Section	Issue	Comment	Response	Commenter
§9789.12.1	Applicability of ground rules by date of service	Commenter states it is important for the Division to specify that all prior OMFS ground rules are superseded by the new fee schedule and ground rules for dates of service after adoption of the fee schedule.	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period. Agree that it is important to specify which OMFS rules apply to date of service. Disagree that further clarification is necessary. Subdivision (a) of §9789.12.1 clearly sets forth the applicability of the fee schedules by date of service.	26.4(Okun); 37.6(Blink)
§9789.12.2	Adequacy of RBRVS reimbursement for Electromyography and Nerve Conduction Velocity test (EMG/NCV)	Commenters states the reimbursement for EMG/NCV will be significantly reduced under the RBRVS. Commenters are concerned this will cause access issues. Commenters state EMG tests are necessary to determine patient treatment and most importantly to determine if surgery is required.	Disagree. The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period. The EMG/NCV is part of the CMS' "Misvalued Code Initiative". The EMG and NCS codes were all re-valued and changed by CMS with input from the AMA RUC and CPT Committees under the direction of CMS. CMS accepted most of the AMA RUC's recommendations. Of note, there was specific attention to resolving the issue CMS identified as being duplication of	2(Simpkins); 3(Mostafavi); 5(Kim); 6(Schreiber); 7(Bahnam); 9(Charchian); 11.2(Brakensiek); 12(Marker); 13(Munoz); 14(Balbas); 15(Batkin); 18(Ho); 20(Lee); 21(Santz); 23(Rutchik); 25(Wang); 28(Tyson); 31(Perrizo); 32(Kraetzer); 33(Meredith); 35(Benhaim); 38(Lerch); 39(Kent); 40(Bamshad); 42(Goldman); 48(Doshi)

			time for multiple units of nerve conduction studies. See Federal Register, Vol. 77, No. 222, November 16, 2012, p. 69067.	
§9789.12.2	Formula for calculating the maximum reasonable fee	Commenter 10 suggests using the term "Geographic Practice Cost Index" instead of using the term "Geographic Adjustment Factor". Commenter states the term "GPCI" is less confusing than "GAF" in the context of work/pe/mp multipliers for single-locality implementation. The term "GAF" instead of "GPCI" is good to indicate the single statewide anesthesia multiplier which is addressed in section 9789.18.1, and to easily differentiate it from the GPCIs.	Disagree. Use of the term "GPCI" might be confused with Medicare's nine locality California GPCIs.	10.5(Ramirez)
§§9789.12.2, .18.1, and .19	Adopting an average statewide GAF	Commenter 1 remains supportive of the use of Medicare GPCIs because they reflect the difference in the cost of doing business between more urban, higher cost areas, and the more rural areas of the state. Further using a GAF will make it harder for providers who are looking to compare their WC reimbursement to their Medicare reimbursement	Disagree. The majority of commenters for the 30-day comment period stated adopting an average statewide GAF will streamline the transition to RBRVS, reduce administrative burden and eliminate potential billing abuse. (e.g. When a provider reports an incorrect service location by entering a 3rd party biller zip code on the form to increase reimbursement.)	1.1(Rothenberg)

		to know if they are being paid correctly.		
§9789.12.2	Adopting an average statewide GAF	Commenter 10 supports adopting RAND calculated statewide GPCI values that treat California as a statewide locality, but, do not adopt the HPSAs. Alternatively, adopt one statewide GAF value for anesthesia and one for all other services, but, do not adopt the HPSAs. Commenter criticizes the accuracy of the Medicare GPCIs and also believes it can lead to billing abuses because of use of inaccurate zip codes. Commenter 34 opposes the HPSA bonuses at this time. Commenter states that the conversion factors should be sufficient to encourage providers to accept WC patients in HPSA eligible areas.	Agree in part. The RAND calculated statewide average GAFs will be administratively less complex as the workers' compensation community transitions to the RBRVS. Disagree with the suggestion that HPSAs be eliminated. It will help encourage access in health professional shortage areas. The HPSA bonuses are applied to more services than just E&M.	10.1(Ramirez); 34.2(Thill/Hauscarriague)
§9789.12.2	Statewide Geographic Price Cost Index	Our coalition commends the DWC for continuing to propose a Statewide Geographic Price Cost Index. Not only is the adoption of a single statewide geographic adjustment factor consistent with the intent of SB 863, but	Agree.	19.4(Merz/Schmelzer); 26.1(Okun); 34.1(Thill/Hauscarriague); 37.1(Blink)

		it will also ease the transition to RBRVS by reducing the administrative and operational burden of managing reimbursement rates throughout the state. Commenter 34 also supports use of statewide GAF.		
§9789.12.2	Calculation of the Maximum Reasonable Fee - Rounding	Commenter states on page 2 of the revised proposed rules, a formula is provided for reimbursement. However, the formula does not indicate which values, if any, are to be rounded and if so, what the appropriate rounding rules are. Commenter suggests modifying the proposed rules to address rounding, including an example of where rounding would appropriately be applied.	Disagree. To the extent figures to be used in the payment formula exceed two decimal places, the intent is to provide greater accuracy in the service fee calculation.	27.5(Forsythe)
§9789.12.3	Status Codes C,I,N, and R, use of OWCP RVUs	Commenter states that this section should specify the use of the 2012 OWCP RVUs. Commenter states that absent specific statutory authority such as the authority provided regarding Medicare and Medi-Cal schedules and rules, may not be able to adopt future versions that are not under the Division's direct control.	Disagree. This regulatory text language specifies the general rule which is to use OWCP RVUs in specified circumstances. The version of OWCP to be used in specified in section 9789.19.	10.6(Ramirez)

§9789.12.3	Status Codes C,I,N, and R, use of OWCP RVUs – BR	Commenter recommends modifying Section 9789.12.3(c) to provide "usual and customary" as the third level of the reimbursement hierarchy in situations where there are no established RVU and OWCP values.	Disagree. §9789.12.4(c) sets forth the factors to be considered in determining the value of a BR code, which include looking at a comparable procedure or analogous code that reflects similar amount of resources such as practice expense, time, complexity, and expertise. BR would provide more equitable reimbursement to compensate for the resources utilized in the procedure than by applying a "usual and customary" rate.	27.3(Forsythe)
§9789.12.3	Status Codes I	Commenter states the payor is required to interpret which other CPT code is used by Medicare instead of the code with a status code I. Commenter suggests either, 1. Prohibiting use of a code with status code I. If a provider bills with an I code, require the provider to re-bill with an appropriate non I-code code; or 2. Have the state provide a cross-walked table of status indicator I codes to the appropriate non-status I indicator codes.	Disagree. §§9789.12.12, 9789.13.2, and 9789.19 provide direction which codes are to be used in place of the I-status indicator codes for frequently provided services. Some of the I-status indicator codes are for non-physician services, but are covered in other fee schedules. For example, ambulance fee schedule and clinical lab.	27.4(Forsythe)
§9789.12.5	Conversion factors for 4-year transition	Commenter opposes the 4-year transition and requests it be eliminated or reduced to 2	Disagree. SB 863 mandates a 4-year transition from the current OMFS to the RBRVS.	8(Adelman)

		years.		
§9789.12.2	Conversion factors during the transition	Commenter states the proposed conversion factors do not raise the multipliers for Medicine as fast as was originally planned in SB 863. E&M codes should be reimbursed rapidly to encourage care.	Disagree. The proposed fee schedule uses a typical blend to transition from the current OMFS to the RBRVS. The conversion factors are based on more recent and robust data than used to formulate the conversion factors in SB 863.	37.2(Blink)
§9789.12.5	Conversion factors – interpretation of statutory cap on fees	Labor Code section 5307.1(b) allows the Administrative Director to adopt different conversion factors from those used by Medicare, provided they will not cause estimated aggregate fees to exceed 120 percent of the estimated aggregate fees paid under the Medicare fee schedule for the same class of services; and (within those limits) as long as the rates and fees established are adequate to ensure a reasonable standard of services and care for injured employees (LC5307.1(f)). As proposed, the schedule will exceed those limits.	Disagree. Same comment was submitted by commenter during the 30-day comment period. DWC reiterates the response made to the 30-day comment. See response to comment 31.9 on the 30-day comment chart.	10.7(Ramirez); 46.1(Suchil)
§9789.12.8	Status Codes	Commenter states that several status code indicators in Medicare Addendum A are not	Disagree. Codes D, F, G, and H indicate codes that have been deleted and do not exist in the	27.6(Forsythe)

		addressed in the proposed regulations: D, F, G, H, R, and Q. Commenter requests instructions on handling these codes when billed by providers.	Medicare physician fee schedule relative value file. No one would be billing codes with these status indicators. Status code Q are therapy functional information codes and are not used for billing. Finally, instruction for handling status code R is in §§9789.12.3 and 9789.12.8.	
§9789.12.12	Consultation Services Coding	Commenter 26 continues to express concern that eliminating separate compensation for consult reports and elimination of CPT Code 99358 for non-face-to-face prolonged services, in each case outside of the fee schedule cap, may incentivize behavior that would be directly counterproductive to the goal of efficient care and faster return to work, thus actually increasing the very costs DWC is trying to contain. Again this is an item to be carefully monitored post-implementation if not included in the initial OMFS. Commenter 37 also recommends the Division look at either keeping report pages for consultations or at the	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period. Commenter 26 raised the same arguments during the 30-day comment period, and the comments were appropriately addressed in the 30-day comment period chart. See response to comment 18.2 in the 30-day comment chart.	26.3(Okun); 37.3(Blink)

		minimum providing a CA specific code to bill for a flat fee report. Commenter 37 also recommends the addition of another WC code to be used for consultation reports. Adopt a single flat fee reimbursement for the WC codes (consultation and PR3, PR4) to avoid the issues of duplicate denials for multiple report pages due to the utilization of the same code for multiple lines.		
§9789.12.12	Prolonged Service Codes	Commenter recommends making CPT code 99358 reimbursable for review of medical records under the new OMFS fee schedule. Commenter also recommends a ground rule to include information required in order for the service to be billable, i.e. whose records were reviewed, how much time was spent and a brief summary of the records reviewed, i.e. source and dates.	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.	37.4(Blink)
§9789.12.13	NCCI	Commenter recommends the rules be clarified to specify that when CMS provides quarterly updates, the state is also incorporating those updates by reference without	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.	27.1(Forsythe)

		requiring a separate adoption process. (NCCI)		
§9789.12.14	CA specific codes – WC008, WC009, WC010, and WC011	Commenter recommends deleting WC008, WC009, WC010, and WC011, because these services are rarely used, are part of another service, or can be reported under an existing or proposed code.	Same comment was submitted by commenter during the 30-day comment period. DWC reiterates the response made to the 30-day comment. See response to comment 31.5 in the 30-day comment chart.	10.4(Ramirez)
§9789.13.1	Supplies	Commenter 26 states they remain uncertain about how "By Report" supplies dispensed outside of an E/M environment (such as in the rehabilitation department) will work practically in a bundled modality. Commenter suggests that the Division monitor this issue closely during the initial phase-in to ensure patients are not bearing the cost of unreimbursed home-use supplies. Commenter 37 states bundling supplies is unreasonable for dispensed supply items, such as home exercise rehabilitation equipment (exercise balls, theraband, shoulder rehab kits, theraputty (A9300)). Commenter 37 recommends	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period. DWC reiterates the response made to the 30-day comment regarding commenter 37. See response to comment 18.5 in the 30-day comment chart.	26.2(Okun); 37.5(Blink)

		the current cost plus methodology and invoice requirement be maintained as an integral part of the fee schedule for supply items which are dispensed to the patient as part of their treatment plan for home use.		
§9789.14	Reimbursement for Reports	Commenter 29 opposes bundling medical reports within the E&M. Commenter states medical care is more complex for WC cases than the typical Medicare patient. Reports in WC consider the patient's job requirements, causation, and apportionment. In addition, there is no additional reimbursement provided for completing DWC RFA form. It takes a lot of time for a doctor to perform the research and type up a report containing MTUS or other Peer-reviewed Guidelines necessary to establish medical necessity. Commenter 41 states the P&S evaluation report and time spent formulating the impairment rating after the patient has been seen should	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period. However, to clarify, regarding commenter 41, the P&S report is separately reimbursable.	29.4(Bazel); 41(Kennerly)

		be able to be charged as well.		
§9789.15.1, et al.	PA/NP payments for services	Commenter states there is a problem with decreasing payments for services rendered by PA/NP. Use of PA/NP is a cost to physician. The benefit is being able to see more patients. If the doctor gets less reimbursement for their services, he would simply not be able to afford them and would not be able to serve as many patients. As noted above, taking care of injured worker is much more complex than Medi-Care patient. Therefore, training of the ancillary staff is much more complex and quality of personal is much higher than regular medical clinic. Thus, the cost of such medical practice far exceeds that of any regular medical clinic.	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.	29.3(Bazel)
§9789.15.4	MPPR for therapy services – More specific delineation	Commenter recommends modification of the proposed RBRVS rules to provide specificity at the code level as to the applicability of the physical therapy and chiropractic rules, including (but not limiting to) the multiple procedure rules.	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.	27.2(Forsythe)

§9789.15.4	MPPR for therapy services	Commenter 1 notes the revised proposed regulations did not amend the section which applies the MPPR for therapy services. Commenter 1 states this is flawed Medicare policy, and should not be used, because the CPT codes already account for duplication. The MPPR assumes duplication exists in the PE portion of therapy codes billed on the same day. Commenter 1 states therapy codes are unlike most CPT codes in that the PE for a typical visit is spread out among multiple codes since multiple services are typically provided to a patient during a visit.	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period. Commenter raised the same arguments during the 30-day comment period, and the comments were appropriately addressed in the 30-day comment period chart. (See Comment 7.8 in the 30-day comment chart.)	1.2(Rothenberg)
§9789.15.4	MPPR for therapy services – Use 2012 MPPR	Commenter 1 states if DWC insists on using the MPPR, DWC should use the Medicare 2012 MPPR since this fee schedule is based on 2012 Medicare reimbursement.	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period. Commenter raised the same arguments during the 30-day comment period, and the comments were appropriately addressed in the 30-day comment period chart. (See Comment 7.8 in the 30-day comment chart.)	1.3(Rothenberg)
§9789.15.4	Physical	Commenter 4 states the	The comment does not address	4(Ott)

	medicine/physical therapy "cap" on number of procedures presumed reasonable absent pre-authorization and fee agreement	physical medicine cap is too restrictive. For an outpatient hospital department patient, it is not uncommon to receive more than 4 procedures/modalities in a single visit. Commenter suggests exempting hospitals from therapy caps or allowing four modalities/procedures per discipline.	the substantive changes made to the proposed regulations during the 1st 15-day comment period.	
§9789.15.4	Billing for the evaluation or re-evaluation therapy visit	Commenter states the proposed limits on procedures and modalities billed per visit appear to be reasonable given current billing patterns, however, on the patient's first visit they are normally given an evaluation and treatment. An evaluation is an untimed code. The policy is not clear about what, if any, limits there are on billing for evaluation or re-evaluation therapy visit. Commenter states this should be clarified to avoid payment issues.	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period. Commenter raised the same arguments during the 30-day comment period, and the comments were appropriately addressed in the 30-day comment period chart. See response to comment 7.7 in the 30-day comment chart.	1.5(Rothenberg)
§9789.16.1, et al.	Global Surgery – Physician Time Table	Commenter states the regulations discourage a surgeon from seeing the patient longer than RBRVS is allowing. Treatment should be left to a physician and not be	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period. Commenter raised the same arguments during the 30-day	29.1(Bazel)

		dictated by reimbursement. Commenter states asking for authorization for extra services is not practical, since most authorization requests go unanswered by the carrier and the timeframe for UR exceeds reasonable follow up visits frequency.	comment period, and the comments were appropriately addressed in the 30-day comment period chart. See response to comments made pertaining to §9789.16.1 in the 30-day comment chart.	
§9789.17.1	Radiology MPPR	Commenter states cascading the x-rays reimbursement is an unfair decrease in reimbursement. It does not cost less for additional x-rays been performed on the same day and reimbursement should not be decreased. Most of injured workers have injuries to multiple body parts. New regulation would discourage physicians from performing all of them on the same day. This would delay care. Also, not performing all the required x-rays would increase a likelihood of missed pathology.	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.	29.2(Bazel); 44.2(Meisel)
General	Hospital outpatient facility and ASC fees	Commenter recommends DWC continue to restrict outpatient facility fee payments to only hospital emergency departments, hospital outpatient surgery	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period. Commenter raised the same arguments during the 30-day	10.3(Ramirez)

		departments and ASCs. Reimburse medical services that are appropriately provided in other outpatient settings under the Physician fee schedule. Restrict payments to ASCs to surgeries on Medicare's ASC list of covered procedures.	comment period, and the comments were appropriately addressed in the 30-day comment period chart	
General	Adequacy of RBRVS RVUs	Commenter states RAND's modeling methodology is purely mathematical with little or no consideration of how individual CPT code reimbursements will affect services, and fails to comply with the spirit of LC §5307.2. Commenters 17,22,30, 36 oppose the reduction in diagnostic radiology codes.	Disagree. The statute requires the physician fee schedule transition to the RBRVS. The RBRVS aligns payment with resources required to perform the procedure. Enormous effort is put in at the federal level to establish the appropriate reimbursement at the code level. This includes input from the American Medical Association and specialty societies. Converting from extremely outdated charge based system to the RBRVS naturally will result in some fee changes at the code level. Access is regularly monitored by the AD pursuant to LC §5307.2.	11.1(Brakensiek); 16(Belfer); 17(Berger); 22(Crues); 24(Rose); 30(Fatemi); 36(Jones); 43(Breuer); 44.1(Meisel); 45(Levine); 47(Herrick)
General	SB863 – Cost savings	Commenters states the transition to RBRVS was never identified as a potential cost increase in any of the materials used to outline the	Disagree. The proposed regulations are in accordance with SB 863 which specifies the maximum shall not exceed 120% of Medicare July 2012 physician	19.1(Merz/Schmelzer)

		costs and savings associated with SB 863. The Division's approach to modernizing the OMFS comes with a significant, and previously unanticipated, price tag. Commenters urges the Division to modify the OMFS so that it mitigates the reduction in employer savings. Commenters believe that the Division has the statutory authority necessary to revise this proposal to better reflect the costs anticipated by employers when SB 863 was passed. Commenters recommend DWC adopt an OMFS based on RBRVS that is consistent with the SB 863 cost savings estimates advertised to and relied upon by employers at the time the reforms were passed. Commenters state the OMFS conversion factor multiplier could result in fees far exceeding 120% of Medicare fees.	fee schedule, and adjusted by the MEI and the relative value scale adjustment factor, if any. There will be many cost savings and efficiencies from updating to a modern fee schedule that are hard to quantify. To the extent that going to 120% of July 2012 Medicare creates an increase, this is in accordance with the legislative intent. It is noteworthy the "default" fee schedule in LC §5307.1(a)(2)(C)(iv) specifies that for dates of services on or after January 1, 2017, the conversion factor would be 120% of the July 2012 Medicare as updated by the MEI and the relative value scale adjustment, if any. In regards the conversion factor multiplier, SB 863 Labor Code §5307.1 (b)(2)(A)(iii) sets the maximum target as 120% of estimated annualized aggregate Medicare physician payment amount *as it appeared on July 1,*	

			2012, and as adjusted by the factors in subdivision (g) (the Medicare Economic Index inflation (MEI) and relative value scale adjustment, if any). The proposed rules carry out these statutory provisions, setting the conversion factor after the transition at 120% of July 2012 Medicare, and updated for inflation and relative value scale adjustment. (Proposed 8 CCR §9789.12.5). SB 863 did not set a blanket "120% of Medicare" for the physician fee schedule. SB 863's specification of the maximum fee as 120% of Medicare as it appeared on July 1, 2012, adjusted for MEI and relative value scale adjustment evidences the legislative intent that the workers' compensation fee schedule diverge from Medicare	
General	Table 2 of the Fact Sheet (Summary of Impacts by Type of Service and By Specialty in 2017	That table purports to show how the proposed fee schedule will affect various medical specialties, but it is misleading because it lumps a wide array	Disagree. The impact analysis is intended to present data on an aggregate level. It is expected that individual practitioners will experience different impacts as a	11.3(Brakensiek)

	Relative to OMFS)	of medical services into a market basket to produce a meaningless average number. A physical medicine and rehabilitation specialist may specialize in particular services within the specialty; very few psychiatrists specialize in all the services. It is disingenuous to allege that PM&R will increase by 51.7%. This is further rendered meaningless by RAND's inclusion of chiropractic, physical therapy and acupuncture services into the definition of "physical medicine and rehabilitation."	result of the conversion to the RBRVS depending on the case mix of his or her practice. Commenter criticizes Table 2 of the Fact Sheet, which is not part of the rulemaking documents. However, table 2 is based upon table 5.3 of the RAND report. Commenter's assumption that PMR includes chiropractic, physical therapy, and acupuncture is incorrect. Table 5.3 shows PMR increases 51.7%, physical therapy increases 64.7%, chiropractic increases 22.3%, and acupuncture increases 9.2%.	
General	Implementation Period	Commenters 19 state stakeholders need at the very least, 60-90 days in order to appropriately plan for the fee schedule transition. Commenter 46 also voices concern about the remaining time frame to complete rulemaking prior to January 1, 2014.	Agree in part. It is desirable to provide as much implementation time as possible. However, the default physician fee schedule would go into effect if these regulations are not adopted prior to 1/1/2014. The proposed regulations would provide more clarity even if the requested 60-90 days is not achievable.	19.2(Merz/Schmelzer); 46.2(Suchil)
		Commenters recommend that the Division complete the transition to an RBRVS-based OMFS in a manner that helps to ensure the savings estimates anticipated by SB 863 and	Agree in part. If access issues arise, they can be addressed through LC §5307.2. Disagree to the extent commenters imply that the proposed regulations need to be	19.3(Merz/Schmelzer)

		address access issues if there is evidence that they actually exist.	revised to achieve savings. The proposed regulations transition to the RBRVS in accordance with the provisions of SB 863 (120% of estimated annualized aggregate Medicare physician payment amount *as it appeared on July 1, 2012*, and as adjusted by (MEI) and relative value scale adjustment, if any) and including services not covered by Medicare at the rate set by the AD. As modeled by RAND, this is estimated to result in an increase of 11.9% when fully implemented in 2017. This increase is the result of the statutory structure. It is anticipated that there will be offsetting savings due to efficiencies and reduced disputes that result from updating to a modern fee schedule.	
General	Provide a fee schedule calculator and post fee schedule	Commenter requests DWC post the actual reimbursement per code annually and have a per visit fee schedule calculator. Commenter states WC TPAs and other payers have little or no experience with the Medicare fee schedule.	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period. Commenter raised the same arguments during the 30-day comment period, and the comments were appropriately addressed in the 30-day comment period chart. (See	1.4(Rothenberg)

			comment 7.9 in the 30-day comment chart.)	