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 circumstances under which a service is to be considered an "integral part" of another service,	The DWC appreciates commenter's suggestions, but respectfully disagrees. It is unreasonable to provide CPT code ranges of what would be considered an "integral part" of a surgical procedure, emergency department service, etc., due to the wide-ranging variations, complexity, and resources required. The rulemaking does not propose to change the criteria in determining when a supply, drug, device, blood product and biological would be considered an "integral part" of other defined services. The DWC does not believe the criteria are subjective or variable, as it is determined according to assigned status indicator codes.	3.7 (Lisa Anne Forsythe, Coventry Work Comp Services)

Section	Issue	Comment	Response	Commenter
		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 payment of all "Other Services".	The DWC believes the definition of "Other Services" must retain reference to CMS HOPPS because in order for services to be payable under the OMFS HOPD fee schedule, the service must also be payable under the CMS HOPPS.	
§9789.31	Adoption of NCCI edits (Hospital PTP Edits and Facility Outpatient Services MUE) specific	Commenter states NCCI edits are formally adopted under the Physician fee schedule	The DWC appreciates commenter's comments and inquiries, but, it is not within the scope of	5.1 (Karen L. Sims, State Compensation Insurance Fund)

Section	Issue	Comment	Response	Commenter
	to outpatient facilities.	regulations. Medìcare publishes similar edits specific to hospital outpatient facilities—Hospital PTP edits and Facility Outpatient Services MUE tables. These NCCI edits protect against improper coding practices, unbundling of services, and billing for excessive units based on nature of procedures and clinical data. Commenter asks whether the DWC plans to explicitly adopt the NCCI edits under the Outpatient Fee Schedule regulations.	this rulemaking. The DWC, however, will take this issue into consideration during a future rulemaking.	
§§9789.31(d), 9789.32(d)(1), and 9789.39(b)	Incorporation of the Medicare Physician Fee Schedule, "Relative Value File"	Commenter 2 states it appears the DWC still intends for some *very limited and specific* services, billed by hospitals as described under proposed Section 9789.32(d)(1), to a paid pursuant to the OMFS RBRVS (services billed by the hospital that are actually professional	The DWC appreciates commenter's suggestions and comments. The intended purpose of §9789.32(d)(1) through (6) is to direct the reader to use other fee schedules of the OMFS for payment of services that are not payable under the OMFS	2.2 (Chris Clayton, Triage Consulting Group) 5.3 (Karen L. Sims, State Compensation Insurance Fund)

Section	Issue	Comment	Response	Commenter
		services, i.e., Reported on the hospital's UB – 04 under revenue codes 96x, 97x, 98x). If this is correct, the OMFS RBRVS (etc.) must be preserved within the framework of the OMFS –HODASC on a go–forward basis, but only with respect to proposed Section 9789.32(d)(1). Commenter encourages the DWC to revisit its proposed changes to the following areas: Section 9789.31(d) and Section 9789.39(b)-row in table for Medicare Physician Fee Schedule Relative Valued File effective for services occurring on or after date amendment is filed with the Secretary of State and mid-year Updates.	hospital outpatient departments/ambulatory surgical centers fee schedule (i.e. other than facility fees). To clarify this intent, DWC proposes to add the following language to §9789.32(d): "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)." It is also proposed §9789.32(d)(1) be modified to state, "The fees for any physician and non-physician practitioner professional services shall be determined in accordance with the	

Section	Issue	Comment	Response	Commenter
			OMFS RBRVS." DWC appreciates commenter's question. Please see above response. In addition, OMFS HOPD/ASC fee schedule has adopted CMS' HOPPS Addendum D1 which provides the description of the HOPPS payment status indicators for the relevant calendar year. (Section 9789.31(a) adopts and incorporates by reference certain CMS HOPPS addenda. And Section 9789.39(b) specifically adopts Addendum D1 by date of service.) Status Indicator Code "T" is a procedure or service where the Multiple Procedure Reduction applies. Section 9789.38 adopts and incorporates by reference 42 CFR §419.44 — payment reductions for procedures. The	
		Commenter 5 asks what MPPR rules and reimbursement caps, if any, contained under OMFS RBRVS will be applicable to hospital outpatient facility fees for Date of Services (DOS) on or after the date amendment is filed with the Secretary State.		

Section	Issue	Comment	Response	Commenter
			proposed amendment to §9789.39(a) adopts and incorporates by reference 42 CFR §419.44, as amended effective January 1, 2016.	
§§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.	DWC appreciates commenter's concerns, but, it is not within the scope of this rulemaking. However, it should be noted that OMFS HOPD/ASC fee schedule has adopted CMS' HOPPS Addendum D1 which provides the description of the OPPS payment status indicators for the relevant calendar year. (Section 9789.31(a) adopts and incorporates by reference certain CMS HOPPS addenda by date of service. And Section 9789.39(b) specifically adopts Addendum D1 by date of service.	3.3 (Lisa Anne Forsythe, Coventry Work Comp Services)
§9789.32	Determining hospital outpatient services based	Commenter supports the proposal to expand	The DWC appreciates commenter's support of	4.1 (Stacy L. Jones, California Workers'

Section	Issue	Comment	Response	Commenter
	on the CMS HOPPS.	hospital outpatient department reimbursement beyond surgery and emergency services using CMS' hospital outpatient prospective payment system rates. Commenter agrees that the proposed change should result in a less complex and more equitable reimbursement formula.	the proposed amendments.	Compensation Institute
§9789.32(a)	Comprehensive Incorporation of "Other Services," as Newly Defined by Proposal	DWC proposes to expand the definition of the "Other Services" (Section 9789.30(u), as proposed) to include those services currently classified as "Facility Only Services," as presently defined, in addition to all services presently classified as "Other Services." As proposed, all such "Other Services" rendered after the effective date of the proposed regulations will be paid pursuant to	DWC appreciates commenter's concerns and suggestions and proposes to amend this subsection as suggested.	2.1 (Chris Clayton, Triage Consulting Group)

Section	Issue	Comment	Response	Commenter
		sections 9789.32(a), (e) – (i), as proposed, and no longer pursuant to the OMFS–RBRVS. In order to fully implement the concept that all "Other Services," as newly defined by the proposed regulations, will follow the same reimbursement rules as Surgical Procedures and Emergency Department Visits (except for the applicable Multiplier), Commenter encourages the DWC add "Other Services" to Section 9789.32(a) for dates of service on or after the effective date of the proposed regulations.		
§9789.32(a)	Determining what services are "integral" and/or "packaged" into ASC surgical services	Commenter asks if the April 2016 Addendum BB is the proper resource to determine what services are "integral" and/or "packaged" into ASC surgical services in order to apply proposed sections 9789.32(a)(1),	DWC appreciates commenter's question. The proposed amendment adopts and incorporates by reference CMS' ASC prospective payment system Addenda AA and EE only for the purpose of identifying surgical	5.2 (Karen L. Sims, State Compensation Insurance Fund)

Section	Issue	Comment	Response	Commenter
		9789.32(a)(2), and 9789.32(e).	service HCPCS codes. The DWC is not proposing to adopt any CMS ASC PPS payment ground rules. To clarify this intent the DWC proposes to adopt only column A ("HCPCS Code") of CMS' ASC Addenda AA and EE.	
§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 the second paragraph is applicable. Commenter suggests clearly defining the circumstances under	The DWC appreciates commenter's concerns and suggestions. The proposed amendments would make §9789.32(c) inapplicable for dates of service *after* the rulemaking is adopted. Thus, there should be no contradiction or confusion with the base facility fee calculation and the proposed amendment to the definition of "Other Services." For services rendered *before* the date the rulemaking is adopted,	3.6 (Lisa Anne Forsythe, Coventry Work Comp Services)

Section	Issue	Comment	Response	Commenter
		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.	subsection (i) states for "Other Services" with a PC/TC component, the hospital outpatient facility fee shall be the Technical Component amount according to the OMFS RBRVS. Whereas (ii) addresses "Other Services" which *do not* have a PC/TC component. In this case, the "base facility fee" calculation would be used to determine the hospital outpatient facility fee. As such, the DWC does not believe any conflict or contradiction exists.	
§9789.32(e)	Applicability	Commenter states there might be an error in the 3rd paragraph of subsection (e) where "to a hospital outpatient" should be replaced with "on an outpatient basis" in the following sentence: "… only hospitals as defined in Section	The DWC appreciates commenter's comments. Current §9789.30(p) (proposed §9789.30(q)) defines "Hospital Outpatient Department Services" to mean "services furnished by any health facility as defined in the California Health and Safety Code Section 1250 and any	4.2 (Stacy L. Jones, California Workers' Compensation Institute

Section	Issue	Comment	Response	Commenter
		9789.30(p) may charge or collect a facility fee for Hospital Outpatient Department Services rendered ***to a hospital outpatient*** and payable under the Medicare (CMS) HOPPS." (emphasis added.)	hospital that is certified to participate in the Medicare program under Title XVIII (42 U.S.C. 1395 et seq.) of the federal Social Security Act to a patient who has not been admitted as an inpatient but who is registered as an outpatient in the records of the hospital." With this definition in mind, the DWC believes "to a hospital outpatient" is correctly used in this subdivision.	
§9789.32(e)	Applicability	Commenter states the last sentence of 9789.32(e) provides, "Only ambulatory surgical centers may charge or collect a facility fee for its services." [emp. added] This benign-sounding sentence could severely limit a management company's ability to provide lawful administrative services to an ASC as well as	The DWC appreciates commenter's comments and concerns. However, this language is not *new* to the codified regulation text. This exact language was present in the fee schedule regulations when it was first adopted in 2004. The 1/1/2004 version of §9789.32(d) states, "[o]nly hospitals may charge or collect a facility fee for	Commenter 8 (Stephen J. Cattolica, California Society of Industrial Medicine and Surgery)

Section	Issue	Comment	Response	Commenter
		limiting a surgery center's ability to sell, pledge or otherwise hypothecate its accounts receivable, even if it was going out of business. We know of no statutory authority given to the Division of Workers' Compensation permitting it to place such an unreasonable restraint on the ability of ASCs to manage their financial resources and impair their ability to manage cash flow." Commenter states, "[o]ur concern is that this language, which appears at the bottom of page 8 of the proposed regulations, goes on to include an extremely important additional change on page 9 about which the "Notice of Modification of Text" omits any mention."	emergency room visits. Only hospital outpatient departments and ambulatory surgical centers as defined in Section 9789.30(n) and Section 9789.30(c) may charge or collect a facility fee for surgical services provided on an outpatient basis." (emphasis added.) The proposed amendment to the regulation merely extends the same language to services rendered by ASCs on or after the date this amendment is filed with the Secretary of State. Commenter's fear that this "new" language will limit the ASCs ability to manage their financial resources and manage cash flow is unwarranted. It is not, and has not been, the intent to limit a provider from utilizing services	

Section	Issue	Comment	Response	Commenter
			of a billing agency. The DWC is unaware of any case law that addresses the concern raised by commenter, despite the fact that the same language has been part of the codified regulatory text since 2004. Indeed, it is worthy to note that §9792.5.4(i) states in pertinent part, "a provider may utilize services of a billing agent, a person or entity that has contracted with the provider to process bills under this article for services or goods rendered by the provider, to request a second bill review or independent bill review." When applying statutory or regulatory construction, courts will construe its words in context and harmonizing its various parts. (*Alford v. Superior Court*, (2003) 29 Cal.4th 1033,	

Section	Issue	Comment	Response	Commenter
			1040.) It is presumed a statute will be interpreted so as to be internally consistent. A particular section of the statute shall not be divorced from the rest of the act. Statutes or statutory sections relating to the same subject must be harmonized, both internally and with each other, to the extent possible. (*Walnut Creek Manor v. Fair Employment & Housing Com.* (1991) 54 Cal.3e 245, 268.)	
§§9789.32(a), 9789.32(d)(4), 9789.33(a)(3), 9789.33(a)(4)	Edits with Potentially Problematic/Unintended Retroactive Impact	Commenter states some proposed revisions, if applied to service dates preceding the effective date of the proposed regulations, could create reimbursement disputes. Commenter encourages the DWC to revisit the following sections with this concern in mind: §§9789.32(a) adds the	The proposed amendment was intended to be declaratory of existing laws and the proposed language was added only for clarification. However, the DWC appreciates the concerns raised by the commenter and will delete the proposed language to avoid any unintended	2.3 (Chris Clayton, Triage Consulting Group)

Section	Issue	Comment	Response	Commenter
		language “and payable under the Medicare (CMS) HOPPS.” in two instances for services rendered prior to the effective date of the proposed regulations. Commenter states this can be problematic if, say, a claims administrator or bill review company chose to interpret the regulations such that, say, if HCPCS 99213 were to be billed by an hospital, it would not be payable because HCPCS 99213 is not the “payable under Medicare (CMS) HOPPS.” For payers other than California Workers’ Compensation payers, hospitals generally billed the service under HCPCS G0463, which is payable under HOPPS. However, G0463 is not listed in the OMFS RBRVS (because it is a	substantive change.	

Section	Issue	Comment	Response	Commenter
		hospital code, not a Physician code), so for California Workers' Compensation cases, hospitals have routinely been asked to report the service under 99213. Furthermore, there are other areas within the Sections 9789.30 – 9789.39 where a service is not payable under HOPPS, yet still described within the aforementioned sections. Examples include services described within Section 9789.32(d) and(f), as proposed. §9789.32(d)(4) contains the additional language, "For instance, when laboratory tests are not packaged under the Medicare (CMS) HOPPS and are listed on the OMFS Pathology and Laboratory fee schedule, they are paid according to the OMFS	The DWC appreciates and accepts Commenter's concerns and in the abundance of caution, will delete the proposed language.	

Section	Issue	Comment	Response	Commenter
		Pathology and Laboratory fee schedule." Commenter states the proposed addition is helpful to clarify how reimbursement is to work *once the proposed regulations become effective*, but could create misunderstanding for services dates prior to the effective date. For instance, under the current OMFS-HODASC, many services and procedures that *are* payable under the Medicare (CMS) HOPPS are *not* paid in accordance with the APC payment methodology; rather, they are paid as "Other Services," as presently defined. The HOPPS APC payment methodology sets the APC Relative Weight taking into account all services (e.g., many clinical diagnostic tests)		

Section	Issue	Comment	Response	Commenter
		typically packaged into the APC-payable procedure, so under *that* reimbursement system, separate payment for said integral services is not warranted or allowed. However, under the current OMFS-HODASC, such an integral service *is and should be* paid separately if the HOPPS-APC-payable procedure is an "Other Service" (i.e., *not* APC-payable). Stated succinctly, the HOPPS packaging rules do not apply to "Other Services", as currently defined, nor to services and supplies integral to said "Other Services." To prevent confusion on services rendered prior to the effective date of the proposed regulations, Commenter recommends the DWC clarify this Section, perhaps addressing the		

Section	Issue	Comment	Response	Commenter
		intention based upon the service date (pre-and post–effective date of the proposed regulations). §9789.33(a)(3), as proposed — Commenter states that added rule pertaining to status indicator code J1 should only apply as of the date status indicator J1 was incorporated into the OMFS-HODASC. §9789.33(a)(4), as proposed — Commenter states that added rule pertaining to status indicator code J1 should only apply as of the date status indicator J1 was incorporated into the OMFS-HODASC.	The DWC appreciates and accepts Commenter's concerns and will add suggested language clarifying applicable dates of service. The DWC appreciates and accepts Commenter's concerns and will add suggested language clarifying applicable dates of service.	
§§9789.32(a) 9789.33(a)	Other/Miscellaneous Drafting Considerations	§9789.32(a) – Commenter suggests adding the following language to the regulatory text: "…provided on an	The DWC appreciates and accepts Commenter's comments and will add the proposed language to the regulatory text.	2.5 (Chris Clayton, Triage Consulting Group)

Section	Issue	Comment	Response	Commenter
		outpatient basis…" for services rendered on or after July 1, 2004 but before September 1, 2014, and for services rendered on or after September 1, 2014 but before the date the proposed amendment is adopted. §9789.32(a)(2) – Commenter is not clear as to whether or not the DWC intends for the term "other services" to carry the meaning of "Other Services" as defined under Section 9789.30(u), as proposed. §9789.33(a) Table – Commenter suggests the Status Code Indicators listed in the final row of the table should include "Q4" for services rendered on and after the date the proposed regulation becomes effective.	The DWC appreciates commenter's concerns and proposes to amend this subsection by deleting this paragraph and adding language to subsection (d). The DWC appreciates commenter's suggestion, however, Status Indictor "Q4" is defined in CMS HOPPS Addendum D1 for CY 2016 as "[c]onditionally packaged laboratory tests" which are paid under the HOPPS or CLFS. "Packaged APC	

Section	Issue	Comment	Response	Commenter
			payment if billed on the same claim as a HCPCS code assigned published status indicator "J1," "J2," "S," "T," "V," "Q1," "Q2," or "Q3." In other circumstances, laboratory tests should have an SI=A and payment is made under the CLFS."	
		Commenter suggests adding regulatory text describing treatment of services with Status Indicators "L" (vaccines), "F" (Corneal Tissue, Hepatitis B), and "P" (partial hospitalizations for psychological treatment and/or detox)	The DWC appreciates commenter's suggestions, but, it is not within the scope of this rulemaking. The DWC, however, will take this issue into consideration during a future rulemaking.	
§9789.33	Items lacking congruence with CMS HOPPS methodologies	§9789.33(a)(3) – Commenter states Status Indicator "K" items are packaged into (and not separately payable if rendered in conjunction with) items with a Status Indicator "J2" , as well as "J1".	The DWC appreciates and accepts Commenter's concerns and will add "J2" to the regulatory text.	2.4 (Chris Clayton, Triage Consulting Group)

Section	Issue	Comment	Response	Commenter
		§9789.33(a)(4) - Commenter states Status Indicator "R" items are packaged into (and not separately payable if rendered in conjunction with) items with a Status Indicator "J2" , as well as "J1".	The DWC appreciates and accepts Commenter's concerns and will add "J2" to the regulatory text.	
§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.	The DWC appreciates Commenter's concerns. The proposed regulations adopt and incorporate by reference CMS' description of status indicator "J1." Section 9789.31(a) adopts and incorporates by reference certain CMS HOPPS addenda by date of service. And Section 9789.39(b) specifically adopts Addendum D1 (OPPS payment status indicators (SI) for CY 2016) for services rendered on or after the date the proposed amendment is adopted. Addendum D1 for CY	3.4 (Lisa Anne Forsythe, Coventry Work Comp Services)

Section	Issue	Comment	Response	Commenter
			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."	
§9789.39(b)	Update Table by Date of Service – Adoption of CMS ASC Addenda AA and EE	Commenter asks whether the proposed adoption of CMS ASC's Addenda AA and EE should be used to determine the HCPCS code payment weights and payment rate values for ASC pricing as opposed to use of the payment weights and payment rate values contained under CMS HOPPS addendum B?	The DWC appreciates Commenter's questions. No, CMS ASC's Addenda AA and EE should not be used to determine the HCPCS code payment weights and payment rate values for ASC surgical services. The proposed amendment adopts and incorporates by reference CMS' ASC prospective payment	5.4 (Karen L. Sims, State Compensation Insurance Fund)

Section	Issue	Comment	Response	Commenter
			system Addenda AA and EE only for the purpose of identifying surgical services HCPCS codes. The DWC is not proposing to adopt any CMS ASC PPS payment ground rules. In order to clarify this, the DWC will propose to adopt only column A ("HCPCS Code") of CMS' ASC Addenda AA and EE.	
§9789.39(b)	Update Table by Date of Service – Adoption of CMS ASC Addenda AA and EE for surgical procedure HCPCS codes	Commenter asks if CMS ASC addendum DD1 (which contains the ASC payment indicators) will be used to determine payment of ASC services, or if the OPPS status indicators listed in addendum D1 and assigned through addendum B be used for determining payments for both ASC services and hospital outpatient department services.	The DWC appreciates Commenter's questions. No, it is not proposed to use CMS' ASC Addendum DD1 to determine payment of ASC services. The proposed amendment adopts and incorporates by reference CMS' ASC prospective payment system Addenda AA and EE only for the purpose of identifying surgical services HCPCS codes. The DWC is not proposing to adopt any CMS ASC PPS payment	5.5 (Karen L. Sims, State Compensation Insurance Fund)

Section	Issue	Comment	Response	Commenter
			ground rules. To clarify this, the DWC will propose to adopt only column A ("HCPCS Code") of CMS' ASC Addenda AA and EE.	
§9789.39(b)	Update Table by Date of Service – Adoption of CMS ASC Addenda AA and EE for surgical procedure HCPCS codes	Commenter asks whether ASCs will be excluded from payment for surgical procedures contained in Addendum EE.	The DWC appreciates Commenter's questions. No, it is proposed both hospital outpatient departments and ASCs be permitted to receive facility fees for all outpatient surgical procedures payable under the CMS HOPPS. It has also been brought to the DWC's attention that CPT codes 21811 - 21813 are not listed on either CMS' ASC Addenda AA or EE, but, are payable under CMS HOPPS. So, the DWC proposes to add these CPT codes to the definition of outpatient HCPCS surgical procedures.	5.6 (Karen L. Sims, State Compensation Insurance Fund)
§9789.39(b)	Update Table by Date of Service – Adoption of CMS ASC Addenda AA	Commenters 6 states it is COA's understanding that the proposed	The DWC appreciates Commenters' comments. It is proposed both	Commenter 6.1 (Lesley Anderson, M.D., California Orthopaedic

Section	Issue	Comment	Response	Commenter
	and EE for surgical procedure HCPCS codes	regulations would expand the list of procedures performed in an ASC to include those procedures listed in schedule EE, unless specifically designated as needing to be performed in an inpatient setting. Even those restricted procedures, could be performed in an ASC with the prior approval from the carrier which would include a breakdown of the costs that the ASC would charge. If this understanding is correct, COA strongly supports these changes. Commenter 7 states CMA is supportive of the proposed amendments to 8 CCR §9789.32 which would expand procedures which may be performed in an ASC. Allowing	hospital outpatient departments and ASCs be permitted to receive facility fees for all outpatient surgical procedures payable under the CMS HOPPS. It has also been brought to the DWC's attention that CPT codes 21811 - 21813 are not listed on either CMS' ASC Addenda AA or EE, but, are payable under CMS HOPPS. So, the DWC proposes to add these CPT codes to the definition of outpatient HCPCS surgical procedures.	Association) Commenter 7.1 (Michelle Rubalcava, California Medical Association)

Section	Issue	Comment	Response	Commenter
		additional procedures to be performed in an ASC setting will hopefully result in more injured workers obtaining timely access to care and lower costs to the WC system. It is CMA's understanding that the expansion under the proposed regulations will expand codes from the current approved surgical codes and further evaluate HCPCS codes that have been reassigned by Medicare. CMA understands there will remain some specific codes that will contain limitations and would likely only be performed in an inpatient setting, however, CMA is supportive of the Division's proposed regulations which grant some flexibility in this matter and may possibly allow an ASC to obtain authorization to perform		

Section	Issue	Comment	Response	Commenter
		such procedures in the ASC setting.		
General	General	Commenter 1 agrees with the proposed modifications, especially with clinic visits. Commenter states they often see facilities that do not know which code to bill G0463 or 99201 – 99215. Commenter believes it is an oversight on the current fee schedule as there is no reimbursement for either code according to the current guidelines. Commenter believes it may actually increase the prices long term, but will be a much less confusing fee schedule for providers and administrators. Commenter attached to a copy of an IBR determination as an example.	DWC appreciates and agrees with commenter's input.	1.1 (Jenn Lathrop, Promesa Health, Inc.)
General	Retroactivity	Commenter states some of the provisions contained in the proposed fee schedule	The DWC appreciates commenter's concerns and refers commenter to DWC's response to	3.5 (Lisa Anne Forsythe, Coventry Work Comp Services)

Section	Issue	Comment	Response	Commenter
		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 an urgent stakeholder need.	Commenter 2.3. The DWC believes, however, the proposed amendments which add end dates of service are declaratory of existing law, and merely clarifies the range of dates of service (beginning and *end* date of service) for which a specific regulatory provision would apply. Thus, the proposed amendments are merely declaratory of existing law and do not operate retroactively.	
General	Formatting	Commenter suggests expanded use of indentation throughout the document would be helpful when referencing sections within the	The DWC appreciates commenter's suggestion, however, the proposed HOPD/ASC fee schedule regulations follow the same	3.1 (Lisa Anne Forsythe, Coventry Work Comp Services)

Section	Issue	Comment	Response	Commenter
		OP/ASC Fee Schedule. Commenter states at times, 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. Commenter recommends the fee schedule regulations add consistent use of clear indentation throughout the "document."	formatting as the Barclays Official Title 8 California Code of Regulations.	
General	Formatting	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 which sections are intended to apply to which dates of service and on which effective dates. Commenter suggests the fee	DWC appreciates commenter's suggestion. The regulation text must address its application for different dates of service, not just for dates of service going forward. To improve reading ease, DWC proposes to reformat certain sections by using a table instead of the current narrative text.	3.2 (Lisa Anne Forsythe, Coventry Work Comp Services)

Section	Issue	Comment	Response	Commenter
		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.		