

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

INITIAL STATEMENT OF REASONS

**Subject Matter of Regulations: Workers' Compensation – Official Medical Fee
Schedule:**

Hospital Outpatient Departments and Ambulatory Surgical Centers

**TITLE 8, CALIFORNIA CODE OF REGULATIONS
SECTIONS 9789.30 et seq.**

AN IMPORTANT PROCEDURAL 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 (HOPD/ASC fee schedule) is being conducted under the Administrative Director's rulemaking power under Labor Code sections 133, 4603.5, 5307.1 and 5307.3. This regulatory proceeding is subject to the procedural requirements of Labor Code sections 5307.1 and 5307.4.

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

BACKGROUND TO REGULATORY PROCEEDING

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

Official Medical Fee Schedule –
Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule
Proposed Regulations

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.

Official Medical Fee Schedule –
Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule
Proposed Regulations

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. 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, which are generally regulated by the California Medical Board, and surgical clinics owned and operated by others, which 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.

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 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 Acting Administrative Director is considering abolishing the alternative payment methodology for services rendered on or after the effective date of the proposed amendments to the regulation.

The Acting Administrative Director now proposes to amend sections 9789.30, 9789.31, 9789.32, 9789.33, 9789.37, and 9789.39 to transition hospital outpatient department facility fee allowances currently paid under the pre-2014 OMFS physician fee schedule to

Official Medical Fee Schedule –
Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule
Proposed Regulations

be paid an OMFS RBRVS-based facility fee; and to repeal the alternative payment methodology for services rendered on or after the effective date of the proposed amendments to the regulation.

NECESSITY

A. Proposed amendment to transition hospital outpatient facility payments for services that are neither surgical procedures nor emergency room visits (“Other Services”¹) from the pre-2014 OMFS physician fee schedule to an OMFS RBRVS-based facility fee.

The Division has determined that amendments to the HOPD/ASC fee schedule is necessary to transition payment for “Other Services” from the very outdated pre-2014 OMFS physician fee schedule to facility payments that are OMFS RBRVS-based. This transition is necessary to harmonize the OMFS HOPD/ASC fee schedule with the newly adopted RBRVS-based physician fee schedule, and reduce administrative burden that would occur if providers and payers were required to continue using the outdated pre-2014 OMFS physician fee schedule to determine the maximum facility allowances for these services.

Background

Current payment methodology for determining maximum allowable amounts for “Other Services” and “Facility Only Services” – Approximately 7% of total expenditures for outpatient services provided by hospitals to workers’ compensation patients are non-surgical procedures and non-emergency room services (“Other Services”/“Facility Only Services”), which are paid according to the pre-2014 OMFS for physician services. These services are mostly diagnostic tests and clinic visits.

Under the pre-2014 OMFS for physician services, the same payment is made regardless of where services are provided. A single payment is made for both the professional service and the facility fee. So, the payment for the provider’s professional service would likely flow to the hospital outpatient department that would bill for the service. Presumably, if the provider is not an employee of the hospital, the hospital outpatient department and provider would agree on how the payment would be divided.

Necessity for changing the payment methodology for determining the maximum allowable amounts for “Other Services” and “Facility Only Services” – It is no longer appropriate to continue the use of the pre-2014 OMFS for physician services to set the maximum allowable amounts for “Other Services”/“Facility Only Services” for the following reasons.

Not only is the pre-2014 OMFS for physician services severely outdated (last major update occurred in 1999), but payment for these services must to be harmonized with the

¹ Excluding “Facility Only Services”, which is proposed to be paid under the hospital outpatient departments/ASC fee schedule.

recently adopted OMFS RBRVS-based physician fee schedule (effective January 1, 2014). To be consistent with how RBRVS values are set, the OMFS for hospital outpatient departments services should establish a separate facility fee for hospital outpatient department facility services that complements the OMFS RBRVS allowance for professional services in a facility setting.

Payment methodology alternatives considered

The Acting Administrative Director considered the following alternative payment methodologies for determining the facility fee for “Other Services” and “Facility Only Services”.

Labor Code section 5307.1 limits aggregate allowances under the OMFS to 120 percent of the amounts that would be payable under Medicare for comparable services, which, in the case of the “Other Services”/“Facility Only Services”, would be 120 percent of the Medicare hospital outpatient department fee schedule rate. Within this aggregate limitation, the Acting Administrative Director has the authority to use different conversion factors, and other factors affecting payment amounts from those used in the Medicare payment system, for selected services to preserve access and/or encourage the efficient delivery of medically appropriate care. In other words, the Acting Administrative Director has the flexibility to consider applying alternative hospital outpatient department-based multipliers within this aggregate limitation for all or selected hospital outpatient services or using a RBRVS-based fee schedule.

The first alternative payment methodology the Acting Administrative Director considered is to pay for “Other Services” using the OMFS RBRVS practice expense (or technical component) relative value units (RVUs) with the OMFS RBRVS multiplier. The maximum allowable amount would be based on the same allowances physicians would receive for their practice expenses when the service is provided in the office setting. For services that have separate technical and professional components (PC/TC), the allowances for each component (and for the full service) would be determined in accordance with the OMFS RBRVS (including the OMFS RBRVS multiplier). For services with no PC/TC components, the practice expense RUVs in a non-facility setting would be used for the outpatient department facility allowance. There would be a separate allowance for the related physician professional services based on the allowances for services provided in facility-settings. This approach is modeled on the Medicare payment methodology for office-based surgeries performed in ambulatory surgical centers, which sets the facility fees for the office-based surgeries at the practice expense component of the RBRVS fee schedule instead of the hospital outpatient departments fee schedule.

However, there is a small subset of non-surgical/non-emergency room visit services currently paid under the pre-2014 OMFS physician fee schedule, that are considered “Facility Only Services” by Medicare. For “Facility Only Services”, Medicare assumes the services are provided only in a facility setting. Hospital observation services (CPT 99218-99220), CPT 94002 (ventilation assist and management; hospital

inpatient/observation initial day), and electromyography services (CPT 96002 and 96003) fall into this category. The RBRVS-based facility payment would not adequately compensate the hospital because the facility-setting RVUs assume that the hospital receives a separate facility fee under the Medicare hospital outpatient departments prospective payment system (HOPPS), for staffing and other costs associated with providing the service. The Acting Administrative Director has, therefore, made the policy decision that facility fee rates for “Facility Only Services” would be 101.01 percent of the HOPPS rate for these services.²

The second alternative payment methodology considered by the Acting Administrative Director is to pay separate facility fees for “Other Services”/“Facility Only Services” at the Medicare HOPPS fee schedule rate with no multiplier. There would be a separate OMFS RBRVS allowance for the related physician professional services based on the allowances for furnishing services in a facility-setting.

The third alternative payment methodology would be to pay separate facility fees for “Other Services”/“Facility Only Services” at 120 percent of the Medicare HOPPS fee schedule rate. This alternative payment methodology represents the maximum allowances permissible under Labor Code section 5307.1.

As explained below, RAND’s impact analysis³ found that the facility payment rate based on the Medicare HOPPS fee schedule rate (with no multiplier) for “Other Services” are generally higher than the rates based on 120 percent of the practice expense RVUs.

Basis for the Acting Administrative Director’s Policy Decision

The Acting Administrative Director has made the policy decision to adopt the first alternative payment methodology (using the OMFS RBRVS practice expense (or technical component) relative value units (RVUs) with the OMFS RBRVS multiplier) for setting the facility fees for “Other Services”.

When the Acting Administrative Director considered different payment methodologies to determine facility fees for “Other Services”, she considered whether workers’ compensation should pay more to hospitals than community providers for services that would be clinically appropriate to provide in a less costly setting.

Various recent studies and a news article⁴ found that payment variations need to be addressed because many services have been migrating from physician’s offices to the usually higher paid hospital outpatient department settings, as hospital employment of

² This multiplier includes an extra percentage reimbursement for high cost outlier cases.

³ *Fee Schedule Options for Services Furnished by Hospitals to Outpatients under the California Workers’ Compensation Program*, Wynn, Barbara, et al., RAND, WR-1016-DIR, February 2014

⁴ Report to Congress, MedPAC, March 2012; *Medicare Payment Policy Report to Congress*, MedPAC, March 2013; *Medicare and the Health Care Delivery System*, MedPAC Report to Congress, June 2013; *Report of The National Commission on Physician Payment Reform*, March 2013; and *Doctors in private practices are now joining hospital staffs*, The Washington Post, March, 12, 2012

Official Medical Fee Schedule –
Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule
Proposed Regulations

physicians have grown. This shift towards hospital outpatient departments settings have resulted in higher spending without significant changes in patient care. The MedPAC (June 2013) report stated that, “[f]rom 2010 to 2011, for example, the share of E&M office visits provided in OPDs increased by 9%, the share of echocardiograms provided in OPDs increased by 15%, and the share of nuclear cardiology tests in OPDs increased by 22%”. MedPAC raised the concern that when a hospital purchases a physician practice, the payment rate for the facility service changes from the RBRVS to the higher hospital outpatient department fee schedule (HOPPS) payment rate despite no change in the nature of the actual services.

The first alternative payment methodology is consistent with the policy direction advocated by MedPAC and the National Commission on Physician Payment Reform.

RAND’s impact analysis found that diagnostic and therapeutic “Other Services” with separate TC/PC components account for 86 percent of the allowances for services furnished by hospital outpatient departments to outpatients, that are currently paid under the pre-2014 OMFS physician fee schedule. With the exception of one code (CPT 72131 CT scan, lumbar spine, without contrast), the TC allowance is higher under the OPSS with no multiplier than under the OMFS RBRVS with a 1.2 multiplier. Generally, the OPSS differential is greater for less resource-intensive services (e.g. x-ray examinations) than for more resource-intensive services (MRI and CT scans).⁵

According to RAND, for the “Other Services” with no TC/PC components, the facility allowances are consistently higher using the OPSS rates than the rates based on 120 percent of the OMFS RBRVS practice expense RVUs.

RAND’s analysis indicates that relative to pre-2014 OMFS allowances, “if the RBRVS PE (or TC) were used to pay for services furnished by hospitals that are currently paid under the pre-2014 OMFS for physician services, there would be a 7.6 percent reduction in allowances after multiple procedure discounting and bundling rules are applied under the RBRVS.”⁶ This represents an estimated 0.5 percent decrease in total expenditures for hospital services to outpatients. The RAND analysis found there would be a redistribution in payment amounts for certain services. (For services with TC components, which are primarily radiology, the facility fee allowances would be reduced 21 percent; and the allowances for the other services would increase 31 percent. These changes, however, would be phased in through the RBRVS transition conversion factors.) The above RAND estimates are based on a fully transitioned RBRVS (120 percent of Medicare in 2014) rather than the actual 2014 transition rate (75% pre-2014 OMFS/25%

⁵ According the RAND report, “[i]n general, the OPSS has broader bundling policies than the RBRVS, which means that the RBRVS allowance may be slightly understated relative to the OPSS payments.”, p. 9.

⁶ RAND, further explains, “Our RBRVS estimate is understated if contrast media used during radiology procedures that would qualify for separate payments are underreported in the workers’ compensation information system data. Further, some services have no nonfacility setting RVUs. We priced the TC services with no PE RVUs using the OPSS rates with no multipliers and other services based on the amounts paid under the pre-2014 OMFS.”, p.17.

at 120% of Medicare). According to the RAND analysis, the actual estimated reduction will be “negligible” in 2014.

On the other hand, relative to pre-2014 OMFS allowances, aggregate maximum allowance amounts would increase 48 to 65 percent if the HOPPS fee schedule were used with no multiplier, and an even greater percent increase if the HOPPS fee schedule were used with a multiplier. This represents an estimated 3 to 5 percent increase in the overall expenditures for hospital services to outpatients.

Both estimates include, where applicable, additional RBRVS allowances for related services provided by physicians in a facility setting.

Option	Estimated percentage change in allowances for services paid under the pre-2014 OMFS for physician services		Estimated percentage change in total expenses for hospital services to outpatients	
	Low estimate	High estimate	Low estimate	High estimate
1. RBRVS with 1.2 multiplier	(7.6)	(7.6)	(0.5)	(0.5)
2. OPSS with no multiplier	48.4	65.2	3.4	4.6

While recognizing payment rates for hospital outpatient services are typically higher due to higher infrastructure and regulatory costs, the Acting Administrative Director has determined the first alternative payment methodology encourages provision of care in the least costly clinically appropriate setting, and “levels the playing field” across hospitals and community-based providers for comparable services. The Acting Administrative Director has also determined that the first alternative payment methodology results in minimal changes in aggregate expenditures for hospital outpatient services.

In conclusion, for the reasons stated above, the Acting Administrative Director has made the policy decision to transition facility fee payment from pre-2014 OMFS physician fee schedule to the OMFS RBRVS practice expense (or TC) RVUs with OMFS RBRVS multiplier

Determining a reasonable multiplier for “Facility Only Services” payment rate – As stated earlier, ideally, the OMFS allowances should be reasonable. Excessive allowances can create the negative incentive of providing excessive and medically unnecessary

⁷ RAND report, Table 1: Summary of Impacts of Alternative Policies for Establishing Allowances for Services Provided by Hospitals to WC Outpatients
 Official Medical Fee Schedule –
 Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule
 Proposed Regulations

“Facility Only Services”. On the other hand, inadequate allowances can also cause undesired consequences of not providing medically necessary “Facility Only Services”.

The Administrative Director has discretion in setting the OMFS allowance level (as long as it does not, in the aggregate, exceed 120 percent of the Medicare hospital outpatient department fee schedule). Only a small subset of services currently paid under the pre-2014 OMFS physician fee schedule, is designated as “Facility Only Services”, and therefore, the overall impact will be negligible.

Based upon the above findings, the Administrative Director believes adopting the HOPPS with no multiplier, for “Facility Only Services” provided to hospital outpatients is adequate and reasonable and will provide neutral cost incentives so that “Facility Only Services” will be provided when medically appropriate.

B. Proposed repeal of Section 9789.33(b), (c), (d) and Section 9789.37, pertaining to the alternative payment methodology.

Background

The hospital outpatient departments and ambulatory surgical centers fee schedule provides a default payment methodology for determining the maximum allowable facility fee for services rendered in ambulatory surgical centers and to hospital outpatients. The maximum allowable payment is based on a multiplier that includes an extra percentage reimbursement 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. In order to determine whether a service qualifies as an outlier case under the alternative payment methodology, the facility is required to provide its cost-to-charge ratio as one of the factors.

Changes since the fee schedule was adopted in 2004 – 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. 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, which are generally regulated by the California Medical Board, and surgical clinics owned and operated by others, which are generally regulated by the DHS (now CDPH). In light of this ruling, DHS (now CDPH) determined it had no jurisdiction over physician-owned

Official Medical Fee Schedule –
Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule
Proposed Regulations

ASCs, and stopped issuing and renewing licenses to all but a handful of non-physician owned ASCs.⁸ 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.

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 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.

Alternative Considered by the Acting Administrative Director

The Acting Administrative Director considered the following alternatives to the alternative payment methodology: 1. No change; 2. Abolish the alternative payment methodology for ASCs; and 3. Abolish the alternative payment methodology entirely.

Basis for the Acting Administrative Director’s Policy Decision

The Acting Administrative Director is considering adopting alternative three, which is to abolish the alternative payment methodology, entirely, for services rendered on or after the effective date of the proposed amendments to the regulation. The Acting Administrative Director bases her decision on the fact that, historically, there has been almost no use of the alternative payment methodology. Abolishing the alternative payment methodology in its entirety will reduce administrative burden; reduce complexity; and eliminate the impracticality of continuing to allow ASCs to elect the alternative payment methodology.

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 O., et.al., *Fee Schedule Options for Services Furnished by*

⁸ In 2010, there were 754 ASCs operating in California. However, only 52 reported data to OSHPD, down from 451 in 2007. (*Ambulatory Surgery Centers: Big Business, Little Data*, California Health Care Almanac, California HealthCare Foundation, June 2013.

Official Medical Fee Schedule –
Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule
Proposed Regulations

Hospitals to Outpatients under the California Workers' Compensation Program, the RAND Center for Health and Safety in the Workplace, WR-1016-DIR, February 2014.

- (2) *Report to the Congress, Medicare Payment Policy*, MedPAC, March 2012.
- (3) *Report to the Congress, Medicare Payment Policy*, MedPAC, March 2013.
- (4) *Report to the Congress, Medicare and the Health Care Delivery System*, MedPAC, June 2013.
- (5) *MedPAC Public Meeting Transcript*, January 16, 2014.
- (6) *Report of the National Commission on Physician Payment Reform*, March 2013.
- (7) *Ambulatory Surgery Centers: Big Business, Little Data, California Health Care Almanac*, California HealthCare Foundation, June 2013.
- (8) *Doctors in private practices are now joining hospital staffs*, Jain, Manoj, The Washington Post, March 12, 2012.

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 facility fees for “Other Services” rendered to outpatients, which will decrease the overall cost to the workers’ compensation system.

The Acting Administrative Director proposes setting the maximum allowance facility fee for services rendered to outpatients, that are currently paid under the pre-2014 OMFS physician fee schedule, as follows:

The hospital outpatient department facility fee would be the OMFS RBRVS non-facility practice expense (or technical component) relative value units (RVUs) with an OMFS RBRVS multiplier. “Facility Only Services” would be determined based on 101.01% of Medicare’s hospital outpatient departments prospective payment system (HOPPS)⁹. There would be a separate allowance for the related physician professional services based on the allowances for services provided in facility-settings.

RAND’s analysis indicates that relative to pre-2014 OMFS allowances, “if the RBRVS PE (or TC) were used to pay for services furnished by hospitals that are currently paid under the pre-2014 OMFS for physician services, there would be a 7.6 percent reduction in allowances after multiple procedure discounting and bundling rules are applied under the RBRVS.” This represents an estimated 0.5 percent decrease in total expenditures for hospital services to outpatients. These estimates are based on a fully transitioned RBRVS (120 percent of Medicare in 2014) rather than the actual 2014 transition rate (75% pre-

⁹ This multiplier includes an extra percentage reimbursement for high cost outlier cases.
Official Medical Fee Schedule –
Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule
Proposed Regulations

2014 OMFS/25% at 120% of Medicare). According to the RAND analysis, the actual estimated reduction will be “negligible” in 2014.

Workers’ compensation insurers, self-insured employers and workers’ compensation third party administrators, will benefit from administrative efficiency by harmonizing the hospital outpatient departments and ambulatory surgical centers fee schedule with the newly adopted RBRVS-based physician fee schedule, and eliminating the continued use of the extremely outdated pre-2014 OMFS physician fee schedule to determine the maximum facility allowances for non-surgical procedures and non-emergency room visit services rendered to outpatients.

The Acting Administrative Director also proposes to repeal sections 9789.33(b), (c), (d) and section 9789.37 pertaining to the alternative payment methodology for services rendered on or after the effective date of the proposed amendments to the regulation. Abolishing this rarely used payment alternative will reduce administrative burden, reduce complexity, and eliminate the impracticality of continuing to allow ASCs to elect the alternative payment methodology.

Injured workers will benefit by continuing to receive medically necessary outpatient treatment, at a reduced administrative cost to the hospitals.

Section 9789.30 – Definitions

Section 9789.30(j):

Specific Purpose: The subdivision is added to define “Facility Only Services” as those services identified by Medicare, that are rarely or are never performed in the non-facility setting, and are not: 1. Emergency room visits; 2. Surgical procedures; or 3. An integral part of the emergency room visit or surgical procedure, in accordance with section 9789.32.

Necessity: This amendment is necessary to clarify which services are considered “Facility Only Services”, to be paid at 101.01% of the Medicare HOPPS (which includes an extra percentage reimbursement for high cost outlier cases). The Acting Administrative Director has made the policy decision to transition facility fee payment from pre-2014 OMFS physician fee schedule to an OMFS RBRVS-based facility fee. However, a small subset of these services is considered “Facility Only Services” by Medicare. For “Facility Only Services”, Medicare assumes the services are provided in a facility setting. The RBRVS-based facility fee would not adequately compensate the hospital because facility-setting relative value units assume the hospital receives a separate facility fee under the Medicare HOPPS, for staffing and other costs associated with providing the service. Therefore, the Acting Administrative Director has determined these handful of “Facility Only Services” facility payment rates would be determined according to 101.01% of the Medicare HOPPS (which includes an extra percentage reimbursement for high cost outlier cases). The Acting Administrative Director has the discretion in setting the OMFS allowance level as long as it does not, in the aggregate,

Official Medical Fee Schedule –
Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule
Proposed Regulations

exceed 120% of the Medicare HOPPS. Based upon RAND’s impact analysis, the Acting Administrative Director believes the payment rate to be adequate and reasonable and will provide neutral cost incentives so that “Facility Only Services” will be provided when 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 above proposed amendments.

Section 9789.30(s):

Specific Purpose: The subdivision is added to define “Other Services” to mean those services rendered on or after the effective date, to outpatients and payable under the CMS HOPPS that are not: 1. Surgical procedures; 2. Emergency room visits; 3. Facility Only Services; or 4. An integral part of the surgical procedure, emergency room visit, or Facility Only Service.

Necessity: This amendment is necessary to define those services rendered to outpatients, except for “Facility Only Services”, that are currently paid under the pre-2014 OMFS physician fee schedule. Given the outdated nature of the pre-2014 OMFS physician fee schedule and the transition to RBRVS-based physician fee schedule, it is no longer appropriate to continue using the pre-2014 OMFS physician fee schedule to set facility fee allowances for these services.

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.

9789.30(u) (formerly “s”):

Specific Purpose: This subdivision is amended to add the word “Hospital” and “H” to acronym “HOPPS”.

Necessity: Amendment of section 9789.30(t) is necessary for clarity and consistency.

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 is added to define ‘OMFS RBRVS’ to mean the Official Medical Fee Schedule for physician and non-physician practitioner services in accordance with sections 9789.12.1 through 9789.19, of Title 8 of the California Code of Regulations.

Necessity: This amendment is necessary to distinguish between the pre-2014 OMFS for physician services and the OMFS RBRVS-based physician fee schedule in effect as of January 1, 2014.

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(aa) (formerly “x”):

Specific Purpose: This subdivision is amended to reformat the subdivision for clarity and to set forth the Workers’ Compensation Multiplier by date of service, type of facility, and service being rendered.

Necessity: This amendment is necessary for clarity and to make the subdivision more readable and understandable. This amendment provides that for services, including “Facility Only Services”, rendered on or after the effective date of the proposed amendments, the multiplier would be a percentage of Medicare’s HOPPS which includes an extra percentage reimbursement in lieu of an additional payment for high cost outlier cases. Because the Acting Administrative Director is proposing to abolish the alternative payment methodology (Section 9789.33(b)) for services rendered on or after the effective date of the proposed amendments, the alternative payment methodology multiplier would be deleted from this subdivision for services rendered on or after the effective date.

The Acting Administrative Director has made the policy decision to transition facility fee payment using the pre-2014 OMFS physician fee schedule to an OMFS RBRVS-based facility fee. However, there is a small subset of services that Medicare considers as “Facility Only Services”. For “Facility Only Services”, Medicare assumes the services are provided in a facility setting. The RBRVS-based facility fee would not adequately compensate the hospital because facility-setting relative value units assume the hospital receives a separate facility fee under the Medicare HOPPS, for staffing and other costs associated with providing the service. Therefore, the Acting Administrative Director has determined this handful of “Facility Only Services” facility payment rates would be determined according to 101.01% of the Medicare HOPPS, which includes an extra percentage reimbursement in lieu of additional payment for high cost outlier cases. The Acting Administrative Director has the discretion in setting the OMFS allowance level as long as it does not, in the aggregate, exceed 120% of the Medicare HOPPS. Based upon RAND’s impact analysis, the Acting Administrative Director believes the payment rate to be adequate and reasonable and will provide neutral cost incentives so that “Facility Only Services” will be provided when medically appropriate.

The Acting Administrative Director has also made the policy decision to repeal the alternative payment methodology for services rendered on or after the effective date of the proposed amendments. 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. 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, which are generally regulated by the California Medical Board, and surgical clinics owned and operated by others, which 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.¹⁰ 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.

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 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.

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(d):

Specific Purpose: This subdivision is added to incorporate by reference, the Medicare Physician Fee Schedule "Relative Value File" published by Medicare, in effect as of the date the Administrative Director Order becomes effective.

¹⁰ In 2010, there were 754 ASCs operating in California. However, only 52 reported data to OSHPD, down from 451 in 2007. (*Ambulatory Surgery Centers: Big Business, Little Data*, California Health Care Almanac, California HealthCare Foundation, June 2013.

Official Medical Fee Schedule –
Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule
Proposed Regulations

Necessity: This amendment is necessary to transition maximum facility allowance based on the outdated pre-2014 OMFS physician fee schedule to an OMFS RBRVS-based facility fee. The Medicare Relative Value File would be used to identify “Facility Only Services” as identified by Medicare.

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: This subdivision is amended to expand the applicability of Sections 9789.30 through 9789.39 to include Facility Only Services furnished by hospital outpatient departments to outpatients on or after the effective date of the proposed amendments.

Necessity: With the transition to an OMFS RBRVS-based facility fee for “Other Services”, it is necessary to amend subdivision 9789.32(a) so that “Facility Only Services” would be paid in accordance with the hospital outpatient departments and ambulatory surgical center fee schedule.

The Acting Administrative Director has made the policy decision to transition facility fee payment from using the pre-2014 OMFS physician fee schedule to an OMFS RBRVS-based facility fee. However, there a small subset of services that are considered “Facility Only Services” by Medicare. For “Facility Only Services”, Medicare assumes the services are provided in a facility setting. The RBRVS-based facility fee would not adequately compensate the hospital because facility-setting relative value units assume the hospital receives a separate facility fee under the Medicare HOPPS, for staffing and other costs associated with providing the service. Therefore, the Acting Administrative Director has determined this handful of “Facility Only Services” facility payment rates would be determined according to 101.01% of the Medicare HOPPS, which includes an extra percentage reimbursement in lieu of additional payment for high cost outlier cases. The Acting Administrative Director has the discretion in setting the OMFS allowance level as long as it does not, in the aggregate, exceed 120% of the Medicare HOPPS. Based upon RAND’s impact analysis, the Acting Administrative Director believes the payment rate to be adequate and reasonable and will provide neutral cost incentives so that “Facility Only Services” will be provided when 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 9789.32(a)(1):

Official Medical Fee Schedule –
Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule
Proposed Regulations

Specific Purpose: Subdivision (a)(1) is amended to set forth when a supply, drug, device, blood product and biological (with status code N, Q1, Q2, or Q3) is considered an integral part of an emergency room visit, surgical procedure, or Facility Only Service rendered on or after the effective date of the proposed amendments.

Necessity: Amendment to subdivision (a)(1) is necessary to conform to changes made to include facility fees for Facility Only Services 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 9789.32(a)(2):

Specific Purpose: Subdivision (a)(2) is amended to set forth when a supply, drug, device, blood product and biological (with status code G,H,K,R, or U) is considered an integral part of an emergency room visit, surgical procedure, or Facility Only Service rendered on or after the effective date of the proposed amendments.

Necessity: Amendment to subdivision (a)(2) is necessary to conform to changes made to include facility fees for Facility Only Services 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 9789.32(c):

Specific Purpose: Subdivision (c) is amended to adapt the section to be applicable to “Other Services” furnished to outpatients on or after the effective date of the proposed amendments.

Necessity: Amendment to subdivision (c) is necessary to set forth how “Other Services” payment rates would be determined.

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(c)(1)(A):

Specific Purpose: Subdivision (c)(1)(A), formerly (c)(1) is reformatted to add a subdivision (A). Subdivision (c)(1)(A) indicates that for professional medical services rendered on or after July 1, 2004, but before January 1, 2014, that do not meet the requirements in subdivision (a) for a facility payment, shall be determined according to the pre-2014 OMFS physician fee schedule, sections 9789.10 and 9789.11.

Official Medical Fee Schedule –
Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule
Proposed Regulations

Necessity: Amendment to this subdivision is necessary to clarify when the pre-2014 OMFS physician fee schedule would still be applicable.

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(c)(1)(B):

Specific Purpose: Subdivision (c)(1)(B) is added to indicate that for services rendered on or after January 1, 2014, the maximum allowable facility fees for “Other Services” that do not meet the requirements in subdivision (a), shall be paid according to the OMFS RBRVS-based physician fee schedule beginning with Section 9789.12.1.

Necessity: This subdivision is necessary to clarify when the OMFS RBRVS-based facility fee schedule would be applicable.

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(c)(1)(B)(i):

Specific Purpose: Subdivision (c)(1)(B)(i) is added to set forth the payment methodology for “Other Services” that have separate professional component/technical components RBRVS relative value units. The hospital outpatient facility fee shall be determined using the technical component OMFS RBRVS relative value units.

Necessity: Addition of subdivision (c)(1)(B)(i) is necessary to set forth the new payment methodology for “Other Services” with separate professional/technical components that were previously paid according to the pre-2014 OMFS physician fee schedule.

Diagnostic and therapeutic services with separate PC/TC components account for more than 80 percent of the allowances for services furnished by hospital outpatient departments to outpatients that are covered by the pre-2014 OMFS for physician services. If the services are provided to a hospital outpatient, the facility would be entitled to the technical component to cover their costs (such as staff and equipment, etc.).

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(c)(1)(B)(ii):

Specific Purpose: Subdivision (c)(1)(B)(ii) is added to set forth the payment methodology for “Other Services” that do not have separate professional component/technical component RBRVS relative value units. The hospital outpatient facility fee shall be determined using the OMFS RBRVS non-facility practice expense relative value units.

Necessity: Addition of subdivision (c)(1)(B)(ii) is necessary to set forth the payment methodology for “Other Services” that do not have separate professional/technical components that were previously paid according to the pre-2014 OMFS physician fee schedule.

Under the RBRVS-based system, Medicare has developed practice expense relative value units specific to the facility and non-facility settings. Generally, the facility practice expense relative values would be used for services performed in inpatient or outpatient hospital settings, emergency rooms, skilled nursing facilities, or ambulatory surgical centers. The non-facility practice expense relative value units would be used for services furnished in other settings such as a physician’s office, which would cover costs for staffing, equipment, and other overhead. Under the proposed payment methodology, the hospital outpatient department facility fee would use the non-facility practice relative values in the calculation of their maximum allowance.

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(c)(1)(B)(iii):

Specific Purpose: Subdivision (c)(1)(B)(iii) is added to set forth the payment methodology for any physician and non-physician practitioner professional services billed by the hospital. The fee shall be determined using the OMFS RBRVS total facility relative value units.

Necessity: Addition of subdivision (c)(1)(B)(iii) is necessary to clarify the payment methodology for any physician and non-physician practitioner professional services billed by the hospital. Most services (other than those with a TC modifier) involve physician work. This means that in addition to the outpatient facility fee, there is a separate allowance for the professional service that is payable under the OMFS RBRVS-based physician fee schedule. Under the proposed payment methodology, the physician/non-physician practitioner professional service fees shall be determined using the OMFS RBRVS total facility relative value units.

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(c)(5):

Specific Purpose: Subdivision (c)(5) is deleted.

Necessity: Subdivision (c)(5) is deleted as it is no longer necessary due to the proposed amendments. Services with status code indicator “X” are included in “Other Services”.

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(d):

Specific Purpose: Subdivision (d) is amended to conform the subdivision to include Facility Only Services and Other Services furnished to outpatients on or after the effective date of the proposed amendments; and to clarify that facility fees are not payable to ambulatory surgical centers for any services that are not an integral part of the surgical procedure.

Necessity: Amendment to section 9789.32(d) is necessary to conform to proposed changes made in this fee schedule and the transition from the pre-2014 OMFS physician fee schedule to an OMFS RBRVS-based facility fee.

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: Subdivision (a) is reformatted for clarity; amended to include the payment methodology for Facility Only Services; and amended to conform the extra percentage reimbursement allowed in lieu of an additional payment for high cost outliers to changes in the CMS HOPPS.

To reduce repetition and unnecessary language, the payment formula is amended by removing “1.22” and “0.82” from the formula, and citing to Section 9789.30(aa) by date of service. The formula now states, “APC payment rate x workers’ compensation multiplier pursuant to Section 9789.30(aa), by date of service”.

To conform to the proposed amendments in this regulation, the subdivisions are re-numbered and all references to former Section 9789.30(x) is amended to reflect the re-lettering of this subdivision (9789.30(aa)).

Necessity: Amendment to section 9789.33(a) is necessary to conform to proposed changes to this fee schedule. A small subset of services (“Facility Only Services”) do not have non-facility setting practice expense RVUs because Medicare assumes the services

are provided in a facility setting only. The RBRVS-based facility fee payment would not adequately compensate the hospital because the facility-setting RVUs assume that the hospital receives a separate facility fee under the Medicare hospital outpatient departments prospective payment system, for staffing and other costs associated with providing the service. Therefore, the Acting Administrative Director has made the policy decision that facility fees for “Facility Only Services” would be determined under the hospital outpatient department fee schedule.

The workers’ compensation multipliers (which include an extra percentage reimbursement in lieu of an additional payment for high cost outlier cases) are adjusted to conform to Medicare. Section 1833(t)(5)(c) of the Social Security Act specifies that the estimated total of additional payments for outliers cannot exceed 3 percent of the estimated total program payments in that year. Currently, Medicare allocates 1 percent of total program payments to outlier payments each year. Therefore, the extra percentage added to the workers’ compensation multipliers was adjusted to reflect Medicare’s allocation of 1 percent of total program 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 subdivision.

Sections 9789.33(a)(1), 9789.33(a)(3), 9789.33(a)(4), and 9789.33(a)(5):

Specific Purpose: These subdivisions are amended to reduce repetition and unnecessary language, the payment formula is amended by removing “1.22” and “0.82” from the formula, and citing to Section 9789.30(aa) by date of service. The formula now states, “APC payment rate x workers’ compensation multiplier pursuant to Section 9789.30(aa), by date of service”.

Necessity: These amendments are necessary to improve clarity and reduce unnecessary repetition, and make it 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):

Specific Purpose: This subdivision is amended to state that this section is repealed as of the effective date of the proposed amendments. The effective date of the proposed amendments is added throughout this subdivision to clarify that this subdivision is only applicable to services rendered before the effective date of the proposed amendments. All references to Section 9789.30(x) is now Section 9789.30(aa), to conform to the re-lettering of sections proposed by these amendments.

Necessity: The hospital outpatient departments and ambulatory surgical centers 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 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. 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, which are generally regulated by the California Medical Board, and surgical clinics owned and operated by others, which 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.

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 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 Acting Administrative Director is considering abolishing the alternative payment methodology for services rendered on or after the effective date of the proposed amendments to the regulation. The amendments to this subdivision conform to the Acting Administrator's decision to repeal the alternative payment methodology for services rendered on or after the effective date of the proposed amendments.

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) and Section 9789.33(d):

Specific Purpose: Subdivisions (c) and (d) are amended to state that this section is repealed as of the effective date of the proposed amendments.

Necessity: These revisions are necessary to conform to the proposal to repeal the alternative payment methodology for services rendered on or after the effective date of the proposed amendments.

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 9789.37 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 repeal this form for services rendered on or after the effective date of the proposed amendments.

Necessity: This amendment is necessary to conform to the proposal to repeal the alternative payment methodology for services rendered on or after the effective date of the proposed amendments.

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: Subdivision (b) is amended to add “Facility Only Services” and “Medicare Physician Fee Schedule Relative Value File” for services rendered on or after the effective date of the proposed amendments.

Necessity: Amendments to this subdivision are necessary to conform to the proposed changes to 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 added section.