

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

**FINAL STATEMENT OF REASONS AND
UPDATED INFORMATIVE DIGEST**

**Subject Matter of Regulations: Official Medical Fee Schedule Hospital Outpatient
Departments and Ambulatory Surgical Centers
Discharge on or after January 1, 2004**

TITLE 8, CALIFORNIA CODE OF REGULATIONS

Sections 9789.30 et seq.

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.

CONSIDERATION OF RELEVANT MATTER PRESENTED

After Notice of the Proposed Rulemaking published pursuant to Labor Code section 5307.4, a public hearing was held on March 11, 2014 at which interested persons could participate through the submission of written data, views, and arguments, including oral presentations. A 15-day comment period was noticed for April 28, 2014 which invited interested persons to participate through the submission of written comments. The Acting Administrative Director has subsequently considered all of the data, views, statements, and arguments presented or submitted.

The Acting Administrative Director of the Division of Workers' Compensation, pursuant to the authority vested in her, has amended the following sections of Division 1, Chapter 4.5, Subchapter 1, of title 8, California Code of Regulations, relating to the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule component of the Official Medical Fee Schedule:

Section 9789.30 Definitions [Amend]

- Section 9789.31 Adoption of Standards [Amend]**
- Section 9789.32 Applicability [Amend]**
- Section 9789.33 Determination of Maximum Reasonable Fee [Amend]**
- Section 9789.37 Election for High Cost Outlier [Amend]**
- Section 9789.39 Federal Regulations and Federal Register Notices by Date of Service [Amend]**

BACKGROUND TO REGULATORY PROCEEDING

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

Labor Code Section 5307.1, (as amended by Senate Bill 228 of 2003 (Chapter 639, Statutes of 2003); Senate Bill 1852 (Chapter 538, Statutes of 2006); Assembly Bill 1269 (Chapter 697, Statutes of 2007); Assembly Bill 378 (Chapter 545, Statutes of 2011); and Senate Bill 863 (Chapter 363, Statutes of 2012)), requires the Administrative Director to adopt and revise periodically an official medical fee schedule that establishes the reasonable maximum fees paid for all medical services rendered in workers' compensation cases.

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

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

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

Labor Section 5307.1 also provides that the Administrative Director shall adjust the HOPD/ASC fee schedule to conform to any relevant changes in the Medicare payment system by issuing an order, exempt from Labor Code sections 5307.3 and 5307.4 and the rulemaking provisions of the Administrative Procedure Act (Chapter 3.2 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), informing the public of the changes and their effective date.

Effective Jan. 1, 2004, the Administrative Director adopted the HOPD/ASC fee schedule (Title 8, California Code of Regulations, sections 9789.30 et seq.), applicable for emergency room visits provided to outpatients and surgical procedures performed in outpatient departments and ambulatory surgical centers. This fee schedule is updated annually by Administrative Director Order.

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

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

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

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

Prior to 2007, the California Department of Health Services (DHS), (now California Department of Public Health (CDPH)), issued licenses to ambulatory surgical centers (ASC). This license was the basis of the Office of Statewide Health Planning and Development's (OSHPD) authority to collect the "Annual Utilization Report of Specialty Clinics" from ASCs. An ASC opting to use the alternative payment methodology is required by section 9789.33(c)(5) to provide the DWC with a completed Annual Utilization Report of Specialty Clinics filed with OSHPD, or equivalent subject to the DWC's audit, for the preceding calendar year. The information provided in this report contained the necessary data used to determine the facility's cost-to-charge ratio.

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

operated by others that are generally regulated by the DHS (now CDPH). In light of this ruling, DHS (now CDPH) determined it had no jurisdiction over physician-owned ASCs, and stopped issuing and renewing licenses to all but a handful of non-physician owned ASCs. As a result the number of ASCs providing “Annual Utilization Reports” dropped dramatically in subsequent years. OSHPD reports that by 2010 more than 400 facilities had been de-licensed. A 2014 RAND study¹ indicates there are over 1,589 ASCs operating in California, of which 1,551 are physician owned.

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

In addition, the Acting Administrative Director has determined that facilities rarely elect to use the alternative payment methodology, and prefer the default payment methodology. For the last two annual election periods (2012/2013 and 2013/2014), only 1 ambulatory surgical center (same ASC) elected to use the alternative payment methodology, and in the prior two annual election periods (2010/2011 and 2011/2012), only 1 ambulatory surgical center and only 1 hospital outpatient department elected to use the alternative payment methodology. Because of these findings, the regulations relating to the alternative payment methodology will no longer be applicable for services rendered on or after September 1, 2014.

As discussed above, the maximum allowable payment is based on a multiplier that includes an extra percentage reimbursement for high cost outlier cases in lieu of additional payment for high cost outlier cases. Section 9789.30(aa) is amended to adjust the multiplier to conform to changes in Medicare’s payment rules as required by Labor Code section 5307.1. Labor Code section 5307.1(a)(1), states in pertinent part, “[e]xcept for physician services, all fees shall be in accordance with the fee-related structure and rules of the relevant Medicare and Medi-Cal payment systems, provided that employer liability for medical treatment, including issues of reasonableness, necessity, frequency, and duration, shall be determined in accordance with Section 4600.” Labor Code section 5307.1(b) states in pertinent part, “the administrative director may adopt different conversion factors, diagnostic-related group weights, and other factors affecting payment amounts from those used in the Medicare payment system, provided estimated aggregate fees do not exceed 120 percent of the estimated aggregate fees paid for the same class of services in the relevant Medicare payment system.” However, SB 863 revised Labor Code section 5307.1(c)(1) to state in pertinent part, that “...[n]otwithstanding subdivisions (a) and (d),...the maximum facility fee for services performed in an ambulatory surgical center shall not exceed 80 percent of the fee paid by Medicare for the same services performed in a hospital outpatient department.”

¹ Wynn, et al., *Ambulatory Surgical Services Provided Under California Workers’ Compensation: An Assessment of the Feasibility and Advisability of Expanding Coverage*, RAND, 2014, p. 16

The amendment to the Medicare multiplier is being made to conform to changes in Medicare's payment rules. The estimated total additional payments for outliers made by Medicare cannot exceed 3 percent of estimated total program payment in that year (section 1833(t)(5)(C) of the Social Security Act). When the hospital outpatient fee schedule regulation was adopted in 2004, Medicare allocated 2 percent of the total program payments to outlier payments for the year. Medicare has since lowered this allocation to 1 percent of total program payments to outlier payments this year (78 FR 74826, December 10, 2013; CMS-1601-FC, page 7490). Therefore, in order to conform with changes to Medicare's payment rules, the additional percentage added for outliers was reduced to 121.2% ($1.20/.99=1.212$) for hospital outpatient departments and 80.81% ($0.8/.99=0.80808$) for ASCs. The percentage is being lowered across the board as required to achieve proportional consistency across all services.

Also of note, is that although SB 863 reduces the OMFS allowances for ASC facility services from 120 percent to 80 percent of Medicare Hospital Outpatient Department (HOPD), the ASC allowances (80 percent of Medicare HOPD) are still about 143 percent of the amounts payable under the Medicare fee schedule for ASC services. Therefore, the 80.81 percent ASC multiplier will still provide a higher payment rate relative to 120 percent of Medicare's ASC fee schedule rates. Medicare's ASC fee schedule reflects the lower costs of performing ambulatory surgery in a freestanding surgical center. The lower costs are well-documented. ASCs can perform procedures more efficiently because they have lower infrastructure costs and concentrate on a narrower range of procedures than hospitals.

Sections 9789.30, 9789.31, 9789.32, 9789.33, 9789.37, and 9789.39 are amended to transition hospital outpatient department facility fee allowances currently paid under the pre-2014 OMFS physician fee schedule to be paid an OMFS RBRVS-based facility fee; to make the alternative payment methodology inapplicable for services rendered on or after September 1, 2014; and to adjust the Medicare multiplier to conform to changes in Medicare's payment rules regarding the additional percentage added for outliers.

UPDATE OF INITIAL STATEMENT OF REASONS AND INFORMATIVE DIGEST

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

The following sections of the proposed regulations were modified following the public hearing and were circulated for a 15-day comment period (From Apr. 11 to Apr. 28, 2014). The proposed regulation changes are summarized below.

THE FOLLOWING SECTIONS WERE AMENDED FOLLOWING THE PUBLIC HEARING AND WERE CIRCULATED FOR A 15-DAY COMMENT PERIOD

(There was one 15-day comment period as follows: first 15-day comment period: Apr. 11 to Apr. 28, 2014)

General modification – In many sections, the text references to proposed dates of service “XXX XX, 2014” is now “September 1, 2014”, in anticipation of allowing a sixty to ninety day implementation period.

Modification to Section 9789.32 Applicability

Subdivision (a) is amended to add the following codes to the definition of an emergency room visit: CPT codes 99291 and 99292, and HCPCS codes G0380-G0384, G0390, G0413 is added to the definition of surgical procedure codes. This subdivision was also amended to refer to section 9789.39(b) for the HCPCS codes included in the definition of emergency room visits and surgical procedures by date of service.

Specific Purpose of Change: Subdivision (a) is amended to conform to changes made in Medicare’s hospital outpatient prospective payment system and HCPCS coding; and to list the HCPCS codes in section 9789.39(b) by dates as services, which is consistent with the organization of other sections of the regulation. Sections 9789.30 through 9789.38 set forth the framework for the fee schedule. Section 9789.39 provides the updated information referenced in the other sections of the fee schedule by date of service. The codes are now listed in Section 9789.39 by date of service.

Subdivision (c)(1)(B)(ii) is amended to include a formula for calculating the base facility fee, when the facility fee for Other Services is determined based solely on the non-facility practice expense relative value units applicable under the OMFS RBRVS.

Specific Purpose of Change: This subdivision is amended to provide additional clarity on how the base facility fee is determined when the facility fee for Other Services is determined based solely on the non-facility practice expense relative value units applicable under the OMFS RBRVS.

Modification to Section 9789.33 Determination of Maximum Reasonable Fee

Subdivision (a) is amended to delete reference to applicable procedure codes for emergency room visits and surgical procedures, since these codes are now listed in section 9789.39 by date of service.

Specific Purpose of Change: This amendment is being made to provide consistency in the organization of the regulation sections. Sections 9789.30 through 9789.38 set forth the framework for the fee schedule. Section 9789.39 provides the updated information referenced in the other sections of the fee schedule by date of service. The codes are now listed in Section 9789.39 by date of service.

Subdivisions (b), (c), and (d) are amended to replace the proposed language, “repealed” for dates of service, to state these subsections are “inapplicable” for dates of service on or after September 1, 2014.

Specific Purpose of Change: This amendment is being made to clarify the specified subdivisions are applicable for dates of service before September 1, 2014, but, the subdivisions will not be applicable for dates of service on or after September 1, 2014.

Modification to Section 9789.37 Election for High Cost Outlier

This section is amended to state DWC Form 15 (Election for High Cost Outlier) is inapplicable for dates of service on or after September 1, 2014.

Specific Purpose of Change: This amendment is being made to clarify this section is applicable for dates of service before September 1, 2014, but, this section will not be applicable for dates of service on or after September 1, 2014.

Modification to Section 9789.39 - Federal Regulations and Federal Register Notices by Date of Service

The title to section 9789.39 is amended to rename the section from “Federal Regulations and Federal Register Notices” to “Update Table”.

Specific Purpose of Change: This amendment is to more accurately reflect the subject matter of the section.

Subdivision (b) is amended to add emergency room visit and surgery procedure HCPCS codes by date of service; add “Update factors” to the subsection title; and correct a typographical error with no regulatory effect, by changing the name of the category from “Unadjusted Conversion Factor” to “Adjusted Conversion Factor”.

Specific Purpose of Change: This amendment updates the emergency room visit and surgery procedure HCPCS codes by date of service to conform to changes made in Medicare’s hospital outpatient prospective payment system and HCPCS coding. The title to this subdivision was amended to more accurately reflect the subject matter of the subdivision. This amendment also corrects a typographical error in the name of the category from “Unadjusted Conversion Factor” to “Adjusted Conversion Factor”. The conversion factor provided under this heading is the adjusted conversion factor, not the unadjusted conversion factor.

UPDATE OF MATERIAL RELIED UPON

The following additional documents beyond those identified in the Initial Statement of Reasons were relied upon by the Acting Administrative Director and added to rulemaking file after close of the initial 30-day comment period. They were identified in the Notice of Modification to Text of Proposed Regulations and Notice of Addition of Documents to

Rulemaking File for the first 15-day comment period. These additional documents were available for 15 day public review and comment from April 11 to April 28, 2014.

1. Vogt WB and Romley JA, *California Ambulatory Surgery Centers: A Comparative Statistical and Regulatory Description*, RAND, TR-757-CAHF, 2009
2. *Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Hospital Value-Based Purchasing Program; Organ Procurement Organizations; Quality Improvement Organizations; Electronic Health Records (EHR) Incentive Program; Provider Reimbursement Determinations and Appeals*, CMS-1601-FC, Federal Register, Vol. 78, No. 237, page 74826, December 10, 2013

Additional documents relied upon by the Acting Administrative Director in proposing the regulations have been added to the rulemaking file after the close of the 15-day comment period ending April 28, 2014:

1. Wynn, et al., *Ambulatory Surgical Services Provided Under California Workers' Compensation: An Assessment of the Feasibility and Advisability of Expanding Coverage*, RAND, 2014 (released by RAND and posted on April 25, 2014);
2. *Could ASCs Lose Their Competitive Pricing Advantage?* Beckers ASC Review Article, April 25, 2014.

LOCAL MANDATES DETERMINATION

- Local Mandate: None. The proposed regulations will not impose any new mandated programs or increased service levels on any local agency or school district.
- Cost to any local agency or school district that is required to be reimbursed under Part 7 (commencing with Section 17500) of Division 4 of the Government Code: None. The proposed amendments do not apply to any local agency or school district.
- Other nondiscretionary costs/savings imposed upon local agencies: None.

CONSIDERATION OF ALTERNATIVES

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