Section	Issue	Comment	Response	Commenter
§9789.30; §9789.32	"Integral Part" and "Other Services" definitions should be clarified to indicate the appropriate applicability of each.	Commenter states several sections within the proposed fee schedule rules reference reimbursement rules for "integral part(s)" of other defined services. However, determinations of what constitutes an "integral part" are subjective and may vary. Furthermore, the "Other Services" definition appears to focus on which services are *excluded* from the definition rather than which services are specifically *included*. Commenter suggests regulations provide CPT code ranges of services and/or concrete definitions of	Please see the response provided in the Hospital Outpatient Departments Services Second 30-Day Comment Period Chart Ending July 6, 2016.	2.4 (Lisa Anne Forsythe, Coventry Work Comp Services) **Late submittal**

Section	Issue	Comment	Response	Commenter
		circumstances under which a service is to be considered an "integral part" of another service, and modify the definition of "Other Services" to specifically indicate which services are to be included (rather than limiting the definition to those services that are specifically excluded). Furthermore, if subsection (u) on page 3 of the proposed rules, under the definition of "Other Services", were amended to strike all language that follows the reference to the CMS Hospital Outpatient Prospective Payment System (OPPS), the definition of "Other Services" would be much "cleaner" and would simply default back to the CMS OPPS payment policies for		

Section	Issue	Comment	Response	Commenter
		payment of all "Other Services".		
§9789.31; §9789.39(b)	Status Indicator Codes	Commenter states for the most part, California has adopted the CMS model when using status indicators to dictate payment methodologies. However, some status indicators remain undefined in the California OP/ASC fee schedule, and others are defined differently than the CMS model. Commenter states the rules should be clarified to indicate which specific procedure codes are subject to the multiple surgical reduction rule in an outpatient setting, and which are not. Commenter includes Attachment B as an example of the reimbursement	Outside the scope of this rulemaking and comment period. However, please see the response provided in the Hospital Outpatient Departments Services Second 30-Day Comment Period Chart Ending July 6, 2016. CMS HOPPS Addendum D1 — which is adopted and incorporated by reference in §9789.31(a) and §9789.39(b) — states that the multiple procedure reduction does not apply to services with status indicator code "S"; and is applicable to services with status indicator code "T."	2.3 and 2.11 (Lisa Anne Forsythe, Coventry Work Comp Services) **Late submittal**

Section	Issue	Comment	Response	Commenter
		differential.		
§9789.31	Adoption of NCCI edits applicable to outpatient and ASC facility bills	Commenter states although not in the present fee schedule rules and proposed rule, commenter requests DWC include a provision to clarify whether the CCI edits is applicable to outpatient hospital/ASC facility bills. For example, it would be odd if the facility fee for a 1 bundled surgery code would be paid while the physician professional service would be disallowed per CCI edits.	Outside the scope of this rulemaking. The DWC, however, will take this issue into consideration during a future rulemaking.	7.1 (Myel Boulter, Genex Services)
§9789.32(c)	Applicability of subdivision (c) to ASCs	Commenter states the "stri[c]ken reference to ASC's in the "Applicability" Section at the bottom of page 8 of the proposed rules creates confusion as to whether retrospective applicability is intended, and should either be removed or clarified.	Outside the scope of this comment period. However, the DWC does not perceive this as retrospective application. The only parts of current subdivision (c) that are applicable to ASCs are (c)(2) - (6).	2.8 (Lisa Anne Forsythe, Coventry Work Comp Services) **Late submittal**

Section	Issue	Comment	Response	Commenter
			The proposed amendments move the above referenced current subdivisions (and current §(c)(1)(B)(iii)) to a new proposed §9789.32(d), which would be applicable to hospital outpatient department services and ASCs.	
§9789.32(c)(1)(B)(ii)	Base Facility Fee calculation	Commenter states the "Base Facility Fee" calculation that is located in the second paragraph under (B)(ii) is confusing and appears to contradict the "Other Services" provision as currently defined. The first and second paragraphs contain two totally different calculations. It is unclear as to whether there are circumstances under which the first paragraph is to apply and others under which	Outside the scope of this comment period. However, please see the response provided in the Hospital Outpatient Departments Services Second 30-Day Comment Period Chart Ending July 6, 2016.	2.10 (Lisa Anne Forsythe, Coventry Work Comp Services) **Late Submittal**

Section	Issue	Comment	Response	Commenter
		the second paragraph is applicable. Commenter suggests clearly defining the circumstances under which the "Base Facility Fee" calculation is to apply vs. the "Other Facilities" calculation. Alternatively, strike one of the two calculations entirely to eliminate any additional confusion.		
§§9789.32(d), (g), and (h)	Treatment of Exempt Hospitals	Commenter states that it is clear that the DWC, through this rulemaking, aims to abolish the utilization of the Physician Fee Schedule for hospital services, and preserve the utilization of that fee schedule for physician and non-physician practitioner professional services *only*. It is also clear that the DWC exempts certain hospitals from the OMFS-HODASC [Section 9789.32(f) and (g), as	It is clear the OMFS-HOPD/ASC fee schedule (sections 9789.30 through 9789.39) pertains to payment of maximum reasonable HOPD/ASC ***facility*** fees for services provided on an outpatient basis. Subdivisions 9789.32(g) and (h) specifically exempt certain hospitals (EXEMPT HOSPITALS) from being subject to the OMFS-HOPD/ASC fee schedule (sections 9789.30 through 9789.39) for purposes of	1.1 (Chris Clayton, Triage Consulting Group) **Late submittal**

Section	Issue	Comment	Response	Commenter
		currently in effect; (g) and (h), as currently proposed]. (These exemptions have been present in the OMFS-HODASC since 2004 and are not changed by the current rulemaking beyond the paragraph numbering.) While the commenter believes the OMFS-HODASC, as in effect since 2004 and as presently proposed to be amended, makes clear these types of exempt hospitals shall not be subjected to the rules and payment methodologies put into play by the OMFS-HODASC (e.g., Sections 9789.30 through 9789.39, inclusive of the other fee schedules referenced therein), commenter worries that the most recent re-writing of Section 9789.32(d), as currently	determining maximum reasonable ***facility*** fees. Therefore, section 9789.32(d), is inapplicable to EXEMPT HOSPITALS for determining ***facility*** fees. When billing, however, for ***other than facility fees***, EXEMPT HOSPITALS are subject to other fee schedules of the OMFS, unless otherwise provided. For example, the EXEMPT HOSPITAL is not subject to the OMFS-HOPD/ASC fee schedule, including section 9789.32(d), for determining payment of facility fees for services rendered in the EXEMPT HOSPITAL; nor should it be inferred from the amended language, or otherwise, that facility fees will be determined using the OMFS-RBRVS. However, if the EXEMPT HOSPITAL bills for	

Section	Issue	Comment	Response	Commenter
		proposed, could be used to justify the application of the other fee schedules or payment methodologies described thereunder [Section 9789.32(d)(1)-(6), as currently proposed] to an exempt hospital's billing. This is because, technically, the "service or goods" of these exempt hospitals are "not covered by the Hospital Outpatient Departments and Ambulatory Surgical Centers fee schedule" *because* they are expressly exempted from this fee schedule pursuant to Section 9789.32(f) and (g), as currently in effect; (g) and (h), as currently proposed. That seems to unintentionally 'open the gate' for exempt hospitals' services to be paid pursuant to Section	professional physician services on behalf of a physician, the EXEMPT HOSPITAL should use the OMFS-RBRVS for determining reimbursement of the physician's professional services. The DWC will monitor and if required, address this issue in a future rulemaking.	

Section	Issue	Comment	Response	Commenter
		9789.32(d)(1)-(6). To eliminate any confusion, commenter offers the following suggestions to clarify, which are *not* mutually exclusive: Section 9789.32(d): "With the exception of those exempt hospitals under Sections 9789.32(g) and (h), Hospital Outpatient Departments and ASCs should utilize other applicable parts of the OMFS to determine maximum allowable fees for services or goods not covered by the Hospital Outpatient Departments and Ambulatory Surgical Centers fee schedule (Sections 9789.30 through 9789.39)." Section 9789.32(d)(1):		

Section	Issue	Comment	Response	Commenter
		"The fees for any physician and non-physician practitioner professional services billed by the hospital on behalf of the physician or non-physician practitioner profession shall be determined in accordance with the OMFS RBRVS." Commenter states this Section 9789.32(d)(1), as proposed, pertains only to services billed by the hospital that are actually *professional* services (i.e., reported on the hospital's UB-04 under Revenue Codes 96x, 97x, and 98x).		
§9789.32(d)	Applicability of this subdivision to ASCs	Commenter states the ASCs may only bill for surgery services or services that are integral to the surgery service; thus, services described under 9789.32(d) do not apply to ASCs. The	The OMFS Hospital Outpatient Departments/ASC (HOPD/ASC) fee schedule (§§9789.30 through 9789.39) determines payment of maximum reasonable	3.1 (Stacy L. Jones, California Workers' Compensation Institute)

Section	Issue	Comment	Response	Commenter
		Institute recommends deleting reference to ASCs in order to eliminate confusion if an ASC bills for non-surgical services or products.	HOPD/ASC facility fees for services provided on an outpatient basis. §9789.32(d), as proposed, directs ASCs to utilize other fee schedules of the OMFS for billing of services furnished in ASCs which are other than facility fees, and therefore, not payable under the HOPD/ASC fee schedule. There may be other items and services furnished in an ASC which do not get a facility fee, but, can be covered and paid for under another applicable OMFS fee schedule. One example would be when an ASC furnishes non-implantable durable medical equipment (DME) to ASC patients for their	

Section	Issue	Comment	Response	Commenter
			use in their homes. In this case, the ASC would bill and receive payment according to the DMEPOS fee schedule.	
§9789.32; §9789.33	Composite APCs	Commenter requests the HOPD/ASC fee schedule address Composite APC reimbursement. Commenter states that although DWC has adopted Addendum M for the past few years, most payers as well as Maximus will not allow proper reimbursement for Composite APCs. Commenter believes additional guidance will help all involved and lessen the possibility that these cases end up at the boards as petitions to IBR determinations.	The current and proposed regulation adopts and incorporates by reference CMS' description of status indicator "Q3" which is described as codes that may be paid through a Composite APC. In particular, §9789.31(a) adopts and incorporates by reference certain CMS HOPPS addenda by date of service. And §9789.39(b) specifically adopts Addendum D1 (OPPS payment status indicators (SI) for CY 2016), Addendum B (OPPS Payment by HCPCS Code), and Addendum M (Final HCPCS Codes for Assignment to Composite APCs) by	6.1 (Marko Vucurevic, Sequetor)

Section	Issue	Comment	Response	Commenter
			date of service. Addendum D1 provides that Status Indicator "Q3" means, "Codes That May Be Paid Through a Composite APC… Paid under OPPS; Addendum B displays APC assignments when services are separately payable. Addendum M displays composite APC assignments when codes are paid through a composite APC. (1) Composite APC payment based on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combination of services. (2) In other circumstances, payment is made through a separate APC payment or packaged into payment for other services."	

Section	Issue	Comment	Response	Commenter
§9789.33	Clarification of use of status indicator "J1"	Commenter states status indicator "J1" is referenced in Sections 9789.33(a)(3) and (4) for the first time. Commenter feels it is unclear from the rules whether all of the "J1" CMS status indicator payment policies are also intended to be incorporated as well, or whether the presence of the J1 status indicator is simply used to flag an accompanying status code "K" or "R" as a "zero pay" at the line level.	Outside the scope of this comment period. However, please see the response provided in the Hospital Outpatient Departments Services Second 30-Day Comment Period Chart Ending July 6, 2016.	2.5 (Lisa Anne Forsythe, Coventry Work Comp Services) **Late Submittal**
§9789.33	Services assigned "J1," "J2," "N," or "Q" status indicator codes	Commenter states in order to avoid inequitable over-reimbursement, *all* services accompanying a J1 or J2 status code procedure should be bundled; not just services with status indicator "K" or "R." Commenter states the	The proposed regulations adopt and incorporate by reference CMS' description of status indicators, including, "J1," "J2," "N," "Q1," "Q2," "Q3," and "Q4." In particular, §9789.31(a) adopts and incorporates by	2.6 and 2.7 (Lisa Anne Forsythe, Coventry Work Comp Services) **Late Submittal**

Section	Issue	Comment	Response	Commenter
		proposed rule contains references to procedures with J1 (major surgical) and J2 (ER service) status code indicators. CMS/Medicare applies packaging rules for many different types of products/services when accompanying a J1 or J2. The wording seems to imply that the only services that would be bundled would be those services with status indicators of "K" and "R". This would result in an inequitably high reimbursement for other services accompanying the J1 and J2 procedure that would previously not have received an additional payment per CMS/Medicare. Commenter provides a spreadsheet providing an example of the	reference certain CMS HOPPS addenda by date of service. And §9789.39(b) specifically adopts Addendum D1 (OPPS payment status indicators (SI) for CY 2016) and Addendum J (Comprehensive APCs (including Addendum J2)) for services rendered on or after the date the proposed amendment is adopted. Addenda D1 and J (for SI "J1" and "J2") address how the services assigned to various status indicator codes are to be reimbursed. Addendum D1 for CY 2016 states "J1" pertains to "Hospital Part B services paid through a comprehensive APC. " The service is paid "under OPPS; all covered Part B services	

Section	Issue	Comment	Response	Commenter
		reimbursement differential that would result. Commenter states the rules should be clarified to indicate whether applicability of the "N" and "Q" status indicator guidelines are intended to apply to all types of services, or just services that are "supplies, drugs, devices, blood products or biologicals."	on the claim are packaged with the primary "J1" service for the claim, except services with OPPS SI= F, G, H, L and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services." Addendum D1 for CY 2016 states "J2" pertains to "Hospital Part B services that may be paid through a Comprehensive APC. Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Comprehensive APC payment based on OPPS comprehensive-specific payment criteria. Payment for all covered Part B services on the	

Section	Issue	Comment	Response	Commenter
			claim is packaged into a single payment for specific combinations of services, except services with OPPS SI = F,G,H,L, and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services. (2) Packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator "J1." (3) In other circumstances, payment is made through a separate APC payment or packaged into payment for other services." Addendum D1 for CY 2016 states "N" pertains to "[i]tems and services packaged into APC rates. Paid under OPPS; payment is packaged into payment for other	

Section	Issue	Comment	Response	Commenter
			services. Therefore, there is no separate APC payment." Likewise, Addendum D1 for CY 2016 also describes "Q1," "Q2," "Q3," and "Q4" and when the service is separately payable or packaged. §9789.33(a) pertains to how the maximum reasonable standard fee is determined according to ***status indicator*** (as well as by date of service, type of service, and site of service). Payment of codes assigned "J1" and "J2" status indicators are addressed in the table found in subdivision (a). Specifically, services with status indicator codes "S," "T," "V," "Q1," "Q2," "Q3," "J1," or "J2" (Status code	

Section	Issue	Comment	Response	Commenter
			indicators must qualify for separate payment) are addressed in this table, for services rendered on or after the date the proposed amendments are adopted. Payment for services with status indicator codes "G," "H," "K," "R," and "U" are addressed in §§9789.33(a)(1) – (5). Status indicator code "N" is not addressed in §9789.33 because, by definition, there is no separate APC payment. §9789.32(a) defines when a supply, drug, device, or blood product and biological is considered an integral part of an emergency room visit, or surgical procedure, or if applicable, Facility Only Service, or if applicable and only if rendered on	

Section	Issue	Comment	Response	Commenter
			or after the date this amendment is adopted, Other Service.	
§9789.33(a)	Comprehensive APC methodologies for APC Status Indicator Codes "J1" and "J2"	Commenter recommends DWC add clarification that the Comprehensive APC methodologies applied in the Medicare OPPS are incorporated by reference, if in fact those "episode of care" concepts are to be followed for CA Workers' Compensation claims.	The proposed regulations adopt and incorporate by reference CMS' description of status indicators "J1" and "J2." In particular, §9789.31(a) adopts and incorporates by reference certain CMS HOPPS addenda by date of service. And §9789.39(b) specifically adopts Addendum D1 (OPPS payment status indicators (SI) for CY 2016) and Addendum J (Comprehensive APCs (including Addendum J2)) for services rendered on or after the date the proposed amendment is adopted. Addenda D1 and J pertain to how "J1" and "J2" codes are to be reimbursed.	5.1 (Lisa Andreozzi, Medata)

Section	Issue	Comment	Response	Commenter
			Addendum D1 for CY 2016 states “J1” pertains to “Hospital Part B services paid through a comprehensive APC. “ The service is paid “under OPPS; all covered Part B services on the claim are packaged with the primary “J1” service for the claim, except services with OPPS SI= F, G, H, L and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services.” Addendum D1 for CY 2016 states “J2” pertains to “Hospital Part B services that may be paid through a Comprehensive APC. Paid under OPPS;	

Section	Issue	Comment	Response	Commenter
			Addendum B displays APC assignments when services are separately payable. (1) Comprehensive APC payment based on OPPS comprehensive-specific payment criteria. Payment for all covered Part B services on the claim is packaged into a single payment for specific combinations of services, except services with OPPS SI = F,G,H,L, and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services. (2) Packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator "J1." (3) In other circumstances, payment is made through a separate APC payment or packaged	

Section	Issue	Comment	Response	Commenter
			into payment for other services." Addendum J includes the complexity adjustments of combinations of comprehensive HCPCS codes.	
§9789.33; §9789.39(b)	ASC payment system	Commenter states there seems to be a conflict on the use of the payment data for outpatient bills. Should the payers be using the ASC payment system or the OPPS APC payment system to pay ASC facility bills? Commenter further asks, is the DWC planning only to use the ASC addendum data to identify the surgical code payable to an ASC, but still intend to use the APC relative weights for the actual payment of these services?	The ASC payment methodology is based upon CMS' Hospital Outpatient Departments Prospective Payment System (HOPPS) APC payment system. As evidenced, §9789.30 definitions of APC, APC Payment Rate, and APC Relative Weight all cite to CMS' HOPPS. Furthermore, §9789.39(b) adopts CMS' HOPPS Addendum B for determining APC payment rates and APC relative weights. These HOPPS APC payment rates and APC relative weights are applicable in	4.1, 4.2, and 4.3 (Sheri North, Mitchell)

Section	Issue	Comment	Response	Commenter
		Finally, commenter refers to §9789.33, stating this section references APC relative weight for payment to ASCs. Should this be the ASC payment weight if they are using the CMS "Ambulatory Surgical Center Payment System?"	determining ASC facility fees in accordance with §9789.33. The only CMS ASC Payment System data proposed to be adopted and incorporated by reference into the OMFS HOPD/ASC fee schedule are the HCPCS codes listed in "column A" of the July 2016 ASC Addendum AA and "column A" of addendum EE. As proposed, the remaining columns of Addendum AA and Addendum EE are NOT adopted by the OMFS HOPD/ASC fee schedule, and therefore, would not be applicable for determining payment to ASCs. The sole purpose for adopting and incorporating by reference HCPCS codes listed in column A of	

Section	Issue	Comment	Response	Commenter
			addendum AA and column A of addendum EE is for inclusion in the definition of "Surgical Procedure HCPCS" set forth in §9789.39(b).	
General	Formatting – Use of indentation	Commenter requests the formatting include indentation for ease of referencing sections within the OP/ASC fee schedule. Commenter states it can be difficult to ascertain which sections are intended to be subsections of larger headings due to the lack of indentation, and it can result in misinterpretations of particular provisions within the Fee Schedule.	Please see the response provided in the Hospital Outpatient Departments Services Second 30-Day Comment Period Chart Ending July 6, 2016.	2.1 (Lisa Anne Forsythe, Coventry Work Comp Services) **Late Submittal**
General	Formatting – Consistent use of versioning	Commenter states that as proposed, the fee schedule contains multiple references to varied effective dates for different provisions. As a result, it can be difficult to decipher	Please see the response provided in the Hospital Outpatient Departments Services Second 30-Day Comment Period Chart Ending July 6, 2016.	2.2 (Lisa Anne Forsythe, Coventry Work Comp Services) **Late Submittal**

Section	Issue	Comment	Response	Commenter
		which sections are intended to apply to which dates of service and on which effective dates. Commenter suggests the fee schedule make all provisions current as of the effective date, and move all historical sections and references to either another document entirely with a different effective date, or into an appendix. Commenter also requests the document highlight the changes from one version of the document (with one set of effective dates) to the newer version. Use of current-only information would eliminate the need for the cumbersome table at the end of the proposed fee schedule that also contributes to		

Section	Issue	Comment	Response	Commenter
		confusion.		
General	Retroactivity	Commenter states some of the provisions contained in the proposed fee schedule have retroactive applicability to as far back as 2009 dates of service. Incorporation of these retroactive provisions would be very difficult for payers, and will cause confusion to providers that have grown accustomed to applying the currently existing rules (and/or historically-applicable rules, as appropriate to the date of service), and will likely result in an increase in the number of disputes. Commenter further states inclusion of retroactive provisions will trigger a lengthier and more comprehensive level of review by OAL, and is not warranted to solve	Please see the response provided in the Hospital Outpatient Departments Services Second 30-Day Comment Period Chart Ending July 6, 2016.	2.9 (Lisa Anne Forsythe, Coventry Work Comp Services) **Late Submittal**

Section	Issue	Comment	Response	Commenter
		an urgent stakeholder need.		
General	Bilateral Services	Commenter states the rules should be clarified to specify the reimbursement methodology guidelines for bilateral procedures performed in an outpatient setting.	Outside the scope of this rulemaking.	2.12 (Lisa Anne Forsythe, Coventry Work Comp Services) **Late Submittal**