STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

INITIAL STATEMENT OF REASONS
Subject Matter of Regulations: Home Health Care Services Fee Schedule
California Code of Regulations, Title 8, Division 1, Chapter 4.5
Subchapter 1, Article 5.3
Sections 9789.90-9789-93.

1. Introduction

This Initial Statement of Reasons ("ISOR") describes the purpose, rationale, and necessity of the Division of Workers' Compensation's ("DWC") proposed Home Health Care Services Fee Schedule and revisions to existing regulations. In passing Senate Bill 863 (Statutes of 2012, Chapter 363), the Legislature directed the Administrative Director to adopt a schedule of reasonable maximum fees payable for home health care services for injured workers. This ISOR fulfills the requirements of California's Administrative Procedure Act (see Government Code sections 11340, *et seq*.).

This proposed Home Health Care Services Fee sets forth a methodology for payment and maximum allowable rates for the full range of home health care services that may be required by injured workers. Although DWC's Administrative Director has promulgated fee schedules covering physician services, hospital services and numerous other health care areas affecting injured workers, presently, there exists no fee schedule for home health care services. Therefore, providers and payors currently spend extensive time negotiating appropriate payment for these services and, when they cannot agree on what constitutes appropriate payment, engage in lien litigation to resolve these disputes, which is both costly and time consuming.

Labor Code section 5307.8, enacted pursuant to SB 863, mandates this Home Health Care Services Fee Schedule, which DWC proposes to implement by adding sections 9789.90-9789.93 to Title 8 of the California Code of Regulations.

DWC welcomes comments on the ISOR and the accompanying proposed regulations. Please see the Notice of Rulemaking for instructions on how to submit comments on the proposed regulations.

2. Technical, Theoretical, or Empirical Studies, Reports, or Documents

The Division relied upon:

(1) RAND Corporation's *Home Health Care for California's Injured Workers: Options for Implementing a Fee Schedule* ("RAND Study"), 2015.

(2) The California Commission on Health and Safety and Workers' Compensation's ("CHSWC"), *Liens Report* of January 5, 2011.

3. Problem Addressed with this Rulemaking

This rulemaking allows DWC to comply with SB 863's mandate to adopt a home health care services fee schedule. Currently, there is no fee schedule in place for home health care services, meaning that payment for such services is currently made on an ad hoc basis, by report or pursuant to a contract. The proposed fee schedule will reduce home health care services fee lien filings by reducing the number of disputes regarding costs for home health care services, and will allow providers to submit fee disputes to the independent bill review procedure. It will also add clarity regarding allowable services and fees to the home health care providers and payors. In addition, providers and payors will no longer have to engage in extensive negotiations over appropriate rates of payment, since they will now have a fee schedule to rely on.

4. Specific Technologies or Equipment

None.

5. Reasonable Alternatives to the Proposed Regulations and Reasons for Rejecting Those Alternatives

In accordance with Labor Code section 5307.8, DWC considered adopting a fee schedule more closely based on the Medicare and In Home Supportive Services (IHSS) programs, but found that neither, nor even a combination of the two, covered the full range of home health care services needed by California's injured worker population. The Medicare home health care fee schedule covers only medical services and personal care services incident to medical services, and only for a limited period of time (generally 60 days). Chore services are not covered at all. Medicare payment rates are based on a 60-day episode of care, paid on a prospective basis and payment rates are based on care for chronic conditions affecting the elderly, such as diabetes and hypertension, rather than the full spectrum of work-related injuries and illnesses impacting the working-age population in California. In addition, according to the RAND Study, payment rates provided by Medicare are lower than what would provide adequate incentive for many providers to participate as home health care providers for injured workers in California. The IHSS program does not cover any medical services, only personal care and chore services. Moreover, the IHSS program does not have a fee schedule. Instead, IHSS pays a set hourly rate which varies across each of the 58 counties in California. The IHSS program does not contain any billing codes,

which workers' compensation insurers require in order to pay providers. The IHSS program also contains caps on monthly allowable hours which are not permissible under Labor Code 4600 or the Medical Treatment Utilization Schedule (MTUS), which provide that an injured worker will be provided with the necessary care to cure or relieve his or her injury, irrespective of any hours cap contained in the IHSS payment schedule.

DWC also considered adopting a home health care fee schedule closely based on the Medi-Cal home health care fee schedule, but concluded, again based on findings in the RAND Study, that the rates of payment were too low to give potential providers an incentive to participate in the treatment of workers' compensation patients. Accordingly, and based on the recommendation contained in the RAND Study, DWC's proposed fee schedule contains elements from the Medicare home health care fee schedule and the IHSS program, and elements from the federal Office of Workers' Compensation Programs (OWCP) fee schedule, such that the full range of medical, personal care and chore services that may be needed by the workers' compensation population are included in the fee schedule.

Lastly, DWC considered including family members and other individual care givers in the fee schedule. However, due to concerns about the quality of care, potential for fraud and abuse, creating an employment relationship between the provider and either the injured worker or the claims administrator, and the ability of family members and other individual caregivers to perform appropriate medical billing procedures, DWC decided to include only home health care agencies and home care organizations in the fee schedule. However, the regulations provide that a claims administrator, an injured worker and a provider can make an agreement that the provider will provide care to the injured worker and the claims administrator will pay for it, and at what rate(s). This way, existing arrangements with individual or family caregivers that are working can continue, and new arrangements can be entered into on a case by case basis, as appropriate to a particular injured worker's situation.

6. Duplication or Conflicts with Federal Regulations (Government Code section 11346.2(b)(7))

The proposed regulations do not duplicate or conflict with any federal regulations.

7. Facts, Evidence, Documents, Testimony, or Other Evidence on Which the Agency Relies to Support an Initial Determination that the Action will not have a Significant Adverse Economic Impact on Business (Government Code section 11346.2(b)(6)(A))

The Administrative Director has determined that the proposed regulations will not have a significant adverse economic impact on business. The fee schedule will reduce costs by reducing the number of fee-related disputes and eliminating the need to negotiate appropriate

fees for home health care services. The home health care services fee schedule provides reasonable maximum fees for home health care services. Home health care service providers will benefit from more certainty regarding payment and reduced lien litigation.

8. The Specific Purpose, Rationale, and Necessity of Each Section of the Proposed New Regulations and Proposed Revisions (Government Code section 11346.2(b)(1))

Section 9789.90 Home Health Care - Definitions

Specific Purpose:

This section lists and defines the terms used in the home health care services fee schedule. The purpose of the definitions is to implement, interpret, and make specific Labor Code section 5307.8, and to ensure that the meanings of the terms are clearly understood by the workers' compensation community.

"CMS," "home care organization," "home health care agency," "home health care services," "IHSS," and "Medicare" are defined to ensure that their meanings, as used in the regulations, will be clear to the regulated public.

Necessity:

It is necessary to define each of the key terms used in the home health care fee schedule to ensure that their content and meaning are clearly understood by the workers' compensation community. The definitions have been added to ensure consistency of interpretation of the statutory requirements and terms being used in order to provide clarity and to ensure proper compliance with the regulations.

It is necessary to define the terms "CMS," "IHSS," and "Medicare" because Labor Code section 5307.8 provides that DWC's home health care services fee schedule be based, at least in part, on these programs. It is necessary to define "home health care services" because this is the subject matter of the fee schedule. It is necessary to define "home care organization" and "home health care agency" so that the regulated community understands which types of entities may provide medical and non-medical home health care services to injured workers under the fee schedule.

Section 9789.91 Home Health Care – Eligibility for Services & Payment.

Specific Purpose:

This section sets forth provisions for eligibility for home health care services for injured workers and certain restrictions on services that will not be covered. The purpose of subdivision (a) is to

limit home health care services covered by the home health care services fee schedule to those that are medically necessary, pursuant to Labor Code section 4600, subdivision (h) and the Medical Treatment Utilization Schedule (MTUS). The purpose of subdivision (b) is to make clear to the regulated community that decisions regarding the scope of home health care services that will be provided will be subject to the utilization review and independent medical review procedures set forth in Labor Code sections 4610 and 4610.5, *et seq*. The purpose of subdivision (c) is to set a uniform standard for assessing the need of an injured worker for home health care services and to advise the regulated community regarding that standard. The purpose of subdivision (d) is to notify the regulated community of the limitation set forth in Labor Code section 4600, subdivision (h), which provides that an employer or their insurer shall not be liable for any home health care services provided by the injured worker's spouse or other member of the injured worker's household, or other entity, if those home health care services were provided to the injured worker prior to the industrial injury, and that an employer or their insurer shall not be liable for home health care services provided more than fourteen days prior to the date of the employer's or insurer's receipt of the physician's prescription or request for authorization for home health care services. Finally, the purpose of subdivision (e) is to notify the regulated community that, in general, caregivers must work for a home care organization or a home health care agency, but that arrangements can be made between an injured worker, an insurer, and an individual provider for care to be provided by an individual provider, including a spouse or family member.

Necessity:

Subdivision (a) provides that home health care services shall be provided as medical treatment only if reasonably required to cure or relieve the injured worker from the effects of his or her injury, if such treatment is prescribed by a licensed physician and surgeon, in accordance with Labor Code section 4600, subdivisions (h) and the MTUS. It is necessary to state that decisions regarding what treatment is and is not medically necessary for injured workers will be made in accordance with the applicable medical standards: Labor Code section 4600, subdivisions (h) and the MTUS. The most recently updated MTUS addresses home health care in the Proposed Chronic Pain Medical Treatment Guidelines that are part of the regulations proposed on July 17, 2015, which states that home health care services will be provided based on scientific evidence supporting the need for, frequency and types of care to be provided. Labor Code section 4600, subdivision (h), which was adopted pursuant to SB 863, provides that home health care services shall be provided as medical treatment only if reasonably required to cure or relieve the injured worker from the effects of his or her injury, if such treatment is prescribed by a licensed physician and surgeon, and it is therefore necessary to reference this standard.

Subdivision (b) provides that home health care services are subject to the utilization review and independent medical review procedures set forth in Labor Code sections 4610 and 4610.5, *et seq*. It is necessary to advise the regulated community that disputes regarding treatment will be subject to the standard utilization review and independent medical review procedures set forth in Labor Code sections 4610 and 4610.5, *et seq*. A request for home health care services is made when a treating physician prescribes or fills out a request for authorization for home health care services for the injured worker. The claims administrator will then review such requests and either approve them or submit them utilization review.

Subdivision (c) provides that, at the outset of care, an in-home assessment of the injured worker's need for home health care shall be performed by a qualified registered nurse. Assessments of an injured workers' need for home health care will be performed using CMS's OASIS (Outcome and Assessment Information Set), a group of standard data elements used by CMS to assess patient's needs for home health care services. A link to the OASIS form is incorporated into subdivision (c) by reference. Provisions are also made for evaluations of needs for rehabilitation services in the areas of speech language pathology, physician therapy or occupational therapy, where applicable. It is necessary to inform the regulated public regarding the uniform standard that will be used to assess the need for home health care services for injured workers.

Subdivision (d) provides that an employer or its insurer shall not be liable for any home health care services provided by the injured worker's spouse or other member of the injured worker's household, or other entity, if those home health care services were provided to the injured worker prior to the industrial injury. This language is necessary to comply with the language in Labor Code section 5307.8, which states that the home health care services fee schedule must not allow payment for services, including any services performed by a member of the employee's household, to the extent the services had been regularly performed in the same manner and to the same degree prior to the date of injury. Subdivision (d) further provides that an employer or its insurer shall not be liable for home health care services provided more than fourteen (14) days prior to the date of the employer's or insurer's receipt of the physician's prescription or request for authorization for home health care services. This is necessary to include pursuant to Labor Code section 4600, subdivision (h), which contains this requirement.

Subdivision (e) provides that the fee schedule does not cover family caregivers or individuals who are not employed by a home care organization or a home health care agency. This is necessary to ensure that caregivers have the appropriate training and licenses to provide home health care services to injured workers. Subdivision (e) further provides that a claims administrator and an injured worker may agree that the injured worker may use an unregistered provider (who is not employed by a home care organization or home health care agency and who

may be a family member of the injured worker) if the individual has the necessary skills to provide the home health care services needed by the injured worker. This provision was added to allow for arrangements for individual providers, including family members, to be made, where appropriate, on a case by case basis, in the discretion of the claims administrator, the injured worker and the individual care provider. The injured worker, the claims administrator and the provider must all agree that the proposed provider is qualified to provide the level of care needed by the injured worker.

Section 9789.92 Home Health Care – Payment Methodology & Billing Rules.

Specific Purpose:

The purpose of subdivision (a) is to notify the regulated community that covered services and payment rates are set forth in Table A, codified as section 9789.93. The purpose of subdivision (b) is to notify the regulated community regarding the time increments and the forms that should be used for billing. Finally, the purpose of subdivision (c) is to notify the regulated community that, pursuant to Labor Code section 5307.11, insurers and providers may enter into contracts for payment of home health care services at rates different than those set forth in the home health care services fee schedule.

Necessity:

Subdivision (a) states that applicable rates for covered services are contained in Table A, which is set forth in section 9789.93. Subdivision (a) also provides that in no case shall any payment rate under the fee schedule be lower than the then-applicable state or local minimum wage. Finally, subdivision (a) provides that the home health care fee schedule operates on a fee for service basis. This statement is necessary to differentiate it from the Medicare home health care fee schedule, which operates on a prospective payment system, where a 60-day episode of care is paid for at the outset of care based on average costs. In contrast, DWC's home health care services fee schedule will operate on a fee for service basis, meaning that services will be billed and paid after they are rendered. This is necessary because under workers' compensation, injured workers are entitled to such home health care services as are necessary to cure and relieve their work-related injuries or illnesses, pursuant to Labor Code section 4600. Care cannot be limited to a 60-day episode of care as is done under the Medicare system.

Subdivision (b)(1) provides that home health care services will be billed in fifteen (15) minute increments, with one unit of time being equal to fifteen (15) minutes. Subdivision (b) further provides that a visit by a home health care provider will be for a minimum of four units, with any additional time beyond the four units to be billed in fifteen (15) minute increments. The four units may be for different services performed within the visit. For example, if only one service is

performed during the visit, the provider would bill the four minimum units to the billing code for that service. However, if two, three or four services were provided during the initial hour of the visit, the provider would bill two, three or four codes, respectively, in relative proportion to the time spent on each service. No more than four services may be billed during a one-hour visit. Subdivision (b)(2) provides that a per diem code shall be used whenever per diem rate is lower than the incremental rate for the number of hours worked in a day providing a particular service. Finally, subdivision (b)(3) provides that providers will bill insurers using the CMS 1500 form, or the CMS 1450/UB-04 form, and the links to download those forms is provided. This information is necessary to explain to the providers and payors how billing should be done and on what form, along with guidance regarding billing for home health care visits. The information regarding per diem billing is intended to contain costs. In addition, Labor Code section 4603.4 requires the use of standardized forms for billing for health care services for injured workers.

Subdivision (c) provides that nothing in section 9789.92 precludes a provider and insurer claims administrator from entering into an agreement that the provider will be paid at rates higher or lower than those set forth in the home health care fee schedule. This is necessary so that the regulated community understands that home health care providers and payors may, if they choose, contract for the provision of home health care services at rates that are higher or lower than those set forth in the home health care fee schedule, pursuant to Labor Code section 5307.11.

Section 9789.93 Table A

Specific Purpose:

This section sets forth billing codes and maximum payment rates that may be billed under the home health care services fee schedule.

Necessity:

Labor Code section 5307.8 mandates this home health care services fee schedule. This section is necessary to list the codes and payment rates for each covered service.

OWCP rates were chosen over Medicare rates because the Medicare prospective payment system for a 60-day episode of care is limited in scope (specifically, the beneficiary must need intermittent part-time skilled nursing care, physical therapy, certified occupational therapy, or speech pathology services) relative to those services that are available under workers' compensation and does not reflect a full range or mix of home health care services that might be needed by an injured worker. Intermittent part-time care is defined as "care that is needed or

given on fewer than 7 days each week or less than 8 hours each day over a period of 21 days (or less)." (RAND report, p. 16.) The Medicare program home health care benefit is designed to provide services needed to treat an illness or injury to homebound beneficiaries. It provides for a narrow range of services over a limited period of time while the beneficiary regains self-sufficiency. It is not intended as a long term benefit. Also, the Medicare program does not cover personal care or chore services. Medicare's 60-day episode rate reflects the cost of providing a typical mix of Medicare-covered services during the 60-day episode and does not reflect the type and duration of home care that might be furnished to injured workers. Thus, the payment rates used under the Medicare system do not apply well to the types of services allowed under workers' compensation law and needed by the injured worker population in California.

The rates listed in Table A include G, S, T, and IHSS codes. The payment rates for G codes derive from the federal Office of Workers' Compensation Programs (OWCP) fee schedule. These G codes are also used in the Medicare home health care fee schedule. Payment rates for S and T codes also derive from the OWCP fee schedule.

For G, S and T codes, the billing rates are based upon the following formula:

[Wrvu + PErvu + MPrvu] × CF = MAA

Where: Wrvu = Work relative value units

PErvu = Practice expense relative value units

MPrvu = Malpractice relative value units

The conversion factor (CF) for the OWCP fee schedule issued January 1, 2014 (the current and most recent version of the OWCP fee schedule), is the 2013 OWCP CF of $48.52, which corresponds to approximately 133% of the 2012 Medicare CF of $40.84.[1] The RAND report concluded that 120% of Medicare rates would be inadequate to cover the costs of providing the services in question, which could result in a shortage of qualified providers willing to provide home health care services to injured workers. The other values (Wrvu, PErvu and MPrvu) are also derived from the January 1, 2014 OWCP fee schedule. The chart below shows the application of the above formula to arrive at the rates for the G, S and T codes in the fee schedule that are billed in 15-minute increments (two-hour and per diem codes are not included below).

[1] This calculation is not based on the Medicare's episodic payment but instead on another feature. If fewer than five visits are provided during a 60-day episode, Medicare makes a low-income utilization payment adjustment (LUPA) and pays the home health agency a per visit amount rather than the per episode amount. Also, there is an additional add-on to recognize that the initial visit is longer than subsequent visits. (RAND report, p. 20.)

Code	Description	Rate per 15 min. Increment	Work RVUs	Practice Expense RVUs	Malpractice Expense RVUs	CF
G0151	Services performed by a qualified physical therapist in the home health setting, each 15 minutes	50.46	0.91	0.11	0.02	48.52
G0152	Services performed by a qualified occupational therapist in the home health setting, each 15 minutes	50.95	0.92	0.11	0.02	48.52
G0153	Services performed by a qualified speech-language pathologist in the home health setting, each 15 minutes	51.43	0.93	0.11	0.02	48.52
G0155	Services of clinical social worker in home health setting, each 15 minutes	61.62	1.14	0.11	0.02	48.52
G0156	Services of home health aide in home health setting, each 15 minutes	6.79	0.12	0.01	0.01	48.52
G0157	Services performed by a qualified physical therapist assistant in the home health setting, each 15 minutes	24.75	0.45	0.05	0.01	48.52
G0158	Services performed by a qualified occupational therapist assistant in the home health setting, each 15 minutes	25.72	0.46	0.06	0.01	48.52
S5125	Attendant care services, per 15 minutes	4.37	0.09	0.00	0.00	48.52
S9122	Home health aide or certified nurse assistant, providing care in the home; per 15 minutes	6.31	0.50	0.01	0.01	48.52
S9123	Nursing care, in the home; by registered nurse, per 15 minutes	27.54	2.27	0.00	0.00	48.52
S9124	Nursing care, in the home, by licensed practical nurse, per 15 minutes	22.08	1.82	0.00	0.00	48.52
T1001	Nursing assessment/evaluation	40.64	1.72	1.56	0.07	48.52

The payment rate for the code IHSS200 is based on 125% of the highest IHSS rate currently in effect (Santa Clara County). IHSS hourly payment rates vary from county to county, and this fee schedule will apply in all counties in California. The rate was multiplied by 125% to ensure that rates are adequate to encourage non-skilled care providers to participate in home health care services for injured workers.

Codes for the fee schedule were chosen to eliminate duplicative codes to the extent possible while allowing for coverage of the broadest range of services that may be needed by injured workers.

ECONOMIC IMPACT ANALYSIS

Evidence Supporting Finding of No Significant Statewide Adverse Impact Directly Affecting Business

The proposed regulations will not have a significant adverse economic impact on representative private persons or directly affected businesses. Currently, home health care services are billed on an ad hoc basis, "by report" or pursuant to contract, and are the subject of much uncertainty, lien filings and litigation. If DWC does not adopt these regulations, providers and payors will continue to have to utilize substantial resources attempting to resolve disputes regarding what reasonable fees for home health care services are and which services are payable. These fee schedule regulations will reduce costs for stakeholders by providing clarity to providers and payors regarding which services are payable and what the maximum allowable fee is for each covered service.

The proposed regulations, including payment rates, were published on the DWC forum. While DWC received many comments from interested stakeholders, none of the comments took issue with the proposed rates. This suggests that the proposed rates may be comparable to what is being paid by insurers currently within the state, or at the very least were not considered wildly high or low by payors or providers.

Creation or Elimination of Jobs within the State of California

None. The Administrative Director has determined that the proposed regulations will not create or eliminate any jobs within the State of California. As noted above, the regulations will not impose any obligations not already being imposed by the federal government. Therefore, it would be inaccurate to conclude that adoption of the proposed regulations would create or eliminate jobs within the State of California.

Creation of New or Elimination of Existing Businesses within the State of California

None. The Administrative Director has determined that the proposed regulations will not create or eliminate any existing businesses within the State of California. As noted above, the regulations will not impose any obligations not already being imposed by the federal government. Therefore, it would be inaccurate to conclude that adoption of the proposed regulations would create new businesses or eliminate existing businesses within the State of California.

Expansion of Businesses Currently Doing Business within the State of California

None. The Administrative Director has determined that the proposed regulations will not cause the expansion or elimination of any existing businesses within the State of California. As noted above, the regulations will not impose any obligations not already being imposed by the federal government. Therefore, it would be inaccurate to conclude that adoption of the proposed regulations would cause an expansion of businesses currently doing business within the State of California.

Benefits of the Regulations to the Health and Welfare of California Residents, Worker Safety, and the State's Environment

Requiring that home health care agencies and home care organizations fall within specific standards and licensing requirements will help ensure that injured workers receive appropriate and quality home health care services. Adopting rates that are reasonable will ensure adequate access to home health care providers. Requiring an assessment at the onset of care and the use of the OASIS form will provide a method to ensure an appropriate home health plan of care for injured workers. Injured workers will benefit by having uniform codes and fees adopted that will ensure that adequate and appropriate home health care services will be available to injured workers.

The proposed regulations will reduce disputes among home health care service providers and payors in the workers' compensation system, thereby making the system more efficient. In addition, the fee schedule will save costs by reducing disputes over appropriate fees for home health care services for injured workers. It will also allow providers to use the Independent Bill Review procedure for fee disputes instead of the more expensive and slower lien filing procedure. A 2011 study by the California Commission on Health and Safety and Workers' Compensation (CHSWC) found that approximately 350,000 liens are filed per year, at an average cost of $1,000.00. Of these liens, approximately 9361 were for home health care services. The potential savings from reduced lien litigation could be as much as $9,361,000.00 annually.