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

INITIAL STATEMENT OF REASONS

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

TITLE 8, CALIFORNIA CODE OF REGULATIONS
SECTION 9789.32

Amend section 9789.32 Applicability

AN IMPORTANT PROCEDURAL NOTE ABOUT THIS RULEMAKING:

The Hospital Outpatient Departments and Ambulatory Surgical Centers (HOPD/ASC) 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 HOPD/ASC 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 Initial Statement of Reasons and the accompanying Notice of Rulemaking 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.

BACKGROUND TO REGULATORY PROCEEDING

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.

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 HOPD/ASC 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 HOPD/ASC fee schedule (Title 8, California Code of Regulations, sections 9789.30 et seq.), which is regularly updated by Administrative Director Order.

Effective Jan. 1, 2013, the Administrative Director amended the HOPD/ASC fee schedule (Title 8, California Code of Regulations, sections 9789.30 et seq.), to implement Senate Bill 863 as it relates to the OMFS HOPD/ASC fee schedule.

In March of 2014, the Division initiated a rulemaking action to amend the HOPD/ASC fee schedule as follows: 1. Transition payment policies from the pre-2014 OMFS physician fee schedule to the OMFS RBRVS-based physician fee schedule; 2. Eliminate the alternative payment methodology for hospital outpatient and ASC services rendered on or after September 1, 2014; and in accordance with changes to Medicare's fee-related structure and payment rules for the hospital outpatient departments prospective payment system (OPPS), adjust the Workers' Compensation Multiplier (which included the additional percentage added to the Medicare Multiplier for outliers).

On May 22, 2014, after considering public comments received during a public hearing and one written comment period, the 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 June 3, 2014. The regulations were effective for services rendered on or after September 1, 2014.

The Division subsequently initiated a rulemaking to correct an inadvertent error in the payment methodology for "Other Services." The RBRVS conversion factor should have been applied in the payment methodology instead of the HOPD/ASC Workers' Compensation Multiplier. This correction became effective for services rendered on or after September 1, 2014.

NECESSITY

This rulemaking action to amend the OMFS HOPD/ASC fee schedule is necessary to make more specific the payment method for "Other Services". Because Medicare occasionally changes its coding practices, it is necessary to provide guidance on the proper HCPCS code to use for calculating "Other Services" maximum payment amounts when a different HCPCS code is used to describe comparable Other Services under CMS' Hospital Outpatient Departments Prospective Payment System (CMS HOPPS) and the OMFS RBRVS. Refining the payment methodology to include guidance on which HCPCS code to use is beneficial because payable outpatient services might otherwise be denied.

For example, effective January 1, 2014, CMS began to recognize HCPCS code G0463 (hospital outpatient clinic visit for assessment and management of a patient) and no longer recognizes CPT codes 99201-99205 (evaluation and management – new patient) and 99211-99215 (evaluation and management – established patient) for payment under the CMS HOPPS. The OMFS RBRVS, however, continues to recognize CPT codes 99201-99205 and 99211-99215, but does not recognize HCPCS code G0463. As a result, it has come to the Division's attention that hospitals are being denied payment for these clinic visits. This amendment will specify that when this circumstance occurs, the clinic visit should be paid in accordance with the HCPCS code used under the OMFS RBRVS.

TECHNICAL, THEORETICAL, OR EMPIRICAL STUDIES, REPORTS, OR DOCUMENTS

None.

SPECIFIC TECHNOLOGIES OR EQUIPMENT REQUIRED (if applicable)

No specific technologies or equipment are required by these proposed regulations.

FACTS ON WHICH THE AGENCY RELIES IN SUPPORT OF ITS INITIAL DETERMINATION THAT THE REGULATIONS WILL NOT HAVE A SIGNIFICANT ADVERSE IMPACT ON BUSINESS

The Administrative Director has determined that these proposed amendments to the regulation will not have a significant adverse impact on business.

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. Claims administrators may incur costs to adjust their payment system to implement the proposed guidance regarding coding of hospital outpatient department Other Services paid according to the RBRVS. However, there will be offsetting benefits by avoiding denial of payable hospital outpatient services that might result if the proposed amendment is not adopted.

SUMMARY OF PROPOSED CHANGES

Proposed amendment to Section 9789.32 Applicability

Section 9789.32(c)(1)(B)(iii):

Specific Purpose: This subdivision is added to provide that for services rendered on or after XXX XX, 2015 [Date amendment is filed with the Secretary of State. Date to be inserted by OAL.], if different HCPCS codes are used to describe comparable Other Services under the CMS HOPPS and the OMFS RBRVS, the HCPCS code used under the OMFS RBRVS shall be used to determine the maximum allowable amount.

Necessity: This amendment is necessary to provide guidance regarding coding of hospital outpatient department Other Services paid according to the RBRVS. This amendment is necessary to avoid denial of payable hospital outpatient services that might result if the proposed amendment is not adopted.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amendment.

Section 9789.32(c)(1)(B)(iv) (formally (iii)):

Specific Purpose: This subdivision is amended to change the subdivision numbering from (iii) to (iv).

Necessity: This amendment is necessary to conform the subdivision numbering to the changes.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amendment.