Impact of SB 863 on California Workers' Compensation Medical Costs through June 30, 2015

Released: December 10, 2015

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Executive Summary

Senate Bill No. 863 (SB 863) had a significant and measurable impact on California workers' compensation medical costs. This analysis of medical transactions from July 2012 through June 2015 encompasses a three-year period reflecting data developed prior to and after the implementation of SB 863.

In this study, the WCIRB shows that from the second half of 2012 to the first half of 2015, the average cost of medical services per claim dropped by 8%. This decrease contrasts with an average 6.5% per year increase in average medical costs per claim from 2005 to 2012. Some of this decrease is explained by the medical components of SB 863 that the WCIRB was able to separately evaluate. However, a significant portion appears to be driven by other SB 863 components that the WCIRB was unable to separately evaluate on a prospective basis, including the impact of independent medical review (IMR).

These cumulative savings were primarily driven by physician fee schedule and pharmacy services, which collectively represent approximately 61% of all medical service payments. Additional savings were generated by outpatient facilities and medical equipment providers, when combined, represent approximately 16% of all medical service payments. Medical-Legal and Inpatient Hospital services, when taken together, represent approximately 23% of all payments and were the only services to register increases in costs per claim over the three-year period.

The findings from the first half of 2015 run counter to the recent downward trend, as there are significant increases on a medical cost per claim basis in 2015 compared to the second half of 2014. This recent reversal may be an early indicator of a potential erosion of SB 863 savings, similar to the erosion that occurred following the full implementation of the comprehensive reforms enacted in 2003 and 2004.

Introduction

This study addresses the impact of the medical reforms enacted in 2012 as part of Senate Bill No. 863 (SB 863). This report supplements the *Senate Bill No. 863 WCIRB Cost Monitoring Report — 2015 Retrospective Evaluation* (Cost Monitoring Report) issued on November 16, 2015 which analyzed all components of the legislation. This study specifically focuses on medical payment trends following the implementation of SB 863 and how those payment trends may have been impacted by the legislation.

Background

SB 863 was passed by the Legislature on August 31, 2012 and signed by the Governor on September 18, 2012. SB 863 increased permanent disability benefits effective January 1, 2013 and January 1, 2014, and provided for a number of structural changes to the California workers' compensation benefit delivery system.

Following the enactment of SB 863, the WCIRB reviewed the impact of the bill on the cost of losses and loss adjustment expenses (LAE) underlying 2013 advisory pure premium rates. On a prospective basis, the WCIRB estimated that the net impact of the provisions of SB 863 that were quantifiable at the time of its prospective evaluation, once fully implemented in 2014, was a 2.7% reduction in the total cost of losses and LAE underlying 2013 policies.[1]

Many of the provisions of SB 863 affected medical treatment costs. For a number of SB 863 components, including the elimination of duplicate reimbursements for spinal implant hardware, medical provider network (MPN) strengthening, fee schedule reductions for ambulatory surgery centers, changes to lien filing procedures and the transition of the California physician fee schedule to a resource-based relative value scale (RBVRS) basis, the WCIRB was able to prospectively estimate the impact of the SB 863 provisions on the average cost of medical. Those estimates have been reflected in the WCIRB's evaluations of SB 863 and in the January 1, 2013 and subsequent WCIRB pure premium rate filings.

For other provisions of SB 863 designed to impact the cost of medical, including a number of provisions that address the utilization of medical services rather than the average cost of services, the future cost impact was heavily dependent on regulations required by the legislation but not yet written, Workers' Compensation Appeals Board (WCAB) interpretations of the new provisions, the results of legal challenges, and resultant changes in medical treatment and other system practices and patterns. As a result, the WCIRB did not reflect estimates for these provisions in its initial prospective evaluation of SB 863, but instead indicated that evaluation of the cost impact of these provisions would require additional time and emerging post-reform data. In particular, the WCIRB did not include a prospective estimate of the impact of IMR on medical treatment levels in its prospective evaluation of SB 863.[2]

Prior to SB 863, disputes over medical treatment were resolved in one of two ways. In some cases, the disputed treatment was provided despite the utilization review denial and a lien for payment of the treatment costs was filed by the provider. In other cases, one or more qualified medical evaluator (QME) reports were prepared and the dispute was resolved at the WCAB, generally through an expedited hearing.

SB 863 added Labor Code Sections 139.5, 4610.5 and 4610.6 and amended Sections 4061, 4062, 4062.2, 4610.1, and 4903 to provide for a newly-created IMR process. Under the IMR process, medical treatment that was initially denied through the utilization review process could be referred for an independent medical review, which would affirm, modify or reject the utilization review decision and authorize the treatment under dispute. SB 863 provisions related to IMR were intended to resolve medical treatment disputes more quickly and efficiently than the pre-SB 863 system and to provide a mechanism whereby medical treatment can be made by medical professionals.

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[1] *WCIRB Evaluation of the Cost Impact of Senate Bill. No 863*, WCIRB, updated October 12, 2012.

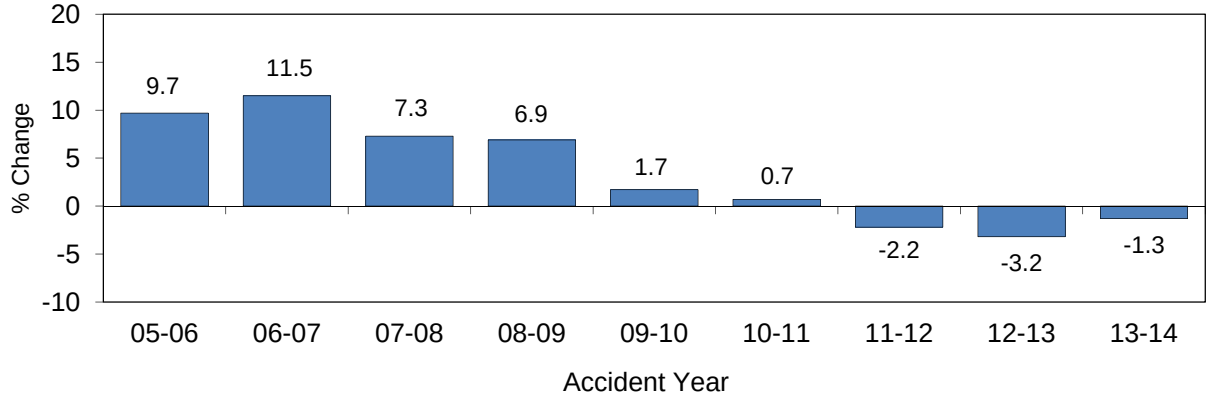
[2] The WCIRB did initially project almost $400 million in savings in reduced frictional costs as a result of IMR. (These savings have not materialized.)

As discussed above, the WCIRB did not reflect any estimate for the impact of IMR on medical treatment levels in its initial prospective evaluation of SB 863. However, the WCIRB did recognize that these provisions, as well as other provisions of SB 863 including those affecting independent bill review, liens, MPNs and the RBRVS fee schedule, did have the potential to significantly affect medical costs. As a result, the WCIRB's Cost Monitoring Report[3] provides that the WCIRB will assess the impact of the SB 863 provisions impacting medical costs, including IMR. This Report is intended to estimate the impact that IMR and other provisions of SB 863 have had collectively on medical utilization levels based on post-SB 863 experience.

Prior to the enactment of SB 863, average medical treatment costs per indemnity claim had risen by approximately 45% since 2005 representing a 6.5% per year increase.[4] In 2013, the California Workers' Compensation Institute (CWCI) issued a report that analyzed increases in medical severities based on detailed pre-SB 863 medical transactional payment data through December 31, 2012.[5] The CWCI analysis showed sharp increases in medical payments per claim following the full implementation of the reforms of 2003 and 2004. These increases encompassed a broad range of medical treatment categories, such as pharmaceutical costs, costs of medical cost containment programs, and medical-legal costs. These increases were attributable to the rise in the number of visits per claim, the number of procedures per visit, and the average cost of procedures.

In contrast to the pre-SB 863 medical trend rates, the WCIRB's January 1, 2016 Pure Premium Rate Filing shows that the estimated average ultimate cost of medical losses per indemnity claim has decreased over the last several accident years.[6] Table 1 summarizes the recent decline in estimated accident year medical claim severities.[7] In fact, as discussed in the Cost Monitoring Report the decrease in medical severities was significantly greater than originally projected, even after adjusting for the initially projected cost impact of all the components of SB 863.[8] This report attempts to understand the role played by SB 863 in driving these lower than projected costs.

Table 1: Change in Ultimate Medical Severity by Accident Year



[3] The WCIRB's SB 863 Cost Monitoring Plan was submitted to the Insurance Commissioner on March 27, 2013.
[4] See the Executive Summary of the WCIRB's January 1, 2013 Pure Premium Rate Filing submitted on August 21, 2012.
[5] *Analysis of Medical and Indemnity Benefit Payments, Medical Treatment and Pharmaceutical Cost Trends in the California Workers' Compensation System*, CWCI, July 2013.
[6] See Section B, Exhibit 6.3 of the WCIRB's January 1, 2016 Pure Premium Rate Filing submitted on August 19, 2015.
[7] Most of the medical-related provisions of SB 863 apply on a date of service basis. As a result, SB 863 has had a significant role in reducing the estimated ultimate medical severities of the more recent pre-SB 863 accident years.
[8] *Senate Bill No. 863. WCIRB Cost Monitoring Report — 2015 Retrospective Evaluation,* WCIRB, November 16, 2015.

WCIRB Approach

To estimate the overall impact of SB 863 on California workers' compensation medical costs, the WCIRB analyzed its medical transaction data covering services from July 2012 through June 2015 for claims from all accident years. These data, from over 40 insurer groups representing 90% of statewide premiums, include 1.1 million unique claims, 50 million paid medical transactions and $5.7 billion in paid medical services.

The WCIRB separately analyzed payments for each specific type of medical service over a 36-month period, encompassing services delivered before and after the implementation of SB 863. These services include those rendered by physicians under several sections of the physician fee schedule, pharmacies, inpatient hospitals, outpatient hospital and Ambulatory Service Centers (ASCs), those covered by the Health Care Procedure Coding System (HCPCS) and medical legal providers. These calculations excluded medical liens because of changes over time in how liens are being reported.

The WCIRB analyzed payments for these services by six month service intervals beginning with the second half of 2012 (the period before the implementation of SB 863) as the comparative baseline. Measures for each six-month interval of services were compared in six months increments of development. Pre-SB 863 and post-SB 863 measures were developed for the average medical costs paid per claim, the number of transactions per claim and the average paid per transaction.

Results

Table 2 summarizes the change in paid amount per claim by six month service intervals through June 30, 2015. This table depicts payment trends for each type of medical service since the second half of 2012 (the pre-SB 863 period).

When all services are aggregated, the data show a gradual and steady drop in total medical costs per claim through 2014. In the first half of 2015, however, this trend has reversed resulting in a 4% incremental increase above the second half of 2014. Despite this recent development, paid per claim for all medical services experienced an 8% cumulative reduction from the second half of 2012 through the first half of 2015.

Table 2: Paid Per Claim by Type of Service
Change by 6-Month Service Period Compared to Prior Service Period

Service Period	Physician Fee Schedule	Pharmacy	Inpatient Facilities	Outpatient Facilities	HCPCS	Medical-Legal	Total Medical Paid All Services
% of Paid Medical	46%	15%	12%	7%	8%	11%	100%
1st Half 2013	-1%	+5%	-5%	-14%	-3%	+2%	-1%
2nd Half 2013	-4%	-4%	+2%	-9%	-5%	+2%	-4%
1st Half 2014	-1%	-5%	+4%	+7%	-15%	+9%	-1%
2nd Half 2014	-6%	-15%	+7%	-7%	-3%	-5%	-7%
1st Half 2015	+3%	-5%	+6%	+21%	+16%	+5%	+4%
Cumulative Change Through 1st Half 2015	***-9%***	***-22%***	***+14%***	***-7%***	***-12%***	***+12%***	***-8%***

Physician Fee Schedule Payment Trends

Approximately 46% of all medical payments are governed by the Physician Fee Schedule, and are summarized in Table 3. In accordance with SB 863, the California Physician Fee Schedule is being transitioned to a Resource Based Relative Value Scale (RBRVS) basis over a four-year period with the first year of the transition effective January 1, 2014.

Table 3 summarizes the changes in cost levels for physician services and illustrates the impact of the transition to RBRVS. By increasing reimbursement formulas for some of the most frequently used services (e.g., Evaluation and Management and Medicine), the paid per transaction measure for the

entire Physician Fee Schedule increased starting in 2014 and has continued to increase into 2015. This increase has resulted in a cumulative 10% paid unit cost increase from the second half of 2012 through the first half of 2015. The RBRVS-based fee schedule, however, appears to have a countervailing impact on utilization (as measured by paid transactions per claim). This measure dropped starting in 2014 and the trend has continued into 2015 resulting in a cumulative 17% utilization decrease from the second half of 2012 through the first half of 2015. This decline in physician procedures per claim primarily reflects (a) the decline in Pathology and Laboratory transactions, which were reimbursed under Medicare rules, stipulating payment by patient visit rather than by individual test, and (b) the reduction in payments for Special Services and Reports, which were not recognized by RBRVS and are now reimbursed by a separate California Division of Workers' Compensation (DWC) schedule.

In total, reductions in the number of paid transactions per claim offset the rise in paid unit costs for services covered by the Physician Fee Schedule. As a result, when compared to 2012, the overall cost per claim for these services registered steady declines through 2014 and then began to rise in the first half of 2015 largely driven by increases in physical medicine. The WCIRB recently published a separate report on the impact of RBRVS on medical cost trends.[9]

Table 3: Physician Fee Schedule
Change by 6-Month Service Period Compared to Prior Service Period

Service Period	Paid Per Transaction	Paid Transactions Per Claim	Paid Per Claim
1st Half 2013	-3%	+3%	-1%
2nd Half 2013	-2%	-2%	-4%
1st Half 2014	+10%	-11%	-1%
2nd Half 2014	-5%	-1%	-6%
1st Half 2015	+10%	-6%	+3%
Cumulative Change Through 1st Half 2015	***+10%***	***-17%***	***-9%***

Pharmaceutical Payment Trends

Table 4 shows payment development for pharmacy services (representing approximately 15% of all payments). The unit costs paid for pharmaceuticals were not addressed by SB 863, and have risen since the second half of 2012 resulting in a cumulative 4% increase through the first half of 2015. However, the utilization of pharmacy services, as reflected in paid transactions per claim, began to decline in the second half of 2013 and the decline has continued into 2015. As a result, pharmacy utilization, on a cumulative basis, decreased by 25% from the second half of 2012 through the first half of 2015. As an example, one of the most frequently prescribed drugs is the opiate OxyContin. Total payments for this drug dropped by 48% and paid transactions declined by 46% in the first half of 2015 compared to the second half of 2012.

This reduction in pharmaceutical utilization more than offset drug unit price increases. As a result, overall pharmacy costs per claim, started to drop in 2013 and continued to decline in 2014 and 2015. As shown in Table 4, the pharmacy costs per claim for the first six months of 2015 are 22% below the totals shown for the second half of 2012. These reductions are likely attributable, in part, to the IMR process established by SB 863 given that nearly one-half of these reviews are related to the prescribing of pharmaceuticals.[10]

[9] *Analysis of the Impact of RBRVS on Medical Payments — 2015 Report,* WCIRB, November 13, 2015.
[10] Independent Medical Review Outcomes in California Workers' Compensation: CWCI Research Update, April 2015.

Table 4: Pharmacy Services
Change by 6-Month Service Period Compared to Prior Service Period

Service Period	Paid Per Transaction	Paid Transactions Per Claim	Paid Per Claim
1st Half 2013	+4%	+1%	+5%
2nd Half 2013	0%	-3%	-4%
1st Half 2014	+3%	-8%	-5%
2nd Half 2014	-2%	-13%	-15%
1st Half 2015	-1%	-5%	-5%
Cumulative Change Through 1st Half 2015	***+4%***	***-25%***	***-22%***

Inpatient Services Payment Trends

Payments for inpatient hospital services, which represent approximately 12% of all California workers' compensation medical costs, are shown in Table 5. Hospital inpatient paid unit costs (measured by paid per transaction) declined from the first half of 2013 through the first half of 2014. This development may have been affected by the elimination of the duplicate reimbursement for surgical implant hardware enacted as part of SB 863, effective in January 2013. This reform was reflected in the decrease of payments per episode for lumbar spinal fusion with complications and co-morbidities (one of the most prevalent implant surgeries) declined by 29.6% after January 1, 2013.

However, inpatient paid unit costs began to rise in the second half of 2014, a trend which continued through the first half of 2015. These recent increases in average paid per inpatient transaction not notwithstanding, inpatient hospital paid unit costs have declined 3% from the second half of 2012 through the first half of 2015.

This study measured the number of paid transactions per claim with an inpatient stay as a way to gauge inpatient utilization. This measure increased starting in the second half of 2013 and has continued to rise through the first half of 2015. As a result, the number of paid transactions per claim for inpatient hospital services increased by 17% since the second half of 2012 through the first half of 2015.

When these measures are combined, on a cumulative paid per claim with an inpatient hospital stay, payments rose 14% through the first half of 2015 compared to the second half of 2012. Factors that may be driving the rise in inpatient hospital paid unit costs include hospital mergers, reductions in discounts to payers, more extensive production of codes on hospital bills and a change in the severity of the patients admitted for inpatient services in workers' compensation. While the average cost of inpatient services on a claim with an inpatient stay has increased, inpatient hospital costs as a total share of all medical costs has not increased over the past three years as the number of inpatient admissions has declined by 15% over that period.

Table 5: Inpatient Services
Change by 6-Month Service Period Compared to Prior Service Period

Service Period	Paid Per Transaction	Paid Transactions Per Claim	Paid Per Claim
1st Half 2013	-4%	-1%	-5%
2nd Half 2013	-1%	+3%	+2%
1st Half 2014	-7%	+12%	+4%
2nd Half 2014	+4%	+3%	+7%
1st Half 2015	+6%	0%	+6%
Cumulative Change Through 1st Half 2015	***-3%***	***+17%***	***+14%***

Outpatient Services Payment Trends

Payment trends for outpatient services are displayed in Table 6.These services are delivered at two types of facilities: Ambulatory Surgical Centers (ASCs) and outpatient hospital settings. Payments for these two types of outpatient service represent approximately 7% of all medical payments. A total of 75% of these payments are generated by ASCs. Paid unit prices for these services (as measured by paid per transaction) declined in 2013 reflecting the SB 863 reduction in the ASC fee schedule values effective in January 1, 2013. In 2014, the paid amounts per transaction remained at the 2013 levels before a sharp increase in the first six months of 2015. Utilization (as measured by transactions per claim) for all outpatient facility services has remained relatively flat until the second six months of 2014 when it began to decline.

When unit cost and utilization measures are combined, overall paid amounts per claim for outpatient services declined through 2014, but registered a sharp increase in the first half of 2015. Despite this recent upward spike, outpatient services experienced a cumulative 7% paid per claim decrease through the first half of 2015 compared to the second half of 2012.

This sudden recent increase in outpatient facility costs per claim in 2015 was not contemplated by SB 863, which indexed outpatient hospital and ASC reimbursements to Medicare rates. However, Medicare increased reimbursements for some procedures effective January 1, 2014 and these increases were adopted by the DWC effective December 1, 2014.[11] As a result, starting in early 2015, the relative cost of certain procedures as well as the mix of procedures performed in ASCs changed significantly. For example, a type of shoulder arthroscopy known as the "Mumford Procedure," was given a 102% upward adjustment by Medicare. In addition to significantly increasing the cost per procedure, the frequency of this procedure increased 32% in California workers' compensation system in the first half of 2015, compared to the second half of 2014. This change in utilization, combined with Medicare's upward price adjustment, resulted in a 116% increase in the total paid amount for this procedure in the first half of 2015.

Table 6: Outpatient Services
Change by 6-Month Service Period Compared to Prior Service Period

Service Period	Paid Per Transaction	Paid Transactions Per Claim	Paid Per Claim
1st Half 2013	-14%	0%	-14%
2nd Half 2013	-8%	-1%	-9%
1st Half 2014	+6%	+1%	+7%
2nd Half 2014	-4%	-4%	-7%
1st Half 2015	+24%	-3%	+21%
Cumulative Change Through 1st Half 2015	***0%***	***-6%***	***-7%***

HCPCS Schedule Payment Trends

Payments under the Health Care Procedure Coding System (HCPCS) schedule represent approximately 8% of all medical transaction payments. Payment trends for these services are shown in Table 7. This schedule is governed by Medicare, and covers a wide range of products and services, including durable medical equipment, prosthetics, orthotics and some transportation, home care, interpreter and lab testing services. SB 863 provided that schedules for some of these services, such as for home health and interpreters, were to be developed. As of this time, however, final schedules have not been promulgated.

Table 7 shows that HCPCS paid unit costs, measured as payments per transaction, declined through 2014 then increased in the first half of 2015. On a cumulative basis, HCPCS paid unit costs declined by 21% from the second half of 2012 through the first half of 2015.

[11] CMS Rules on Hospital Outpatient and ASC Reimbursement, 1601-FC, Addendum A: November 27, 2013.

Utilization of these services (as measured by transactions per claim) rose sharply in the first half of 2014 driven, in part, by the redirection from RBRVS of some drug testing and electrical stimulation procedures to HCPCS. For example, 97% of the payments for unattended electrical stimulation procures shifted from Medicine codes in the physician fee schedule to HCPCS starting in January 2014. These changes helped generate an overall cumulative increase in HCPCS utilization through the first half of 2015 when compared to the second half of 2012 that was largely offset by fewer transactions in the Medicine section of the fee schedule.

When unit cost and utilization measures are combined, the paid amount per claim with HCPCS services showed a cumulative 12% reduction through the first half of 2015 compared to the second half of 2012. As is the case with other services described in this report, HCPCS payments per claim increased in the first half of 2015 compared to the prior half.

Table 7: HCPCS Schedule
Change by 6-Month Service Period Compared to Prior Service Period

Service Period	Paid Per Transaction	Paid Transactions Per Claim	Paid Per Claim
1st Half 2013	-3%	0%	-3%
2nd Half 2013	+2%	-6%	-5%
1st Half 2014	-32%	+24%	-15%
2nd Half 2014	+2%	-6%	-3%
1st Half 2015	+14%	+2%	+16%
Cumulative Change Through 1st Half 2015	***-21%***	***+12%***	***-12%***

Medical Legal Payment Trends
Payments governed by the Medical Legal Fee Schedule represent approximately 11% of all medical payments. The number of medical-legal reports were expected to be reduced by the IMR, lien, medical provider network (MPN) and independent bill review (IBR) provisions of SB 863. Payment information for Medical Legal services are displayed in Table 8. These data show paid unit prices for Medical Legal services (as measured by paid per transaction) have steadily climbed since 2012 while utilization (as measured by transactions per claim) has declined only modestly subsequent to SB 863. The most complex and highly reimbursed Medical-Legal report accounted for 67% of all Medical Legal payments over this three-year period and experienced a 15% unit cost increase starting in 2014. On an overall paid per claim basis, Medical Legal services have risen by 12% through the first half of 2015 compared to the second half of 2012.

Table 8: Medical Legal Schedule
Change by 6-Month Service Period Compared to Prior Service Period

Service Period	Paid Per Transaction	Paid Transactions Per Claim	Paid Per Claim
1st Half 2013	+5%	-3%	+2%
2nd Half 2013	+3%	-1%	+2%
1st Half 2014	+8%	+1%	+9%
2nd Half 2014	-1%	-4%	-5%
1st Half 2015	0%	+5%	+5%
Cumulative Change Through 1st Half 2015	***+15%***	***-3%***	***+12%***

Payment Trends: All Medical Services
Payment trends for all medical services over the past three years are aggregated in Table 9. These data show that on a paid unit price basis (as measured by paid per transaction), payments declined in the first half of 2013 and then began to increase, sharply escalating in the first six months of 2015. These unit

cost developments led to a cumulative 10% increase through the first half 2015, compared to the second half of 2012.

As a countervailing influence, medical utilization (as measured by transactions per claim) declined significantly beginning in the second six months of 2013. This decline in the number of transactions per claim contrasts significantly with the pre-SB 863 trends and results in a cumulative 16% reduction in the number of transactions per claim through the first half of 2015 compared to the second half of 2012.

In total, even with the 2015 increase in average costs per transaction, instead of increasing at anywhere close to the pre-SB 863 rate of growth, total medical costs per claim are down from the pre-SB 863 level. While it is not possible to isolate the specific impacts of various SB 863 components (e.g., IMR, IBR, MPN provisions, lien reforms, RBRVS, fee schedule changes related to ASC fees and the elimination of the duplicate reimbursement for spinal implant hardware) on the utilization of medical services, it is clear that the total impact of SB 863 has been significant. In the WCIRB's 2015 Cost Monitoring Report, the WCIRB attributed savings of 5% in total medical costs to the combined impact of the provisions of SB 863 on the utilization of medical services.[12]

Table 9: All Services
Change by 6-Month Service Period Compared to Prior Service Period

Service Period	Paid Per Transaction	Paid Transactions Per Claim	Paid Per Claim
1st Half 2013	-3%	+3%	-1%
2nd Half 2013	-1%	-3%	-4%
1st Half 2014	+7%	-7%	-1%
2nd Half 2014	-3%	-4%	-7%
1st Half 2015	+11%	-6%	+4%
Cumulative Change Through 1st Half 2015	***+10%***	***-16%***	***-8%***

Appendix A includes payment development exhibits for each type of medical service described above, as well as for the specific sections of the Physician Fee schedule (Evaluation & Management, Medicine, Surgery, Radiology, Anesthesiology, Pathology & Laboratory and Special Services & Reports).

Report Summary

In summary, the enactment of SB 863 in September 2012 has contributed to the reduction in overall California workers' compensation medical costs. This outcome reversed a rate of medical cost growth that was approximately 6.5% per year between 2005 and 2012. In addition to the impact on medical costs of a number of SB 863 medical-related provisions that could be separately evaluated, the WCIRB has estimated that the combined provisions of SB 863 have reduced medical utilization from the pre-SB 863 level by approximately 5%. In total, the WCIRB now estimates that SB 863 has reduced statewide medical costs by approximately $0.9 billion annually.[13] Most components of the California workers' compensation medical delivery system have experienced medical utilization declines. However, like many of the other frictional cost components of the system, the utilization of medical-legal reports has not declined.

SB 863 influenced the reduction in medical costs in three major ways:

1. The January 2013 curbs on reimbursements for ASCs and hospital surgical implants generated immediate declines in unit costs for these services. This reform made a small impact on overall medical trends, as these services represented less than 10% of all payments.

[12] *Senate Bill No. 863. WCIRB Cost Monitoring Report — 2015 Retrospective Evaluation,* WCIRB, November 16, 2015.
[13] *Senate Bill No. 863. WCIRB Cost Monitoring Report — 2015 Retrospective Evaluation,* WCIRB, November 16, 2015.

2. The January 2014 introduction of the RBRVS-based physician fee schedule affected 46% of all payments and had a significant savings impact. The most immediate effect was a reduction in utilization (as measured by transactions per claim). This utilization decline offset an increase in unit costs (as measured by paid amounts per transaction).
3. IMR was introduced in mid-2013 and grew in prevalence in 2014 and 2015. IMR appeared to have an impact on curbing medical utilization, primarily for pharmaceutical services. Utilization of pharmacy services started to decline significantly in 2014 and has continued to decline into 2015.

Although the immediate impact on SB 863 in reducing medical costs is significant and measurable, past experience warrants caution in concluding that these trends will be sustained over the long-term. The prior reforms adopted by Assembly Bill No. 227 (2003), Senate Bill No. 228 (2003) and Senate Bill No. 899 (2004) generated very significant savings for a two to three year period, only to eroded in part by subsequent increased treatment levels, including the prescribing of opiates. As noted in the report, there are some indicators of significant growth in medical costs per claim in the first six months of 2015.

The payment trend increases observed in the first half of 2015 merit continued scrutiny. When compared to the second half of 2014, paid amounts per claim increased for most services—including those for physicians, hospitals, equipment suppliers and medical legal reporters—resulting in a 4% overall increase over the prior six-month period. This development may represent an early indication of the erosion of some of the savings generated by SB 863. The WCIRB will continue monitoring the ongoing impact of SB 863 as well as other legislative reforms that affect workers' compensation medical costs.

Appendix A: Payment Development Exhibits

Appendix A: Summary of Paid Procedure Code Types
Exhibit 1: All Services

Cumulative Paid/Claim by Service and Payment Half

Service Half	Paid In Service Half	Ratio to 2H2012	Paid through SH + 1	Ratio to 2H2012	Paid through SH + 2	Ratio to 2H2012	Paid through SH + 3	Ratio to 2H2012	Paid through SH + 4	Ratio to 2H2012	Paid through SH + 5
2H2012	2,137		2,828		2,936		2,983		3,008		3,022
1H2013	2,169	1.01	2,852	1.01	2,935	1.00	2,965	0.99	2,987	0.99	
2H2013	2,171	1.02	2,753	0.97	2,821	0.96	2,851	0.96			
1H2014	2,154	1.01	2,738	0.97	2,800	0.95					
2H2014	2,034	0.95	2,555	0.90							
1H2015	2,118	0.99									

Cumulative Transactions/Claim by Service and Payment Half

Service Half	Paid In Service Half	Ratio to 2H2012	Paid through SH + 1	Ratio to 2H2012	Paid through SH + 2	Ratio to 2H2012	Paid through SH + 3	Ratio to 2H2012	Paid through SH + 4	Ratio to 2H2012	Paid through SH + 5
2H2012	21.17		25.46		26.02		26.23		26.34		26.43
1H2013	21.38	1.01	26.24	1.03	26.71	1.03	26.87	1.02	27.03	1.03	
2H2013	21.25	1.00	25.39	1.00	25.83	0.99	26.05	0.99			
1H2014	19.04	0.90	23.62	0.93	24.04	0.92					
2H2014	19.35	0.91	22.76	0.89							
1H2015	18.21	0.86									

Cumulative Paid/Transaction by Service and Payment Half

Service Half	Paid In Service Half	Ratio to 2H2012	Paid through SH + 1	Ratio to 2H2012	Paid through SH + 2	Ratio to 2H2012	Paid through SH + 3	Ratio to 2H2012	Paid through SH + 4	Ratio to 2H2012	Paid through SH + 5
2H2012	101		111		113		114		114		114
1H2013	101	1.00	109	0.98	110	0.97	110	0.96	110	0.96	
2H2013	102	1.01	108	0.97	109	0.96	109	0.96			
1H2014	113	1.12	116	1.05	116	1.03					
2H2014	105	1.04	112	1.01							
1H2015	116	1.15									

Appendix A: Summary of Paid Procedure Code Types
Exhibit 2: Physician Fee Schedule

Cumulative Paid/Claim by Service and Payment Half

Service Half	Paid In Service Half	Ratio to 2H2012	Paid through SH + 1	Ratio to 2H2012	Paid through SH + 2	Ratio to 2H2012	Paid through SH + 3	Ratio to 2H2012	Paid through SH + 4	Ratio to 2H2012	Paid through SH + 5
2H2012	1,142		1,442		1,485		1,500		1,511		1,518
1H2013	1,121	0.98	1,441	1.00	1,474	0.99	1,489	0.99	1,501	0.99	
2H2013	1,107	0.97	1,381	0.96	1,413	0.95	1,430	0.95			
1H2014	1,086	0.95	1,363	0.95	1,392	0.94					
2H2014	1,061	0.93	1,284	0.89							
1H2015	1,095	0.96									

Cumulative Transactions/Claim by Service and Payment Half

Service Half	Paid In Service Half	Ratio to 2H2012	Paid through SH + 1	Ratio to 2H2012	Paid through SH + 2	Ratio to 2H2012	Paid through SH + 3	Ratio to 2H2012	Paid through SH + 4	Ratio to 2H2012	Paid through SH + 5
2H2012	16.98		20.41		20.84		21.00		21.09		21.16
1H2013	17.06	1.00	21.00	1.03	21.36	1.02	21.49	1.02	21.63	1.03	
2H2013	17.12	1.01	20.52	1.01	20.90	1.00	21.08	1.00			
1H2014	14.64	0.86	18.37	0.90	18.70	0.90					
2H2014	15.51	0.91	18.20	0.89							
1H2015	14.50	0.85									

Cumulative Paid/Transaction by Service and Payment Half

Service Half	Paid In Service Half	Ratio to 2H2012	Paid through SH + 1	Ratio to 2H2012	Paid through SH + 2	Ratio to 2H2012	Paid through SH + 3	Ratio to 2H2012	Paid through SH + 4	Ratio to 2H2012	Paid through SH + 5
2H2012	67		71		71		71		72		72
1H2013	66	0.99	69	0.97	69	0.97	69	0.97	69	0.96	
2H2013	65	0.97	67	0.94	68	0.96	68	0.96			
1H2014	74	1.10	74	1.04	74	1.04					
2H2014	68	1.01	71	1.00							
1H2015	75	1.12									

Appendix A: Summary of Paid Procedure Code Types
Exhibit 3: Pharmacy

Cumulative Paid/Claim by Service and Payment Half

Service Half	Paid In Service Half	Ratio to 2H2012	Paid through SH + 1	Ratio to 2H2012	Paid through SH + 2	Ratio to 2H2012	Paid through SH + 3	Ratio to 2H2012	Paid through SH + 4	Ratio to 2H2012	Paid through SH + 5
2H2012	685		748		766		776		782		785
1H2013	736	1.07	799	1.07	811	1.06	818	1.05	823	1.05	
2H2013	714	1.04	772	1.03	783	1.02	789	1.02			
1H2014	701	1.02	733	0.98	744	0.97					
2H2014	596	0.87	626	0.84							
1H2015	565	0.82									

Cumulative Transactions/Claim by Service and Payment Half

Service Half	Paid In Service Half	Ratio to 2H2012	Paid through SH + 1	Ratio to 2H2012	Paid through SH + 2	Ratio to 2H2012	Paid through SH + 3	Ratio to 2H2012	Paid through SH + 4	Ratio to 2H2012	Paid through SH + 5
2H2012	6.57		7.09		7.18		7.22		7.24		7.26
1H2013	6.74	1.03	7.24	1.02	7.29	1.02	7.31	1.01	7.32	1.01	
2H2013	6.57	1.00	7.04	0.99	7.06	0.98	7.08	0.98			
1H2014	6.17	0.94	6.47	0.91	6.49	0.90					
2H2014	5.43	0.83	5.66	0.80							
1H2015	5.18	0.79									

Cumulative Paid/Transaction by Service and Payment Half

Service Half	Paid In Service Half	Ratio to 2H2012	Paid through SH + 1	Ratio to 2H2012	Paid through SH + 2	Ratio to 2H2012	Paid through SH + 3	Ratio to 2H2012	Paid through SH + 4	Ratio to 2H2012	Paid through SH + 5
2H2012	104		106		107		107		108		108
1H2013	109	1.05	110	1.04	111	1.04	112	1.05	112	1.04	
2H2013	109	1.05	110	1.04	111	1.04	111	1.04			
1H2014	114	1.10	113	1.07	115	1.07					
2H2014	110	1.06	111	1.05							
1H2015	109	1.05									

Appendix A: Summary of Paid Procedure Code Types
Exhibit 4: Inpatient

Cumulative Paid/Claim by Service and Payment Half

Service Half	Paid In Service Half	Ratio to 2H2012	Paid through SH + 1	Ratio to 2H2012	Paid through SH + 2	Ratio to 2H2012	Paid through SH + 3	Ratio to 2H2012	Paid through SH + 4	Ratio to 2H2012	Paid through SH + 5
2H2012	22,199		27,140		28,244		28,956		29,272		29,356
1H2013	23,200	1.05	27,143	1.00	27,703	0.98	27,716	0.96	27,823	0.95	
2H2013	24,771	1.12	27,999	1.03	28,333	1.00	28,371	0.98			
1H2014	27,128	1.22	29,559	1.09	29,442	1.04					
2H2014	29,468	1.33	31,695	1.17							
1H2015	31,100	1.40									

Cumulative Transactions/Claim by Service and Payment Half

Service Half	Paid In Service Half	Ratio to 2H2012	Paid through SH + 1	Ratio to 2H2012	Paid through SH + 2	Ratio to 2H2012	Paid through SH + 3	Ratio to 2H2012	Paid through SH + 4	Ratio to 2H2012	Paid through SH + 5
2H2012	13.36		14.93		15.33		15.49		15.54		15.55
1H2013	13.34	1.00	15.00	1.00	15.28	1.00	15.36	0.99	15.40	0.99	
2H2013	13.64	1.02	15.65	1.05	15.82	1.03	15.85	1.02			
1H2014	16.88	1.26	17.79	1.19	17.71	1.16					
2H2014	18.08	1.35	18.29	1.23							
1H2015	18.04	1.35									

Cumulative Paid/Transaction by Service and Payment Half

Service Half	Paid In Service Half	Ratio to 2H2012	Paid through SH + 1	Ratio to 2H2012	Paid through SH + 2	Ratio to 2H2012	Paid through SH + 3	Ratio to 2H2012	Paid through SH + 4	Ratio to 2H2012	Paid through SH + 5
2H2012	1,662		1,818		1,843		1,869		1,884		1,888
1H2013	1,739	1.05	1,809	1.00	1,814	0.98	1,805	0.97	1,807	0.96	
2H2013	1,816	1.09	1,789	0.98	1,790	0.97	1,790	0.96			
1H2014	1,607	0.97	1,662	0.91	1,662	0.90					
2H2014	1,630	0.98	1,733	0.95							
1H2015	1,724	1.04									

Appendix A: Summary of Paid Procedure Code Types
Exhibit 5: Outpatient

Cumulative Paid/Claim by Service and Payment Half

Service Half	Paid In Service Half	Ratio to 2H2012	Paid through SH + 1	Ratio to 2H2012	Paid through SH + 2	Ratio to 2H2012	Paid through SH + 3	Ratio to 2H2012	Paid through SH + 4	Ratio to 2H2012	Paid through SH + 5
2H2012	2,178		2,544		2,623		2,647		2,660		2,669
1H2013	2,105	0.97	2,239	0.88	2,259	0.86	2,271	0.86	2,293	0.86	
2H2013	1,863	0.86	2,006	0.79	2,049	0.78	2,063	0.78			
1H2014	2,038	0.94	2,161	0.85	2,184	0.83					
2H2014	1,759	0.81	2,001	0.79							
1H2015	2,120	0.97									

Cumulative Transactions/Claim by Service and Payment Half

Service Half	Paid In Service Half	Ratio to 2H2012	Paid through SH + 1	Ratio to 2H2012	Paid through SH + 2	Ratio to 2H2012	Paid through SH + 3	Ratio to 2H2012	Paid through SH + 4	Ratio to 2H2012	Paid through SH + 5
2H2012	4.33		4.89		4.99		5.02		5.04		5.05
1H2013	4.54	1.05	5.03	1.03	5.05	1.01	5.07	1.01	5.06	1.00	
2H2013	4.48	1.03	4.94	1.01	5.00	1.00	5.01	1.00			
1H2014	4.61	1.06	4.98	1.02	5.03	1.01					
2H2014	4.35	1.00	4.79	0.98							
1H2015	4.24	0.98									

Cumulative Paid/Transaction by Service and Payment Half

Service Half	Paid In Service Half	Ratio to 2H2012	Paid through SH + 1	Ratio to 2H2012	Paid through SH + 2	Ratio to 2H2012	Paid through SH + 3	Ratio to 2H2012	Paid through SH + 4	Ratio to 2H2012	Paid through SH + 5
2H2012	503		521		525		527		528		529
1H2013	464	0.92	446	0.86	447	0.85	448	0.85	453	0.86	
2H2013	416	0.83	406	0.78	410	0.78	412	0.78			
1H2014	442	0.88	434	0.83	435	0.83					
2H2014	404	0.80	418	0.80							
1H2015	500	0.99									

Appendix A: Summary of Paid Procedure Code Types
Exhibit 6: HCPCS

Cumulative Paid/Claim by Service and Payment Half

Service Half	Paid In Service Half	Ratio to 2H2012	Paid through SH + 1	Ratio to 2H2012	Paid through SH + 2	Ratio to 2H2012	Paid through SH + 3	Ratio to 2H2012	Paid through SH + 4	Ratio to 2H2012	Paid through SH + 5
2H2012	520		620		638		651		655		657
1H2013	497	0.96	594	0.96	628	0.98	633	0.97	634	0.97	
2H2013	511	0.98	590	0.95	601	0.94	604	0.93			
1H2014	438	0.84	497	0.80	511	0.80					
2H2014	401	0.77	480	0.77							
1H2015	466	0.90									

Cumulative Transactions/Claim by Service and Payment Half

Service Half	Paid In Service Half	Ratio to 2H2012	Paid through SH + 1	Ratio to 2H2012	Paid through SH + 2	Ratio to 2H2012	Paid through SH + 3	Ratio to 2H2012	Paid through SH + 4	Ratio to 2H2012	Paid through SH + 5
2H2012	4.11		4.53		4.61		4.67		4.69		4.70
1H2013	4.06	0.99	4.55	1.00	4.66	1.01	4.69	1.00	4.70	1.00	
2H2013	3.98	0.97	4.32	0.95	4.37	0.95	4.39	0.94			
1H2014	4.74	1.15	5.36	1.18	5.42	1.18					
2H2014	4.52	1.10	5.06	1.12							
1H2015	4.60	1.12									

Cumulative Paid/Transaction by Service and Payment Half

Service Half	Paid In Service Half	Ratio to 2H2012	Paid through SH + 1	Ratio to 2H2012	Paid through SH + 2	Ratio to 2H2012	Paid through SH + 3	Ratio to 2H2012	Paid through SH + 4	Ratio to 2H2012	Paid through SH + 5
2H2012	126		137		138		140		140		140
1H2013	122	0.97	131	0.96	135	0.98	135	0.96	135	0.96	
2H2013	129	1.02	137	1.00	138	1.00	138	0.99			
1H2014	92	0.73	93	0.68	94	0.68					
2H2014	89	0.71	95	0.69							
1H2015	101	0.80									

Appendix A: Summary of Paid Procedure Code Types
Exhibit 7: Medical Legal

Cumulative Paid/Claim by Service and Payment Half

Service Half	Paid In Service Half	Ratio to 2H2012	Paid through SH + 1	Ratio to 2H2012	Paid through SH + 2	Ratio to 2H2012	Paid through SH + 3	Ratio to 2H2012	Paid through SH + 4	Ratio to 2H2012	Paid through SH + 5
2H2012	1,799		2,082		2,105		2,108		2,110		2,113
1H2013	1,841	1.02	2,129	1.02	2,149	1.02	2,154	1.02	2,157	1.02	
2H2013	1,896	1.05	2,170	1.04	2,189	1.04	2,193	1.04			
1H2014	2,068	1.15	2,358	1.13	2,377	1.13					
2H2014	1,989	1.11	2,236	1.07							
1H2015	2,079	1.16									

Cumulative Transactions/Claim by Service and Payment Half

Service Half	Paid In Service Half	Ratio to 2H2012	Paid through SH + 1	Ratio to 2H2012	Paid through SH + 2	Ratio to 2H2012	Paid through SH + 3	Ratio to 2H2012	Paid through SH + 4	Ratio to 2H2012	Paid through SH + 5
2H2012	1.35		1.45		1.46		1.46		1.46		1.46
1H2013	1.31	0.97	1.41	0.97	1.42	0.97	1.42	0.97	1.42	0.97	
2H2013	1.30	0.96	1.39	0.96	1.40	0.96	1.40	0.96			
1H2014	1.30	0.96	1.40	0.97	1.41	0.97					
2H2014	1.26	0.93	1.35	0.93							
1H2015	1.32	0.98									

Cumulative Paid/Transaction by Service and Payment Half

Service Half	Paid In Service Half	Ratio to 2H2012	Paid through SH + 1	Ratio to 2H2012	Paid through SH + 2	Ratio to 2H2012	Paid through SH + 3	Ratio to 2H2012	Paid through SH + 4	Ratio to 2H2012	Paid through SH + 5
2H2012	1,330		1,439		1,445		1,444		1,443		1,444
1H2013	1,402	1.05	1,512	1.05	1,515	1.05	1,514	1.05	1,514	1.05	
2H2013	1,458	1.10	1,557	1.08	1,562	1.08	1,562	1.08			
1H2014	1,589	1.19	1,680	1.17	1,681	1.16					
2H2014	1,575	1.18	1,658	1.15							
1H2015	1,575	1.18									

Appendix A: Summary of Paid Procedure Code Types

Exhibit 8: Physician Fee Schedule: Evaluation & Management

Cumulative Paid/Claim by Service and Payment Half

Service Half	Paid In Service Half	Ratio to 2H2012	Paid through SH + 1	Ratio to 2H2012	Paid through SH + 2	Ratio to 2H2012	Paid through SH + 3	Ratio to 2H2012	Paid through SH + 4	Ratio to 2H2012	Paid through SH + 5
2H2012	336		398		405		408		410		411
1H2013	340	1.01	411	1.03	416	1.03	419	1.03	422	1.03	
2H2013	347	1.03	406	1.02	412	1.02	416	1.02			
1H2014	385	1.15	458	1.15	466	1.15					
2H2014	396	1.18	459	1.15							
1H2015	422	1.26									

Cumulative Transactions/Claim by Service and Payment Half

Service Half	Paid In Service Half	Ratio to 2H2012	Paid through SH + 1	Ratio to 2H2012	Paid through SH + 2	Ratio to 2H2012	Paid through SH + 3	Ratio to 2H2012	Paid through SH + 4	Ratio to 2H2012	Paid through SH + 5
2H2012	3.87		4.51		4.57		4.60		4.61		4.63
1H2013	3.90	1.01	4.62	1.02	4.68	1.02	4.70	1.02	4.73	1.03	
2H2013	4.00	1.03	4.62	1.02	4.67	1.02	4.71	1.02			
1H2014	3.54	0.91	4.17	0.92	4.23	0.93					
2H2014	3.59	0.93	4.14	0.92							
1H2015	3.73	0.96									

Cumulative Paid/Transaction by Service and Payment Half

Service Half	Paid In Service Half	Ratio to 2H2012	Paid through SH + 1	Ratio to 2H2012	Paid through SH + 2	Ratio to 2H2012	Paid through SH + 3	Ratio to 2H2012	Paid through SH + 4	Ratio to 2H2012	Paid through SH + 5
2H2012	87		88		89		89		89		89
1H2013	87	1.00	89	1.01	89	1.00	89	1.00	89	1.00	
2H2013	87	1.00	88	1.00	88	0.99	88	0.99			
1H2014	109	1.25	110	1.25	110	1.24					
2H2014	110	1.26	111	1.26							
1H2015	113	1.30									

Appendix A: Summary of Paid Procedure Code Types

Exhibit 9: Physician Fee Schedule: Medicine (Includes PT, Chiropractic, Acupuncture)

Cumulative Paid/Claim by Service and Payment Half

Service Half	Paid In Service Half	Ratio to 2H2012	Paid through SH + 1	Ratio to 2H2012	Paid through SH + 2	Ratio to 2H2012	Paid through SH + 3	Ratio to 2H2012	Paid through SH + 4	Ratio to 2H2012	Paid through SH + 5
2H2012	574		677		693		700		704		707
1H2013	579	1.01	692	1.02	706	1.02	712	1.02	716	1.02	
2H2013	567	0.99	659	0.97	672	0.97	678	0.97			
1H2014	593	1.03	708	1.05	721	1.04					
2H2014	625	1.09	707	1.04							
1H2015	677	1.18									

Cumulative Transactions/Claim by Service and Payment Half

Service Half	Paid In Service Half	Ratio to 2H2012	Paid through SH + 1	Ratio to 2H2012	Paid through SH + 2	Ratio to 2H2012	Paid through SH + 3	Ratio to 2H2012	Paid through SH + 4	Ratio to 2H2012	Paid through SH + 5
2H2012	16.92		19.04		19.32		19.43		19.49		19.52
1H2013	16.95	1.00	19.49	1.02	19.75	1.02	19.83	1.02	19.87	1.02	
2H2013	16.90	1.00	19.06	1.00	19.30	1.00	19.38	1.00			
1H2014	15.56	0.92	18.47	0.97	18.72	0.97					
2H2014	16.71	0.99	18.65	0.98							
1H2015	17.33	1.02									

Cumulative Paid/Transaction by Service and Payment Half

Service Half	Paid In Service Half	Ratio to 2H2012	Paid through SH + 1	Ratio to 2H2012	Paid through SH + 2	Ratio to 2H2012	Paid through SH + 3	Ratio to 2H2012	Paid through SH + 4	Ratio to 2H2012	Paid through SH + 5
2H2012	34		36		36		36		36		36
1H2013	34	1.00	35	0.97	36	1.00	36	1.00	36	1.00	
2H2013	34	1.00	35	0.97	35	0.97	35	0.97			
1H2014	38	1.12	38	1.06	38	1.06					
2H2014	37	1.09	38	1.06							
1H2015	39	1.15									

Appendix A: Summary of Paid Procedure Code Types
Exhibit 10: Physician Fee Schedule: Surgery

Cumulative Paid/Claim by Service and Payment Half

Service Half	Paid In Service Half	Ratio to 2H2012	Paid through SH + 1	Ratio to 2H2012	Paid through SH + 2	Ratio to 2H2012	Paid through SH + 3	Ratio to 2H2012	Paid through SH + 4	Ratio to 2H2012	Paid through SH + 5
2H2012	1,022		1,195		1,218		1,226		1,233		1,235
1H2013	919	0.90	1,039	0.87	1,056	0.87	1,062	0.87	1,063	0.86	
2H2013	812	0.79	937	0.78	949	0.78	952	0.78			
1H2014	999	0.98	1,101	0.92	1,114	0.91					
2H2014	890	0.87	1,015	0.85							
1H2015	948	0.93									

Cumulative Transactions/Claim by Service and Payment Half

Service Half	Paid In Service Half	Ratio to 2H2012	Paid through SH + 1	Ratio to 2H2012	Paid through SH + 2	Ratio to 2H2012	Paid through SH + 3	Ratio to 2H2012	Paid through SH + 4	Ratio to 2H2012	Paid through SH + 5
2H2012	2.43		2.80		2.85		2.87		2.88		2.89
1H2013	2.47	1.02	2.79	1.00	2.83	0.99	2.84	0.99	2.86	0.99	
2H2013	2.36	0.97	2.64	0.94	2.68	0.94	2.69	0.94			
1H2014	2.40	0.99	2.70	0.96	2.73	0.96					
2H2014	2.32	0.95	2.56	0.91							
1H2015	2.33	0.96									

Cumulative Paid/Transaction by Service and Payment Half

Service Half	Paid In Service Half	Ratio to 2H2012	Paid through SH + 1	Ratio to 2H2012	Paid through SH + 2	Ratio to 2H2012	Paid through SH + 3	Ratio to 2H2012	Paid through SH + 4	Ratio to 2H2012	Paid through SH + 5
2H2012	420		427		427		427		427		427
1H2013	372	0.89	373	0.87	374	0.88	374	0.88	372	0.87	
2H2013	344	0.82	354	0.83	354	0.83	353	0.83			
1H2014	416	0.99	408	0.96	408	0.96					
2H2014	384	0.91	396	0.93							
1H2015	407	0.97									

Appendix A: Summary of Paid Procedure Code Types
Exhibit 11: Physician Fee Schedule: Anesthesiology

Cumulative Paid/Claim by Service and Payment Half

Service Half	Paid In Service Half	Ratio to 2H2012	Paid through SH + 1	Ratio to 2H2012	Paid through SH + 2	Ratio to 2H2012	Paid through SH + 3	Ratio to 2H2012	Paid through SH + 4	Ratio to 2H2012	Paid through SH + 5
2H2012	407		431		436		437		437		437
1H2013	408	1.00	428	0.99	431	0.99	431	0.99	432	0.99	
2H2013	404	0.99	422	0.98	424	0.97	424	0.97			
1H2014	383	0.94	401	0.93	403	0.92					
2H2014	380	0.93	394	0.91							
1H2015	370	0.91									

Cumulative Transactions/Claim by Service and Payment Half

Service Half	Paid In Service Half	Ratio to 2H2012	Paid through SH + 1	Ratio to 2H2012	Paid through SH + 2	Ratio to 2H2012	Paid through SH + 3	Ratio to 2H2012	Paid through SH + 4	Ratio to 2H2012	Paid through SH + 5
2H2012	1.17		1.24		1.25		1.26		1.26		1.26
1H2013	1.18	1.01	1.24	1.00	1.24	0.99	1.25	0.99	1.25	0.99	
2H2013	1.18	1.01	1.23	0.99	1.23	0.98	1.24	0.98			
1H2014	1.12	0.96	1.17	0.94	1.17	0.94					
2H2014	1.13	0.97	1.16	0.94							
1H2015	1.14	0.97									

Cumulative Paid/Transaction by Service and Payment Half

Service Half	Paid In Service Half	Ratio to 2H2012	Paid through SH + 1	Ratio to 2H2012	Paid through SH + 2	Ratio to 2H2012	Paid through SH + 3	Ratio to 2H2012	Paid through SH + 4	Ratio to 2H2012	Paid through SH + 5
2H2012	346		347		348		348		347		347
1H2013	347	1.00	346	1.00	346	0.99	346	0.99	346	1.00	
2H2013	343	0.99	344	0.99	344	0.99	343	0.99			
1H2014	340	0.98	344	0.99	344	0.99					
2H2014	338	0.98	339	0.98							
1H2015	324	0.94									

Appendix A: Summary of Paid Procedure Code Types
Exhibit 12: Physician Fee Schedule: Radiology

Cumulative Paid/Claim by Service and Payment Half

Service Half	Paid In Service Half	Ratio to 2H2012	Paid through SH + 1	Ratio to 2H2012	Paid through SH + 2	Ratio to 2H2012	Paid through SH + 3	Ratio to 2H2012	Paid through SH + 4	Ratio to 2H2012	Paid through SH + 5
2H2012	297		333		340		344		347		350
1H2013	294	0.99	322	0.97	327	0.96	333	0.97	335	0.97	
2H2013	289	0.97	323	0.97	330	0.97	335	0.97			
1H2014	262	0.88	282	0.85	287	0.84					
2H2014	258	0.87	278	0.83							
1H2015	245	0.82									

Cumulative Transactions/Claim by Service and Payment Half

Service Half	Paid In Service Half	Ratio to 2H2012	Paid through SH + 1	Ratio to 2H2012	Paid through SH + 2	Ratio to 2H2012	Paid through SH + 3	Ratio to 2H2012	Paid through SH + 4	Ratio to 2H2012	Paid through SH + 5
2H2012	2.26		2.55		2.59		2.61		2.61		2.62
1H2013	2.27	1.00	2.55	1.00	2.59	1.00	2.61	1.00	2.62	1.00	
2H2013	2.27	1.00	2.54	1.00	2.58	1.00	2.60	1.00			
1H2014	2.24	0.99	2.50	0.98	2.54	0.98					
2H2014	2.21	0.98	2.45	0.96							
1H2015	2.23	0.99									

Cumulative Paid/Transaction by Service and Payment Half

Service Half	Paid In Service Half	Ratio to 2H2012	Paid through SH + 1	Ratio to 2H2012	Paid through SH + 2	Ratio to 2H2012	Paid through SH + 3	Ratio to 2H2012	Paid through SH + 4	Ratio to 2H2012	Paid through SH + 5
2H2012	131		131		131		132		133		133
1H2013	129	0.98	126	0.96	126	0.96	128	0.97	128	0.96	
2H2013	127	0.97	127	0.97	128	0.98	129	0.98			
1H2014	117	0.89	113	0.86	113	0.86					
2H2014	117	0.89	113	0.86							
1H2015	110	0.84									

Appendix A: Summary of Paid Procedure Code Types

Exhibit 13: Physician Fee Schedule: Pathology & Laboratory

Cumulative Paid/Claim by Service and Payment Half

Service Half	Paid In Service Half	Ratio to 2H2012	Paid through SH + 1	Ratio to 2H2012	Paid through SH + 2	Ratio to 2H2012	Paid through SH + 3	Ratio to 2H2012	Paid through SH + 4	Ratio to 2H2012	Paid through SH + 5
2H2012	457		525		541		549		554		558
1H2013	422	0.92	503	0.96	517	0.96	527	0.96	537	0.97	
2H2013	436	0.95	518	0.99	532	0.98	544	0.99			
1H2014	440	0.96	471	0.90	481	0.89					
2H2014	348	0.76	388	0.74							
1H2015	148	0.32									

Cumulative Transactions/Claim by Service and Payment Half

Service Half	Paid In Service Half	Ratio to 2H2012	Paid through SH + 1	Ratio to 2H2012	Paid through SH + 2	Ratio to 2H2012	Paid through SH + 3	Ratio to 2H2012	Paid through SH + 4	Ratio to 2H2012	Paid through SH + 5
2H2012	7.43		8.44		8.63		8.69		8.73		8.75
1H2013	7.76	1.04	9.00	1.07	9.17	1.06	9.24	1.06	9.29	1.06	
2H2013	7.95	1.07	9.14	1.08	9.39	1.09	9.47	1.09			
1H2014	9.02	1.21	10.08	1.19	10.27	1.19					
2H2014	10.24	1.38	11.40	1.35							
1H2015	5.86	0.79									

Cumulative Paid/Transaction by Service and Payment Half

Service Half	Paid In Service Half	Ratio to 2H2012	Paid through SH + 1	Ratio to 2H2012	Paid through SH + 2	Ratio to 2H2012	Paid through SH + 3	Ratio to 2H2012	Paid through SH + 4	Ratio to 2H2012	Paid through SH + 5
2H2012	62		62		63		63		64		64
1H2013	54	0.87	56	0.90	56	0.89	57	0.90	58	0.91	
2H2013	55	0.89	57	0.92	57	0.90	57	0.90			
1H2014	49	0.79	47	0.76	47	0.75					
2H2014	34	0.55	34	0.55							
1H2015	25	0.40									

Appendix A: Summary of Paid Procedure Code Types

Exhibit 14: Physician Fee Schedule: Special Services & Reports

Cumulative Paid/Claim by Service and Payment Half

Service Half	Paid In Service Half	Ratio to 2H2012	Paid through SH + 1	Ratio to 2H2012	Paid through SH + 2	Ratio to 2H2012	Paid through SH + 3	Ratio to 2H2012	Paid through SH + 4	Ratio to 2H2012	Paid through SH + 5
2H2012	150		194		204		207		209		211
1H2013	155	1.03	223	1.15	228	1.12	231	1.12	232	1.11	
2H2013	176	1.17	226	1.16	231	1.13	233	1.13			
1H2014	123	0.82	162	0.84	165	0.81					
2H2014	107	0.71	133	0.69							
1H2015	151	1.01									

Cumulative Transactions/Claim by Service and Payment Half

Service Half	Paid In Service Half	Ratio to 2H2012	Paid through SH + 1	Ratio to 2H2012	Paid through SH + 2	Ratio to 2H2012	Paid through SH + 3	Ratio to 2H2012	Paid through SH + 4	Ratio to 2H2012	Paid through SH + 5
2H2012	3.64		4.22		4.28		4.31		4.32		4.34
1H2013	3.64	1.00	4.30	1.02	4.35	1.02	4.37	1.01	4.40	1.02	
2H2013	3.71	1.02	4.28	1.01	4.32	1.01	4.35	1.01			
1H2014	2.94	0.81	3.42	0.81	3.44	0.80					
2H2014	3.11	0.85	3.40	0.81							
1H2015	2.87	0.79									

Cumulative Paid/Transaction by Service and Payment Half

Service Half	Paid In Service Half	Ratio to 2H2012	Paid through SH + 1	Ratio to 2H2012	Paid through SH + 2	Ratio to 2H2012	Paid through SH + 3	Ratio to 2H2012	Paid through SH + 4	Ratio to 2H2012	Paid through SH + 5
2H2012	41		46		48		48		48		49
1H2013	43	1.05	52	1.13	52	1.08	53	1.10	53	1.10	
2H2013	47	1.15	53	1.15	53	1.10	53	1.10			
1H2014	42	1.02	47	1.02	48	1.00					
2H2014	34	0.83	39	0.85							
1H2015	53	1.29									

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