

**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  
Discharge on or after January 1, 2004**

**TITLE 8, CALIFORNIA CODE OF REGULATIONS  
SECTIONS 9789.30, 9789.31, 9789.32, 9789.33, 9789.36, 9789.37, 9789.38 and  
9789.39**

**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 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**

In 2003, the Legislature enacted Senate Bill 228 (Alarcon, Chapter 639, Statutes of 2003; SB 228) as part of workers' compensation reform legislation intended to reduce unnecessary medical and litigation expenses, among other things, in workers' compensation cases in California.

As one of its provisions, the bill substantially amended Labor Code section 5307.1, which provided for the Administrative Director to adopt a medical fee schedule for workers' compensation claims which would establish maximum reasonable fees. Labor Code section 5307.1, as amended by SB 228, provides that, commencing January 1, 2004, all fees shall be paid in accordance with the fee-related structure and rules of the relevant

Medicare payment systems and that the maximum reasonable fees shall be 120 percent of the estimated aggregate fees prescribed in the Medicare payment system before the application of the inflation factor set forth in the statute. In particular, Labor Code section 5307.1 caps the maximum facility fee for services performed in an ambulatory surgical center or in a hospital outpatient department to not exceed 120 percent of the fee paid by Medicare for the same services performed in a hospital outpatient department.

On January 2, 2004, to comply with the requirements of Labor Code section 5307.1, through emergency rulemaking, the Administrative Director adopted a Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule section of the Official Medical Fee Schedule (OMFS) (set forth in California Code of Regulations, title 8, sections 9789.30-38) for fees in accordance with the Medicare payment system. A Certificate of Compliance was filed on April 30, 2004, and the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule regulations became effective on June 15, 2004.

Labor Code section 5307.1 further 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.

Sections 9789.30 through 9789.38 set forth the general information, definitions and payment schedule for the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule section of the OMFS. The proposed amendments to the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule section of the OMF Schedule regulations address sections 9792.30, 9792.31, 9789.32, 9789.33, 9789.36, 9789.37, and 9789.38, which are intended to revise the methodology for reimbursement of facility services for surgical procedures provided in the ambulatory surgical centers setting, and make minor revisions to conform to the proposed changes in reimbursement, and to update or clarify sections of the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule. The Administrative Director also proposes to adopt section 9789.39 which provides for the updates to the federal regulation and federal register references made in the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule updates by Order of the Administrative Director, in order to conform to changes in the Medicare payment system as required by Labor Code section 5307.1.

## **NECESSITY**

The Division has determined that amendments to the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule is necessary to more accurately reflect the costs of providing services in ambulatory surgical center settings so that neutral cost incentives will encourage surgical services will be provided in the least costly setting that

is medically appropriate. Labor Code section 5307.1 caps the aggregate allowances for ambulatory surgery facility fees at 120 percent of the fee paid by Medicare for the same services performed in a hospital outpatient department. The current OMFS allows the same fees for surgical services provided in hospital outpatient departments (HOPD) and ambulatory surgical center (ASC) settings.

Background of development of ASCs: According to a report by KNG, prepared for ASC Coalition<sup>1</sup>, the first ASCs were established in the early 1970s, with Medicare first recognizing this setting in 1982. Since that time, a significant share of surgeries shifted from inpatient settings to hospital outpatient setting. Likewise, there has been a steady shift of surgery away from hospital outpatient settings to ASCs and physician offices. KNG also found strong growth over the last several years in the number of Medicare-certified ASCs. The number of Medicare-certified ASCs grew at an average annual rate of 7.1 percent from 1997 to 2008. Since 2000, an average of 341 new Medicare-certified ASCs entered each year with a net gain of 273 ASCs after accounting for closures and mergers. In 2001, the ASC growth rate reached its highest point of 11.3% (since 2000). In 2008, the ASC growth rate was 3.6%, its lowest rate since 2000. The KNG study suggests three reasons for the recent slow growth rate: 1. The economic environment; 2. Transition to a new Medicare payment system where payments for high-volume services to Medicare patients (e.g. gastrointestinal services such as colonoscopies) are being reduced while payments are increasing for many low-volume services; and 3. More fundamentally, physician supply constraints may limit the growth rates in future years. The KNG report found the vast majority of ASCs are under private ownership, with approximately 91% of ASCs having at least 1 physician owner, and that ASCs are concentrated most heavily in California, Florida, and Texas (694, 387, and 347 facilities, respectively, in 2008).

A March 2010 MedPAC study<sup>2</sup> presented similar findings where it found that ASCs are a source of revenue for many physicians because physicians who perform procedures in ASCs receive ASC facility payments in addition to their separately paid professional fees. A study by Health Affairs similarly concluded that physician ownership of specialty facilities allows physicians to “collect fees for their own professional services and to share in any profit generated from the facility fee paid to the organization that operates the facility.”<sup>3</sup> The MedPAC study found that about 90% of ASCs were for profit and have a least one physician owner; and that ASCs are concentrated in five states – California, Florida, Maryland, Texas, and Georgia. MedPAC also found that there is significant evidence that ambulatory surgical centers treat different types of patients than hospital outpatient departments. ASCs are less likely to serve medically complex patients, Medicaid patients, African Americans, and Medicare beneficiaries who are older (85 years old or older) or eligible for Medicare because of disability (under 65 years old).

---

<sup>1</sup> Lane Koenig, Phd, Julia Doherty, MHSA, Jennifer Dreyfus, MBA, Judy Xanthopoulos, PhD., *An Analysis of Recent Growth of Ambulatory Surgical Centers – Final Report*, KNG Health Consulting, LLC., June 5, 2009

<sup>2</sup> *Medicare Payment Policy: Report to Congress*, MedPAC, March 2010

<sup>3</sup> Lawrence O. Casalino, Kelly J. Devers, and Linda R. Brewster, *Focused Factories? Physician-Owned Specialty Facilities*, Health Affairs, November/ December 2003

Official Medical Fee Schedule –

Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule  
Proposed Regulations

Initial Statement of Reasons (December, 2010)

A report<sup>4</sup> which studied physician-ownership of ambulatory surgery centers and the impact on the volume of surgeries found a significant association between physician-ownership of ambulatory surgical centers and greater use of five common outpatient procedures (carpal tunnel release, cataract excision, colonoscopy, knee arthroscopy, and myringotomy with tympanostomy tube replacement). Moreover, their study revealed that the acquisition of ownership status coincided with significant increases in a physician's use of carpal tunnel release, cataract excision, colonoscopy, and knee arthroscopy. The study recommended, as one possible remedy, that the government consider further reducing facility payments to "dilute" the incentives of ownership.

Adoption of the 2004 OMFS Hospital Outpatient Department and Ambulatory Surgical Center fee schedule - When the fee schedule for ambulatory surgery facility fees was first adopted in 2004, the same fees for surgical services performed in HOPDs and ASCs were adopted largely because Medicare's list of procedures that can be safely performed in an ASC, and therefore, eligible for an ASC facility fee, and the ASC facility fees, were outdated. With an exception of updating the coding changes, the list of approved ASC procedures was not modified from 1995 to 2003. A study by Gerald Kominski and Laura Gardner examined a sample of California workers' compensation program payment records involving facility fees, and were only able to crosswalk 65% of the records with approved ASC procedure codes.<sup>5</sup> A RAND report found that "it is clear that if the ASC fee schedule is utilized, a significant issue will be how procedures that are not on the approved list should be treated."<sup>6</sup>

The estimated cost used to establish the then Medicare ASC procedure groupings was based on a 1986 survey of costs and charges. A more recent survey was conducted in 1994 by Medicare, but, was not adopted to establish updated payment groupings and rates. Thus, prior to 2008, when Medicare implemented major changes in its ASC payment system, the cost information on which rates were based was very dated and may not have represented the then current procedures costs.<sup>7</sup>

Major changes to Medicare ASC payment system - Effective January 1, 2008, Medicare implemented major changes in its ASC payment system. Medicare now pays for most ASC facility services under a system that parallels the Hospital Outpatient Department prospective payment system, but at a lower rate (about 59 percent in 2009<sup>8</sup>). By comparison, the OMFS ASC payment rate is approximately 206 percent of the Medicare ASC payment rate. Since, the Medicare ASC payment system is now regularly updated

---

<sup>4</sup> John M. Hollingsworth, Zaojun Ye, Seth A. Strobe, Sarah L. Krein, Ann T. Hollenbeck, and Brent K. Hollenbeck, *Physician-Ownership of Ambulatory Surgery Centers Linked to Higher Volume of Surgeries*, Health Affairs, April 2010

<sup>5</sup> Kominski, Gerald, F., Gardner, Laura, G., *Inpatient Hospital Fee Schedule and Outpatient Surgery Study, Final Report*, prepared for Commission on Health and Safety and Workers' Compensation, December 2001

<sup>6</sup> Wynn, Barbara O., *Adopting Medicare Fee Schedules*, Prepared for the California Commission on Health and Safety and Workers' Compensation, the RAND Institute for Civil Justice, 2003

<sup>7</sup> Wynn, Barbara O., *Adopting Medicare Fee Schedules*, Prepared for the California Commission on Health and Safety and Workers' Compensation, the RAND Institute for Civil Justice, 2003

<sup>8</sup> Lane Koenig, Julia Doherty, Jennifer Dreyfus, and Judy Xanthopoulos, *An Analysis of Recent Growth of Ambulatory Surgical Centers, Final Report*, KNG Health Consulting, LLC, prepared for ASC Coalition, June 5, 2009

for both approved ASC procedures and payment rates, the OMFS policy rationale for adopting the hospital outpatient departments facility fee rates for procedures performed in ASC settings is no longer applicable.

Studies support the finding that ASC facility costs are less than when the same procedure is performed in HOPDs - The lower costs of performing ambulatory surgery in a freestanding surgical center as compared to performing the surgery in a hospital outpatient department is well documented and undisputed. The ASC industry recognizes and promotes the fact that they offer a low-cost alternative to hospital outpatient departments. A 2009 ASC Coalition press release (“Report Details Positive Contribution of ASCs to Health Care Reform Goals”) stated, “The use of ASCs has likely slowed growth in total Medicare spending for outpatient surgical services because they offer a low-cost alternative to hospital outpatient departments (HOPDs), a goal the ASC industry suggests is consistent with the Administration’s health reform priorities”.<sup>9</sup> In a June 16, 2009, press release, the Ambulatory Surgery Center Association stated “[t]o enable ASCs to continue playing a positive role in the migration of services into less expensive outpatient settings, the ASC Association is supporting H.R. 2049, the Ambulatory Surgical Center Access Act of 2009. The bill ensures that Medicare will always save more than 40% in ASCs when compared to HOPDs, [and] patients will be able to compare the price and quality of services ASCs and HOPDs provide.”<sup>10 11</sup>

A 2008 RAND study maintains that what may seem like “inefficiencies” in a hospital outpatient setting when compared to service delivery in ASCs, may actually be an unavoidable consequence of the joint production of inpatient and outpatient care to a broader mix of patients, types of services provided, charity care, and accreditation and regulation.<sup>12</sup> Other factors affecting the cost of providing care include infrastructure and medical equipment, and staffing requirements. For example, two studies (Health Affairs study and 2010 MedPAC Report to Congress) found that hospital outpatient departments treat patients who are more medically complex, so, ASCs are likely to incur lower costs than hospital outpatient departments when providing the same types of procedures.<sup>13</sup>

---

<sup>9</sup> According to ASC Coalition, the “ASC Coalition is a diverse coalition of associations and companies representing all types of ASCs – single- and multi-specialty, physician owned, joint ventures between hospitals and physicians, and joint ventures between physicians and management companies.”

<sup>10</sup> According the ASC Association, the “ASC Association is a national, nonprofit association that represents the interests of those who own, operate and seek the services of ASCs throughout the nation. The organization represents more than 2,500 ASCs, the professionals who provide care in such ASCs and the patients who seek care there.”

<sup>11</sup> H.R. 2049, in pertinent part states, “...the amount of payment to be made under this subsection for facility services furnished to an individual in an ambulatory surgical center in accordance with paragraph (1) shall be equal to 59 percent of the fee schedule amount determined under paragraph (3)(D) of subsection (t) for payment of the same service furnished in hospital outpatient departments...”

<sup>12</sup> Barbara Wynn, Lee Hilborne, Peter Hussey, Elizabeth Sloss, and Erin Murphy, *Medicare Payment Differentials Across Ambulatory Settings*, Prepared for the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, RAND, December 2008

<sup>13</sup> Winter, Ariel, *Comparing the Mix of Patients in Various Outpatient Surgery Settings*, Health Affairs, Vol. 22, No. 6, November/December 2003. Also see *Medicare Payment Policy: Report to Congress*, MedPAC, March 2010

Ideally, the OMFS allowances should provide incentives to provide surgical services in the least costly setting that is medically appropriate. Excessive allowances can create the negative incentive of providing surgical services in a more costly setting (e.g. procedures that can be safely performed in a physician office setting shifting to ASCs) or medically inappropriate setting (e.g. surgical services that should be performed in an inpatient setting being performed as ambulatory surgery). Inadequate allowances can also cause undesired consequences of delivering procedures that can be safely performed as ambulatory surgery as inpatient procedures. However, because procedure times are shorter in the ASC setting, surgeons are able to perform more procedures and generate higher revenues in ASCs and are unlikely to support a shift to hospital outpatient settings. The services, therefore, are only likely to shift if the ASC allowances are inadequate.

A 2003 RAND report<sup>14</sup> found that overall, California ASCs reported high patient margins in 2000 with an overall payment-to-cost ratio of 1.37, which implies patient care revenues were 37% higher than costs. In the 2003 report, RAND found that if the Medicare hospital outpatient department payment system is adopted for ASC facility services, ASCs would not need as high of a conversion factor (multiplier) as HOPDs for the following reasons: 1. MedPAC concluded that hospital outpatient departments probably have higher cost structures than ASCs because they must meet higher regulatory requirements, such as the Emergency Medical Treatment and Active Labor Act, and stricter Medicare certification and state licensure requirements (MedPAC, 2003); 2. MedPAC also found that hospitals were more likely than ASCs to perform procedures on Medicare patients at higher risk than the Medicare patients receiving the same procedures in ASCs; and 3. Hospitals offer a broader range of services than ASCs, so they do not have the efficiencies and productivity gains associated with specialization in certain services (e.g. orthopedic procedures), and they have higher uncompensated care costs. The RAND report advised that setting the conversion factor at an unnecessarily high level would provide incentives for unnecessary utilization.

A 2006 study performed by the United States Government Accountability Office<sup>15</sup> found that the payment groups in the hospital outpatient departments' payment system, known as ambulatory payment classification (APC) groups, accurately reflect the relative cost of procedures performed in ASCs. The median cost ratio among all ASC procedures was 0.39, whereas the median cost ratio for hospital outpatient department procedures was 1.04. Thus, the cost of procedures in ASCs is substantially lower than the corresponding cost in hospital outpatient departments. The GAO recommended Medicare implement a payment system for procedures in ASCs based on the OPDS, taking into account the lower relative costs of procedures performed in ASCs compared to hospital outpatient departments.

---

<sup>14</sup> Wynn, Barbara O., *Adopting Medicare Fee Schedules*, Prepared for the California Commission on Health and Safety and Workers' Compensation, the RAND Institute for Civil Justice, 2003

<sup>15</sup> Report to Congressional Committees, *Medicare: Payment for Ambulatory Surgical Centers Should Be Based on the Hospital Outpatient Payment System*, United States Government Accountability Office, GAO-07-86, November 2006

Official Medical Fee Schedule –

Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule  
Proposed Regulations

8 CCR §§ 9789.30-39

According to a 2008 RAND study that looked at Medicare payment differentials across ambulatory settings, using California ASC data, the overall payment differential between HOPDs and ASCs appears roughly comparable to the cost differentials.<sup>16</sup>

In a September 2009 RAND study<sup>17</sup> that examined ambulatory surgery facility fees provided to injured workers, over a two year period (2005-2007), the total maximum allowable facility fees for ambulatory surgery increased 16 percent despite an 8 percent decline in the number of encounters. In 2007, about 69 percent of ambulatory surgical procedures were performed in ASCs, and 31 percent were performed in hospital outpatient departments. In comparison, 59 percent of surgical procedures performed on the non-workers' compensation comparison group were done in hospital outpatient departments.

Basis for Administrative Director's policy decision to continue basing the ambulatory surgical center payment system on Medicare's hospital outpatient department payment system – Under the Medicare ASC payment system as revised in 2008, most ASC services are paid under a system that parallels the payment system for hospital outpatient department services but at a lower payment rate. Under the Medicare fee schedules for ASCs and hospital outpatient services, clinically coherent sets of procedures that require similar resources are grouped into an ambulatory payment classification (APC). Each APC has a relative weight that reflects the median cost for the procedure in a hospital outpatient setting relative to other procedures. The payment rate is determined as follows:

$$\text{Rate} = \text{APC relative weight} \times \text{conversion factor} \times \text{geographic adjustment factor}$$

The ASC payment system and hospital outpatient payment system payment rates, however, will diverge in the future because of the following: 1. The APC relative weights used for hospital outpatient and ASC payment will diverge in the future because the annual budget neutrality calculation used in recalibrating the relative weights will be performed separately for hospital outpatient departments and ASCs; and 2. The ratio between the hospital outpatient departments and ASC conversion factors will also change in the future because of the different conversion factor update methodologies. Medicare adjusts the ASC conversion factor for inflation based on the rate of increase in the Consumer Price Index-All Urban Consumers, which in 2010 is 1.2 percent. The hospital outpatient department conversion factor is updated by the hospital market basket, which in 2010 is 2.1 percent.

The March 2010 MedPAC report to Congress, however, found that the ASC cost data used in determining the inflation factors is five years old and do not contain information on several types of costs. MedPAC, therefore, recommended that new cost data is

---

<sup>16</sup> Barbara Wynn, Lee Hilborne, Peter Hussey, Elizabeth Sloss, and Erin Murphy, *Medicare Payment Differentials Across Ambulatory Settings*, Prepared for the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, RAND, December 2008

<sup>17</sup> Barbara O. Wynn and Beth Ann Griffin, *Ambulatory Surgery Facility Services Provided to California's Injured Workers*, Prepared for the Commission on Health, Safety and Workers' Compensation, RAND, September 2009

needed before a determination can be made as to whether the existing Consumer Price Index-All Urban Consumers is the appropriate proxy for ASC costs or whether a different ASC inflation factor should be used.<sup>18</sup>

Another difference between Medicare's hospital outpatient payment system and the ASC payment system is the geographic adjustment factor. Medicare uses the hospital wage index to adjust both the hospital outpatient and ASC payment rates for geographic differences in cost. Under the hospital outpatient payment system, the geographic adjustment factor is applied to 62 percent of the rate compared to 50 percent of the ASC rate. The actual difference in payment under the two systems will vary across locations based on the wage index values, but, because California has relatively high wage levels, the overall effect will be lower payments for ASCs as compared to hospital outpatient settings.

The Administrative Director has made the policy decision to adopt a lower multiplier but retain other aspects of the Medicare hospital outpatient department payment system methodology. This will allow payment for procedures performed in ASCs to parallel payment made for the same procedures performed in hospital outpatient settings. The Administrative Director believes the OMFS ASC APC relative weights should not be impacted by Medicare's budget neutrality adjustments, and further study needs to be conducted before adopting Medicare's use of the Consumer Price Index-All Urban Consumers to adjust the ASC conversion factor for inflation. Finally, the Administrative Director believes adopting a lower multiplier but retaining all other aspects of the current OMFS fee schedule will achieve the desired administrative efficiency as well.

Determining a reasonable multiplier for ASC payment rate – As stated earlier, ideally, the OMFS allowances should provide incentives to provide surgical services in the least costly setting that is medically appropriate. Excessive allowances can create the negative incentive of providing surgical services in a more costly setting (e.g. procedures that can be safely performed in a physician office setting shifting to ASCs) or medically inappropriate setting (e.g. surgical services that should be performed in an inpatient setting being performed as ambulatory surgery). Inadequate allowances can also cause undesired consequences of delivering procedures that can be safely performed as ambulatory surgery as inpatient procedures. However, because procedures times are shorter in the ASC setting, surgeons are able to perform more procedures and generate higher revenues in ASCs and are unlikely to support a shift to hospital outpatient settings. The services, therefore, is only likely to shift if the ASC allowances are inadequate.

The Administrative Director has discretion in setting the OMFS allowance level (as long as it does not exceed 120 percent of the Medicare hospital outpatient department fee schedule). The OMFS allows 120 percent of Medicare's hospital outpatient payment rate for procedures performed in ASC settings, which is approximately 206 percent of Medicare's ASC payment rate. The Administrative Director is proposing to lower the multiplier to 100 percent of Medicare's hospital outpatient payment rate, which is approximately 171 percent of Medicare's ASC payment rate.

---

<sup>18</sup> *Medicare Payment Policy: Report to Congress*, MedPAC, March 2010  
Official Medical Fee Schedule –  
Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule  
Proposed Regulations  
Initial Statement of Reasons (December, 2010)



The March 2010 MedPAC report<sup>19</sup> to Congress concluded that Medicare payment rates are adequate to provide Medicare beneficiaries with access to ASC care. MedPAC found continued growth in the number of Medicare-certified ASCs; a robust growth in the volume of services, number of beneficiaries receiving care in ASCs, and the number of services per beneficiary treated in ASCs. MedPAC noted the growth in ASCs indicates they have at least adequate access to capital, and the number of ASCs increased in 2008 and has continued to increase in 2009 despite a substantial downturn in credit markets.

The September 2009 RAND study found that for ASC procedures that merit consideration in treating workers' compensation patients, the revised Medicare ASC payment system pay at about 67 percent of the hospital outpatient department payment rate. In a 2008 study, RAND researchers also made preliminary findings that suggest California ASC costs are 66 to 71 percent of the estimated hospital outpatient department costs in 2008.<sup>20</sup>

A survey of various states' workers' compensation fee schedules for ambulatory surgical centers revealed a number of states that set their rate equal to Medicare's ASC rate plus a percent.

State	Percent of Medicare ASC
California	206 <sup>a</sup>
Hawaii	110
Maryland	125
Ohio	108 <sup>b</sup>
South Carolina	140
Tennessee	257 <sup>c</sup>
Texas	235
West Virginia	135

<sup>a</sup> California bases its payment rate on 120 percent of Medicare's hospital outpatient payment rate, which is approximately 206 percent of Medicare's ASC payment rate. The Administrative Director proposes lowering the multiplier to 100 percent of Medicare's hospital outpatient payment rate, which is approximately 171 percent of Medicare's ASC payment rate.

<sup>b</sup> Ohio's rate is 100 percent of the Medicare transitional rates. The Medicare payment rates during the transition period are a blend of the CY 2007 rate and the rate for the pertinent CY. CY 2008 payment will be a blend of 75% of the CY 2007 rate and 25% of the revised ASC rate. For CY 2009, the blend will be 50/50, and for CY 2010 the blend will be made up of 25% of the CY 2007 rate and 75% of the revised ASC rate. The revised ASC rates will be fully implemented in CY 2011.<sup>21</sup>

<sup>19</sup> *Medicare Payment Policy: Report to Congress*, MedPAC, March 2010

<sup>20</sup> Barbara Wynn, Lee Hilborne, Peter Hussey, Elizabeth Sloss, and Erin Murphy, *Medicare Payment Differentials Across Ambulatory Settings*, Prepared for the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, RAND, December 2008

<sup>21</sup> CMS CY 2008 Revised Ambulatory Surgical Center Payment System – Questions and Answers

<sup>c</sup> Tennessee's rate is 150 percent of Medicare unadjusted hospital outpatient payment rate which is approximate 257 percent of Medicare ASC payment rate. Tennessee does not allow for any adjustments to the national Medicare amount.

Therefore, of the eight states reviewed, with the proposed 100 percent of Medicare's hospital outpatient department payment system rate, California will have the third highest payment rate for ASC facility fees (approximately 171 percent of Medicare's ASC payment rate).

As discussed earlier, various organizations representing the interests of ambulatory surgical centers promote the fact that they offer a low-cost alternative to procedures being performed in hospital outpatient settings.

A 2009 ASC Coalition press release ("Report Details Positive Contribution of ASCs to Health Care Reform Goals") stated, "The use of ASCs has likely slowed growth in total Medicare spending for outpatient surgical services because they offer a low-cost alternative to hospital outpatient departments (HOPDs), a goal the ASC industry suggests is consistent with the Administration's health reform priorities".<sup>22</sup> In a June 16, 2009, press release, the Ambulatory Surgery Center Association stated "[t]o enable ASCs to continue playing a positive role in the migration of services into less expensive outpatient settings, the ASC Association is supporting H.R. 2049, the Ambulatory Surgical Center Access Act of 2009. The bill ensures that Medicare will always save more than 40% in ASCs when compared to HOPDs, [and] patients will be able to compare the price and quality of services ASCs and HOPDs provide."<sup>23 24</sup>

Based upon the above studies and comparison of other state workers' compensation fee schedules, the Administrative Director believes adopting 100 percent of Medicare hospital outpatient department payment system for procedures performed in ASC settings is adequate and reasonable and will provide neutral cost incentives so that surgical services will be provided in the least costly setting that is medically appropriate.

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

The Division relied upon the following technical, theoretical, or empirical studies, reports, decisions or similar documents in proposing the above-identified regulations:

---

<sup>22</sup> According to ASC Coalition, the "ASC Coalition is a diverse coalition of associations and companies representing all types of ASCs – single- and multi-specialty, physician owned, joint ventures between hospitals and physicians, and joint ventures between physicians and management companies."

<sup>23</sup> According the ASC Association, the "ASC Association is a national, nonprofit association that represents the interests of those who own, operate and seek the services of ASCs throughout the nation. The organization represents more than 2,500 ASCs, the professionals who provide care in such ASCs and the patients who seek care there."

<sup>24</sup> H.R. 2049, in pertinent part states, "...the amount of payment to be made under this subsection for facility services furnished to an individual in an ambulatory surgical center in accordance with paragraph (1) shall be equal to 59 percent of the fee schedule amount determined under paragraph (3)(D) of subsection (t) for payment of the same service furnished in hospital outpatient departments..."

- (1) Wynn, Barbara O., *Adopting Medicare Fee Schedules, Considerations for the California Workers' Compensation Program, Prepared for the California Commission on Health and Safety and Workers' Compensation*, the RAND Institute for Civil Justice and RAND Health, 2003.
- (2) Wynn, Barbara, Hilborne, Lee, Hussey, Peter, Sloss, Elizabeth, and Murphy, Erin, *Medicare Payment Differentials Across Ambulatory Settings*, the RAND Institute for Civil Justice and RAND Health, December 2008.
- (3) Wynn, Barbara O., and Griffin, Beth Ann, *Ambulatory Surgery Facility Services Provided to California's Injured Workers*, the RAND Institute for Civil Justice and RAND Health, September 2009.
- (4) Wynn, Barbara O., *Regulatory Actions that Could Reduce Unnecessary Medical Expenses Under California's Workers' Compensation Program, Prepared for the Commission on Health, Safety and Workers' Compensation*, the RAND Institute for Civil Justice and RAND Health, July 2009.
- (5) Vogt, William B., and Romley, John A., *California Ambulatory Surgery Centers: A Comparative Statistical and Regulatory Description*, the RAND Institute for Civil Justice and RAND Health, 2009.
- (6) *Medicare: Payment for Ambulatory Surgical Centers Should Be Based on the Hospital Outpatient Payment System*, United States Government Accountability Office, November 2006.
- (7) Koenig, Lane, PhD., Doherty, Julia, MHSA, Dreyfus, Jennifer, MBA, Xanthopoulos, Judy, PhD, *An Analysis of Recent Growth of Ambulatory Surgical Centers, Final Report*, KNG Health Consulting LLC, June 5, 2009.
- (8) *KNG Report Details Positive Contribution of ASCs to Health Care Reform Goals*, ASC Coalition.
- (9) *Ambulatory Surgery Centers "Pivotal" in Moving Outpatient Surgical Services into Less Expensive, Clinically Appropriate Settings*, ASC Association, June 16, 2009.
- (10) Kominski, Gerald and Gardner, Laura, *Inpatient Hospital Fee Schedule and Outpatient Surgery Study*, UCLA School of Public Health and Axiomedics Research, Inc., December 2001.
- (11) *Medicare Payment Policy: Report to Congress*, MedPAC, March 2010.
- (12) Coomer, Nicole, M., *Fee Schedules for Hospitals and Ambulatory Surgical Centers: A Guide for Policymakers*, WCRI, February 2010.
- (13) Coomer, Nicole, M., *National Inventory of Workers' Compensation Fee Schedules for Hospitals and Ambulatory Surgical Centers*, WCRI, February 2010.
- (14) *CMS CY 2008 Revised Ambulatory Surgical Center Payment System – Questions and Answers*, CMS.
- (15) Hollingsworth, John M., Ye, Zaojun, Strobe, Seth A., Krein, Sara L., Hollenbeck, Ann T., and Hollenbeck, Brent K., *Physician-Ownership of Ambulatory Surgery Centers Linked to Higher Volume of Surgeries*, Health Affairs, April 2010.
- (16) Winter, Ariel, *Comparing the Mix of Patients in Various Outpatient Surgery Settings*, Health Affairs, November/ December 2003.
- (17) Casalino, Lawrence P., Devers, Kelly J., and Brewster, Linda R., *Focused Factories? Physician-Owned Specialty Facilities*, Health Affairs, December 2003.
- (18) California Health and Safety Code, Division 2. Licensing Provisions, Chapter 1.3. Outpatient Settings

- (19) Institute for Medical Quality website: [www.imq.org/programs/ambulatory-care/accreditation/](http://www.imq.org/programs/ambulatory-care/accreditation/)
- (20) *Billing and Reimbursement Manual, Chapter Three*, Ohio Bureau of Workers' Compensation, <http://www.ohiobwc.com/provider/services/brmdefault.asp>
- (21) *Detail Reference Guide to Determining CMS Medicare + 35% for Offices of the Insurance Commissioner (OIC) Workers' Compensation Maximum Medical Reimbursement Fee Schedules*, Effective: July 1, 2010, West Virginia, <http://www.wvinsurance.gov/Default.aspx?tabid=372>
- (22) *Subtitle 09 WORKERS' COMPENSATION COMMISSION, 14.09.03 Guide of Medical and Surgical Fees, Authority: Labor and Employment Article, §§9-309, 9-663 and 9-731, Annotated Code of Maryland, Effective 3/24/08, Version 4/04/08*, Maryland, [http://www.wcc.state.md.us/MFG/Medical\\_Fee\\_Schedule.html](http://www.wcc.state.md.us/MFG/Medical_Fee_Schedule.html)
- (23) *Hospital and Ambulatory Surgery Center Payment Manual*, Effective October 1, 2006, South Carolina Workers' Compensation Commission, <http://www.wcc.sc.gov/medical/>
- (24) *Title 28. Insurance, Part 2. Texas Department of Insurance, Division of Workers' Compensation, Chapter 134. Benefits – Guidelines For Medical Services, Charges, and Payments, Subchapter E. Health Facility Fees (28 TAC §134.402)*, <http://www.tdi.state.tx.us/wc/fee/index.html>
- (25) *Tennessee's Workers' Compensation Medical Fee Schedule*, [http://www.tennessee.gov/labor-wfd/wc\\_medfeebook.pdf](http://www.tennessee.gov/labor-wfd/wc_medfeebook.pdf)

#### **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 regulations will not have a significant adverse impact on business. The proposed regulations will reduce the amount of excess facility services allowance for procedures performed in ASC settings, which will decrease the overall cost to the workers' compensation system.

The March 2010 MedPAC report<sup>25</sup> to Congress concluded that Medicare ASC payment rates are adequate to provide Medicare beneficiaries with access to ASC care. MedPAC found continued growth in the number of Medicare-certified ASCs; a robust growth in the volume of services, number of beneficiaries receiving care in ASCs, and the number of services per beneficiary treated in ASCs. MedPAC noted the growth in ASCs indicates they have at least adequate access to capital, and the number of ASCs increased in 2008 and has continued to increase in 2009 despite a substantial downturn in credit markets.

---

<sup>25</sup> *Medicare Payment Policy: Report to Congress*, MedPAC, March 2010

The September 2009 RAND study found that for ASC procedures that merit consideration in treating workers' compensation patients, the revised Medicare ASC payment system pay at about 67 percent of the hospital outpatient department payment rate. In a 2008 study, RAND researchers also made preliminary findings that suggest California ASC costs are 66 to 71 percent of the estimated hospital outpatient department costs in 2008.<sup>26</sup> The Administrative Director proposes setting the maximum allowance for procedures performed in ASCs at 100 percent of Medicare hospital outpatient department payment rates, which is greater than the average California ASC costs.

Workers' compensation insurers, self-insured employers and workers' compensation third party administrators, will benefit from administrative efficiency and, overall, the amount of excessive payment for facility services provided for surgical procedures performed in ASCs should be reduced, and lessen the incentive to shift surgical services to a more costly setting (e.g. procedures that can be safely performed in a physician office setting shifting to ASCs) or medically inappropriate setting (e.g. surgical services that should be performed in an inpatient setting being performed as ambulatory surgery).

Injured workers will benefit by receiving better treatment, because reducing the amount of excessive payment will reduce profit motive and encourage choices of treatment settings that are in the best interest of the injured worker.

## **Section 9789.30 – Definitions**

### Section 9789.30(a):

#### Specific Purpose:

The subdivision is amended to move references to the federal regulation and federal register made in the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule updates by Order of the Administrative Director, to section 9789.39.

This subdivision is also amended to revise the definition of "Adjusted Conversion Factor." Instead of setting forth a specific value for the formula to determine the adjusted conversion factor, the definition is set forth in terms, with reference made to where the values can be found, as follows:

"Adjusted Conversion Factor" is determined as follows: unadjusted conversion factor x (1-labor-related share + (labor-related share x wage index)). For each update, the unadjusted conversion factor for the preceding period is adjusted by the rate of change in the market basket inflation factor. The market basket inflation factor and labor-related share are specified in the Federal Register notices announcing revisions in the Medicare payment rates. See Section 9789.39(b) for the unadjusted conversion factor, market

---

<sup>26</sup> Barbara Wynn, Lee Hilborne, Peter Hussey, Elizabeth Sloss, and Erin Murphy, *Medicare Payment Differentials Across Ambulatory Settings*, Prepared for the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, RAND, December 2008

Official Medical Fee Schedule –

Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule

Proposed Regulations

Initial Statement of Reasons (December, 2010)

basket inflation factor, and labor-related share by date of service.” The year by year update references are deleted.

Subdivision (a) is also amended to state that for services rendered on or after February 15, 2006, the Federal Register adjusting the conversion factor for a rural Sole Community Hospital is “incorporated by reference and will be made available upon request to the Administrative Director.”

Necessity: This amendment is necessary to improve the understanding of the terms used in the formula, to incorporate by reference the relevant Federal Register adjusting the conversion factor for a rural Sole Community Hospital, for clarity, and change the format to make the Hospital Outpatient Department and Ambulatory Surgical Centers Fee Schedule regulations more readable and understandable.

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 above proposed amendments.

Section 9789.30(c):

Specific Purpose: This subdivision which defines “Ambulatory Surgical Center (ASC)” is amended to modify a surgical clinic as one that is certified “to use anesthesia, except local anesthesia or peripheral nerve blocks, or both, in compliance with the community standard of practice, in doses that, when administered have the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes.”

Necessity: Amendment of section 9789.30(c) is necessary to clarify when a stand-alone “ambulatory surgical center” facility would qualify for a facility fee under the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule. If this subdivision is not clarified, it is possible that when certain procedures are performed in a physician office setting, it would inappropriately qualify for a facility fee under this fee schedule, resulting in possible duplicate payment under the OMFS physician fee schedule and this fee schedule. The amended language is derived from California Health and Safety Code section 1248, which defines an “outpatient setting”.

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 amended subdivision.

Section 9789.30(e):

Specific Purpose: This subdivision which defines the “APC Payment Rate,” is amended to move references to the federal regulation and federal register made in the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule updates by Order

of the Administrative Director, to section 9789.39. The year by year update references are deleted.

**Necessity:** This amendment is necessary for clarity and the format change is necessary to make the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule regulations more readable and understandable.

**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 amended subdivision.

Section 9789.30(f):

**Specific Purpose:** This subdivision which defines the “APC Relative Weight,” is amended to move references to the federal regulation and federal register made in the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule updates by Order of the Administrative Director, to section 9789.39. The year by year update references are deleted.

**Necessity:** This amendment is necessary for clarity and the format change is necessary to make the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule regulations more readable and understandable.

**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 amended subdivision.

Section 9789.30(p):

**Specific Purpose:** The purpose of section 9789.30(p) is to add a definition for “Labor-related Share” as “the portion of the payment rate that is attributable to labor and labor-related cost determined by CMS, pursuant to Section 1833(t)(2)(D) of the Social Security Act and as specified in the Federal Register notices announcing revisions in the Medicare payment rates. See Section 9789.39(b) for the Federal Register reference that references the labor-related share by date of service.

**Necessity:** This definition is added for clarity, as it was inadvertently omitted from the current regulation.

**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 added subdivision.

Section 9789.30(q):

Specific Purpose: This subdivision which defines “Market Basket Inflation Factor” is amended to remove the specific reference to the 3.4% market basket increase in the August 1, 2003 Federal Register and instead moves references to the federal regulation and federal register made in the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule updates by Order of the Administrative Director, to section 9789.39. The year by year update references are deleted.

Necessity: This amendment is necessary for clarity and the format change is necessary to make the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule regulations more readable and understandable.

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 amended subdivision.

Section 9789.30(r):

Specific Purpose: The purpose of section 9789.30(r) is to add a definition for “Outlier Threshold” to mean “the Medicare outlier threshold used in determining high cost outlier payments.”

Necessity: This definition is added for clarity, as it was inadvertently omitted from the current regulation.

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 added subdivision.

Section 9789.30(s):

Specific Purpose: This subdivision which defines “Outpatient Prospective Payment System (OPPS)” was formerly subdivision (q) and is re-lettered as (s).

Necessity: This amendment is necessary to conform the lettering 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 amended subdivision.

Section 9789.30(t):

Specific Purpose: The purpose of section 9789.30(t) is add the definition for “Price adjustment” to mean “any and all price reductions, offsets, discounts, rebates, adjustments, and or refunds which accrue to or are factored into the final net cost to the hospital outpatient department or ambulatory surgical center.”



Necessity: This subdivision is added for clarity, as the adjustments to the price encompass more than just discounts and rebates. The term also includes price reductions, offsets, adjustments, and refunds.

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 added subdivision.

Section 9789.30(u):

Specific Purpose: This subdivision which defines “Total Gross Charges” was formerly subdivision (r) and is re-lettered as (u).

Necessity: This amendment is necessary to conform the lettering 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 amended subdivision.

Section 9789.30(v):

Specific Purpose: This subdivision which defines “Total Operating Costs” was formerly subdivision (s), and is re-lettered as (v).

Necessity: This amendment is necessary to conform the lettering 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 amended subdivision.

Section 9789.30(w):

Specific Purpose: This subdivision which defines “Wage Index” is amended to remove the specific reference to the CMS’ 2004 Hospital Outpatient Prospective Payment System and instead moves references to the federal regulation and federal register made in the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule updates by Order of the Administrative Director, to section 9789.39. The year by year update references are deleted.

Necessity: This amendment is necessary for clarity and the format change is necessary to make the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule regulations more readable and understandable.

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 amended subdivision.

Section 9789.30(x):

**Specific Purpose:** This subdivision which defines “Workers’ Compensation Multiplier” is amended to clarify that the 120% Medicare multiplier required by Labor Code Section 5307.1, or the 122% multiplier that includes an extra 2% reimbursement for high cost outlier cases applies to services rendered before March 1, 2011 in both hospital outpatient departments and ambulatory surgical centers. After March 1, 2011, the rate for hospital outpatient departments will be the same. For services rendered in ambulatory surgical centers on or after March 1, 2011, the workers’ compensation multiplier will be 100% Medicare multiplier, or the 102% multiplier that includes an extra 2% reimbursement for high cost outlier cases.

**Necessity:** As stated earlier, ideally, the OMFS allowances should provide incentives to provide surgical services in the least costly setting that is medically appropriate. Excessive facility service allowances can create the negative incentive of providing surgical services in a more costly setting (e.g. procedures that can be safely performed in a physician office setting shifting to ASCs) or medically inappropriate setting (e.g. surgical services that should be performed in an inpatient setting being performed as ambulatory surgery). Inadequate allowances can also cause undesired consequences of delivering procedures that can be safely performed as ambulatory surgery as inpatient procedures. However, because procedures times are shorter in the ASC setting, surgeons are able to perform more procedures and generate higher revenues in ASCs and are unlikely to support a shift to hospital outpatient settings. The services, therefore, is only likely to shift if the ASC allowances are inadequate.

The Administrative Director has discretion in setting the OMFS allowance level (as long as it does not exceed 120 percent of the Medicare hospital outpatient department fee schedule). The OMFS allows 120 percent of Medicare’s hospital outpatient payment rate for procedures performed in ASC settings, which is approximately 206 percent of Medicare’s ASC payment rate. The Administrative Director is proposing to lower the multiplier to 100 percent of Medicare’s hospital outpatient payment rate, which is approximately 171 percent of Medicare’s ASC payment rate.

The March 2010 MedPAC report<sup>27</sup> to Congress concluded that Medicare payment rates are adequate to provide Medicare beneficiaries with access to ASC care. MedPAC found continued growth in the number of Medicare-certified ASCs; a robust growth in the volume of services, number of beneficiaries receiving care in ASCs, and the number of services per beneficiary treated in ASCs. MedPAC noted the growth in ASCs indicates they have at least adequate access to capital, and the number of ASCs increased in 2008 and has continued to increase in 2009 despite a substantial downturn in credit markets.

The September 2009 RAND study found that for ASC procedures that merit consideration in treating workers’ compensation patients, the revised Medicare ASC payment system pay at about 67 percent of the hospital outpatient department payment

---

<sup>27</sup> *Medicare Payment Policy: Report to Congress*, MedPAC, March 2010  
Official Medical Fee Schedule –  
Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule  
Proposed Regulations  
Initial Statement of Reasons (December, 2010)

rate. In a 2008 study, RAND researchers also made preliminary findings that suggest California ASC costs are 66 to 71 percent of the estimated hospital outpatient department costs in 2008.<sup>28</sup>

A survey of various states' workers' compensation fee schedules for ambulatory surgical centers revealed a number of states that set their rate equal to Medicare's ASC rate plus a percent.

State	Percent of Medicare ASC
California	206 <sup>a</sup>
Hawaii	110
Maryland	125
Ohio	108 <sup>b</sup>
South Carolina	140
Tennessee	257 <sup>c</sup>
Texas	235
West Virginia	135

<sup>a</sup> California bases its payment rate on 120 percent of Medicare's hospital outpatient payment rate, which is approximately 206 percent of Medicare's ASC payment rate. The Administrative Director proposes lowering the multiplier to 100 percent of Medicare's hospital outpatient payment rate, which is approximately 171 percent of Medicare's ASC payment rate.

<sup>b</sup> Ohio's rate is 100 percent of the Medicare transitional rates. The Medicare payment rates during the transition period are a blend of the CY 2007 rate and the rate for the pertinent CY. CY 2008 payment will be a blend of 75% of the CY 2007 rate and 25% of the revised ASC rate. For CY 2009, the blend will be 50/50, and for CY 2010 the blend will be made up of 25% of the CY 2007 rate and 75% of the revised ASC rate. The revised ASC rates will be fully implemented in CY 2011.<sup>29</sup>

<sup>c</sup> Tennessee's rate is 150 percent of Medicare unadjusted hospital outpatient payment rate which is approximate 257 percent of Medicare ASC payment rate. Tennessee does not allow for any adjustments to the national Medicare amount.

Therefore, of the eight states reviewed, with the proposed 100 percent of Medicare's hospital outpatient department payment system rate, California will have the third highest payment rate for ASC facility fees (approximately 171 percent of Medicare's ASC payment rate).

As discussed earlier, various organizations representing the interests of ambulatory surgical centers promote the fact that they offer a low-cost alternative to procedures being performed in hospital outpatient settings.

<sup>28</sup> Barbara Wynn, Lee Hilborne, Peter Hussey, Elizabeth Sloss, and Erin Murphy, *Medicare Payment Differentials Across Ambulatory Settings*, Prepared for the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, RAND, December 2008

<sup>29</sup> CMS CY 2008 Revised Ambulatory Surgical Center Payment System – Questions and Answers

Official Medical Fee Schedule –

Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule

Proposed Regulations

Initial Statement of Reasons (December, 2010)

A 2009 ASC Coalition press release (“Report Details Positive Contribution of ASCs to Health Care Reform Goals”) stated, “The use of ASCs has likely slowed growth in total Medicare spending for outpatient surgical services because they offer a low-cost alternative to hospital outpatient departments (HOPDs), a goal the ASC industry suggests is consistent with the Administration’s health reform priorities”.<sup>30</sup> In a June 16, 2009, press release, the Ambulatory Surgery Center Association stated “[t]o enable ASCs to continue playing a positive role in the migration of services into less expensive outpatient settings, the ASC Association is supporting H.R. 2049, the Ambulatory Surgical Center Access Act of 2009. The bill ensures that Medicare will always save more than 40% in ASCs when compared to HOPDs, [and] patients will be able to compare the price and quality of services ASCs and HOPDs provide.”<sup>31 32</sup>

Based upon the above studies and comparisons of other state workers’ compensation fee schedules, the Administrative Director believes adopting 100 percent of Medicare hospital outpatient department payment system for procedures performed in ASC settings is adequate and reasonable and will provide neutral cost incentives so that surgical services will be provided in the least costly setting that is medically appropriate.

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 amended subdivision.

### **SECTION 9789.31- Adoption of Standards**

#### Section 9789.31(a):

Specific Purpose: This subdivision which incorporates by reference certain addenda published in the Federal Register notices is amended to move references to the federal regulation and federal register made in the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule updates by Order of the Administrative Director, to section 9789.39. The year by year update references are deleted.

Necessity: This amendment is necessary for clarity and the format change is necessary to make the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule regulations more readable and understandable.

---

<sup>30</sup> According to ASC Coalition, the “ASC Coalition is a diverse coalition of associations and companies representing all types of ASCs – single- and multi-specialty, physician owned, joint ventures between hospitals and physicians, and joint ventures between physicians and management companies.”

<sup>31</sup> According the ASC Association, the “ASC Association is a national, nonprofit association that represents the interests of those who own, operate and seek the services of ASCs throughout the nation. The organization represents more than 2,500 ASCs, the professionals who provide care in such ASCs and the patients who seek care there.”

<sup>32</sup> H.R. 2049, in pertinent part states, “...the amount of payment to be made under this subsection for facility services furnished to an individual in an ambulatory surgical center in accordance with paragraph (1) shall be equal to 59 percent of the fee schedule amount determined under paragraph (3)(D) of subsection (t) for payment of the same service furnished in hospital outpatient departments...”

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 amended subdivision.

Section 9789.31(b):

Specific Purpose: This subdivision which incorporates by reference certain tables published in the Federal Register notices is amended to move references to the federal regulation and federal register made in the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule updates by Order of the Administrative Director, to section 9789.39. The year by year update references are deleted.

Necessity: This amendment is necessary for clarity and the format change is necessary to make the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule regulations more readable and understandable.

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 amended subdivision.

Section 9789.31(c):

Specific Purpose: This subdivision which incorporates by reference CMS Hospital Inpatient Prospective Payment “Payment Impact File” is amended to move references to the federal regulation and federal register made in the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule updates by Order of the Administrative Director, to section 9789.39. The year by year update references are deleted.

Necessity: This amendment is necessary for clarity and the format change is necessary to make the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule regulations more readable and understandable.

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 amended subdivision.

Section 9789.31(d):

Specific Purpose: This subdivision which incorporates by reference the American Medical Associations’ Physician “Current Procedural Terminology” is amended to incorporate by reference the American Medical Associations' "Current Procedural Terminology," 4th Edition, annual revision in effect for the year that includes the date of service. The revised subdivision also provides the mailing address, the internet address and the phone number where copies may be purchased. The year by year update references are deleted.

Necessity: This amendment is necessary for clarity and the format change is necessary to make the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule regulations more readable and understandable.

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 amended subdivision.

Section 9789.31(e):

Specific Purpose: This subdivision which incorporates by reference CMS' 2004 Alphanumeric "Healthcare Common Procedure Coding System (HCPCS)" is amended to incorporate by reference CMS' 2004 Alphanumeric "Healthcare Common Procedure Coding System (HCPCS)," annual revision in effect for the year that includes the date of service. The revised subdivision also provides the mailing address, the internet address, and the phone number where copies may be purchased. The year by year update references are deleted.

Necessity: This amendment is necessary for clarity and the format change is necessary to make the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule regulations more readable and understandable.

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 amended subdivision.

**SECTION 9789.32 Applicability**

Section 9789.32(a):

Specific Purpose: The purpose of section 9789.32(a) is to identify the sections of Title 8, California Code of Regulations, which constitute the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule, and to identify the procedures that qualify for facility service payment under this fee schedule. Currently, sections 9789.30 through 9789.38 apply to the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule. The amendment to section 9789.32(a) will add section 9789.39 to the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule and will increase the list of CPT codes which define the surgical procedures eligible to receive facility fees when performed in an ambulatory surgical setting. The CPT codes 10040-69990 are increased to include 10021 through 69990.

This subdivision is also amended to move updates to the federal regulation and federal register references made in the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule updates by Order of the Administrative Director, to section 9789.39, in order to conform to changes in the Medicare payment system as required by Labor Code section 5307.1.

Necessity: Amendment of subdivision 9789.32(a) is necessary so that the new section 9789.39 will be included in the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule. It is also necessary to correct the list of CPT codes, which define surgical procedures eligible for a facility allowance when performed in an ambulatory surgical setting, and make the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule regulations more readable and understandable.

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 amended subdivision.

Section 9789.32(b):

Specific Purpose: This subdivision which identifies those facilities that are eligible for a facility payment under the Hospital Outpatient Departments and Ambulatory Surgical Centers fee schedule is revised to state: “Sections 9789.30 through 9789.39 apply to any hospital outpatient department as defined in Section 9789.30(n) and any ASC as defined in Section 9789.30(c). The references to other outpatient departments and clinics are deleted.

Necessity: Amendment to subdivision (b) is necessary to conform to changes made to this fee schedule and to reference the definition of an ASC which is now defined in section 9789.30(c).

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 amended subdivision.

Section 9789.32(e):

Specific Purpose: The purpose of section 9789.32(e) is to identify in-patient only procedures that are not eligible for reimbursement under the Hospital Outpatient Departments and Ambulatory Surgical Centers fee schedule except when pre-authorized payable at a pre-negotiated fee arrangement. Subdivision (e) has a syntax change, adding the words “referenced in,” and changes the reference to Section 9789.31(a)(5) to Section 9789.31(a).

Necessity: Amendment to section 9789.32(e) is necessary to conform to changes made in this fee schedule and to make the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule regulations more readable and understandable.

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 amended subdivision.

## **SECTION 9789.33 Determination of Maximum Reasonable Fee**

### Section 9789.33(a):

**Specific Purpose:** This subdivision which sets forth how the maximum allowable payment is determined for hospital outpatient facility fees for hospital emergency room services or for surgical services performed at a hospital outpatient department or an ambulatory surgical center is revised to state “In accordance with Section 9789.30(x), an extra 2% reimbursement,” instead of “The 1.22 factor.”

**Necessity:** Amendment to section 9789.33(a) is necessary to conform to changes made in this fee schedule.

**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 amended subdivision.

### Section 9789.33(a)(1):

**Specific Purpose:** This subdivision which sets forth how the maximum allowable payment is determined for hospital outpatient facility fees for hospital emergency room services or for surgical services performed at a hospital outpatient department or an ambulatory surgical center is amended to increase the CPT codes 10040-69990, which define surgical procedures, to include 10021 through 69990 in three places.

Subdivision (a)(1) is also amended to revise the method of determining the maximum allowable payment for outpatient facility fees for hospital emergency room services or for surgical services performed at a hospital outpatient department or at an ambulatory surgical center. The term “Adjusted Conversion Factor” is substituted into the formula, and instead of setting forth a specific value for the formula to determine the payment, the methodology is set forth in terms, with reference made to where the values can be found, as follows:

“APC relative weight x adjusted conversion factor x applicable workers’ compensation multiplier. See Section 9789.39(b) for the APC relative weight by date of service. See Section 9789.30(x) for the applicable workers’ compensation multiplier by date of service”.

The year by year update references are deleted.

**Necessity:** This amendment is necessary to improve the understanding of the terms used in the formula, to conform to the changes made in this fee schedule, and change the format to make The Hospital Outpatient Department and Ambulatory Surgical Centers Fee Schedule regulations more readable and understandable.



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 amended subdivision.

Section 9789.33(a)(1)(A):

Specific Purpose: This subdivision which sets forth the method of determining the maximum payment rate for ASCs and non-listed hospitals is amended to revise the method of determining the maximum payment rate for ASCs and non-listed hospitals. Instead of setting forth a specific value for the formula to determine the payment, the methodology is set forth in terms, with reference made to where the values can be found, as follows:

“APC relative weight x adjusted conversion factor x applicable workers’ compensation multiplier pursuant to Section 9789.30(x)”

Necessity: This amendment is necessary to improve the understanding of the terms used in the formula, to conform to the changes made in this fee schedule, and change the format to make the Hospital Outpatient Department and Ambulatory Surgical Centers Fee Schedule regulations more readable and understandable.

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 amended subdivision.

Section 9789.33(a)(1)(B):

Specific Purpose: This subdivision which sets forth the method of determining the maximum payment rate for listed hospital outpatient departments is amended to include the following language: “For services rendered on or after February 15, 2006, table B in Section 9789.35 contains an “adjusted conversion factor” which incorporates the standard conversion factor, wage index, rural SCH adjustment factor, and inflation factor, as described in CMS’ 2006 Hospital Outpatient Prospective Payment System final rule of November 10, 2005, published in the Federal Register (CMS-1501-FC, 70 FR 68516), at page 68556.”

Additionally, the words “outpatient departments” are added after the phrase “The maximum payment rate for the listed hospitals” as clarification. The number “1.22” in the formula to determine the payment rate for the listed hospitals outpatient departments is replaced with the phrase “applicable workers’ compensation multiplier pursuant to Section 9789.30(x).”

Necessity: The reference to the “Adjusted Conversion Factor” as described in CMS’ 2006 Hospital Outpatient Prospective Payment System final rule is added to establish the initial adjusted conversion factor used for the OMFS Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule. Labor Code section 5307.1(g)(1)(A)(i) provides that the annual inflation adjustment for outpatient hospital facility fees shall be

determined solely by the estimated increase in the hospital market basket. Thus, in lieu of using the Medicare rates in effect for the year that includes the date of service to determine the updated conversion factor, the estimated increase in the hospital market basket was applied to the prior year's conversion factor.

This amendment is also necessary to improve the understanding of the terms used in the formula, to conform to the changes made in this fee schedule, and change the format to make the Hospital Outpatient Department and Ambulatory Surgical Centers Fee Schedule regulations more readable and understandable.

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 amended subdivision.

Section 9789.33(a)(2):

Specific Purpose: This subdivision which sets forth the method of determining the maximum payment rate for the eligible emergency room and surgical code procedures and for supplies, drugs, devices, blood products and biological that are an integral part of an emergency room visit or surgical procedure is amended to replace the number "1.22" in the formula for procedure codes for drugs and biologicals with status code indicator "G" with the phrase "applicable workers' compensation multiplier pursuant to Section 9789.30(x)."

Necessity: This amendment is also necessary to conform to the changes made in this fee schedule.

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 amended subdivision.

Section 9789.33(a)(3):

Specific Purpose: Section 9789.33(a)(3) sets forth the method of determining the maximum payment rate for the eligible emergency room and surgical code procedures and for supplies, drugs, devices, blood products and biological that are an integral part of an emergency room visit or surgical procedure. The formula for procedure codes for devices with status code indicator "H" is revised to clarify how devices with status code indicator "H" will be paid: "Documented paid cost, plus an additional 10% of the hospital outpatient department's or ASC's documented paid cost, net of immediate and anticipated price adjustments based upon the hospital outpatient department's or ASC's prior calendar year's usage for comparable devices, not to exceed a maximum of \$ 250.00, plus any sales tax and/or shipping and handling charges actually paid."

Necessity: This amendment is necessary to clarify and to improve the understanding of how devices with status code indicator "H" will be paid.

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 amended subdivision.

Section 9789.33(a)(4):

Specific Purpose: Section 9789.33(a)(4) sets forth the method of determining the maximum payment rate for the eligible emergency room and surgical code procedures and for supplies, drugs, devices, blood products and biological that are an integral part of an emergency room visit or surgical procedure. Subdivision (a)(4) is amended to replace the number “1.22” in the formula for procedure codes for drugs and biologicals with status code indicator "K" with the phrase “applicable workers’ compensation multiplier pursuant to Section 9789.30(x).”

Necessity: This amendment is also necessary to conform to the changes made in this fee schedule.

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 amended subdivision.

Section 9789.33(a)(5):

Specific Purpose: Section 9789.33(a)(5) sets forth the method of determining the maximum payment rate for the eligible emergency room and surgical code procedures and for supplies, drugs, devices, blood products and biological that are an integral part of an emergency room visit or surgical procedure. Subdivision (a)(5) is amended to replace the number “1.22” in the formula for procedure codes for blood and blood products with status code indicator "R" with the phrase “applicable workers’ compensation multiplier pursuant to Section 9789.30(x).”

Necessity: This amendment is also necessary to conform to the changes made in this fee schedule.

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 amended subdivision.

Section 9789.33(a)(6):

Specific Purpose: Section 9789.33(a)(6) sets forth the method of determining the maximum payment rate for the eligible emergency room and surgical code procedures and for supplies, drugs, devices, blood products and biological that are an integral part of an emergency room visit or surgical procedure. The formula for procedure codes for brachytherapy services with status code indicator “U” is revised clarify how

brachytherapy services will be paid: “Documented paid cost, plus an additional 10% of the hospital outpatient department’s or ASC’s documented paid cost, net of immediate and anticipated price adjustments based upon the hospital outpatient department’s or ASC’s prior calendar year’s usage for comparable devices, not to exceed a maximum of \$ 250.00, plus any sales tax and/or shipping and handling charges actually paid.”

Subdivision (a)(6) is also amended to revise the formula for services rendered on or after April 15, 2010, where the number “1.22” in the formula for procedure codes for brachytherapy services with status code indicator “U” is replaced with the phrase “applicable workers’ compensation multiplier pursuant to Section 9789.30(x).”

Necessity: This amendment is necessary to clarify and to improve the understanding of how brachytherapy services with status code indicator “U” will be paid, and to conform to changes made in this fee schedule.

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 amended subdivision.

Section 9789.33(b)(1)(A):

Specific Purpose: This subdivision which sets forth the alternate payment methodology in lieu of the maximum allowable fees set forth in subdivision (a) is amended as follows:

The CPT codes 10040-69990, which define surgical procedures, are increased to include 10021 through 69990 in three places.

Instead of setting forth a specific value for the formula to determine the payment, the methodology is set forth in terms, with reference made to where the values can be found, and the number “1.20” in the formula is replaced with the term, “applicable workers’ compensation multiplier by date of service” pursuant to Section 9789.30(x).

The following sentence was deleted as being duplicative: “For services rendered on or after July 15, 2005, use: (APC relative weight x unadjusted conversion factor) x (.40 + .60 x applicable wage index) x 1.20”

For services rendered on or after February 15, 2006, by rural SCH hospitals, the formula was revised to conform to Medicare’s updates by adding an adjustment factor of 1.071. In addition, the number “1.20” in the formula is replaced with the term, “applicable workers’ compensation multiplier by date of service” pursuant to Section 9789.30(x).

Necessity: This amendment is necessary to conform to changes made to this fee schedule, and change the format to make the Hospital Outpatient Department and Ambulatory Surgical Centers Fee Schedule regulations more readable and understandable.

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 amended subdivision.

Section 9789.33(b)(1)(B):

Specific Purpose: Section 9789.33(b)(1)(B) sets forth the alternate payment methodology for drugs and biological with status code indicator “G” that is furnished in conjunction with an emergency room visit or surgical procedure, in lieu of the maximum allowable fees set forth in subdivision (a). Subdivision (b)(1)(B) is amended to replace the number “1.20” in the formula for procedure codes for drugs and biologicals with status code indicator "G" with the phrase “applicable workers’ compensation multiplier pursuant to Section 9789.30(x).

Necessity: This amendment is also necessary to conform to the changes made in this fee schedule.

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 amended subdivision.

Section 9789.33(b)(1)(C):

Specific Purpose: Section 9789.33(b)(1)(C) sets forth the alternate payment methodology for devices with status code indicator “H” that is furnished in conjunction with an emergency room visit or surgical procedure, in lieu of the maximum allowable fees set forth in subdivision (a). Subdivision (b)(1)(C) is amended to clarify how devices with status code indicator “H” will be reimbursed: “Documented paid cost, plus an additional 10% of the hospital outpatient department’s or ASC’s documented paid cost, net of immediate and anticipated price adjustments based upon the hospital outpatient department’s or ASC’s prior calendar year’s usage for comparable devices, not to exceed a maximum of \$ 250.00, plus any sales tax and/or shipping and handling charges actually paid.”

Necessity: This amendment is necessary to clarify and to improve the understanding of how devices with status code indicator “H” will be paid.

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 amended subdivision.

Section 9789.33(b)(1)(D):

Specific Purpose: Section 9789.33(b)(1)(D) sets forth the alternate payment methodology for drugs and biologicals with status code indicator “K” that is furnished in

conjunction with an emergency room visit or surgical procedure, in lieu of the maximum allowable fees set forth in subdivision (a). Subdivision (b)(1)(D) is amended to replace the number “1.20” in the formula for procedure codes for drugs and biologicals with status code indicator "K" with the phrase “applicable workers’ compensation multiplier pursuant to Section 9789.30(x).”

Necessity: This amendment is also necessary to conform to the changes made in this fee schedule.

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 amended subdivision.

Section 9789.33(b)(1)(E):

Specific Purpose: Section 9789.33(b)(1)(E) sets forth the alternate payment methodology for blood and blood products with status code indicator “R” that is furnished in conjunction with an emergency room visit or surgical procedure for services rendered on or after March 1, 2009, in lieu of the maximum allowable fees set forth in subdivision (a). Subdivision (b)(1)(E) is amended to replace the number “1.20” in the formula for procedure codes for blood and blood products with status code indicator “R” is replaced with the phrase “applicable workers’ compensation multiplier pursuant to Section 9789.30(x).”

Necessity: This amendment is also necessary to conform to the changes made in this fee schedule.

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 amended subdivision.

Section 9789.33(b)(1)(F):

Specific Purpose: Section 9789.33(b)(1)(F) sets forth the alternate payment methodology for brachytherapy services with status code indicator “U” that is furnished in conjunction with an emergency room visit or surgical procedure for services rendered on or after March 1, 2009, in lieu of the maximum allowable fees set forth in subdivision (a). Subdivision (b)(1)(F) is amended clarify how brachytherapy services with status code indicator “U” will be reimbursed: “Documented paid cost, plus an additional 10% of the hospital outpatient department’s or ASC’s documented paid cost, net of immediate and anticipated price adjustments based upon the hospital outpatient department’s or ASC’s prior calendar year’s usage for comparable devices, not to exceed a maximum of \$ 250.00, plus any sales tax and/or shipping and handling charges actually paid.”

Also in this subdivision, for services rendered on or after April 15, 2010, the number “1.20” in the formula for procedure codes for brachytherapy services with status code

indicator “U” is replaced with the phrase “applicable workers’ compensation multiplier pursuant to Section 9789.30(x).”

Necessity: This amendment is necessary to clarify and to improve the understanding of how brachytherapy services with status code indicator “U” will be paid, and to conform to changes made in this fee schedule.

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 amended subdivision.

Section 9789.33(b)(2):

Specific Purpose: Section 9789.33(b)(2) sets forth the alternate payment methodology for determining the additional payment for high cost outlier cases. Subdivision (b)(2) is amended to move references to the outlier threshold specified in the federal register notices made in the Hospital Outpatient Departments and Ambulatory Surgical Centers fee schedule updates by the Administrative Director, to section 9789.39.

Necessity: This amendment is necessary to make the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule regulations more readable and understandable.

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 amended subdivision.

Section 9789.33(c)(1):

Specific Purpose: The purpose of section 9789.33(c)(1) is to set forth the requirements that must be met for election of the alternative payment methodology. Subdivision (c)(1) is amended to update the Division of Workers’ Compensation Medical Unit address.

Necessity: This amendment is necessary to update the Division of Workers’ Compensation Medical Unit address.

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 amended subdivision.

Section 9789.33(c)(5):

Specific Purpose: Section 9789.33(c)(5) sets forth the requirements that must be met for election of the alternative payment methodology. Subdivision (c)(5) is amended to update the Division of Workers’ Compensation Medical Unit address.

Necessity: This amendment is necessary to update the Division of Workers' Compensation Medical Unit address.

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 amended subdivision.

Section 9789.33(c)(6):

Specific Purpose: Section 9789.33(c)(6) sets forth the requirements that must be met for election of the alternative payment methodology. Subdivision (c)(6) is amended to update the Division of Workers' Compensation Medical Unit address. Subdivision (c)(6) is also amended to reflect the correct webpage link for the Division of Workers' Compensation: [http://www.dir.ca.gov/dwc/dwc\\_home\\_page.htm](http://www.dir.ca.gov/dwc/dwc_home_page.htm)

Necessity: This amendment is necessary to update the Division of Workers' Compensation Medical Unit address and webpage link for the Division of Workers' Compensation.

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 amended subdivision.

**SECTION 9789.36 Update Rules to Reflect Changes in the Medicare Payment System**

Specific Purpose: Section 9789.36 sets forth the timeframe for updating the Hospital Outpatient Departments and Ambulatory Surgical Centers fee schedule, posting requirements, and effective dates of the updates. Section 9789.33 is amended to add reference to the proposed section 9789.39 to the Hospital Outpatient Departments and Ambulatory Surgical Centers fee schedule section of the Official Medical Fee Schedule. In addition, the effective date for annual updates to the Hospital Outpatient Departments and Ambulatory Surgical Centers fee schedule is changed from January 1 to March 1 of each year, to provide for a more realistic effective date given the constraints of when the Medicare publishes the final rule and providing adequate notice (30-days) to affected parties.

This section is also revised to reflect the correct webpage link for the Division of Workers' Compensation: [http://www.dir.ca.gov/dwc/dwc\\_home\\_page.htm](http://www.dir.ca.gov/dwc/dwc_home_page.htm)

Necessity: This amendment is necessary to conform this section to the changes in this fee schedule, to update the webpage link for the Division of Workers' Compensation, and to provide a more realistic effective date given the constraints of when the Medicare publishes the final rule and providing adequate notice to affected parties. Since 2004, depending on the year, Medicare has published its final rule as early as November 7<sup>th</sup> and as late as November 27<sup>th</sup>, with an effective date of January 1<sup>st</sup>. It is not unusual for Medicare to publish notices and corrections to its final rule after the final rule is



published. In order to give adequate notice (30 days) to affected parties, the current date of January 1<sup>st</sup> is unrealistic. The proposed effective date of March 1<sup>st</sup> is in conformance with Labor Code section 5307.1(g)(1)(A), which states in pertinent part, “Notwithstanding any other provision of law, the official medical fee schedule shall be adjusted to conform to any relevant changes in the Medicare and Medi-Cal payment systems no later than 60 days after the effective date of those 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 amended section.

### **SECTION 9789.37 Election for High Cost Outlier**

Specific Purpose: Section 9789.37 provides the form for election to participate in the alternative payment methodology for high cost outlier cases under section 9789.33, subdivision (b) in lieu of the maximum allowable fees set forth under section 9789.33, subdivision (a). Section 9789.37 is amended to update the DWC Medical Unit address to: P.O. Box 71010, Oakland, CA 94612. The revision date is also changed to state “03/01/2011.”

Necessity: This amendment is necessary to conform, correct, and update the form.

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 amended section.

### **SECTION 9789.38 Appendix X**

Specific Purpose: Section 9789.38 provides the federal regulations as incorporated by reference and/or referred to in the Hospital Outpatient Departments and Ambulatory Surgical Centers fee schedule. This section is amended to move references to the federal regulations made in the Hospital Outpatient Departments and Ambulatory Surgical Centers fee schedule updates by the Administrative Director, to section 9789.39(a). The year by year update references are deleted.

Necessity: This amendment is necessary to make the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule regulations more readable and understandable.

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 amended section.

### **SECTION 9789.39 Federal Regulations and Federal Register Notices by Date of Service**

Specific Purpose: This section is added to provide the updates to the federal regulation and federal register notice references made in the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule updates by Order of the Administrative Director, in order to conform to changes in the Medicare payment system as required by Labor Code section 5307.1.

Subdivision (a) lists the federal regulations by date of service that are referenced in the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule updates and are incorporated by reference.

Subdivision (b) lists the federal register notices by date of service that are referenced in the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule updates and are incorporated by reference.

Necessity:

All references to a federal regulation and federal register notices made in a Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule update (by Administrative Order) is moved to this section, so the other sections of the regulation will be more readable and understandable.

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 added section.