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

INITIAL STATEMENT OF REASONS

Subject Matter of Regulations: Official Medical Fee Schedule
Physician Fee Schedule

TITLE 8, CALIFORNIA CODE OF REGULATIONS
SECTIONS 9789.12.1 et seq.

Amend section 9789.12.1 Physician Fee Schedule: Official Medical Fee Schedule for Physician and Non-Physician Practitioner Services – For Services Rendered On or After January 1, 2014

Amend section 9789.12.2 Calculation of the Maximum Reasonable Fee - Services Other than Anesthesia

Amend section 9789.12.6 Health Professional Shortage Area Bonus Payment: Primary Care; Mental Health

Amend section 9789.12.8 Status Codes

Amend section 9789.12.12 Consultation Services Coding – use of visit codes

Amend section 9789.13.2 Physician-Administered Drugs, Biologicals, Vaccines, Blood Products

Amend section 9789.16.1 Surgery – Global Fee

Amend section 9789.16.7 Surgery – Co-surgeons and Team Surgeons

Amend section 9789.18.1 Payment for Anesthesia Services - General Payment Rule

Amend section 9789.18.2 Anesthesia - Personally Performed Rate

Amend section 9789.18.3 Anesthesia - Medically Directed Rate

Amend section 9789.18.11 Anesthesia Claims Modifiers

Amend section 9789.19 Update Table

Adopt section 9789.19.1 Table A

AN IMPORTANT PROCEDURAL NOTE ABOUT THIS RULEMAKING:

The Physician 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 Physician Fee Schedule is being conducted under the administrative director's rulemaking power under Labor Code sections 133, 4603.5, 5307.1 and 5307.3. This regulatory proceeding is subject to the procedural requirements of Labor Code sections 5307.1 and 5307.4.

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

BACKGROUND TO REGULATORY PROCEEDING

Existing law establishes a workers' compensation system, administered by the Administrative Director of the Division of Workers' Compensation, to compensate an employee for injuries sustained in the course of his or her employment. Labor Code section 4600 requires an employer to provide medical, surgical, chiropractic, acupuncture, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatus, including orthotic and prosthetic devices and services, that is reasonably required to cure or relieve the injured worker from the effects of his or her injury. Under existing law, payment for medical treatment shall be no more than the maximum amounts set by the Administrative Directive in the Official Medical Fee Schedule (OMFS) or the amounts set pursuant to a contract. (Labor Code sections 5307.1, 5307.11.)

In September of 2012, the California legislature passed Senate Bill 863 (Statutes of 2012, Chapter 363), a sweeping reform bill that, among other things, amended Labor Code section 5307.1. The new provisions of the statute direct the Administrative Director to "adopt and review periodically an official medical fee schedule based on the resource-based relative value scale for physician services and non-physician practitioner services."

In June of 2013 the Acting Administrative Director commenced a rulemaking action to adopt a new physician fee schedule based upon the Resource Based Relative Value Scale (RBRVS). After considering public comments received during a public hearing and two written comment periods, the Acting Administrative Director adopted regulations to establish a new physician fee schedule based upon the RBRVS. The regulations were filed with the Secretary of State for publication in the California Code of Regulations on September 24, 2013. The regulations became effective for services rendered on or after January 1, 2014.

As part of the physician fee schedule regulations, the Acting Administrative Director adopted an average statewide geographic adjustment factor in lieu of Medicare's locality-specific geographic adjustment factors. Thus, the physician fee schedule makes no adjustments for differences in costs of maintaining a practice across geographic areas. When the physician fee schedule was adopted for services rendered on or after January 1, 2014, use of a statewide geographic adjustment factor was retained for a number of

reasons. In addition to retaining the pre-RBRVS physician fee schedule precedent of using a statewide geographic adjustment factor, simplifying bill processing through a statewide fee schedule, the nine Medicare payment localities had not been updated since 1997, and therefore, no longer reflected current demographics, local economic conditions, or local costs. In general, physicians practicing in urban areas within the "Rest of California" locality were underpaid and physicians practicing in rural counties were overpaid. Also, because of the outdated Medicare locality structure, there was substantial differences in payment between bordering urban counties. For instance, physicians practicing in urban counties assigned to the "Rest of California" locality (consisting of 47 counties), such as San Diego, received less reimbursement than physicians located in neighboring Orange county, even though the two counties had similar labor markets and rents.

Effective January 1, 2017, Medicare was required to use Metropolitan Statistical Areas (MSAs) to determine fee schedule payment areas. This change in locality structure increased the number of localities from 9 under the former structure to 27 under the MSA-based locality structure. However, both the former localities and the MSA-based localities are comprised of various component counties, and in some localities only some of the component counties are subject to the blended six-year phase-in and hold-harmless provisions Medicare is required to implement. Therefore, for purposes of payment, the actual number of localities under the MSA-based locality structure would be 32 to account for instances where unique locality numbers are needed. The localities subject to the six-year phase-in (from 2017 through 2021) are the localities for 2013 that were within the "Rest of State" locality, and locality 3 (comprised of Marin County, Napa County, and Solano County). Medicare is required to provide a hold-harmless provision for transition areas beginning with CY 2017 whereby the applicable GPCI values for a year under the new MSA-based locality structure may not be less than what they would have been for the year under the former locality structure. There are a total of 58 counties in California, 50 of which are in transition areas. Therefore, 50 counties in California are subject to the hold-harmless provision. The other 8 counties, which are metropolitan counties that are not defined as transition areas, are not held harmless for the impact of the new MSA-based locality structure. The 8 counties that are not within transition areas are: Orange; Los Angeles; Alameda; Contra Costa; San Francisco; San Mateo; Santa Clara; and Ventura counties.

The revised payment localities are consistent with the objective of providing allowances that reflect resources required to provide a service in a particular geographic area, resulting in improved payment accuracy. A recent RAND memo determined the OMFS statewide fee schedule is paying relatively more in low cost areas and less in high cost areas than either Medicare or commercial payers. The RAND memo states, "[r]elative to the statewide fee schedule, implementation of the MSA-based localities in 2018 would increase for 6 payment localities representing 59.6 percent of payments and would decrease allowances in 23 payment localities accounting for 40.4 percent of allowances." Adoption of Medicare's MSA-based localities and GAF would improve payment accuracy and would better align OMFS allowances with Medicare rates and private payer payments.

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:

1. Wynn, Barbara Senior Health Policy Researcher, RAND, Memo re: *Locality-Based Geographic*

Adjustment Factors Under the Resource-Based Relative Value Scale, August 29, 2017
2. CMS (Centers for Medicare & Medicaid Services), *Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Bid Pricing Data Release; Medicare Advantage and Part D Medical Loss Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model; Medicare Shared Savings Program Requirements* (Federal Register, Vol. 81, Issue 220, page 80170, CMS-1654-F, November 15, 2016)
3. Thomas MaCurdy, Kristy Piccinini, Matt Chou, Sonam Sherpa, Anna Kamen, Tanvir Bhuyain, Nathan Sponberg, Kerstin Baer, Kathryn Wong, Russel Haron-Feiertag, Laurie Feinberg, Joshua Rolnick, *Report on the CY 2017 Update of the Geographic Practice Cost Index for the Medicare Physician Fee Schedule*, Acumen, 2016
4. California Medical Association White Paper, *Implementation of H.R. 4302 "Protecting Access to Medicare Act of 2014" Improving Medicare Payment Accuracy by Moving the California Physician Payment Localities to MSAs*, 2016
5. CMS *Claims Processing Manual*, Transmittal 3747, Change Request 10001, April 14, 2017
6. *Summary of Policies in the Calendar Year (CY) 2017 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, and CT Modifier Reduction List*, MLN Matters Number: MM9844, Effective Date: January 1, 2017
7. *Medicare Geographic Areas Used to Adjust Physician Payments for Variation in Practice Costs Should Be Revised, Report to the Chairman, Subcommittee on Health, Committee on Ways and Means, House of Representatives*, United States Government Accountability Office, June 2007

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 RAND memo identified two impacts relative to the OMFS statewide geographic adjustment factor that was implemented effective March 1, 2017 and using the Medicare GPCIs. The first impact compares the changes in the GAF that would be effective with the 2018 annual fee schedule update if the locality structure and updated GPCI values were implemented. RAND found the impact would include a -0.1 percent reduction in the statewide GAF. The second impact compares the difference between the 2017 statewide fee schedule and a locality-based fee schedule when the new locality structure is fully transitioned after six years in 2022. The second impact includes a 0.4 percent increase in the statewide GAF. It should be noted, the Medicare 6-year transition policies are specific to the former 9-locality Medicare fee schedule and do not accomplish a transition of the OMFS from a statewide fee schedule to the 27-locality fee schedule. RAND made two key findings:

1) "[T]he major impact would occur with the movement from the statewide fee schedule to the locality-based fee schedule. The impacts from the six-year transition to the new payment localities would have relatively small impact compared to the impact of moving to a locality-based payment system. An implication of this finding is that there is no benefit to deferring adoption of an MSA-based until the full transition is completed."
2) "[T]he initial impacts vary widely, ranging from an increase of 9.2 percent in Santa Clara County (part of the San Jose/Sunnyvale/Santa Clara MSA) to -5.2 percent in MSAs comprised of former counties in the old "rest of state" locality that benefit from a hold harmless provision. Relative to the statewide fee schedule, implementation of the MSA-based localities in 2018 would increase for 6 payment localities representing 59.6 percent of payments and would decrease allowances in 23 payment localities accounting for 40.4 percent of allowances."

Below is a table from the RAND memo showing the impacts at the MSA level. All localities affected by the transition policy are shaded. If a county within a MSA is subject to the transition policy for the new payment localities, it is listed separately within the MSA since it may have different GPCI values. The table shows a -0.1 percent reduction in the statewide GAF with the 2018 update if the locality structure and updated GPCI values were implemented. There would be a 0.4 percent increase in the statewide GAF when the new locality structure is fully transitioned after six years in 2022.

Table 1 Estimated OMFS Allowances Using MSA-based Localities Relative to Statewide Fee Schedule: Percentage Change in 2018 and in 2023

MSA Name	Counties	Percent of 2017 WC Payments	Percent Change in Allowances[1] 2018	2022
Bakersfield	Kern	2.0%	-5.1%	-4.9%
Chico	Butte	0.4%	-5.2%	-5.2%
El Centro	Imperial	0.4%	-5.1%	-5.1%
Fresno	Fresno	2.6%	-5.2%	-5.2%
Hanford-Corcoran	Kings	0.3%	-5.2%	-5.2%
Los Angeles-Long Beach-Anaheim	Los Angeles, Orange	42.9%	0.9%	0.9%
Madera	Madera	0.1%	-5.0%	-5.0%
Merced	Merced	0.3%	-5.2%	-5.2%
Modesto	Stanislaus	1.2%	-5.1%	-5.1%
Napa	Napa	0.4%	4.0%	4.0%
Oxnard-Thousand Oaks-Ventura	Ventura	1.8%	-0.2%	-0.2%
Redding	Shasta	0.6%	-5.3%	-5.3%
Riverside-San Bernardino-Ontario	Riverside, San Bernardino	9.8%	-4.7%	-4.0%
Sacramento--Roseville--Arden-Arcade	El Dorado, Placer, Sacramento, Yolo	4.6%	-4.4%	-2.9%
Salinas	Monterey	1.2%	-4.3%	-2.3%
San Diego-Carlsbad	San Diego	7.6%	-3.8%	-1.3%
San Francisco-Oakland-Hayward	San Francisco, Alameda, Contra Costa	10.8%	7.6%	7.6%
San Francisco-Oakland-Hayward	Marin	0.4%	5.1%	7.6%
San Jose-Sunnyvale-Santa Clara	San Benito	0.1%	-0.1%	9.8%
San Jose-Sunnyvale-Santa Clara	Santa Clara	4.4%	9.2%	9.2%

San Luis Obispo-Paso Robles-Arroyo Grande	San Luis Obispo	0.8%	-4.8%	-4.3%
Santa Cruz-Watsonville	Santa Cruz	0.6%	-2.3%	2.8%
Santa Maria-Santa Barbara	Santa Barbara	1.0%	-3.4%	0.3%
Santa Rosa	Sonoma	1.2%	-3.4%	0.0%
Stockton-Lodi	San Joaquin	1.4%	-5.2%	-5.2%
Vallejo-Fairfield	Solano	0.7%	3.9%	3.9%
Visalia-Porterville	Tulare	1.1%	-5.2%	-5.2%
Yuba City	Sutter, Yuba	0.2%	-5.2%	-5.2%
Rest Of California	All other counties	1.3%	-5.0%	-5.0%
Statewide		100%	-0.1%	0.4%

[1]Based on the economic data used in the 2017 GPCI update this is an estimate of the percentage change at the end of the Medicare transition to MSA-based payment localities. The economic data is updated every three years and an additional update will occur in 2020.

The proposed physician fee schedule would impact medical providers, insurers, and self-insured employers.

Costs

There will be some costs to payers and providers to convert from a statewide fee schedule to a MSA-based locality fee schedule. Claims administrators may incur one-time up-front costs to adjust their payment system to accommodate the MSA-based locality structure. However, the payment accuracy should be improved which should increase overall access in higher cost areas. In lower cost areas, it is not so much the adequacy of the allowances rather the adequacy of the physician workforce. The OMFS addresses access in underserved areas by providing an additional 10 percent payment for physician and non-physician practitioner services provided in geographic primary care health professional shortage areas or to mental health practitioners in geographic mental health shortage areas.

Savings

Savings will be achieved by adoption of the proposed Medicare MSA-based localities. One goal of the OMFS physician fee schedule is to set accurate allowances that reflect the resources required to provide medical services to injured workers. The statewide geographic adjustment factor is contrary to this principle because it provides no adjustment for differences in costs of maintaining a practice across geographic areas. Adoption of Medicare MSA-based localities will provide allowances that reflect the resources required to provide a service thereby improve payment accuracy. Increasing payment accuracy for medical services according to geographic areas should improve access, especially in the higher cost areas. The statewide economic impact is nominal. With the 2018 update, the impact includes a -0.1 percent reduction in the statewide GAF, and a 0.4 percent increase in the statewide GAF in 2022, when the new locality structure is fully transitioned.

SUMMARY OF PROPOSED CHANGES

Section 9789.12.1 Physician Fee Schedule: Official Medical Fee Schedule for Physician and Non-Physician Practitioner Services – For Services Rendered On or After January 1, 2014:

Specific Purpose:

This section sets forth the scope and applicability of the Physician Fee Schedule. The proposed amendment adds section 9789.19.1 to the regulation sections that comprise the Official Medical Fee Schedule for physician and non-physician practitioners.

Necessity:

This amendment is necessary to include the proposed adoption of section 9789.19.1 to the physician and non-physician practitioners fee schedule regulations.

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 9789.12.2 Calculation of the Maximum Reasonable Fee - Services Other than Anesthesia

Specific Purpose:

This section sets forth the formulas for calculating the maximum fee for physician and non-physician practitioner services other than anesthesia. One formula is for physician services rendered in a "facility" and one formula is for physician services rendered in a "nonfacility." The proposed amendment provides the payment formulas for services rendered on or after January 1, 2019, which incorporate the work, practice expense, and malpractice expense MSA-based locality GPCIs in lieu of the work, practice expense, and malpractice expense average statewide geographic adjustment factors. GPCI values by locality would be updated by date of service in section 9789.19.

Necessity:

This amendment is necessary because it informs the workers' compensation community how to calculate the reasonable maximum fees for physician and non-physician practitioner services that are adjusted for cost differences across geographic areas (MSA-based localities).

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 9789.12.6 Health Professional Shortage Area Bonus Payment: Primary Care; Mental Health

Specific Purpose:

This section adopts the Medicare Geographic Health Professional Shortage Area (HPSA) 10% bonus payment for services provided in an area designated by the US Dept. of Health & Human Services

Health Resources and Services Administration as a primary care geographic health professional shortage area or a geographic mental health shortage area. The proposed amendment clarifies the "shortage area" pertains to a shortage of providers for the entire population within a defined geographic area, not to be confused with Medicare shortage designation based on a specific population group or facility. It is proposed to amend the heading by adding the word "Geographic" before "Health Professional Shortage Area Bonus Payment: Primary Care; Mental Health." The word "Geographic" is added, as necessary, throughout section 9789.12.6, to clarify the shortage area pertains to the geographic shortage area.

Necessity:

This amendment is necessary to clarify the "shortage area" pertains to a shortage of providers for the entire population within a defined geographic area, and not to be confused with Medicare shortage designations based on specific population or facility. Medicare has a population shortage area which identifies a shortage of providers for a specific population group(s) within a defined geographic area (e.g., low income, migrant farmworkers, and other groups). Medicare also has designated facility-based shortage areas, such as correctional facilities with a shortage of health providers or state mental hospitals with a shortage of psychiatric professionals.

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 9789.12.8 Status Codes

Specific Purpose:

This section adopts the Status Code Indicators that are used in the National Physician Fee Schedule Relative Value File, but sets forth modified definitions of the status codes where needed for use in the workers' compensation context. The proposed amendment clarifies that status code "C" means, "[i]f payable, these codes will be paid using the RVUs listed in the Centers for Medicare and Medicaid Services (CMS') National Physician Fee Schedule Relative Value File, or if no RVUs are assigned, then "By Report," generally following review of documentation such as an operative report."

Necessity:

This amendment is necessary because the current regulation inadvertently omits language directing payment based on the RVUs listed in the CMS National Physician Fee Schedule Relative Value File, and only paying "By Report" if no RVUs are assigned.

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 9789.12.12 Consultation Services Coding – use of visit codes

Specific Purpose:

This section requires use of CPT evaluation and management "visit codes" and prolonged service codes, if warranted under CPT guidelines, rather than CPT "consultation codes" for physician consultations in outpatient settings. This section requires use of hospital care codes or nursing facility care codes, as appropriate, for physician consultations performed in inpatient and nursing facility settings. This section specifies that consultation reports are bundled into the underlying evaluation and management visit code and are not separately payable, except when the consultation report is requested by the Workers' Compensation Appeals Board or the Administrative Director, or when requested by a Qualified Medical Evaluator or Agreed Medical Evaluator in the context of a medical-legal evaluation. The proposed amendment to subdivision (b) of this section would clarify consultation reports would be bundled into the underlying evaluation and management visit "or hospital care code."

Necessity:

This amendment is necessary to clarify the codes that would be applicable for consultation services and consultation reports.

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 9789.13.2 Physician-Administered Drugs, Biologicals, Vaccines, Blood Products

Specific Purpose:

This section specifies how physician-administered drugs, biological, vaccines, blood products are paid. In particular, subdivision (b) specifies the RBRVS fee schedule shall be used to determine the maximum reimbursement for the drug administration fee. The proposed amendment replaces "RBRVS" with "physician."

Necessity:

This amendment is necessary to utilize consistent nomenclature.

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 9789.16.1 Surgery – Global Fee

Specific Purpose:

This section sets forth the definition of the global surgical package, indicates how surgical procedures with a global period are identified in the National Physician Fee Schedule Relative Value File, and sets forth the components included and those not included in the global surgical package. The proposed amendment to subdivision (a)(1)(C), replaces "column U" with "Global Days column" in order to provide greater clarity.

Necessity:

This amendment is necessary to provide greater clarity regarding the column heading that is referenced in this subdivision.

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 9789.16.7 Surgery – Co-surgeons and Team Surgeons.

Specific Purpose:

This section sets forth the billing and payment rules for surgeries involving co-surgeons and team surgeons. The section includes direction on the use of modifiers and identifies relevant indicators in the Co-Surgeon and Team Surgeon columns of the National Physician Fee Schedule Relative Value File. The proposed amendment to subdivision (b)(1) adds clarifying language that, "[i]f the surgery is billed with a "-62" modifier and the Co-Surgeons column contains an indicator of "0," payment for co-surgeons is not allowed."

Necessity:

This amendment is necessary to make this subdivision more complete and provide greater clarity.

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 9789.18.1 Payment for Anesthesia Services - General Payment Rule

Specific Purpose:

This section sets forth the basic calculation of the fee schedule amount for physician anesthesia services: allowable base units and time units multiplied by the anesthesia conversion factor. The section specifies that Medicare's Anesthesia Base Units by CPT Code file are used to determine the base units. The proposed amendment provides the payment

formulas for anesthesia services rendered on or after January 1, 2019, which incorporate the work, practice expense, and malpractice expense MSA-based locality GPCIs in lieu of the average statewide anesthesia geographic adjustment factor. Reference to GPCI values by locality of county where the service was rendered would be updated by date of service in section 9789.19. Proposed adoption of section 9789.19.1, Table A, would provide the anesthesia conversion factor adjusted by the anesthesia shares and GPCIs by locality, by date of service. The proposed amendment would also reformat the section to provide greater clarity and readability.

Necessity:

As part of the physician fee schedule regulations adopted effective January 1, 2014, the Acting Administrative Director adopted an average statewide geographic adjustment factor in lieu of Medicare's locality-specific geographic adjustment factors. Thus, the physician fee schedule makes no adjustments for differences in costs of maintaining a practice across geographic areas. At the time the physician fee schedule was adopted, use of a statewide geographic adjustment factor was retained for a number of reasons. In addition to retaining the pre-RBRVS physician fee schedule precedent of using a statewide geographic adjustment factor, simplifying bill processing through a statewide fee schedule, the nine Medicare payment localities had not been updated since 1997, and therefore, no longer reflected current demographics, local economic conditions, or local costs. In general, physicians practicing in urban areas within the "Rest of California" locality were underpaid and physician practicing in rural counties were overpaid. Also, because of the outdated Medicare locality structure, there was substantial differences in payment between bordering urban counties. For instance, physicians practicing in urban counties assigned to the "Rest of California" locality (consisting of 47 counties), such as San Diego, received less reimbursement than physicians located in neighboring Orange county, even though the two counties had similar labor markets and rents.

Effective January 1, 2017, Medicare was required to use Metropolitan Statistical Areas (MSAs) to determine fee schedule payment areas. This change in locality structure increased the number of localities from 9 under the former structure to 27 under the MSA-based locality structure. However, both the former localities and the MSA-based localities are comprised of various component counties, and in some localities only some of the component counties are subject to the blended six-year phase-in and hold-harmless provisions Medicare is required to implement. Therefore, for purposes of payment, the actual number of localities under the MSA-based locality structure would be 32 to account for instances where unique locality numbers are needed. The localities subject to the six-year phase-in (from 2017 through 2021) are the localities for 2013 that were within the "Rest of State" locality, and locality 3 (comprised of Marin County, Napa County, and Solano County). Medicare is required to provide a hold-harmless provision for transition areas beginning with CY 2017 whereby the applicable GPCI values for a year under the new MSA-based locality structure may not be less than what they would have been for the year under the former locality structure. There are a total of 58 counties in California, 50 of which are in transition areas. Therefore, 50 counties in California are subject to the hold-harmless provision. The other 8 counties, which are metropolitan counties that are not defined as

transition areas, are not held harmless for the impact of the new MSA-based locality structure. The 8 counties that are not within transition areas are: Orange; Los Angeles; Alameda; Contra Costa; San Francisco; San Mateo; Santa Clara; and Ventura counties.

The RAND memo identified two impacts relative to the OMFS statewide geographic adjustment factor that was implemented effective March 1, 2017 and using the Medicare GPCIs. The first impact compares the changes in the GAF that would be effective with the 2018 annual fee schedule update if the locality structure and updated GPCI values were implemented. RAND found the impact would include a -0.1 percent reduction in the statewide GAF. The second impact compares the difference between the 2017 statewide fee schedule and a locality-based fee schedule when the new locality structure is fully transitioned after six years in 2022. The second impact includes a 0.4 percent increase in the statewide GAF. It should be noted, the Medicare 6-year transition policies are specific to the former 9-locality Medicare fee schedule and do not accomplish a transition of the OMFS from a statewide fee schedule to the 27-locality fee schedule. RAND made two key findings:

1) "[T]he major impact would occur with the movement from the statewide fee schedule to the locality-based fee schedule. The impacts from the six-year transition to the new payment localities would have relatively small impact compared to the impact of moving to a locality-based payment system. An implication of this finding is that there is no benefit to deferring adoption of an MSA-based until the full transition is completed."

2) "[T]he initial impacts vary widely, ranging from an increase of 9.2 percent in Santa Clara County (part of the San Jose/Sunnyvale/Santa Clara MSA) to -5.2 percent in MSAs comprised of former counties in the old "rest of state" locality that benefit from a hold harmless provision. Relative to the statewide fee schedule, implementation of the MSA-based localities in 2018 would increase for 6 payment localities representing 59.6 percent of payments and would decrease allowances in 23 payment localities accounting for 40.4 percent of allowances."

The revised payment localities are consistent with the objective of providing allowances that reflect resources required to provide a service in a particular geographic area, resulting in improved payment accuracy. A recent RAND memo determined the OMFS statewide fee schedule is paying relatively more in low cost areas and less in high cost areas than either Medicare or commercial payers. Adoption of Medicare's MSA-based localities and GAF would improve payment accuracy and would better align OMFS allowances with Medicare rates and private payer payments.

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 9789.18.2 Anesthesia - Personally Performed Rate

Specific Purpose:

This section sets forth the method for determining payment for anesthesia reimbursement at the "personally performed" rate and the circumstances that warrant that rate. The section states that the anesthesia calculation will recognize the base unit for the anesthesia code and one time unit per 15 minutes of anesthesia time when the personally performed rate is applicable. The proposed amendment would clarify the anesthesia fee calculation will recognize the base unit for the anesthesia code and time units as calculated in accordance with section 9789.18.8.

Necessity:

This amendment is necessary to clarify the time units would be calculated in accordance with section 9789.18.8.

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 9789.18.3 Anesthesia - Medically Directed Rate

Specific Purpose:

This section sets forth the reimbursement for anesthesia where the physician's service is medical direction of the anesthesia: 50% of the allowance for the service performed by the physician alone. The section sets forth the criteria for a physician's service to constitute "medical direction" and specifies documentation necessary to establish payment at the medically directed rate. The proposed amendment to subdivision (a) clarifies that "qualified individuals" means "all of whom could be CRNAs, AAs, interns, residents, or combinations of these individuals." The proposed amendment to subdivision (a)(3) clarifies, "Personally participates in the most demanding procedures in the anesthesia plan, including, 'if applicable,' induction and emergence."

Necessity:

This amendment is necessary to provide greater clarity.

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 9789.18.11 Anesthesia Claims Modifiers

Specific Purpose:

This section requires physicians to report the appropriate anesthesia modifier to denote whether the service was personally performed, medically directed, or medically supervised in addition to any applicable CPT modifier. The proposed amendment clarifies that modifier QS – requires providers to report actual anesthesia time and "payment modifier" on the claim. The proposed amendment to modifier QY – replaces "certified registered nurse" with "qualified non-physician."

Necessity:

This amendment is necessary to clarify and conform to updates to Medicare payment rules.

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 9789.19 Update Table

Specific Purpose:

This section sets forth a table of documents incorporated by reference that are used in physician billing and payment. The table specifies the document name and provides a link to access the document. For several entries the updated data itself is included in the table, such as the conversion factors, California Specific Codes, and List of CPT Codes that Shall Not Be Used. The proposed amendments to section 9789.19 include the following:

1. Subdivisions (a) through (e), first column, labeled "Document/Data": For the row currently labeled as, "Health Professional Shortage Area zip code data files," add the word *"Geographic"* before "Health Professional Shortage Area zip code data files." For the row currently labeled as, "Health Resources and Services Administration: HPSA shortage area query," add the word "*Geographic"* after "Health Resources and Services Administration:."

Document/Data
Geographic Health Professional Shortage Area zip code data files
Health Resources and Services Administration: Geographic HPSA shortage area query (By State & County) (By Address)

2. Add subdivision (f) for services rendered on or after January 1, 2019. Place-holder information is added to select columns and rows of subdivision (f). When CMS publishes the 2019 Physician Fee Schedule final rule, relevant information will be adopted and inserted through future updates by Administrative Director order. The proposed amendment will adopt and incorporate by reference the following: 1. Add a new row which references the GPCI by locality (other than anesthesia services) file and county-to-locality crosswalk file; 2. Add a new row which references GPCI by locality and anesthesia shares (anesthesia) file and county-to-locality crosswalk file; and 3. Add all files in the 2019 CMS Medicare National Physician Fee Schedule Relative Value File, except the Anesthesia – Anes file.

Necessity: This amendment is necessary to provide a list of documents and data, including new documents and data needed to transition to MSA-based locality GPCIs that would be incorporated by reference and updated by administrative order. These documents and data are necessary to determine the appropriate payment rate by date of service under the physician 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 section.

Section 9789.19.1. Table A

Specific Purpose: This section is proposed to be adopted to provide a table of anesthesia conversion factors adjusted by GPCI locality and anesthesia shares.

Necessity: This table is necessary so the provider may determine the appropriate adjusted anesthesia conversion factor based on the MSA-based locality corresponding to the county where the service is rendered.

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 section.