STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
Division of Workers' Compensation

NOTICE OF PROPOSED RULEMAKING

Subject Matter of Regulations: Workers' Compensation – Official Medical Fee Schedule: Hospital Outpatient Departments and Ambulatory Surgical Centers

TITLE 8, CALIFORNIA CODE OF REGULATIONS
Sections 9789.30 et seq.

NOTICE IS HEREBY GIVEN that the Acting Administrative Director of the Division of Workers' Compensation, pursuant to the authority vested in her by Labor Code sections 59, 133, 4603.5, 5307.1 and 5307.3 proposes to amend sections 9789.30, 9789.31, 9789.32, 9789.33, 9789.37, and 9789.39 in Article 5.3 of Subchapter 1, Chapter 4.5, Division 1, of Title 8, California Code of Regulations, relating to the Official Medical Fee Schedule – Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule.

PROPOSED REGULATORY ACTION

The Division of Workers' Compensation, proposes to amend Article 5.3 of Subchapter 1, Chapter 4.5, Division 1, of Title 8, California Code of Regulations, by amending regulations commencing with section 9789.30:

1. **Amend section 9789.30 Definitions**
2. **Amend section 9789.31 Adoption of Standards**
3. **Amend section 9789.32 Applicability**
4. **Amend section 9789.33 Determination of Maximum Reasonable Fee**
5. **Amend section 9789.37 Election for High Cost Outlier, DWC Form 15**
6. **Amend section 9789.39 Federal Regulations and Federal Register Notices by Date of Service**

AN IMPORTANT PROCEDURAL NOTE ABOUT THIS RULEMAKING:

The Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule component of the Official Medical Fee Schedule "establish(es) or fix(es) rates, prices, or tariffs" within the meaning of Government Code section 11340.9(g) and is therefore not subject to Chapter 3.5 of the Administrative

Procedure Act (commencing at Government Code section 11340) relating to administrative regulations and rulemaking.

This rulemaking proceeding to amend the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule is being conducted under the Administrative Director's rulemaking power under Labor Code sections 133, 4603.5, 5307.1 and 5307.3. This regulatory proceeding is subject to the procedural requirements of Labor Code sections 5307.1 and 5307.4.

This Notice and the accompanying Initial Statement of Reasons are being prepared to comply with the procedural requirements of Labor Code section 5307.4 and for the convenience of the regulated public to assist the regulated public in analyzing and commenting on this non-APA rulemaking proceeding.

PUBLIC HEARING

A public hearing has been scheduled to permit all interested persons the opportunity to present statements or arguments, either orally or in writing, with respect to the subjects noted above. The hearing will be held at the following time and place:

Date: **Tuesday, March 11, 2014**
Time: **10:00 a.m. to 5:00 p.m. or conclusion of business**
Place: **Elihu M. Harris State Building, Auditorium**
1515 Clay Street,
Oakland, CA 94612

In order to ensure unimpeded access for disabled individuals wishing to present comments and facilitate the accurate transcription of public comments, camera usage will be allowed in only one area of the hearing room. To provide everyone a chance to speak, public testimony will be limited to 10 minutes per speaker and should be specific to the proposed regulations. Testimony which would exceed 10 minutes may be submitted in writing.

Please note that public comment will begin promptly at 10:00 a.m. and will conclude when the last speaker has finished his or her presentation or 5:00 p.m., whichever is earlier. If public comment concludes before the noon recess, no afternoon session will be held.

The Acting Administrative Director requests, but does not require that, any persons who make oral comments at the hearings also provide a written copy of their comments. Equal weight will be accorded to oral comments and written materials.

ACCESSIBILITY

The State Office Buildings and Auditoriums are accessible to persons with mobility impairments. Alternate formats, assistive listening systems, sign language interpreters, or other type of reasonable accommodation to facilitate effective communication for persons with disabilities, are available upon request. Please contact the Statewide Disability Accommodation Coordinator, Kathleen Estrada, at 1-866-681-1459 (toll free), or through the California Relay Service by dialing 711 or 1-800-735-2929 (TTY/English) or 1-800-855-3000 (TTY/Spanish) as soon as possible to request assistance.

WRITTEN COMMENT PERIOD

Any interested person, or his or her authorized representative, may submit written comments relevant to the proposed regulatory action to the Department of Industrial Relations, Division of Workers' Compensation. The written comment period closes at **5:00 p.m., on Tuesday, March 11, 2014.** The Department of Industrial Relations, Division of Workers' Compensation will consider only comments received at the Department of Industrial Relations, Division of Workers' Compensation by that time. Equal weight will be accorded to oral comments presented at the hearing and written materials.

Submit written comments concerning the proposed regulations prior to the close of the public comment period to:

Maureen Gray
Regulations Coordinator
Department of Industrial Relations
Division of Workers' Compensation
Post Office Box 420603
San Francisco, CA 94142

Written comments may be submitted by facsimile transmission (FAX), addressed to the above-named contact person at (510) 286-0687. Written comments may also be sent electronically (via e-mail) using the following e-mail address: dwcrules@dir.ca.gov.

Unless submitted prior to or at the public hearing, Ms. Gray must receive all written comments no later than **5:00 p.m. on Tuesday, March 11, 2014**.

AUTHORITY AND REFERENCE

The Acting Administrative Director is undertaking this regulatory action pursuant to the authority vested in her by Labor Code sections 59, 133, 4603.4, 4603.5, and 5307.3.

Reference is to Labor Code sections 4600, 4603.2, 5307.1l and 5307.1.

INFORMATIVE DIGEST AND POLICY STATEMENT OVERVIEW

Existing law establishes a workers' compensation system, administered by the Administrative Director of the Division of Workers' Compensation, to compensate an employee for injuries sustained in the course of his or her employment. Labor Code section 4600 requires an employer to provide medical, surgical, chiropractic, acupuncture, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatus, including orthotic and prosthetic devices and services, that is reasonably required to cure or relieve the injured worker from the effects of his or her injury. Under existing law, payment for medical treatment shall be no more than the maximum amounts set by the Administrative Director in the Official Medical Fee Schedule or the amounts set pursuant to a contract.
Labor Code Section 5307.1, (as amended by Senate Bill 228 of 2003 (Chapter 639, Statutes of 2003); Senate Bill 1852 (Chapter 538, Statutes of 2006); Assembly Bill 1269 (Chapter 697, Statutes of 2007); Assembly Bill 378 (Chapter 545, Statutes of 2011); and Senate Bill 863 (Chapter 363, Statutes of 2012)), requires the Administrative Director to adopt and revise periodically an official medical fee

schedule that establishes the reasonable maximum fees paid for all medical services rendered in workers' compensation cases.

Prior to the passage of Senate Bill 863, Labor Code Section 5307.1 provided that, except for physician services, all fees in the adopted schedule must be in accordance with the fee-related structure and rules of the relevant Medicare (administered by the Center for Medicare & Medicaid Services of the United States Department of Health and Human Services) and Medi-Cal payment systems. With the passage of Senate Bill 863, Labor Code Section 5307.1(a)(2)(A), requires the Administrative Director to adopt a fee schedule based on the resource-based relative value scale (RBRVS) for physician services, provided the maximum reasonable fees paid shall not exceed 120 percent of estimated annualized aggregate fees prescribed in the Medicare payment system for physician services, with a four-year transition. Labor Code Section 5307.1(a)(2)(C) provides that commencing January 1, 2014, and continuing until the time the Administrative Director has adopted a physician fee schedule in accordance with the resource-based relative value scale, a default fee schedule shall be in accordance with the fee-related structure and rules of the Medicare payment system for the physician services, except that an average statewide geographic adjustment factor of 1.078 shall apply, with a four-year transition.

On August 29, 2013, the Acting Administrative Director submitted the adopted RBRVS-based physician fee schedule, effective for services rendered on or after January 1, 2014 (Title 8, California Code of Regulations title 8 sections 9789.12.1 et seq.) to the Office of Administrative Law for file and print only. The Office of Administrative Law filed the regulations with the Secretary of State on September 24, 2013. Subsequently, the Acting Administrative Director commenced a rulemaking proceeding in November 2013 to amend the RBRVS-based physician fee schedule to eliminate the use of the federal Office of Workers' Compensation Program (OWCP) relative value units, for services rendered on or after January 1, 2014. Elimination of the use of OWCP relative values was necessary because the structure of the OWCP data file results in erroneous fee calculations for certain procedures. On December 16, 2013, the Acting Administrative Director submitted the amended regulations to the Office of Administrative Law for file and print only. The amended regulations were filed with the Secretary of State on December 26, 2013. On December 23, 2013, the Acting Administrative Director issued and posted an Order to update the RBRVS-based physician fee schedule to conform to relevant changes made to the 2014 Medicare Physician Fee schedule, for services rendered on or after January 1, 2014.

As set forth in Labor Code section 5307.1(c)(1), the maximum facility fee for services performed in a hospital outpatient department, shall not exceed 120 percent of the fee paid by Medicare for the same services performed in a hospital outpatient department. Senate Bill 863 also required that for services rendered in ambulatory surgical centers on or after January 1, 2013, the maximum facility fee shall not exceed 80 percent of the fee paid by Medicare for the same services performed in a hospital outpatient department. The inflation factor for hospital outpatient services and ambulatory surgical center services is determined solely by the estimated adjustment in the hospital market basket for the 12 months beginning October 1 of the preceding calendar year. The Administrative Director may adopt different conversion factors, diagnostic related group weights, and other factors affecting payment amounts from those used in the Medicare payment system, provided estimated aggregate fees do not exceed the maximum percent of the estimated aggregate fees set forth in Labor Code section 5307.1.

Labor Section 5307.1 also provides that the Administrative Director shall adjust the hospital outpatient departments and ambulatory surgical centers fee schedule to conform to any relevant changes in the Medicare payment system by issuing an order, exempt from Labor Code sections 5307.3 and 5307.4 and the rulemaking provisions of the Administrative Procedure Act (Chapter 3.2 (commencing with Section

11340) of Part 1 of Division 3 of Title 2 of the Government Code), informing the public of the changes and their effective date.

Effective Jan. 1, 2004, the Administrative Director adopted the hospital outpatient departments and ambulatory surgical centers fee schedule (Title 8, California Code of Regulations, sections 9789.30 et seq.), which is updated annually by Administrative Director Order.

Effective Jan. 1, 2013, the Acting Administrative Director amended the hospital outpatient departments and ambulatory surgical centers fee schedule (Title 8, California Code of Regulations, sections 9789.30 et seq.), to implement Senate Bill 863 as it relates to the OMFS hospital outpatient departments and ambulatory surgical centers fee schedule.

For services rendered before January 1, 2014, the OMFS physician fee schedule applies to all covered medical services provided, referred, or prescribed by physicians, regardless of the type of facility in which the services are provided. With the exception of facility fees for the use of emergency room visits or surgical services, the OMFS for physician services applies to services furnished by hospital outpatient departments, including clinic services and diagnostic tests (other than tests that are payable under the OMFS for diagnostic laboratory services). As a result, for example, regardless of whether a diagnostic test is provided in a physician's office, a freestanding diagnostic testing facility, or a hospital outpatient department, the same facility allowances apply. In other words, the OMFS hospital outpatient departments and ambulatory surgical centers fee schedule applies only to facility fees for emergency room services performed in a hospital outpatient department and surgical procedures performed in a hospital outpatient department or ambulatory surgical center.

However, given the outdated nature of pre-2014 OMFS physician fee schedule (last major update occurred in 1999) and the transition to the implementation of a RBRVS-based physician fee schedule, it is not appropriate to continue to use the pre-2014 OMFS physician fee schedule to set facility fee allowances for hospital services to outpatients.

On another issue, the hospital outpatient departments and ambulatory surgical centers fee schedule provides a default payment methodology for determining the maximum allowable facility fee. The maximum allowable payment is based on a multiplier that includes an extra percentage reimbursement for high cost outlier cases in lieu of additional payment for high cost outlier cases. Facilities, however, have the option of making an annual election to use an alternative payment methodology for determining the maximum allowable facility fee. The alternative payment methodology does not provide the extra percentage reimbursement, but, allows for additional payment for high cost outlier cases.

Prior to 2007, the California Department of Health Services (DHS), (now California Department of Public Health (CDPH)), issued licenses to ambulatory surgical centers (ASC). This license was the basis of the Office of Statewide Health Planning and Development's (OSHPD) authority to collect the "Annual Utilization Report of Specialty Clinics" from ASCs. The information provided in this report contained the necessary data used to determine the facility's cost-to-charge ratio.

In 2007, however, a California Court of Appeal decision (*Capen v. Shewry*, 155 Cal.App.4th 378, September 2007) held that ASCs with partial or total physician-ownership would no longer be licensed by DHS (now CDPH). The court held that the legislature distinguished between surgical clinics owned and operated by doctors, which are generally regulated by the California Medical Board, and surgical clinics owned and operated by others, which are generally regulated by the DHS (now CDPH). In light

of this ruling, DHS (now CDPH) determined it had no jurisdiction over physician-owned ASCs, and stopped issuing and renewing licenses to all but a handful of non-physician owned ASCs.[1] As a result the number of ASCs providing "Annual Utilization Reports" dropped dramatically in subsequent years. OSHPD reports that by 2010 more than 400 facilities had been de-licensed.

Now, if a physician-owned ASC opts to be paid using the alternative method of payment, the Division is no longer able to audit the accuracy of the information provided by the ASC to derive its cost-to-charge ratio, making this alternative payment methodology unworkable.

In addition, the Acting Administrative Director has determined that facilities rarely elect to use the alternative payment methodology, and prefer the default payment methodology. For the last two annual election periods (2012/2013 and 2013/2014), only 1 ambulatory surgical center elected to use the alternative payment methodology, and in the prior two annual election periods (2010/2011 and 2011/2012), only 1 ambulatory surgical center and only 1 hospital outpatient department elected to use the alternative payment methodology. Because of these findings, the Acting Administrative Director is considering abolishing the alternative payment methodology for services rendered on or after the effective date of the proposed amendments to the regulation.

The Acting Administrative Director now proposes to amend sections 9789.30, 9789.31, 9789.32, 9789.33, 9789.37, and 9789.39 to transition hospital outpatient department facility fee allowances currently paid under the pre-2014 OMFS physician fee schedule to an OMFS RBRVS-based facility fee; and to repeal the alternative payment methodology for services rendered on or after the effective date of the proposed amendments to the regulation.

The proposed regulations implement, interpret, and make specific sections 4600 and 5307.1 of the Labor Code as follows:

In a number of the sections, quotes ("") and the word "indicator" are added to where the phrase "status code indicator" is referenced in the regulation for consistency and clarity.

1. Section 9789.30 – Definitions

Subdivision (j) "Facility Only Services" is added to this section to mean those services defined by Medicare, that rarely or are never performed in the non-facility setting, and are not: 1. Emergency room visits; 2. Surgical procedures; or 3. An integral part of the emergency room visit or surgical procedure, in accordance with section 9789.32.

Former subdivisions "j" through "x" are re-lettered.

Subdivision (s) "Other Services" is added to this section to mean those services rendered on or after the effective date, to outpatients and payable under the CMS HOPPS that are not: 1. Surgical procedures; 2. Emergency room visits; 3. Facility Only Services; or 4. An integral part of the surgical procedure, emergency room visit, or Facility Only Service.

Subdivision ("u", formerly "s") is amended to add the word "Hospital" and "H" to the acronym "HOPPS".

[1] In 2010, there were 754 ASCs operating in California. However, only 52 reported data to OSHPD, down from 451 in 2007. (*Ambulatory Surgery Centers: Big Business, Little Data*, California Health Care Almanac, California HealthCare Foundation, June 2013.

Subdivision (w) “OMFS RBRVS” is added to this section to mean the Official Medical Fee Schedule for physician and non-physician practitioner services in accordance with sections 9789.12.1 through 9789.19, of Title 8 of the California Code of Regulations.

Subdivision (aa, formerly “x”) is amended to reformat the subdivision for clarity; to set forth the Workers’ Compensation Multiplier by date of service, type of facility, and service being rendered; and to adjust the extra percentage reimbursement for high cost outlier cases to conform to changes in the Medicare HOPPS.

2. Section 9789.31 Adoption of Standards

Subdivision (d) is added to incorporate by reference, the Medicare Physician Fee Schedule “Relative Value File” published by Medicare, by date of service.

Subdivisions “d” and “e” are re-lettered to “e” and “f”, respectively.

3. Section 9789.32 Applicability

Subdivision (a) is amended to expand the applicability of Sections 9789.30 through 9789.39 to include Facility Only Services furnished by hospital outpatient departments to outpatients on or after the effective date of the proposed amendments.

Subdivision (a)(1) is amended to set forth when a supply, drug, device, blood product and biological (with status code N, Q1, Q2, or Q3) is considered an integral part of an emergency room visit, surgical procedure, or Facility Only Service rendered on or after the effective date of the proposed amendments.

Subdivision (a)(2) is amended to set forth when a supply, drug, device, blood product and biological (with status code G,H,K,R, or U) is considered an integral part of an emergency room visit, surgical procedure, or Facility Only Service rendered on or after the effective date of the proposed amendments.

Subdivision (b) is amended to conform to the re-lettering of the subdivisions.

Subdivision (c) is amended to adapt the section to also be applicable to Facility Only Services furnished by hospital outpatient departments to outpatients on or after the effective date of the proposed amendments.

Subdivision (c)(1)(A), formerly (c)(1) is reformatted to add a subdivision (A). Subdivision (c)(1)(A) is amended to clarify that hospital outpatient facility fees for professional medical services rendered prior to the effective date of the proposed amendments, that do not meet the requirements in subdivision (a), shall be determined according to the pre-2014 OMFS physician fee schedule, sections 9789.10 and 9789.11.

Subdivision (c)(1)(B) is added to indicate that for Other Services rendered on or after the effective date of the proposed amendments, the maximum allowable hospital outpatient facility fee shall be an OMFS RBRVS-based facility fee.

Subdivision (c)(1)(B)(i) is added to set forth the payment methodology for Other Services that have professional component/technical component relative value units. The hospital outpatient facility fee shall be determined using the technical component OMFS RBRVS relative value units.

Subdivision (c)(1)(B)(ii) is added to set forth the payment methodology for Other Services that do not have separate professional component/technical component. The hospital outpatient facility fee shall be determined based solely on the non-facility practice expense OMFS RBRVS relative value units.

Subdivision (c)(1)(B)(iii) is added to set forth the payment methodology for any physician and non-physician practitioner professional services billed by the hospital. The fee shall be calculated using the OMFS RBRVS total facility relative value units.

Subdivision (c)(5) is deleted as unnecessary due to the proposed amendments to the regulation.

Subdivisions (c)(5) and (c)(6), formerly (c)(6) and (c)(7), respectively, are re-numbered.

Subdivision (d) is amended to conform the subdivision to include Facility Only Services and Other Services furnished to outpatients on or after the effective date of the proposed amendments; and to clarify that facility fees are not payable to ambulatory surgical centers for any services that are not an integral part of the surgical procedure.

3. Section 9789.33 Determination of Maximum Reasonable Fee

Subdivision (a) is reformatted for clarity; amended to include the payment methodology for Facility Only Services; and amended to conform the extra percentage reimbursement allowed in lieu of an additional payment for high cost outliers to changes to the CMS HOPPS.

To reduce repetition and unnecessary language, the payment formula is amended by removing "1.22" and "0.82" from the formula, and citing to Section 9789.30(aa) by date of service. The formula now states, "APC payment rate x workers' compensation multiplier pursuant to Section 9789.30(aa), by date of service".

To conform to the proposed amendments in this regulation, the subdivisions are re-numbered and all references to former Section 9789.30(x) is amended to reflect the re-lettering of this subdivision (9789.30(aa)).

Subdivision (b) is amended to state that this section is repealed as of the effective date of the proposed amendments. The effective date of the proposed amendments are added throughout the body of the text to clarify that this section is only applicable to services rendered before the effective date of the proposed amendments. All references to Section 9789.30(x) is now Section 9789.30(aa), to conform to the re-lettering of sections proposed by these amendments.

Subdivisions (c) and (d) are amended to state that this section is repealed as of the effective date of the proposed amendments.

4. Section 9789.37 Election for High Cost Outlier, DWC Form 15

This section is amended to state that this form is repealed as of the effective date of the proposed amendments

5. Section 9789.39 Federal Regulations and Federal Register Notices by Date of Service

Subdivision (b) is amended to add "Facility Only Services" and "Medicare Physician Fee Schedule Relative Value File" for services rendered on or after the effective date of the proposed amendments.

DISCLOSURES REGARDING THE PROPOSED REGULATORY ACTION

The Acting Administrative Director has made the following initial determinations:

- Significant statewide adverse economic impact directly affecting business, including the ability of California businesses to compete with businesses in other states: None.

- Adoption of these regulations will not: (1) create or eliminate jobs within the State of California, (2) create new businesses or eliminate existing businesses within the State of California, or (3) affect the expansion of businesses currently doing business in California.

- Effect on Housing Costs: None.

- The Division of Workers' Compensation is aware of cost impacts that a representative private person or business would necessarily incur in reasonable compliance with the proposed action. The proposed regulations will most significantly affect hospital outpatient departments, workers' compensation insurers, self-insured employers and workers' compensation third party administrators.

  The maximum reasonable allowance payment methodology for non-surgical procedures /non-emergency room visits rendered to outpatients, is being transitioned from the pre-2014 OMFS physician fee schedule in effect for physician and non-physician practitioner services rendered before January 1, 2014 (Title 8, California Code of Regulations sections 9789.10 and 9789.11) to an OMFS RBRVS-based facility fee, with the exception of "Facility Only" services. It is proposed that hospital outpatient facility fees for Facility Only Services would be 101.01 percent multiplier of the Medicare hospital outpatient departments prospective payment system (which includes an extra percentage reimbursement for high cost outlier cases).

  Therefore, in the aggregate, the hospital outpatient departments will be receiving the same allowances paid to physicians for their practice expenses when services are provided in office settings. RAND[2] analysis of the WCIS data show RBRVS-based maximum reimbursements will be approximately 7.6 percent lower than the maximum reimbursement under the pre- 2014 OMFS physician fee schedule (Title 8, California Code of Regulations sections 9789.10 and 9789.11), and approximately -0.5% estimated percentage change in total expenses for hospital services to outpatients. These estimates are based on a fully transitioned RBRVS (120 percent of Medicare in 2014) rather than the actual 2014 transition rate (75% pre-2014 OMFS/25% at 120% of Medicare). According to the RAND analysis, the actual estimated reduction will be "negligible" in 2014. These services represent approximately 7 percent of payments to hospital

[2] Wynn, Barbara, et al., *Fee Schedule Options for Services Furnished by Hospitals to Outpatients Under the California Workers' Compensation Program*, RAND, February 2014, WR-1016-DIR

outpatient departments for services provided to workers' compensation patients on an outpatient basis.

Eliminating the alternative payment methodology has the potential of reducing costs through increased efficiencies and reduced administrative burden.

EFFECT ON SMALL BUSINESS

The Acting Administrative Director has determined that the proposed regulation will not affect small business. Small business employers will have nominal change in costs due to the diminutive change in aggregate facility fees for non-surgical/non-emergency room visit services furnished to hospital outpatients. Hospital outpatient departments will not be greatly affected as the maximum allowed fees in the aggregate will not result in a substantive change as a result of transitioning reimbursement of non-surgical/non-emergency room visit procedures from the pre-2014 OMFS physician fee schedule (Title 8, California Code of Regulations sections 9789.10 and 9789.11) to an OMFS RBRVS-based facility fee. In addition, there may be some cost saving as a result of eliminating the alternative payment methodology.

The OMFS hospital outpatient departments/ASC fee schedule refers payment for non-surgical/non-emergency room visit services to be paid in accordance with the pre-2014 OMFS for physician services. (Title 8, California Code of Regulations sections 9789.10 and 9789.11). The last major update to the pre-2014 OMFS physician fee schedule occurred in 1999. Cost savings will be realized by hospitals and payers alike to no longer have to maintain a system which uses outdated procedure codes and values to determine payment of hospital outpatient facility fees for certain services.

FISCAL IMPACTS

- Costs or savings to state agencies: These regulations will not have a major affect on the State Compensation Insurance Fund (SCIF), which is the largest workers' compensation insurer in the state. The RAND study has estimated a 7.6 percent reduction in the aggregate cost of these Other Services performed in hospital outpatient departments, and a 0.5 percent decrease in the overall expenditures for hospital services to outpatients. These estimates are based on a fully transitioned RBRVS (120 percent of Medicare in 2014) rather than the actual 2014 transition rate (75% pre-2014 OMFS/25% at 120% of Medicare). According to the RAND analysis, that the actual estimated reduction will be "negligible" in 2014.

- Costs/savings in federal funding to the State: None.

- Local Mandate: None. The proposed regulations will not impose any new mandated programs or increased service levels on any local agency or school district. The Acting Administrative Director has determined that the proposed regulations will not impose any new mandated programs or additional costs on any local agency or school district.

- Cost to any local agency or school district that is required to be reimbursed under Part 7 (commencing with Section 17500) of Division 4 of the Government Code: None. The proposed regulations do apply to a local agency or school district in its capacity as an

employer required to provide workers' compensation benefits to injured workers.

- Other nondiscretionary costs/savings imposed upon local agencies: None.

CONSIDERATION OF ALTERNATIVES

The Acting Administrative Director invites interested persons to present statements or arguments with respect to alternatives to the proposed regulations at the scheduled hearing or during the written comment period.

AVAILABILITY OF INITIAL STATEMENT OF REASONS, TEXT OF PROPOSED REGULATIONS, RULEMAKING FILE AND DOCUMENTS SUPPORTING THE RULEMAKING FILE / INTERNET ACCESS

An Initial Statement of Reasons and the text of the proposed regulations in plain English have been prepared and are available from the contact person named in this notice. The entire rulemaking file will be made available for inspection and copying at the address indicated below. However, documents subject to copyright may be inspected but not copied.

As of the date of this notice, the rulemaking file consists of the notice; the initial statement of reasons; the proposed text of the regulations (underline and strikeout version); and the documents incorporated by reference. Also included are studies and documents relied upon in drafting the proposed regulations.

In addition, the Notice, Initial Statement of Reasons, and proposed text of regulations may be accessed and downloaded from the Division's website at http://www.dir.ca.gov/dwc/dwc_home_page.htm. To access them, click on the link for the Division of Workers' Compensation homepage, then click on the ''Participate in DWC Rulemaking'' link and scroll down the list of rulemaking proceedings to find the current Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule rulemaking link.

Any interested person may inspect a copy of the proposed regulations and any supplemental information contained in the rulemaking file. The rulemaking file will be available for inspection at the Department of Industrial Relations, Division of Workers' Compensation, 1515 Clay Street, 18th Floor, Oakland, California, between 9:00 a.m. and 4:30 p.m., Monday through Friday, unless the state office is closed for a state holiday. Copies of the proposed regulations, initial statement of reasons and any information contained in the rulemaking file may be requested in writing to the contact person.

CONTACT PERSON

Nonsubstantive inquiries concerning this action, such as requests to be added to the mailing list for rulemaking notices, requests for copies of the text of the proposed regulations, the Initial Statement of Reasons, and any supplemental information contained in the rulemaking file may be requested in writing at the same address. The contact person is:

Maureen Gray
Regulations Coordinator

Department of Industrial Relations
Division of Workers' Compensation
Post Office Box 420603
San Francisco, CA 94142
E-mail: mgray@dir.ca.gov

The telephone number of the contact person is (510) 286-7100.

BACKUP CONTACT PERSON

In the event the contact person is unavailable, inquiries should be directed to the following backup contact person:

Jarvia Shu, Industrial Relations Counsel
Department of Industrial Relations
Division of Workers' Compensation
Post Office Box 420603
San Francisco, CA 94142
E-mail: (jshu@dir.ca.gov)

The telephone number of the backup contact person is (510) 286-7100.

AVAILABILITY OF CHANGES FOLLOWING PUBLIC HEARING

If the Acting Administrative Director makes changes to the proposed regulations as a result of the public hearing and public comment received, the modified text with changes clearly indicated will be made available for public comment for at least 15 days prior to the date on which the regulations are adopted.

AVAILABILITY OF THE FINAL STATEMENT OF REASONS

Upon its completion, the Final Statement of Reasons will be available and copies may be requested from the contact person named in this notice or may be accessed on the website: www.dir.ca.gov , then click on the link for the Division of Workers' Compensation homepage, then click on the ''Participate in Rulemaking'' link and scroll down the list of rulemaking proceedings to find the current Outpatient Hospital Departments and Ambulatory Surgical Centers Fee Schedule rulemaking link.

AUTOMATIC MAILING

A copy of this Notice will automatically be sent to those interested persons on the Acting Administrative Director's mailing list.

If adopted, the regulations as amended and adopted will appear in Title 8, California Code of Regulations, commencing with section 9789.30.