 to use anesthesia, except local anesthesia or peripheral nerve blocks, or both, in compliance with the community standard of practice, in doses that, when administered have the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes..

Bureau of Labor Statistics (BLS): U.S. government agency that collects and analyzes economic data, including inflation and employment statistics.

California Department of Health Care Services (DHCS): The agency that oversees Medi-Cal, California's Medicaid program, and other health services for residents.

Capital Market Basket: Is the Medicare capital input price index used. To determine the capital standard federal payment rate, the capital market basket is applied to the preceding capital standard federal payment rate.

Centers for Medicare & Medicaid Services (CMS): A federal agency that administers the nation’s major healthcare programs, including Medicare and Medicaid.

CMS Market Baskets: A fixed-weight, Laspeyres-type index that measures the change in price, over time, of the same mix of goods and services purchased in the base period. Market baskets are used by CMS to update payment rates.

CMS’s Hospital Outpatient Prospective Payment System (HOPPS): Medicare’s payment system for hospital outpatient services based on Ambulatory Payment Classifications (APCs).

Competitive Bidding Program (CBP): A Medicare program that determines payment rates for certain DMEPOS through competitive bids to ensure cost-effective prices.

Consolidated Appropriations Act (CAA): A law that provides funding for various government programs, including adjustments to Medicare payments.

Consumer Price Index for all Urban Consumers (CPI-U): A measure of inflation based on the average change over time in the prices paid by urban consumers for a market basket of goods and services.

Conversion Factor: A factor used in the OMFS and Medicare’s fee schedules to convert the relative value units (RVUs) of medical services into dollar amounts.

Diagnosis-Related Group (DRG): An inpatient classification scheme used by CMS for hospital inpatient reimbursement. The DRG system classifies patients based on principal diagnosis, surgical procedure, age, presence of comorbidities and complications and other pertinent data.

DRG weight: Means the weighting factor for a diagnosis-related group assigned by CMS for the purpose of determining payment under Medicare.

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS): Items such as medical equipment, prosthetics, orthotics, and supplies covered by insurance plans, including Medicare.

Employment Cost Index (ECI): Measures the change in the hourly labor cost to employers, independent of the influence of employment shifts among occupations and industry categories.

Federal Upper Limit (FUL): The maximum amount that Medicaid will reimburse for certain generic drugs.

Hospital Inpatient Market Basket: Refers to the CMS Inpatient Prospective Payment System (IPPS) Hospital market basket.

Maximum Allowable Ingredient Cost (MAIC): A state-set price limit for the ingredient cost of generic drugs in Medicaid programs.

Medicare Access and CHIP Reauthorization Act (MACRA): A 2015 law that reformed Medicare payments to physicians, replacing the Sustainable Growth Rate (SGR) formula with the Quality Payment Program.

Medicare Ambulance Fee Schedule (AFS): The payment structure used by Medicare to reimburse ambulance providers for transport services.

Medicare Clinical Laboratory Fee Schedule (CLFS): A schedule that lists the payments for clinical diagnostic laboratory tests covered by Medicare.

Medicare Economic Index (MEI): An input price index that measures inflation faced by physicians with respect to their practice costs and general wage levels. The MEI is comprised of two cost categories: 1) physicians' compensation, and 2) physician's practice expense.

Medicare Physician Fee Schedule (PFS): A list of fees that Medicare pays to physicians and healthcare providers for services.

Medicare RVU Budget Neutrality Adjustment: An adjustment made to maintain Medicare's budget neutrality when calculating relative value units (RVUs) for services.

Medicare's Acute Inpatient Prospective Payment System (IPPS): A system that determines payments to hospitals for inpatient stays under Medicare, based on DRGs.

Medicare's Prospective Payment Systems (PPSs): Payment systems that provide predetermined rates for services based on patient classification systems, such as DRGs, rather than actual costs.

Medi-Cal: California's Medicaid program, which provides health coverage for low-income individuals and families.

National Average Drug Acquisition Cost (NADAC): A pricing benchmark that reflects the national average cost for pharmacies to purchase prescription drugs.

Office of the Actuary (OACT): The office within CMS responsible for providing cost estimates and financial analysis for Medicare and Medicaid.

Private Nonfarm Business Multi-Factor Productivity (MFP): A measure of the efficiency of production in private non-agricultural sectors, accounting for multiple inputs like labor and capital.

Protecting Medicare and American Farmers from Sequester Cuts Act: Legislation that provides temporary relief from Medicare payment cuts triggered by federal budget sequesters.

Resource-Based Relative Value Scale (RBRVS): A system used by CMS to determine payment amounts for physicians based on the resources required to provide services.

Relative Value Unit (RVU): It is a standardized measure used in the Resource-Based Relative Value Scale system to quantify the complexity and resources required for medical services.

Sustainable Growth Rate (SGR): A former Medicare payment formula designed to control spending on physician services, repealed by MACRA in 2015.

Wholesale Acquisition Cost (WAC): The manufacturer's list price for a drug sold to wholesalers before any discounts or rebates.

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The California Workers' Compensation Institute, incorporated in 1964, is a private, nonprofit organization of insurers and self-insured employers conducting and communicating research and analyses to improve the California workers' compensation system. Institute members include insurers that collectively write more than 76 percent of California workers' compensation direct written premium, as well as many of the largest public and private self-insured employers in the state. Additional information about CWCI research and activities is available on the Institute's web site (www.cwci.org).

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