Section	Comment	DWC Response	Commenter
9792, et seq., and specifically subdivision (c) of section 9792	Commenter states that the Department is promulgating a rule that the regulations (9790 et seq.) only apply to dates of service prior to January 1, 2004. However, in *Guillermo Bayley* (WCAB panel decision), the Appeals Board determined that CCR section 9792 would apply for the following reason: said regulation had 3 subsections, a, b, and c recognizing that subsections a and b were no longer applicable, however, subsection c had no end date. Commenter states the Court recognized that if the Official Medical Fee Schedule (OMFS) was less than adequate to compensate a provider for services and if the provider was able to establish through evidence the value of said services, the Court would grant recovery in excess of the OMFS. Commenter states the OMFS was established to provide a basis for determining the maximum reasonable value of medical services. However, the values must be adequate to ensure a reasonable standard of services and care to the injured worker. Commenter states that ordinarily, the administrative director can address this issue by adopting different	Disagree. The DWC believes the proposed amendments are declaratory of existing law, and merely clarifies that the subsequent Official Medical Fee Schedule found in Article 5.3 Title 8 CCR sections 9789.10 et seq. (hereinafter referred to as "Article 5.3 OMFS") supersedes the Official Medical Fee Schedule found in Article 5.5 Title 8 CCR sections 9790 et seq. (hereinafter referred to as "Article 5.5 OMFS")–including section 9792(c)–for dates of service or discharge after January 1, 2004. The purpose of amending a regulation–as in this case–is not necessarily to change the law. The court in *Department of Corrections and Rehabilitation, Petitioner, v. Workers' Compensation Appeals Board, Respondent; James E. Alexander, Real Party in Interest* (2008) 166 Cal.App.4th 911,) held that a "consideration of the surrounding circumstances may indicate,…, that the amendment was merely the result of a legislative attempt to clarify the true meaning of the statute." A proposed amendment to a regulation that merely clarifies existing law does not operate retrospectively even if applied to dates of services or discharges predating its enactment, because the true meaning of the regulation remains the same. When the proposed amendment—as in this case—clarifies existing law, the provisions true effective date is that of the law it clarifies. (See *Department of*	Reid L. Steinfeld, Esq. (written comment)

	conversion factors, DRG weights, and other factors allowed by statute. However, this does not address additional fees that may reasonably be claimed for extraordinary circumstances related to the unusual nature of the services rendered. Commenter states the proposed amendment would set January 1, 2004 as the end date for CCR sections 9790 et seq. Commenter recommends the administrative director consider adding language in the Code of Regulations sections 9789.10-9789.111 in lieu of CCR 9792(c) that would recognize the existence of a "less than adequate reimbursement scenario" in the existing OMFS. Commenter states it would be potentially a violation of due process to limit CCR 9790 et seq. retrospectively; as such a change may affect pending cases already argued. Commenter recommends that if the administrative director modifies the Code of Regulation section 9790 et seq., it must be prospective only, and become effective for dates of service on or after its enactment. Commenter recommends the	*Corrections and Rehabilitation.*) The general rule of statutory construction would require the regulatory section to be read together with related provisions as part of an overall statutory scheme, so as to harmonize them and give them all effect if possible. (See *Department of Corrections and Rehabilitation.*) In following this rule of statutory construction, when the subparts of section 9792 are read together within the context of Article 5.5 OMFS regulations, it becomes clear that subdivision 9792(c) is part of the OMFS applicable for dates of service/discharge on or before January 1, 2004. Because subdivision (c) does not reference any "dates" is not meaningful when read in context with the related provisions. The beginning notes to Article 5.3 OMFS set forth the effective dates of OMFS fee schedule provisions (physician services; inpatient services; outpatient/ASC services; pharmacy; pathology and laboratory services; durable medical equipment, prosthetics, orthotics, supplies; and ambulance services) and are codified in Article 5.3 OMFS section 9789.111. In addition, each fee schedule within the Article 5.3 OMFS contains a provision which sets forth the applicable dates of service/discharge. The WCAB in *Bayley* reasons that the specific OMFS provision concerning fees for inpatient hospital services on the "dates applicant received them" are found in Rules 9789.20-9789.24,	

	proposed modifications to Code of Regulation section 9790 "Sections 9790.1-9792.1 and Appendices A-C, contained in this Article, are not applicable for physician services rendered and inpatient hospital facility services for discharges after January 1, 2004, unless otherwise specified in this Subchapter 1. Administrative Director-Administrative Rules," should be stricken. Or in the alternative have the language become effective for dates of service on or after the date of enactment of said regulation.	which is part of Article 5.3, entitled, "Official Medical Fee Schedule". However, Rule 9792 is part of Article 5.5, entitled "Application of the Official Medical Fee Schedule." Here the WCAB uses the headings of the regulatory sections to alter the explicit scope, meaning, or intent of the regulation. A number of Supreme Court of California cases, however, have held that the statutory title or chapter headings are unofficial and do not alter the explicit scope, meaning, or intent of a statute. Moreover, a title or chapter heading merely states the general subject of the legislative act, and are not binding upon the courts. The provisions found within the body are not restricted in operation by the statement in the heading. (*Mark DaFonte v. Up-Right, Inc.* (1992) 2 Cal.4th 593; *The People v. Allen Garfield* (1985) 40 Cal.3d 192; and *In re Grady Holcomb* (1942) 21 Cal.2d 126.) This statutory construction would be applicable to regulatory title or chapter headings as well (See *In the Matter of Appeal of: Forklift Sales of Sacramento, Inc.* (2011) 2011 CA OSHA App. Bd. Lexis 102 and *In the Matter of the Appeal of: PMR Race Cars* (2009) 2009 CA OSHA App. Bd. Lexis 145.) It is clear when the regulatory text of Article 5.5 OMFS is read in context–including 9792(c)–that it constitutes the OMFS applicable to services rendered on or before January 1, 2004. Article 5.5 OMFS is superseded by Article 5.3 OMFS for dates of service/discharge after January 1, 2004. When the rules of statutory construction	

		are applied, there is no valid argument that would support the assertion that subdivision (c) of section 9792 remains applicable while the rest of Article 5.5 OMFS is superseded by the Article 5.3 OMFS. Commenter cites to *Bayley* which further reasons subdivision (c) of section 9792 remains applicable for services rendered after January 1, 2004, because the OMFS does not address additional fees that may be reasonably claimed for extraordinary circumstances related to the unusual nature of the services rendered. The WCAB, however, failed to consider a number of features of the current Article 5.3 OMFS and changes to the Medicare diagnosis-related groups (DRGs.) The current Article 5.3 OMFS provides for additional payment for extraordinary high-cost cases (known as "outlier" cases) and additional payments for new medical services and technologies. (See Article 5.3 OMFS sections 9789.22(f)(1) and (h), respectively.) The additional payment for outlier cases is specifically designed to protect a hospital from large financial losses due to unusually expensive cases. The outlier payment policy is instituted to alleviate any financial disincentive a hospital may have against providing any medically necessary care the injured worker may require, even those patients who require extraordinary resources. Also, in 2008, Medicare underwent a significant restructuring of the diagnosis-related group	

		(DRG) system by replacing the system that had been in place since 1983 (CMS-DRG) with Medicare-Severity DRGs (MS-DRGs). The MS-DRG system significantly increased the number of DRGs used to group patients to better match payment levels to variations in patient severity. The MS-DRGs have up to three patient severity levels for each diagnosis group. Because of the above described Article 5.3 OMFS payment policies, it was, and is, unnecessary to have a provision such as subdivision (c) of section 9792 to address "extraordinary circumstances." If this provision was deemed necessary, the Administrative Director would have included such a provision when the Article 5.3 OMFS—and subsequent revisions—were adopted for services rendered and for discharges occurring after January 1, 2004. The fact this did not happen, is indicative that it was *not* the Administrative Director's intent that Article 5.5 OMFS subdivision (c) of section 9792 should be applicable to services rendered or for discharges occurring after January 1, 2004. In contrast, when the Administrative Director intended for certain provisions to be carried over from Article 5.5 OMFS to Article 5.3 OMFS, the specific Article 5.5 OMFS provision was incorporated into the Article 5.3 OMFS regulatory text. For instance, Article 5.3 OMFS, section	

		9789.10(h) defines "Official Medical Fee Schedule 2003" to mean the Official Medical Fee Schedule incorporated into Section 9791.1 in effect on December 31, 2003, which consists of the OMFS book revised April 1, 1999 and as amended for dates of service on or after July 12, 2002." Furthermore, Article 5.3 OMFS section 9789.11 adopts and omits certain provisions of the Article 5.5 OMFS. A sampling of Article 5.3 OMFS section 9789.11 that carry over specific Article 5.5 OMFS provisions are as follows: (a) Except as specified below, or otherwise provided in this Article [5.3], the ground rule materials set forth in each individual section of the OMFS 2003 are applicable to physician services rendered on or after July 1, 2004." (1) The OMFS 2003's "General Information and Instructions" section is not applicable…. (b) For physician services rendered on or after July 1, 2004 the maximum allowable reimbursement amount set forth in the OMFS 2003 for each procedure code is reduced by five (5) percent, …	

		Article 5.3 OMFS does *not* carry over Article 5.5 OMFS section 9792(c) or similar provision. Again, this is indicative of the Administrative Director's intent to *not* carry forward this type of provision into the current Article 5.3 OMFS. When Article 5.3 OMFS and Article 5.5 OMFS regulatory text are read according to the principles of statutory construction, it becomes clear that Article 5.5 section 9792(c) was not intended to be applicable to services rendered or to discharges after January 1, 2004. Thus, the proposed amendments are merely declaratory of existing law and do not operate retrospectively. The effective date is that of the law it clarifies (January 2, 2004.)	
9792(c)	Commenter states, when the new regulations were enacted effective January 2004, no end date was placed in Code of Regulation section 9792(c). For ten years providers have had the ability to argue when circumstances warrant, that the Official Medical Fee Schedule (OMFS) may not have been adequate to compensate them for services relating to an industrial injury. Commenter quotes from *Bayley*	Disagree. See response to Commenter Reid L. Steinfeld.	Alex Khazin, Lien Representative, Law Office of Reid L. Steinfeld (oral presentation and written comment)

	(WCAB panel decision), "As can be seen, rule 9792(c) expressly contemplates that in applying the OMFS there may be extraordinary circumstances that would cause a fee calculated under the OMFS less than reasonable in light of the unusual nature of the services rendered." Commenter states in order to recover fees in excess of the fee schedule, evidence must be presented establishing why the provider deems that the OMFS is insufficient or inadequate. Commenter states if this regulation is modified retrospectively it would appear to be a violation of due process, as it may cause harm and unintended consequences such as undoing cases that have been litigated or cases currently under review and claims resolved from 2004…to the potential date of modification. Commenter states that 9792(a) and (b) are tied to specific units of the fee schedule. However, 9792(c) recognizes that there will be circumstances that are so unique to a provider or a facility such as to allow fees in excess of the OMFS, so long as reimbursement is reasonable to the providers and ensure the applicant's quality of care.		

	Commenter states not all providers are alike and that is why CCR 9792(c) anticipates the indescribable that is why there is the immediate need for burn centers and trauma centers in emergency and/or traumatic injuries, wherein most general acute care facility is simply that, "general" and unable to provide the care necessary. Commenter states that limiting the applicability of regulation 9792(c) may create a system wherein a provider simply cannot afford to treat injuries not generally suffered by injured workers.		
9789.21(f) "Costs"	a. Commenter states the requirement to submit cost documentation for spinal devices ignores the fact that CMS has already addressed this 'charge compression' issue starting in FY2009 when CMS began to require that hospitals report cost data separately for medical supplies and implantable devices, allowing CMS to differentiate cost data and more accurately calculate the relative weights for DRGs	a. Disagree. The adjustments for charge compression affect the DRG-specific relative weights and improve the payment accuracy for the device-intensive DRGs. Separate reporting was required because most hospitals do not mark-up high cost items such as devices as much as other items and services. It has no impact on the hospital's overall cost-to-charge ratio that is used to determine outlier payments because the costs and charges for device costs are already included in the overall cost-to-charge ratio. For the device-intensive DRGs, using the documented paid costs for the hardware provides an	Chris Clayton, Triage Consulting Group (written comment)

	(using cost-to-charge ratios) and to adjust for 'charge compression' beginning in FY 2014. Commenter further states, even in the absence of the CMS 'fix', the overall facility cost-to-charge ratio neutralizes, in the aggregate, any charge inflation practices (whether considered reasonable or otherwise). Any material mark-up on the implants (or any other service/supply for that matter) beyond the average mark-up for all services/supplies would drive *down* the total facility cost-to-charge ratio, thereby *reducing* outlier-eligibility and outlier reimbursement on non-implant-intensive claims in general. The proposed regulation creates a situation where the payers get to have their cake (limit the calculated costs of spinal implants to the true, documented costs) and eat it, too (receive the benefit of still applying the total facility cost-to-charge ratio, which is negatively affected by the implant mark-ups, to	accurate measurement of cost that is independent of a particular hospital's mark-up policies for devices. If the overall cost-to-charge ratio were applied to the device charges, the typical hospital with low mark-ups on devices would be underpaid while those hospitals with high mark-ups would be overpaid relative to actual device costs. While the commenter's comments regarding the effect of charge inflation practices are theoretically correct, the concern has been the opposite. For most hospitals, the practice has been to have a lower mark-up for devices than for other items and services and applying the overall cost-to-charge ratio to the charges for device costs would underestimate their costs. Determining outlier payments on actual hardware costs protects against underpayments as well as overpayments and is not biased in favor of payers. As far as the effects on outlier payments more generally, it is important to note that only a small portion of WC discharges qualify for outlier payments and those that do tend to be in the device-intensive DRGs. This highlights the importance of making accurate cost estimations for these DRGs. Moreover, the differential mark-up for hardware has on average only a small impact on the overall cost-to-charge ratio, which is derived from Medicare inpatient costs and charges. Because of these two considerations, there is a negligible impact on outlier eligibility on non-devise intensive DRGs.	

	the remaining charges on the claim) b. Commenter states, requiring cost documentation for spinal devices is inconsistent in that it isolates devices for complex spinal surgeries yet does not address a potentially similar issue with implants for other cases (i.e. knee replacements, hip replacements, shoulder replacements, cardiovascular cases) or non-implantable medical supplies, pharmaceuticals, etc. c. Commenter states the requirement for documented paid costs for spinal devices no longer serves the original, and now obsolete, purpose, which was to establish a reimbursement mechanism for these items at a rate of payment equal to the hospital's out-of-pocket expense. d. Commenter states the requirement for documented paid costs for spinal devices remains highly burdensome	However, because most hospitals have differentially lower markups for devices than for other items and services (the 2015 average cost-to-charge ratio for devices is .349 relative to an overall cost-to-charge ratio of .261) the overall effect, although negligible, would be to increase the total facility cost-to-charge ratio and increase outlier eligibility. b. Agree in part. Unlike what is occurring in complex spinal surgeries, the DWC is unaware of incidences relating to over-inflated charges for implants used in non-complex spinal surgery cases. Since the DWC seeks to minimize unnecessary burden on stakeholders, DWC does not find it necessary to extend the cost documentation requirement to other implantable devices. c. Agree in part. The DWC agrees the current purpose is different from the earlier purpose stated by commenter. It has come to the DWC's attention, however, that continuing to require proof of documented paid costs for spinal devices is necessary. Otherwise, the hospital would not be required to provide the payer any documentation substantiating their charges for spinal devices. The DWC is aware of instances where hospitals have charged in excess of $200,000 for spinal implants in a spinal surgery DRG, without providing the	

	on both hospitals and claims administrators. e. Commenter states one reasonable interpretation of the proposed regulation is that the determination of "costs" for discharges occurring on or after January 1, 2014 shall not be subjected to removal of charges for implantable medical devices nor to the addition of the documented costs of said items…primarily because said devices for said dates of service are no longer "reimbursed under subdivision (g) of Section 9789.22". If this is not what the DWC intends, commenter requests the DWC consider the following: i. Be more explicit in the above definition. ii. Specify that the hospital's documented paid spinal device costs be added *only* ", for implantable medical devices,	payer the required documentation. In addition, State Compensation Insurance Fund's (State Fund) comment to this proposed rulemaking states that State Fund has also seen excessive charges for invoices for spinal devices that far exceed the cost of surgery and hospitalization. State Fund further stated they expect the number of outlier cases to increase dramatically. d. Disagree. The DWC believes the level of burden on hospitals and claims administrators has decreased for discharges occurring on or after January 1, 2013, because documented paid costs for spinal devices are only required in outlier cases. For discharges occurring prior to January 1, 2013, documented paid costs were required for all spinal devices used during specified complex spinal surgery DRGs. The proposed amendment will not cause added burden, because it does not alter when documented paid costs for spinal devices is required. e. Disagree. The DWC believes the language of subdivision (f) of section 9789.21 is clear and unambiguous. Giving the regulatory text their usual and ordinary meaning, it is clear that the commenter's interpretation of the proposed regulation is incorrect. The	

	hardware, and/or instrumentation reimbursed under subdivision (g) of Section 9789.22," (i.e., add the text in quotation marks after the word "plus" and before "the hospital's) iii. Make clear that any requirement of a hospital to submit cost documentation is limited to only those where the total billed charges on the claim qualify the claim for outlier *irrespective of whether or not any of the charges are related to spinal implants* (i.e., the payer's request for cost documentation may not be demonstrably irrelevant) *and* that the payer may not withhold the non-outlier component of the final payment pending receipt of the cost documentation.	proposed language in Subdivision (f) of section 9789.21 states, "'Costs' means the total billed charges for an admission, excluding non-medical charges such as television and telephone charges, charges for Durable Medical Equipment for in home use, charges for implantable medical devices, hardware, and/or instrumentation reimbursed under subdivision (g) of Section 9789.22, multiplied by the hospital's total cost-to-charge ratio ~~and except for cases reimbursed under section 9789.22(g)(1),~~ plus the hospital's documented paid spinal device costs, plus an additional 10% of the hospital's documented paid cost, net of discounts and rebates, not to exceed a maximum of $250.00, plus any sales tax and/or shipping and handling charges actually paid.". There is no language in this proposed definition that excludes a hospital discharge from the cost documentation requirement. e.i. Disagree. The DWC believes the language of subdivision (f) of section 9789.21 is clear and unambiguous. The requirement for documented paid spinal device costs is currently included in the codified definition of "costs", and the DWC is unaware of any disputes arising from the meaning or intent of the provision.	

		e.ii. Disagree. The DWC does not believe the requirement for the hospital's documented paid costs for spinal devices should be restricted to only devices reimbursed under subdivision (g) of section 9789.22. If this restriction were added to the definition of "costs", discharges on or after January 1, 2014, would not be subject to providing documented paid costs for spinal devices because subdivision (g)(3) of section 9789.22 states, "[f]or discharges occurring on or after January 1, 2014, complex spinal surgery DRGs shall not receive any additional reimbursement for spinal devices, unless the Administrative Director extends section 9789.22(g)(2) to discharges occurring on or after January 1, 2014, in accordance with Labor Code section 5307.1(m) through a later enacted regulation." The Administrative Director did not extend section 9789.22(g)(2) to discharges occurring on or after January 1, 2014. It has come to the DWC's attention, that continuing to require proof of documented paid costs for spinal devices is necessary. Otherwise, the hospital would not be required to provide the payer any documentation substantiating their charges for spinal devices. The DWC is aware of instances where hospitals have charged in excess of	

		$200,000 for spinal implants in a spinal surgery DRG, without providing the payer the required documentation. In addition, State Compensation Insurance Fund's (State Fund) comment to this proposed rulemaking states that State Fund has also seen excessive charges for invoices for spinal devices that far exceed the cost of surgery and hospitalization. State Fund further stated they expect the number of outlier cases to increase dramatically. e.iii. Disagree. The definition of "costs" requires documented paid costs for spinal devices in the current codified section 9789.21(f). So, this requirement for documented paid costs for spinal devices is not new to the definition. The general rule of statutory construction requires section 9789.21(f) to be read together with related provisions—which is the entire inpatient hospital fee schedule regulations— as part of an overall statutory scheme, so as to harmonize them and give them all effect if possible. (See *Department of Corrections and Rehabilitation, Petitioner, v. Workers' Compensation Appeals Board, Respondent; James E. Alexander, Real Party in Interest* (2008) 166 Cal.App.4th 911.) In following this rule of statutory construction, when	

		section 9789.21(f) is read in context with the provisions of the inpatient hospital fee schedule, only one provision, section 9789.22(f)—Cost Outlier Cases—refers to "costs" as defined in section 9789.21(f). Therefore, documented paid costs of spinal devices are only required when determining if a claim qualifies for additional outlier payments, and if so, when calculating the amount of additional payment. There is no reference to section 9789.21(f) (or requirement to provide documented paid costs for spinal devices) in any other provision of the inpatient hospital fee schedule regulatory text.	
9789.21(f) Costs	The commenter states the functionality of applying a hospital's actual costs for spinal devices to the outlier threshold is concerning as there is nothing in the regulations indicating what shall be deemed as sufficient proof of a hospital's "documented paid spinal device costs." State Fund has also seen excessive charges for invoices for spinal devices that far exceed the cost of surgery and hospitalization. Commenter expects the number of outlier cases to increase dramatically. Commenter recommends that the DWC specify what constitutes evidence of a hospital's actual cost	Disagree. The DWC does not feel it can regulate "what constitutes evidence of a hospital's actual cost for spinal devices" beyond requiring the hospital's documented paid costs. To require the hospital to obtain and provide specific documents that might need to be obtained from third parties—such as an "original manufacturer's invoice"—would require the regulations to go beyond the regulated community.	Peggy Thill, State Compensation Insurance Fund (SCIF) (written comment)

	for spinal devices. This would lend further clarity to the inpatient hospital fee schedule, provide the claims administrator with a definite method for verifying the validity of billing and help reduce unnecessary exorbitant costs for outlier cases. Finally, specifying the documentation needed to show costs incurred by the hospital for spinal devices would help to circumvent potential disputes which would otherwise be handled by Independent Bill Review (IBR).		
9789.22 Payment for inpatient hospital services	Commenter states Triage appreciates the DWC's acknowledgement that the OMFS lacked specific instruction for calculating reimbursement in the instance of a transfer case hitting cost outlier. In its *Initial Statement of Reasons*, commenter notes that the DWC is intending to "clarify that hospitals transferring an inpatient to another hospital or post-acute care provider are eligible to receive an outlier payment for cases that qualify."… Further, this clarification is in conformance with Labor Code section 5307.1(a)(1), as the DWC notes in its *Initial Statement of Reasons*. Accordingly, commenter asks that the DWC communicate this particular update as being retroactively effective for the purpose	Disagree. The current codified regulatory text pertaining to the inpatient hospital fee schedule is silent regarding whether inpatient services provided by a hospital transferring an inpatient to another hospital or post-acute care provider is eligible for an outlier payment, and if so, how the outlier payment would be calculated. The proposed amendment to section 9789.22 is intended to fill this void and to clearly specify outlier payments would be available for eligible transfer cases. DWC believes this amendment makes material additions to the regulations; therefore, amendments to the regulation become effective on the effective date of the amendments.	Chris Clayton, Triage Consulting Group (written comment)

	of providing hospitals and payers a better framework to resolve claims affected by this issue prior to the implementation of the proposed regulation.		
9789.50 (pathology and laboratory) 9789.60 (durable medical equipment, prosthetics, orthotics, supplies) 9789.70 (ambulance services)	The commenter states the revisions to the OMFS include deletion of the references to the OMFS in place prior to 2004. The DWC expresses in its Initial Statement of Reasons that these sections are being deleted because fee schedules have been in place since 2004. Thus, it appears that the DWC is implying that the deletions are declaratory of existing law; however, the DWC does not clarify that this is the intent and reasoning behind deleting the references to pre-2004 fees. Commenter recommends the DWC either retain the language referencing pre-2004 fees or clearly indicate that the OMFS is declaratory of existing law somewhere in the regulations.	Disagree. DWC believes deletion of references to payment under the pre-2004 OMFS will bring the regulation into conformity with Labor Code section 5307.1. Labor Code section 5307.1(a)(1) states in pertinent part, "Commencing January 1, 2004, and continuing until the time the administrative director has adopted an official medical fee schedule in accordance with the fee-related structure and rules of the relevant Medicare payment systems,…maximum reasonable fees shall be 120 percent of the estimated aggregate fees prescribed in the relevant Medicare payment system for the same class of services…" Further, Labor Code section 5307.1(e)(1) states, "***Prior to the adoption by the administrative director of a medical fee schedule pursuant to this section,*** for any treatment, facility use, product, or services not covered by a Medicare payment system, including acupuncture services, the maximum reasonable fee paid shall not exceed the fee specified in the official medical fee schedule in effect on December 31, 2003, except as otherwise provided in this subdivision." [Emphasis added.] Hence, Labor Code section 5307.1(e)(1) was no longer applicable once the Administrative Director adopted fee schedules for these services effective January 2, 2004. For	Peggy Thill, State Compensation Insurance Fund (SCIF) (written comment)

		these reasons, the DWC does not see any reason to retain the language proposed to be deleted.	
9789.23(b)(1)	Commenter asks a question regarding section 9789.23(b)(1): The DRGs and applicable notices on pages 20 and 30 of the proposed regulations refer to the fiscal year 2014 which are currently loaded for California in the last inpatient update effective 3/15/2014. Commenter asks if going forward whether they should continue to use fiscal 2014 or was that a typo and did DWC mean fiscal 2015 DRG tables?	There is no section 9789.23(b)(1). However, looking at page 20 and 30, there are references to Table 5 for FY2014 in section 9789.39(b). The FY 2014 citation is correct.	Lisa Anne Forsythe, Coventry Work Comp Services (oral presentation)
All sections	The commenter states they support the administrative director's proposed revisions to the Official Medical Fee Schedule (OMFS) regulations.	Agree.	Stacy L. Jones, Senior Research Associate, California Workers' Compensation Institute (written comment)