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

FINAL STATEMENT OF REASONS AND UPDATED INFORMATIVE DIGEST

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

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

AN IMPORTANT PROCEDURAL NOTES ABOUT THIS RULEMAKING:

1. The Hospital Outpatient Departments and Ambulatory Surgical Centers (HOPD/ASC) 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.

2. The HOPD/ASC Fee Schedule component of the Official Medical Fee Schedule is established by the authority of Labor Code section 5307.1. Subsection (g) provides the Official Medical Fee Schedule – HOPD/ASC Fee Schedule shall be adjusted to conform to any relevant changes in the Medicare payment systems, and the Administrative Director shall determine the effective date of the changes, and shall issue an order, exempt from sections 5307.3 and 5307.4 and the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (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. All orders issued shall be published on the Internet Web site of the Division of Workers' Compensation.

This rulemaking proceeding to amend the HOPD/ASC Fee Schedule is being conducted under the Acting Administrative Director's rulemaking power pursuant to Labor Code sections 133, 4603.5, 5307.1 and 5307.3. This regulatory proceeding adheres to the procedural requirements of Labor Code sections 5307.1 and 5307.4. Despite the fact that amendments adjusting the fee schedule regulations to conform to relevant changes in the Medicare payment system for calendar years 2015 and 2016 are not subject to the rulemaking requirements of sections 5307.3 and 5307.4 and the rulemaking provisions of the Administrative Procedure Act referenced above, the Division has voluntarily chosen to follow the procedural requirements of Labor Code sections 5307.1 and 5307.4 for these changes. Including the annual updates in this rulemaking will lessen the administrative burden on stakeholders by having only one effective date for changes to the HOPD/ASC Fee Schedule regulations.

CONSIDERATION OF RELEVANT MATTER PRESENTED

After Notice of the Proposed Rulemaking published pursuant to Labor Code section 5307.4, a public hearing was held on June 17, 2015 where interested persons could participate through the submission of written data, views, and arguments, including oral presentations. A second 30-day comment period was noticed for July 6, 2016 and a 15-day comment period was noticed for September 23, 2016, which invited interested persons to participate through the submission of written comments. The Acting Administrative Director has subsequently considered all of the data, views, statements, and arguments presented or submitted.

The Acting Administrative Director of the Division of Workers' Compensation, pursuant to the authority vested in him, has amended the following sections of Division 1, Chapter 4.5, Subchapter 1, of title 8, California Code of Regulations, relating to the HOPD/ASC Fee Schedule component of the Official Medical Fee Schedule:

Section 9789.30 Definitions [Amend]
Section 9789.31 Adoption of Standards [Amend]
Section 9789.32 Applicability [Amend]
Section 9789.33 Determination of Maximum Reasonable Fee [Amend]
Section 9789.34 Table A [Add]
Section 9789.35 Table B [Add]
Section 9789.39 Update Table by Date of Service [Amend]

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[1] 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.

[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).

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; and 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 Code 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 to implement Senate Bill 863 as it relates to this fee schedule.

Effective September 1, 2014, the Administrative Director amended the HOPD/ASC fee schedule to: 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).

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.

This rulemaking action to amend the OMFS-HOPD/ASC fee schedule became necessary because Medicare changed its coding practices triggering confusion whether certain

"Other Services" are payable, and if so, the maximum payment amount, 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.

For example, effective January 1, 2014, CMS began to recognize new HCPCS code G0463 (hospital outpatient clinic visit for assessment and management of a patient) and discontinued recognizing 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.

A public hearing held on June 17, 2015 proposed to amend the HOPD/ASC fee schedule to clarify that the clinic visit should be paid in accordance with the HCPCS code used under the OMFS-RBRVS. However, after considering public comments, the Acting Administrative Director determined that not only was interweaving the two Medicare payment systems (HOPPS and RBRVS) into a consistent and coherent OMFS for hospital outpatient services complex from the outset; but it is unsustainable given recent and anticipated future Medicare changes to one or both of the Medicare payment systems. Therefore, in the second 30-day comment period noticed for July 6, 2016 and a 15-day comment period noticed for September 23, 2016, the Acting Administrative Director proposed to establish maximum payment for all services rendered to a hospital outpatient (and payable under the Medicare HOPPS) based on CMS' HOPPS.

Sections 9789.30 et seq. are amended to transition hospital outpatient department facility fee allowances currently paid under the OMFS-RBRVS physician fee schedule to be paid based on CMS' HOPPS facility rates in a manner that is budget neutral under the current rules applicable to services provided to hospital outpatients.[2]

UPDATE OF INITIAL STATEMENT OF REASONS AND INFORMATIVE DIGEST

The Acting Administrative Director incorporates the Initial Statement of Reasons prepared in this matter. The purposes and rationales for the regulations as set forth in the Initial Statement of Reasons continue to apply, unless otherwise noted in the Final Statement of Reasons.

The following sections of the proposed regulations were modified following the public hearing and were circulated for a second 30-day comment period (July 6, 2016) and a 15-day comment period (September 23, 2016). The regulation changes are summarized below.

[2] 117.8% multiplier for "Hospital Outpatient Department Services" that are surgical procedures, emergency room visits, or an integral part of the surgical procedure or emergency room visit and 101.01% multiplier for "Other Services."

THE FOLLOWING SECTIONS WERE AMENDED FOLLOWING THE PUBLIC HEARING AND WERE CIRCULATED FOR A SECOND 30-DAY (July 6, 2016) AND A 15-DAY COMMENT PERIOD (September 23, 2016)

Amendment to Section 9789.30 Definitions

Subdivision (d) is added to provide the definition of the "Ambulatory Surgical Center Payment System". "Ambulatory Surgical Center Payment System" means Medicare's payment system for specific ambulatory surgical center covered surgical procedures published in the Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems final rule for the relevant payment year.

Specific Purpose of Change: The term Ambulatory Surgical Center Payment System (ASC payment system) was defined because this rulemaking adopts and incorporates by reference column A of the ASC payment system addendum AA and column A of the ASC payment system addendum EE.

Subdivisions formerly (d) through (t) and (v) through (aa) are re-lettered to (e) through (q) and (s) through (ab), respectively.

Specific Purpose of Change: These former subdivisions are re-lettered to conform to the amendments.

Subdivision (r) is formerly subdivision (u).

Specific Purpose of Change: The subdivision which defines "Hospital Outpatient Prospective Payment System (HOPPS)" is re-lettered to place the term in alphabetical order within this section for greater clarity.

Subdivision (u) formally (s) is amended to clarify "Other Services" means Hospital Outpatient Department Services rendered on or after September 1, 2014, but before the date this amendment is filed with the Secretary of State, to hospital outpatients and payable under the CMS hospital outpatient prospective payment system 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. This subdivision is also amended to add that for services rendered on or after the date this amendment is filed with the Secretary of State, "Other Services" means "Hospital Outpatient Department Services rendered to hospital outpatients and payable under the CMS hospital outpatient prospective payment system that are not: 1. Surgical procedures; 2. Emergency room visits; or 3. An integral part of the surgical procedure or emergency room visit.

Specific Purpose of Change: This rulemaking changes the payment methodology so that maximum payment for all services rendered to a hospital outpatient (and payable under the Medicare HOPPS) would be based on the Medicare HOPPS. Under this rulemaking,

"Other Services" would now be paid based on the Medicare HOPPS using the same workers' compensation multiplier of 101.01 percent as Facility Only Services. Because of these amendments, Facility Only Services can now be included as an "Other Service."

Former Subdivision (u) is deleted and added as subdivision (r).

Specific Purpose of Change: This subdivision is re-lettered to place "Hospital Outpatient Prospective Payment System (HOPPS)" in alphabetical order within this section for greater clarity.

Subdivision (ab) formally (aa) is amended as follows: 1. For services rendered on or after the date this amendment is filed with the Secretary of State, a 101.01 percent multiplier is adopted for Hospital Outpatient Department Services that are Other Services; a 117.8 percent multiplier is adopted for Hospital Outpatient Department Services that are surgical procedures or emergency room visits; and the 80.81 percent for ASC surgical procedures remains unchanged. 2. The title for "Facility Only Services" column in the table is amended to clarify that the services are rendered to hospital outpatients, and that "(A) Medicare multiplier" is not applicable to this category of services.

Specific Purpose of Change: With this rulemaking, for services rendered on or after the date this amendment is filed with the Secretary of State, maximum allowances for "Other Services" are based on 100 percent of Medicare's Hospital Outpatient Prospective Payment system (HOPPS)[3] instead of 120 percent of the OMFS Physician fee schedule RBRVS relative values. Basing payment for all Hospital Outpatient Department Services on Medicare's HOPPS would reduce payment system complexities and regulatory burden. However, without a budget neutrality adjustment to the multiplier for Hospital Outpatient Department Services that are surgical procedures or emergency room visits, there would be an overall increase in maximum allowable fees for Hospital Outpatient Department Services. Therefore, based upon a RAND impact analysis, in order to remain budget neutral to current system payments, the multiplier for Hospital Outpatient Department Services that are surgical procedures or emergency room visits is adjusted to 117.8 percent for services rendered to on or after the date this amendment is filed with the Secretary of State.

Modifications to Section 9789.31 – Adoption of Standards

Subdivision (d) is amended to include the date range this subdivision (adoption and incorporation of the Medicare Physician Fee Schedule "Relative Value File") is applicable.

Specific Purpose of Change: With this rulemaking, for services rendered on or after the date this amendment is filed with the Secretary of State, maximum allowances for "Other Services" are based on 100 percent of Medicare's Hospital Outpatient Prospective

[3] The multipliers for services rendered on or after the date this amendment is filed with the Secretary of State includes an extra percentage reimbursement for high cost outlier cases.

Payment system (HOPPS) instead of 120 percent of the OMFS Physician fee schedule RBRVS relative values. This amendment clarifies the Medicare Physician Fee Schedule Relative Value File is only applicable for a particular range of dates of services rendered.

Subdivision (e) is added to adopt and incorporate by reference particular columns of certain addenda published in Medicare's Ambulatory Surgical Centers (ASC) Payment System published in the Federal Register for services rendered on or after the date this amendment is filed with the Secretary of State. In particular, only column A (titled "HCPCS code") of the July 2016 ASC Addendum AA and column A (titled "HCPCS code") of the July 2016 ASC Addendum EE are adopted and incorporated by reference. (See section 9789.39(b)) The remaining columns of ASC Addendum AA and Addendum EE are NOT adopted by the OMFS-HOPD/ASC fee schedule, and therefore, would not be applicable for determining payment to ASCs.

Specific Purpose of Change: The sole purpose for adopting and incorporating by reference HCPCS codes listed in column A of Medicare's ASC payment system addendum AA and column A of addendum EE are for inclusion in the definition of "Surgical Procedure HCPCS" set forth in §9789.39(b).

Subdivisions formerly known as (e) and (f) are re-lettered to (f) and (g), respectively.

Specific Purpose of Change: This formatting change reflects changes made as a result of the amendments.

Modification to Section 9789.32 Applicability

Subdivision (a) is amended to: 1. Clarify that for dates of service prior to the effective date of this amendment this fee schedule (sections 9789.30-9789.39) shall be applicable to services provided on an outpatient basis that are surgical and emergency room visits, and when applicable, Facility Only Services. 2. For services rendered on or after the date this amendment is filed with the Secretary of State this subdivision is amended to provide that maximum reasonable fees for all services provided on an outpatient basis and payable under the Medicare Hospital Outpatient Prospective Payment System shall be determined according to this fee schedule (sections 9789.30 through 9789.39). 3. Clarify that a supply, drug, device, blood product and biological is considered an integral part of an emergency room visit, or surgical procedure, or if applicable, Facility Only Service, or if applicable and only if rendered on or after the date this amendment is filed with the Secretary of State, Other service, are defined in subdivisions (a)(1) and (a)(2).

Specific Purpose of Change: It is necessary to include the range of dates of service and identify the types of services that would be subject to the HOPD/ASC fee schedule for determining the facility fees for hospital outpatient department and ASC services rendered to outpatients.

Subdivision (a)(1) is amended to revise the format of the subdivision. In particular, subdivision (a)(1) is now presented as a table as opposed to text narrative. In addition,

dates of service ranges are added; and for services rendered on or after the date this amendment is filed with the Secretary of State, status indicator code "Q4" is added to conform to changes Medicare made in its CY 2016 final rule[4].

Specific Purpose of Change: This change is made to improve the readability of this subdivision by presenting the information in a table format, and including the range of dates of service.

Subdivision (a)(2) is amended to revise the format of the subdivision. In particular, subdivision (a)(2) is now presented as a table as opposed to text narrative. In addition, dates of service ranges are added for certain services identified by status indicator code. Finally, the paragraph preceding subdivision 9789.32(b) is deleted because language is added to "new" subdivision (d).

Specific Purpose of Change: These changes are made to improve clarity, readability, and overall organization.

Subdivision (b) is amended to re-letter former subdivision (o) of section 9789.30 to now subdivision (p).

Specific Purpose of Change: This formatting change reflects changes made as a result of the amendments.

Subdivision (c) is amended to indicate that this subdivision is inapplicable for dates of service on or after the date this amendment is filed with the Secretary of State. Former subdivisions 9789.32(c)(1)(B)(iii), 9789.32(c)(2), 9789.32(c)(3), 9789.32(c)(4), 9789.32(c)(5), and 9789.32(c)(6) are removed from subdivision 9789.32(c) and are now part of a new subdivision (d). Reference to "ambulatory surgical centers" is deleted from the first paragraph in subdivision 9789.32(c) because the amended subdivision (c) is not applicable to ambulatory surgical centers.

Specific Purpose of Change: The re-organized subdivision (c) is inapplicable for dates of service on or after the date this amendment is filed with the Secretary of State because payment of facility fees for "Other Services" will now be determined based on the Medicare HOPPS instead of the OMFS Physician fee schedule RBRVS relative values. Subdivisions 9789.32(c)(1)(B)(iii), 9789.32(c)(2), 9789.32(c)(3), 9789.32(c)(4), 9789.32(c)(5), and 9789.32(c)(6), are re-organized as a new subdivision (d) which is applicable to hospital outpatient departments and ASCs for determining payment of services rendered to outpatients that are "other than facility fees."

Subdivision (c)(1)(B) is amended to indicate this subdivision is applicable to Other Services rendered on or after September 1, 2014, but before the date this amendment is filed with the Secretary of State.

[4] In accordance with Labor Code section 5307.1 subsection (g)

Specific Purpose of Change: It is necessary to clarify when this subdivision would be applicable.

Subdivision (c)(1)(B)(iii) as proposed in the first 30-day comment period (ending June 17, 2015) is deleted.

Specific Purpose of Change: For services rendered on or after the date this amendment is filed with the Secretary of State, the maximum reasonable fees for all services — including "Other Services"— provided on an outpatient basis and payable under the Medicare Hospital Outpatient Prospective Payment System (HOPPS) shall now be determined according to this fee schedule (sections 9789.30 through 9789.39). Therefore, proposed subdivision (c)(1)(B)(iii) is deleted as it does not reflect the adopted payment methodology.

Subdivision (d) – A new subdivision (d) is added and subdivision (iv) as proposed in the first 30-day comment period (ending June 17, 2015) is deleted. An introductory paragraph is added stating the following, "Hospital Outpatient Departments and ASCs should utilize other applicable parts of the OMFS to determine maximum allowable fees for services or goods not covered by the Hospital Outpatient Departments and Ambulatory Surgical Centers fee schedule (sections 9789.30 through 9789.39)."

Specific Purpose of Change: For other than facility fees, the introductory paragraph directs hospital outpatient departments and ASCs to other applicable parts of the OMFS to determine maximum allowable fees for services or goods.

The DWC received a comment for the comment period ending September 23, 2016, expressing concern that although the OMFS-HOPD/ASC, as in effect since 2004 and as presently amended, makes clear that exempt hospitals (§§9789.32(g) and (h)) shall not be subject to the rules and payment methodologies set forth in the OMFS-HOPD/ASC (e.g., sections 9789.30 through 9789.39, inclusive of the other fee schedules referenced therein), that section 9789.32(d), as amended, could be used to justify the application of the other fee schedules or payment methodologies described under section 9789.32(d)(1)-(6), as amended, to an exempt hospital's billing. Commenter is concerned it will be argued that because "service or goods" of the exempt hospitals are "not covered by the OMFS-HOPD/ASC fee schedule," that, subdivision (d) of section 9789.32, would therefore, apply to exempt hospitals. This potential argument is an incorrect application of the fee schedule regulations and unsupported when considered in context of the entire OMFS-HOPD/ASC fee schedule regulatory language.

It is clear the OMFS-HOPD/ASC fee schedule (sections 9789.30 through 9789.39) pertains to payment of maximum reasonable HOPD/ASC ***facility*** fees for services provided on an outpatient basis. Subdivisions 9789.32(g) and (h) specifically exempt certain hospitals (EXEMPT HOSPITALS) from being subject to the OMFS-HOPD/ASC fee schedule (sections 9789.30 through 9789.39) for purposes of determining maximum reasonable ***facility*** fees. Therefore, section 9789.32(d), is inapplicable to EXEMPT HOSPITALS for determining ***facility*** fees. When billing, however, for ***other than facility***

fees, EXEMPT HOSPITALS are subject to other fee schedules of the OMFS, unless otherwise provided. For example, the EXEMPT HOSPITAL is not subject to the OMFS-HOPD/ASC fee schedule, including section 9789.32(d), for determining payment of facility fees for services rendered in the EXEMPT HOSPITAL; nor should it be inferred from the amended language, or otherwise, that facility fees will be determined using the OMFS-RBRVS. However, if the EXEMPT HOSPITAL bills for professional physician services on behalf of a physician, the EXEMPT HOSPITAL should use the OMFS-RBRVS for determining reimbursement of the physician's professional services.

Subdivision (d)(1) formerly (c)(1)(B)(iii) is moved to new subdivision (d), and amended to state, "The fees for any physician and non-physician practitioner professional services shall be determined in accordance with the OMFS-RBRVS."

Specific Purpose of Change: This subdivision was re-numbered and moved for organizational clarity. The language is amended to be more consistent with other parts of this subdivision.

Subdivisions (d)(2) through (d)(6) formerly subdivisions (c)(2) through (c)(6) are moved to new subdivision (d).

Specific Purpose of Change: These subdivisions were re-numbered and moved for organizational clarity.

Subdivision (e) formally (d) is amended to re-letter the subdivision, to conform citation references as amended, and to clarify how this subdivision is applied by dates of service. The following language is added to conform to the adopted payment methodology where maximum reasonable fees for all services provided on an outpatient basis and payable under the Medicare Hospital Outpatient Prospective Payment System shall be determined according to this fee schedule (sections 9789.30 through 9789.39), for services rendered on or after the date this amendment is filed with the Secretary of State:
"For services rendered on or after XXX XX, 2016 [Date amendment is filed with the Secretary of State. Date to be inserted by OAL.], only hospitals as defined in section 9789.30(p) may charge or collect a facility fee for Hospital Outpatient Department Services rendered to a hospital outpatient and payable under the HOPPS. Ambulatory surgical centers as defined in section 9789.30(c) may charge or collect a facility fee for only surgical services or services that are an integral part of the surgical service provided on an outpatient basis and payable under the HOPPS. Facility fees are not payable to an ambulatory surgical center for any services that are not an integral part of a surgical service. Only ambulatory surgical centers may charge or collect a facility fee for its services."

Specific Purpose of Change: This subdivision was amended to conform citation references and to clarify how this subdivision is applied by dates of service. For services rendered on or after the date this amendment is filed with the Secretary of State, language was added to conform to the payment methodology where maximum reasonable fees for all services provided on an outpatient basis and payable under the Medicare HOPPS shall

be determined according to the OMFS-HOPD/ASD fee schedule (sections 9789.30 through 9789.39).

Subdivisions (f), (g), (h), and (i) formally (e), (f), (g), and (h) are re-lettered.

Specific Purpose of Change: These subdivisions were re-numbered for organizational clarity.

Modification to Section 9789.33 Determination of Maximum Reasonable Fee

Subdivision (a) is amended to conform to the change where the maximum reasonable fees for all services provided on an outpatient basis and payable under the Medicare Hospital Outpatient Prospective Payment System shall be determined according to this fee schedule (sections 9789.30 through 9789.39), for services rendered on or after the date this amendment is filed with the Secretary of State; and to conform citation references as amended. In particular:

- The first paragraph in subdivision (a) is amended to state the following, "In accordance with section 9789.32, the maximum allowable payment for hospital outpatient department or ambulatory surgical center facility fees for services provided on an outpatient basis and payable under that Medicare (CMS) HOPPS, shall be determined based on the following. In accordance with section 9789.30(ab), an extra percentage reimbursement shall be used in lieu of an additional payment for high cost outlier cases."
- 5th column heading for "Facility Only Services" is amended to clarify that the services are "Hospital Outpatient Department Services (as defined in section 9789.30(q)) that are Facility Only Services (as defined in section 9789.30(k))."
- A 6th column is added to address "Hospital Outpatient Department Services (as defined in section 9789.30(q)) that are Other Services (as defined in section 9789.30(u))."
- A new row is added for services rendered on or after the date this amendment is filed with the Secretary of State, to conform the fee schedule to relevant changes in the Medicare payment system for calendar years 2015 and 2016, in accordance with Labor Code section 5307.1 subsection (g), and to provide revised multipliers in accordance with section 9789.30(ab).
- Dates of service ranges are added for clarity, citations are updated, and "1" is added to the ASC multiplier "0.8081" and the Facility Only Services multiplier "1.0101" to be consistent with section 9789.30(ab).

Specific Purpose of Change: Subdivision (a) is amended to conform to the change where the maximum reasonable fees for all services provided on an outpatient basis and payable under the Medicare Hospital Outpatient Prospective Payment System shall be determined according to this fee schedule (sections 9789.30 through 9789.39), for services rendered on or after the date this amendment is filed with the Secretary of State, and make minor clarifications and adjustments.

Subdivision (a)(1) is amended to re-letter citation references to conform as amended.

Specific Purpose of Change: These subdivisions were re-lettered for organizational clarity.

Subdivision (a)(3) is amended to: 1. conform the fee schedule to relevant changes in the Medicare payment system for calendar years 2015 and 2016, in accordance with Labor Code section 5307.1 subsection (g), 2. add the range of dates of service when status indicator codes "J1" and "J2" are applicable, and 3. re-letter citation references to conform as amended. This subdivision is amended to state the following, "Procedure codes for drugs and biologicals with status code indicator "K" unless rendered on or after XXX XX, 2016 [Date amendment is filed with the Secretary of State. Date to be inserted by OAL.] and packaged into a procedure with a status indicator code J1 or J2, in which case no additional fee is allowable:
APC payment rate x workers' compensation multiplier pursuant to section 9789.30(ab), by date of service."

Specific Purpose of Change: This subdivision is amended to conform the fee schedule to relevant changes in the Medicare payment system for calendar years 2015 and 2016, in accordance with Labor Code section 5307.1 subsection (g), to add the range of dates of service when status indicator codes "J1" and "J2" are applicable, and to re-letter citation references to conform as amended.

Subdivision (a)(4) is amended to: 1.conform the fee schedule to relevant changes in the Medicare payment system for calendar years 2015 and 2016, in accordance with Labor Code section 5307.1 subsection (g), 2. add the range of dates of service when status indicator codes "J1" and "J2" are applicable, 3. re-letter citation references to conform as amended, 4. replace the term "APC payment" with "APC relative weight x adjusted conversion factor" which was incorrectly referenced in the payment formula, and 5. add a citation to section 9789.39(b) for APC relative weight by date of service.

This subdivision is amended to state the following, "For services rendered on or after March 1, 2009: Procedure codes for blood and blood products with status code indicator "R" unless rendered on or after XXX XX, 2016 [Date amendment is filed with the Secretary of State. Date to be inserted by OAL.] and packaged into a procedure with a status indicator code J1 or J2, in which case no additional fee is allowable:
APC relative weight x adjusted conversion factor x workers' compensation multiplier pursuant to section 9789.30(ab), by date of service. See section 9789.39(b) for APC relative weight by date of service."

Specific Purpose of Change: This subdivision is amended to conform the fee schedule to relevant changes in the Medicare payment system for calendar years 2015 and 2016, in accordance with Labor Code section 5307.1 subsection (g), to add the range of dates of service when status indicator codes "J1" and "J2" are applicable, to re-letter citation references to conform as amended, to replace the term "APC payment" with "APC relative weight x adjusted conversion factor" which was incorrectly referenced in the

payment formula, and to add a citation to section 9789.39(b) for APC relative weight by date of service.

Subdivision (a)(5) is amended to: 1. replace the term "APC payment" with "APC relative weight x adjusted conversion factor" which was incorrectly referenced in the payment formula, 2. re-letter citation references to conform as amended, and 3. add a citation to section 9789.39(b) for APC relative weight by date of service.

Specific Purpose of Change: This subdivision is amended to correct an error in the payment formula, to re-letter citation references to conform as amended, and to add a citation to section 9789.39(b) for APC relative weight by date of service.

Subdivision (b) is amended to re-letter citation references to conform as amended.

Specific Purpose of Change: This subdivision is re-lettered for organizational clarity.

Subdivision (b)(1)(E) is amended to replace the term "APC payment" or "APC payment rate" with "APC relative weight x adjusted conversion factor" which was incorrectly referenced in the payment formulas and to add a citation to section 9789.39(b) for APC relative weight by date of service.

Specific Purpose of Change: This subdivision is amended to correct an error in the payment formula.

Subdivision (b)(1)(F) is amended to replace the term "APC payment" or "APC payment rate" with "APC relative weight x adjusted conversion factor" which was incorrectly referenced in the payment formulas and to add a citation to section 9789.39(b) for APC relative weight by date of service.

Specific Purpose of Change: This subdivision is amended to correct an error in the payment formula.

Modifications to Section 9789.34 is amended to add Table A to conform to relevant changes in the Medicare Hospital Outpatient Payment System for calendar year 2016, in accordance with Labor Code section 5307.1 subsection (g).

Specific Purpose of Change: This table reflects the relevant changes in the Medicare HOPPS for calendar year 2016.

Modifications to Section 9789.35 is amended to add Table B to conform to relevant changes in the Medicare Hospital Outpatient Payment System for calendar year 2016, in accordance with Labor Code section 5307.1 subsection (g).

Specific Purpose of Change: This table reflects the relevant changes in the Medicare HOPPS for calendar year 2016.

Modification to Section 9789.39 – Update Table by Date of Service

Subdivision (a) is amended to conform the fee schedule to relevant changes in the Medicare payment system for calendar years 2015 and 2016, in accordance with Labor Code section 5307.1 subsection (g), by adopting and incorporating by reference amendments made to Title 42, Code of Federal Regulations.

Specific Purpose of Change: This subdivision is updated to reflect the relevant changes in the Medicare HOPPS for calendar years 2015 and 2016.

Subdivision (b) is amended to conform the fee schedule to relevant changes in the Medicare payment system for calendar year 2016, in accordance with Labor Code section 5307.1 subsection (g) for the following categories:

- Applicable Federal Register Notices
- APC Payment Rate
- APC Relative Weight
- Emergency Department HCPCS Codes
- HOPPS Addenda
- Inpatient hospital prospective payment (IPPS) tables
- Labor-related Share
- Market Basket Inflation Factor
- Conversion Factor adjusted for inflation factor
- Wage Index

This subdivision is also amended to conform citation references as amended, and to conform to the change where the maximum reasonable fees for all services provided on an outpatient basis and payable under the Medicare Hospital Outpatient Prospective Payment System shall be determined according to this fee schedule (sections 9789.30 through 9789.39), for services rendered on or after the date this amendment is filed with the Secretary of State. In particular:

- Column A (labeled “HCPCS code”) of CMS’ Ambulatory Surgical Centers Payment System (CMS’ ASC) Addendum AA and column A (labeled “HCPCS code”) of the CMS’ ASC Addendum EE are adopted and incorporated by reference.
- Facility Only Service codes will no longer be applicable for services rendered on or after the date this amendment is filed with the Secretary of State. These codes will now fall within the Other Services category as defined by section 9789.30(u).
- Medicare Physician Fee Schedule Relative Value File is not applicable for services rendered on or after the date this amendment is filed with the Secretary of State.
- Surgical Procedure HCPCS codes are defined as HCPCS codes listed in column A of CMS’ ASC Addendum AA, column A of CMS’ ASC Addendum EE, and CPT codes 21811 through 21813, but, excluding HCPCS codes listed on CMS’ HOPPS Addendum E as an inpatient only procedure. This amendment aligns the

list of surgical procedures with Medicare's list of surgical procedures that are payable under Medicare's (CMS') HOPPS.

Specific Purpose of Change: This subdivision is updated to conform citation references as amended, to reflect the relevant changes in the Medicare HOPPS for calendar years 2015 and 2016, to expand the list of surgical procedures to align with Medicare's list of surgical procedures that are payable under CMS' HOPPS, and to conform to the change where the maximum reasonable fees for all services provided on an outpatient basis and payable under the Medicare Hospital Outpatient Prospective Payment System shall be determined according to this fee schedule (sections 9789.30 through 9789.39), for services rendered on or after the date this amendment is filed with the Secretary of State.

UPDATE OF MATERIAL RELIED UPON

The following additional document beyond those identified in the Initial Statement of Reasons was relied upon by the Acting Administrative Director and added to rulemaking file after close of the initial 30-day comment period. The document is identified in the Notice of Modification to Text of Proposed Regulations and Notice of Addition of Documents to Rulemaking File for the second 30-day comment period. This additional document was available for 30 day public review and comment ending July 6, 2016.

1. Wynn, Barbara, *What would be an appropriate adjustment factor if all hospital outpatient services were paid under the OPPS?*, RAND, 2016.

LOCAL MANDATES DETERMINATION

- Local Mandate: None. The proposed regulations will not impose any new mandated programs or increased service levels 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 amendments do not apply to any local agency or school district.
- Other nondiscretionary costs/savings imposed upon local agencies: None.

CONSIDERATION OF ALTERNATIVES

The Division considered all comments submitted during the public comment period, and made modifications based on those comments to the regulations as initially proposed. The Acting Administrative Director has now determined that no alternatives proposed by the regulated public or otherwise considered by the Division of Workers' Compensation would be more effective in carrying out the purpose for which these regulations were proposed, nor would they be as effective as and less burdensome to affected private persons and businesses than the regulations that were amended.