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

FINAL STATEMENT OF REASONS AND UPDATED INFORMATIVE DIGEST

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

TITLE 8, CALIFORNIA CODE OF REGULATIONS

AN IMPORTANT PROCEDURAL NOTE ABOUT THIS RULEMAKING:

The Official Medical Fee Schedule (OMFS) "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 OMFS is being conducted under the Administrative Director's rulemaking power under Labor Code sections 133, 4603.5, 5307.1 and 5307.3. This regulatory proceeding is subject to the procedural requirements of Labor Code sections 5307.1 and 5307.4.

CONSIDERATION OF RELEVANT MATTER PRESENTED

After Notice of the Proposed Rulemaking published pursuant to Labor Code section 5307.4, a public hearing was held on November 14, 2014 at which interested persons could participate through the submission of written data, views, and arguments, including oral presentations. The Acting Administrative Director has subsequently considered all of the data, views, statements, and arguments presented or submitted.

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

Article 5.3

1. Section 9789.10 Physician Services Definitions [Amend]
2. Section 9789.11 Physician Services Rendered on or After July 1, 2004 [Amend]
3. Section 9789.20 Inpatient Hospital Fee Schedule: General Information for Inpatient Hospital Fee Schedule – Discharge On or After July 1, 2004 [Amend]
4. Section 9789.21 Definitions for Inpatient Hospital Fee Schedule [Amend]
5. Section 9789.22 Payment of Inpatient Hospital Services [Amend]
6. Section 9789.23 Hospital Cost to Charge Ratios, Hospital Specific Outliers, and Hospital

Composite Factors [Amend]

7. Section 9789.25 Federal Regulations, Federal Register Notices, and Payment Impact File by Date of Discharge [Amend]
8. Section 9789.50 Pathology and Laboratory [Amend]
9. Section 9789.60 Durable Medical Equipment, Prosthetics, Orthotics, Supplies [Amend]
10. Section 9789.70 Ambulance Services [Amend]
11. Section 9789.110 Update of Rules to Reflect Changes in the Medicare Payment System [Amend]
12. Section 9789.111. Effective Date of Fee Schedule Provisions [Amend]

Article 5.5

1. Section 9790 Authority [Amend]

BACKGROUND TO REGULATORY PROCEEDING

Existing law establishes a workers' compensation system, administered by the Administrative Director of the Division of Workers' Compensation, to compensate an employee for injuries sustained in the course of his or her employment. Labor Code section 4600 requires an employer to provide medical, surgical, chiropractic, acupuncture, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatus, including orthotic and prosthetic devices and services, that is reasonably required to cure or relieve the injured worker from the effects of his or her injury.

Prior to amendment of Labor Code Section 5307.1[1], and subsequent adoption by the Administrative Director of Medicare-based fee schedules effective 2004 in Article 5.3, the manner by which health care providers were compensated for medical services rendered in cases within the jurisdiction of the California workers' compensation system was determined according to sections 9790, et al. in Article 5.5.

Under existing law, payment for medical treatment shall be no more than the maximum amounts set by the Administrative Director in the Official Medical Fee Schedule or the amounts set pursuant to a contract. Labor Code Section 5307.1[2] 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. 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

[1] Senate Bill 228 of 2003 (Chapter 639, Statutes of 2003)

[2] 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)

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." The Administrative Director adopted the OMFS under Article 5.3 for the following services rendered after January 1, 2004: physician and non-physician practitioner services, inpatient hospital, hospital outpatient departments/ASC, pharmacy, pathology and laboratory, durable medical equipment, prosthetics, orthotics, supplies, and ambulance services.

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 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. The Acting Administrative Director has subsequently adopted a RBRVS-based physician fee schedule, effective for services rendered on or after January 1, 2014.[3]

As set forth in Labor Code section 5307.1, the maximum reasonable facility fees for services performed in an inpatient hospital, shall not exceed 120 percent of estimated aggregate fees prescribed in the Medicare payment system for the same class of services before application of the inflation factor. (Lab. Code, § 5307.1(a).) The inflation factor is determined solely by the estimated adjustment in the hospital market basket for the 12 months beginning October 1 of the preceding calendar year. (Lab. Code, § 5307.1(g).) The Administrative Director, however, may adopt different conversion factors, diagnostic related group weights, and other factors affecting payment amounts from those used in the Medicare payment system, provided estimated aggregate fees do not exceed 120 percent of the estimated aggregate fees paid for the same class of services in the Medicare Payment System. (Lab. Code, § 5307.1(b).)

In 2003, the legislature enacted Labor Code section 5318, which provided a separate reimbursement for implantable medical devices, hardware, and instrumentation for certain Diagnostic Related Groups (DRGs). The statute also provided that the pass-through section would only be operative until the Administrative Director adopts a

[3] Title 8, California Code of Regulations title 8 sections 9789.12.1 et seq.

regulation specifying separate reimbursement, if any, for implantable medical hardware or instrumentation for complex spinal surgeries. (Lab. Code, § 5307.1(b).)

On January 2, 2004, to comply with the requirements of Labor Code sections 5307.1 and 5318, through emergency rulemaking, the Administrative Director adopted an Inpatient Hospital Fee Schedule section of the Official Medical Fee (OMF) Schedule (set forth in Title 8 CCR Article 5.3 sections 9789.20, et seq.) for fees in accordance with the Medicare payment system. A Certificate of Compliance was filed on April 30, 2004, and the Inpatient Hospital Fee Schedule regulations became effective on June 15, 2004. The Labor Code section 5318 pass-through methodology was incorporated as part of this fee schedule.

In 2012, the Legislature enacted Senate Bill 863[4] as part of workers' compensation reform legislation intended to reduce unnecessary medical and litigation expenses, among other things, in workers' compensation cases in California. As one of its provisions, SB 863 repealed Labor Code section 5318 and added subsection (m) to Labor Code section 5307.1, which provided that on or before July 1, 2013, the Administrative Director shall adopt a regulation specifying an additional reimbursement for Medicare Severity Diagnostic Groups (MS-DRGs) 028, 029, 030, 453, 454, 455, and 456 to ensure that the aggregate reimbursement is sufficient to cover costs, including the implantable medical device, hardware, and instrumentation. This regulation shall be repealed as of January 1, 2014, unless extended by the Administrative Director. In compliance with SB 863, the Administrative Director amended the inpatient hospital fee schedule provisions for discharges occurring on or after January 1, 2013. The Administrative Director, however, did not extend section 9789.22(g) providing for additional reimbursement for implantable spinal devices beyond January 1, 2014.

Labor Code section 5307.1 further provides that the Administrative Director shall adjust the OMFS provisions 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. (Lab. Code, § 5307.1(g)(2).)

The Acting Administrative Director now proposes to amend Article 5.3, sections 9789.10 - 9789.11 (physician services), 9789.20 - 9789.23, 9789.25 (inpatient hospital), 9789.50 (pathology and laboratory), 9789.60 (durable medical Equipment, prosthetics, orthotics, supplies), 9789.70 (ambulance services), and 9789.111 (effective date of fee schedule provisions); and Article 5.5, section 9790 (authority).

Title 8 CCR Article 5.3 sections 9789.10-9789.11, 9789.20-9789.23, 9789.25, 9789.50, 9789.60, 9789.70, 9789.110, and 9789.111 and Article 5.5 section 9790 are amended to: reiterate the applicable dates of fee schedule provisions that are declaratory of existing laws; address the operating disproportionate share hospital (DSH) adjustments; address

[4] De León, CHAPTER 363, Statutes of 2012; SB 863

the inpatient hospital outlier payments for eligible transfer cases; update factors to 2014, and make minor adjustments to various sections of the Official Medical Fee Schedule.

UPDATE OF INITIAL STATEMENT OF REASONS AND INFORMATIVE DIGEST

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

UPDATE OF MATERIAL RELIED UPON

No additional documents beyond those identified in the Initial Statement of Reasons were relied upon by the Acting Administrative Director.

LOCAL MANDATES DETERMINATION

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

CONSIDERATION OF ALTERNATIVES

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