Section	Issue	Comment	Response	Commenter
§9789.30(a)	Geographic-adjusted conversion factor	Commenter 2 requests the DWC to adopt the same HOPPS geographic-adjusted conversion factor utilized by Medicare	Not within the scope of this rulemaking. However, a response to the comment was previously provided in the 30-day comment chart.	2.2 (Davis, Bill, CASA); See attachment of commenters submitting a form letter supporting CASA's comment.
§9789.30(aa)	Payment rate of 101.01 for facility only services	Commenter states the proposed payment rate of 101.01% for "facility only services" is insufficient to cover hospital costs. Commenter states that based on publicly available 2012 data from OSPHD, CA hospitals are only paid 78% of their actual costs under the Medicare program, meaning if WC adopts a 101.01% multiplier, only 79% of hospital's costs will be covered when treating injured workers. This shortfall may result in limited access, making it more challenging for injured workers to return to the workforce in a timely manner. Hospitals experience significant payment delays and administrative hurdles with	A response to the comment was previously provided in the 30-day comment chart.	1.1 (Ott, Amber, CHA)

		WC payers as compared to Medicare. (Commenter cites examples of the difference in efficiencies). Commenter recommends the AD adopt a 120% multiplier for facility-only services due to the increased administrative burdens associated with billing and processing WC claims, coupled with payment shortfalls experienced under the Medicare system.		
§9789.30(aa)	Payment rate of 80.81% for ASC services	Commenter 2 is opposed to the proposed amendments which "eliminates the option" for ASCs to use an alternative payment methodology and further decrease the facility fees from a Medicare multiplier of 82% to 80.1%. Commenter 2 states SB 863 already reduced ASC payment rates from 120% HOPD to 80%. This has realized more savings than originally projected by the WCIRB. Therefore, further	A response to the comment by commenter 2 was previously provided in the 30-day comment chart. With regards to commenter 4, in addition to the response provided here and in the 30-day comment chart, the California workers' compensation laws require medical, surgical, chiropractic, acupuncture, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatuses, including	2.1 (Davis, Bill, CASA); 4.1 (Ettinger, Bruce); 5.1 (Payan, Heidi); 6.1 (Di Stefano, Katherine, Advanced Ambulatory Surgery Center); 10.1 (Durick, Thomas) See attachment of commenters submitting a form letter supporting CASA's comment.

		reducing the "optional alternative ASC fee schedule methodology by even 1.19% (82% from 80.1%), as proposed by these regulations, is unacceptable to ensuring injured workers' access to robust outpatient surgery alternatives such as ASCs. In addition to the form letter, commenter 4 states WC cases are almost exclusively populated by people from the under-serviced communities. They have no insurance, either because they are uninformed, or they do not have appropriate access to the new ACA coverage. If payments for their care are reduced, they will go without care, because medical and surgical practices cannot and will not be sustained. In addition to the form letter, commenter 5 states hospitals should have to foot (at least) half of the bill for outpatient surgery. ASCs should not	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 shall be provided by the employer. In regards to commenter 5, in addition to the response provided here and the response provided in the 30-day comment chart, similar multiplier adjustments were made to both outpatient departments as well as ASCs in order to conform to changes in Medicare payment rules. In regards to commenters 6 and 10, in addition to the response provided here and the response provided in the 30-day comment chart, an April 25, 2014, Becker's ASC Review article, *Could ASCs Lose Their Competitive Pricing Advantage?*, stated that "[a]ccording to the Ambulatory Surgery Center Association, ASCs are currently paid less than 60 percent of what hospital	

		solely take the hit. Commenter 5 recommends smaller cuts for everybody across the board. In addition to the form letter, commenter 6 states payment rates for ASCs pursuant to SB863 are already inadequate for many of the resource intensive surgeries with implanted devices performed by orthopedic surgeons. In addition, the increased administrative burdens associated with billing and processing WC claims, coupled with the payment shortfalls experienced under the Medicare system and the adoption of this proposed amendment will cause ASCs to turn away or "redirect" scheduling requests for WC patients. Physicians will no longer use an ASC for injured workers' outpatient surgery and those surgeries will be done at the hospital at much higher medical cost to the WC system. The hospitals will experience a	outpatient departments receive for the same procedures – which results in savings to both the insurer and patient." The ASCs payment rate as a result of SB863 is 80% of the Medicare hospital outpatient department rates. As is stated in the response made in the 30-day comment chart, the multiplier for ASCs was proposed to be amended from 82% to 80.81% (not 80.1% as stated by CASA and commenter 6) to conform to changes made by Medicare regarding the additional percent added for outlier cases.	

		back log of surgeries causing the injured worker to wait longer for surgery and delay rehabilitation and their ultimate return to work. In addition to the form letter, commenter 10 states the passage of SB 863 drastically cut payments to surgery centers providing care to WC patients are a harbinger of things to come. Commenter is aware of 3 surgery centers in his area that have closed due to these severe cuts in payments. This will force the few remaining providers to send them to inpatient hospitals, increasing the risk of hospital acquired infections and forcing them to find care in places unfamiliar with regional anesthesia techniques common in ASCs. The quality of care will plummet, the risks (and subsequent costs) will soar and will result in higher costs and significantly higher complications to the workers.		

§9789.32(a)	Definition of Emergency Room Visits/Surgical procedures	Commenters supports the proposed amendment to add codes for critical care, emergency services provided in Type B emergency departments, and trauma response team activation.	Agree.	3.1 (Ramirez, Brenda, CWCI); 8.1 (Gangl, Mark, CA Service Bureau)
§9789.32(a)	Reference to CPT and HCPCS codes	Commenter disagrees with removal of the CPT code range and deletion of "CPT" from this subdivision. Commenter states there are a wide range of CPT codes that would fall under emergency room visits and surgical procedures. Replacing "CPT" with "HCPCS" may confuse medical providers and lead to an increase in disputes regarding medical reimbursement. The change would allow medical providers to argue that since CPT codes are not mentioned or listed in the regulations, they do not apply. Additionally, commenter states Section 9789.39 lists the CPT code ranges	Disagree. As is consistent throughout the regulation, Sections 9789.30 through 9789.38 set forth the framework for the fee schedule. Section 9789.39 provides the updated information referenced in the other sections of the fee schedule by date of service. Therefore, DWC does not think making similar reference to Section 9789.39 for the CPT/HCPCS code ranges would cause confusion. Section 9789.30 defines "HCPCS" to mean "CMS' Healthcare Common Procedure Coding System, which describes products, supplies, procedures and health professional services and includes, *the American Medical Associations (AMA's)*	9.3 (Thill, Peggy, SCIF)

		referred to in Section 9789.32, so removal of them in this section is inconsistent. Commenter recommends keeping the reference to CPT and also including HCPCS. Doing so would prove helpful in determining what procedures are defined in the regulations. Finally, commenter states that keeping reference to CPT code ranges would reflect the changes made in Section 9789.39.	*Physician "Current Procedural Terminology", Fourth Edition (CPT-4) codes, alphanumeric codes, and modifiers*". Given this definition, DWC feels the use of the term HCPCS without reference to CPT is appropriate.	
§9789.32(a)(2)	Reimbursement of Status Indicators G, H, K, R, or U Services without Accompanying Surgical/ER/Facility Only Service	Commenter states the rules do not specify what reimbursement instructions are to be followed in the event that a supply, drug, device, blood product or biological with one of these status indicators is billed without an accompanying ER, Surgical or Facility Only service. Commenter recommends expanding the language to either (a) indicate that services with status indicators G,H,K,R, or U are never to be billed	Not within the scope of this comment period.	7.1 (Forsythe, Lisa Anne, Coventry)

		without a corresponding ER, Surgical or Facility Only Service, or (b) to provide payment instructions in the event that one of these services is billed without an accompanying ER, Surgical, or Facility Only Service.		
§9789.32(c)(a)(2)	Definition of the term "Other Service"	Commenter states Section 9789.32(a)(2) uses the term "other services" differently than how "Other Services" is defined in section 9789.30. Commenter states the "Other Service" billed *a la carte*, without an accompanying ER, Surgical or Facility Only Service has no reimbursement rules to address this scenario. Commenter recommends subsection 2 to either a) indicate the "Other Services" are never to be billed without corresponding ER, Surgical or Facility Only Service or b) to provide payment instructions in the event that one of these services is billed on a stand-alone basis without an accompanying ER, Surgical or Facility	Not within the scope of this comment period.	7.2 (Forsythe, Lisa Anne, Coventry)

		Only Service		
§9789.32(c)(1)(B)	"Other Services" to be paid according to the OMFS RBRVS	Commenter 1 states the Medicare RBRVS payment system is exclusively used to calculate payment for physician services, and the OPPS system is used to calculate payment rates for hospitals. Payment rates to hospitals under the OPPS system are typically higher than those paid to physicians in order to recognize the increased costs associated with maintaining standby capacity for emergencies, greater patient severity in hospital outpatient departments than in office settings and the need for more specialized equipment in the hospital setting. Payment rates to hospitals under the OMFS RBRVS do not consider these factors and are, therefore, woefully inadequate. WC carriers would be paying less in total for other services provided in a hospital than Medicare would pay for the same	A response to the comment was previously provided in the 30-day comment chart.	1.2 (Ott, Amber, CHA)

		service. Commenter 1 recommends DWC adopt 120% of the OPPS as the single payment system for all hospital outpatient services, which is consistent with Medicare rules and will also help reduce the opportunities for payment errors that may result from having 2 separate and distinct payment systems for hospital claims.		
§9789.32(c)(1)(B)(ii)	"Other Services" to be paid according to the OMFS RBRVS	Commenters support the proposed amendment to include a formula that clarifies how the base facility fee is calculated when the facility fee for Other Services is determined solely on the non-facility practice expense.	Agree.	3.2 (Ramirez, Brenda, CWCI); 8.2 (Gangl, Mark, CA Service Bureau); 9.2 (Thill, Peggy, SCIF)
§9789.32(c)(1)(B)	"Other Services" Therapy Caps	Commenter states the OMFS RBRVS imposes various caps on physical and occupational therapy visits and requires written, pre-negotiated fee arrangement if a provider anticipates exceeding those caps.	A response to the comment was previously provided in the 30-day comment chart.	1.3 (Ott, Amber, CHA)

		Commenter 1 states the proposed regulation would have a disproportionately negative effect on providers of multiple therapies as compared to free-standing providers of single therapies. Commenter 1 states that it is common practice in hospital outpatient departments for individuals with significant disabilities to receive several therapy treatments in a single day, and that it is clinically in the best interests of the patient. Commenter 1 feels that capping the number of payable modalities and procedures performed in one visit to no more than 4 codes requires a prolonged timeframe for treatment. Commenter recommends DWC allow a greater number of modalities and procedures to be performed in a single visit, or at minimum, the number of payable modalities and procedures per visit should be applied per discipline.		
§9789.33(a)	Calculating	Commenter asks how to	Not within the scope of this	8.3 (Gangl, California

	payment rates for services with status indicator code Q3	determine when an HCPCS code with a Q3 status indicator uses the APC separate rate assignment or APC composite rate assignment (APC assignments found in Addendum M and rates by APC assignment found in Addendum A) and if the composite assignment rate is used, how it is used.	rulemaking. The proposed amendment re-formats this subdivision to streamline without changing the substance of the subdivision (e.g. Q2/Q3) and, to add a section regarding how facility-only services payment rates are to be determined.	Service Bureau)
§§9789.33(b),(c), and (d)	Alternative outlier payment methodology	Commenters 3 and 9 support the proposed language that clarifies that the alternate payment methodology for high cost outliers is inapplicable for dates of service on or after September 1, 2014.	Agree.	3.3 (Ramirez, Brenda, CWCI); 9.1 (Thill, Peggy, SCIF)
§9789.33	Status indicators "A", "B", "E", and "M"	Commenter states that this section does not instruct how to pay for services with status indicators "A", "B", "E", and "M". Commenter recommends expanding the language in subsection "a" to either a) indicate that ER, Surgical, or Facility Only services with status indicators "A", "B", "E", and "M" are never	Not within the scope of this rulemaking.	7.3 (Forsythe, Lisa Ann, Coventry)

		billable/payable or b) provide payment instructions in the event that one of these services is billed that meets the criteria outlined above.		
§9789.39(b)	Non-substantive change with no regulatory effect to correct typographical error	Commenter recommends correcting a typographical error in section 9789.39(b) by changing the name of the category in the first column from "Unadjusted Conversion Factor" to "Adjusted Conversion Factor".	Agree. This is a non-substantive change with no regulatory effect, which corrects a typographical error. It is apparent that the formula results in the "adjusted conversion factor" which is derived from the unadjusted conversion factor multiplied by the estimated inflation factor.	3.4 (Ramirez, Brenda, CWCI)
§§9789.30 through 9789.39	Effective date of proposed amendments	Commenter supports an effective date that is anticipated to allow at least sixty to ninety days after revised regulations are approved by the OAL and filed with the Secretary of State for programming, training, and implementation	Agree. However, it should be noted this rulemaking is not subject to Chapter 3.5 of the Administrative Procedure Act relating to administrative regulations and rulemaking. These regulations are being amended under the independent authority of the Administrative Director under Labor Code §§4603.5, 5307.1, and 5307.3.	3.4 (Ramirez, Brenda, CWCI)

Hospital Outpatient Departments/ASC fee schedule rulemaking

Attachment to 15-Day Comment Chart (ending 04/28/2014)

The commenters listed below provided comments in support of the comments submitted by the California Ambulatory Surgery Association (CASA).

Abdoo, David
Adelchanow, Juliana
Alexander, Richard, II
Angle, Toni
Arledge, Susan, RN
Audiss, Paula
Aycock, Robert, MD
Azaren, Kent
Barnes, Gary
Baier, Allison
Bayne, Tracie
Behm, Chris
Belcher, Jacquelin
Benner, Jon, MD, Medical Director
Benson, Adrian, R.N., CNOR
Billesdon, John
Bone, Ken
Boswell, Catherine
Bracamontes, Sandie
Burton, Paul, D.
Bryant-Daniels, Katherine
Campos, Rashel
Canzano, John
Caputo, Roy
Cartwright, Grady
Catherwood, Lisa
Chang, Julie
Chew, Vicki, MD
Chung, Taehyun
Clarke, BJ
Clausen, Krystal
Colicchio, Tom
Covington, Carol
Cox, Stephanie
Day, Jocelyn

De Ciutiis, James
De La Torre, Yolanda
Dieparine, Erwin, MD
DiStefano, Kathryn, MSN, RN, CNOR
Doornik, Albert
Douglas, David
Duncan, Christine
Duran, Roger, Jr.
Durick, Thomas
Evans, Lisa
Ettinger, Bruce, MD MPH
Faria, Karen
Feltenstein, Leah
Ferland, Johnna
Flemming, David, MD
Friedlander, Eric
Fronda, Janet
Gaal, Tina
Gallagher, Christine
Garza, Richard
Gerbino, Peter
German, Denise
Ghazal, Ronny
Giancanelli, Cecilia
Gilbert, James
Gomez, Jennifer
Gonia, Stephanie
Gonzales-Marin, Lisa
Goodman, Cynthia
Green, William, MD
Hall, Marilyn, RN, Director of Clinical Ser.
Harding, Laura
Hare, Nina
Harris, Michelle

Harless, Judy
Harris, Rod, MD
Hartman, Daniel, MD
Henthorn, Diane
Hernandez, Edith
Herron, Celeste
Hertel, Stacey
Hertzog, Leif
Hibler, Lorie
Hill, Dasha
Hollenbeck, Jot
Holmes, Alexander
Hopkins, Gail, MD
Inovejas, Dina
Jackson, Corbett
James, Cindy
Janeway, Robert
Jaureguito, John, MD
Jensen, Jessica
Johnson, Erin, RN
Jones, Ken
Kaczmar, Theodore, Jr., MD
Kantor, Scott
Kardos, Leslie, MD
Kennett, Anna
Kenney, Cassandra
Kern, Katie
Kim, David, MD
Kim-Anciso, Soeuy
Klassen, Michael, MD
Kolb, Ken, CEO/Adm
Krol, Kathleen
Kurzweil, Peter
LaBouyer, Elizabeth
Lagana, Vittorio, DPM
Lang, Wendy
Larose, Connor
LaStrape, Shari
Lau, David
Lech, Tersa
Lewis, Kimberly
Liceaga, Al, MD
Lin, James
Loomer, Ruth
Luckett, Tim

Macer, George, MD
Mack, Debbie, MSN, CASC
Maldonado, Lydia
Martens, Alexis
Manzo, Beatriz
Marquez, Cristina
Masten, Susie
Matiko, James
Mayle, Robert, Jr., MD
Mayo, Gina, RN, BSN
McMillan, Colin
McNease, Laurie
Meckel, Chris, MD
Medina, Beatrice
Merkel, Cliff, MD
Meyer, Mandy
Miller, Deborah, VP AMSURG
Mills, Domini, RN
Minero, Pat
Molles, Kenia
Monnier, Jessie, RN
Moore, Steven, MD
Nathan, Ross
Nguyen, Hong, Dir. Of Operations, USPI
Nicolas, David, RN
Nowak, Kenneth
Oelker, Glenn
Ogimachi, David
Parker, William
Parsons, Trey
Payan, Heidi
Pena, Loly
Pena, Stacy
Penrose, Philip
Perez, Tito, RN
Peterson, Dan
Pfeiffer, Kimberly
Pipes, Linda
Pirkle, Elisabeth
Pon, Jenna
Posey, Lynn, RN, CNOR
Powers, Bret
Powers, Debi
Pruzansky, Jay, D., Director, E3 Healthcare LLC

Quinn, Jill, RN, BSN, EMBA
Quinn, Michael, DPM
Ramos, Bernie
Ramseur, James, Jr., MD
Reese, Mena, RN, BSN, CAPA
Reiter, Karen
Renfer, Leonard, III
Richards, Peter, C., MD
Robinson, Stacey
Rosenblum, Leland, MD
Rubenstein, Ronald, MD
Russo-Smith, Margaret
Salomon, Jeanette
Sanchez, Kelly
Satow, Gregg
Scannell, Mike
Schram, Kevin, RN
Schwartz, Donald
Scott, Ed
Scott, Jessie
Shaheen, Emile
Shaheen, John
Shapazian, Judy, RN
Silk, Jeremy
Simpson, Shawndra, RN, MPA, CASC
Slaton, Theresa, RN
Slosar, Paul
Smith-Huff, Melissa, RN
Sobotka, Jackie
Solache, Jennifer
Spector, Eugene
Steffora, Nancy
Steinmann, John

Stewart, Laurel
Stuntz, Michael
Sugar, Richard
Sugar, Robert, MD
Sunde, Douglas
Swafford, Selena
Tanner, Tammy
Torres, Sandra
Trapp, Terrence, MD
Vos, Nathan
Warden, William, III
Watson, Bill
Webb, Annette
Weiss, Diana
Weith, Lisa, RN, Center Director
Wellman, Peggy
Wenham, Lori
White, Geoffrey, G.
White, Jan
Wilcox, Charlene, RN
Williams, Mimi
Williamson, Rita
Wilson, Tom
Wintermute, Keith
Wittenberg, Heidi
Wolford, Carrie, RN
Wong, Willard, MD
Ybarra, Patsy
Yun, Dennis
Zamora, Maria
Zapanta-Murphy, Gina
Zasa, Robert