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, in response to the commenter, the Medicare OPPS uses the same wage index as is used under the Medicare inpatient hospital prospective payment system (IPPS). The IPPS wage adjustments reflect a number of adjustments including reclassification of hospitals to different geographic areas and an adjustment to the wage index based on commuting patterns of employees (the out-migration adjustment) that non-reclassified hospitals located in an out-migration county may qualify for. Although there is no process for geographic reclassifications for ASCs under the Medicare program, the OMFS hospital outpatient departments/ASC fee schedule does provide a county-level wage index for the geographic area in which the ASC is located adjusted to incorporate the out-migration adjustment applicable to non-reclassified hospitals located in the same geographic area. The	2.2 (Docherty, CASA - written and oral)

			out-migration adjustments are listed in Addendum L of the OPPS final rule, which is incorporated by reference by the OMFS. The second issue is the level of conversion factor that is used to determine the OMFS allowance. The initial conversion factor was established when the OMFS for hospital outpatient departments/ASC fee schedule was implemented in 2004 pursuant to LC section 5307.1. Consistent with LC section 5307.1(g)(1)(A)(i), the conversion factor has been updated annually based on the rate of increase in the hospital market basket. Policy adjustments to the update factor that are made under the Medicare program do not affect the OMFS update factor.	
§9789.30(aa)	Payment rate of 101.01 for facility only services	Commenters 1, 4, and 7 state the proposed payment rate of 101.01% for "facility only services" is insufficient to cover hospital costs.	Disagree, for the following reasons. Facility-only services is a small subset of the services. Under the pre-2014 OMFS	1.1 Cotter (HealthBridge Children's Hospital) 4.1 (Ott, CHA – written and oral); 7.2 (Clayton, Triage – oral)

		Commenter 4 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 WC payers as compared to Medicare. (Commenter cites examples of the difference in efficiencies). Commenter 4 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	physician fee schedule, they represent 1.7 percent of OMFS allowances. None of the procedures are high volume and we are not aware of any access problems. Overall, Table 4 of the RAND report indicates that the facility fees for services that do not have technical components will have more than a 100 percent increase in allowances using the OPPS rates with no multiplier *before* the separate payments that will be made for professional services are taken into account. Providing a higher allowance for these services could create a negative incentive of providing excessive and medically unnecessary service. When we compare the average OMFS allowances for crosswalked codes reported in the RAND RBRVS time file with the estimated payments that would be made using 101 percent of the Medicare OPPS fee schedule, we find indication that there would be a substantial increase in the	

		shortfalls experienced under the Medicare system. Commenter 7 is unsure how the parallel is drawn between recognizing that these services are facility-only services and still telling the facility it doesn't get its maximum reimbursement allowed under the legislation and regulations in the form of a 1.2 multiplier given that the claims administrator has no other option to send these patients to a lower cost setting. The other services in contrast can be performed in a lower cost setting. Commenter would encourage the claims administrator to channel that volume proactively to achieve its own discount rather than the DWC try to accomplish that by setting the rates unreasonably low at the physician's fee schedule allowable. DWC is putting pressure on the hospital to practically turn away patients. It is going to encourage behavior from the	allowances before the separate payment for the physician's professional services is considered. The OSHPD data referenced by commenter 4 does not directly provide a number for CA hospitals, so the Division lacks adequate information to respond to commenter 4's findings.	

		claims administrator to over-utilize care because you're getting a significant discount with the hospitals effectively not paying much more or any more than they would pay to have the procedure done in a physician's office and the discount is coming at the expense of the hospital and largely outside its control.		
§9789.30(aa)	Facilities Only multiplier	Commenters 5 and 6 support the adoption of the proposed facility only multiplier. Commenter 5 believes that adopting the HOPPS with no multiplier, for "Facility Only Services" provided to hospital outpatients is adequate and reasonable, and will provide neutral cost incentives so that "Facility Only Services" will be provided when medically appropriate. Commenter 6 states the proposed regulations take into account all reasonable scenarios, including those services identified as	Agree.	5.2 (Ramirez, CWCI) 6.4 (Thill, SCIF)

		"Facility Only Services". The DWC's definition of facility only services is consistent with Medicare's physician fee schedule and relative value files. The AD has appropriately set apart these services for reimbursement at 101.01% of the Medicare rate. While this somewhat complicated the fee schedule for the purpose of calculating payment, it is a reasonable, cost-effective and fair approach. Adopting the fee schedule based upon the HOPPS for facility-only procedures conforms to the MedPAC policy direction regarding the provision of fairly priced quality care for out-patient services.		
§9789.30(aa)	Payment rate of 80.81% for ASC services	Commenter 2 is opposed to the proposed amendments that "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%.	Disagree for the following reasons. a. The proposed multiplier is actually 80.81%, not 80.1% as stated by the commenter. b. The reason the regulation was amended to revise the Medicare Multiplier was to	2.1 (Docherty, CASA - written and oral)

		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 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.	conform to changes Medicare made to its fee-related structure and payment rules as required by Labor Code section 5307.1. Labor Code section 5307.1(a)(1), states in pertinent part, "[e]xcept for physician services, all fee shall be in accordance with the fee-related structure and rules of the relevant Medicare and Medi-Cal payment systems, provided that employer liability for medical treatment, including issues of reasonableness, necessity, frequency, and duration, shall be determined in accordance with Section 4600." Labor Code section 5307.1(b) states in pertinent part, "the administrative director 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 relevant	

			Medicare payment system." ." However, SB 863 revised Labor Code section 5307.1(c)(1) to state in pertinent part, that "…[n]otwithstanding subdivisions (a) and (d),…the maximum facility fee for services performed in an ambulatory surgical center shall not exceed 80 percent of the fee paid by Medicare for the same services performed in a hospital outpatient department." The amendment to the Medicare multiplier is being made to conform to changes in Medicare's payment rules. The estimated total additional payments for outliers made by Medicare cannot exceed 3 percent of estimated total program payment in that year (Section 1833(t)(5)(C) of the Social Security Act). When the hospital outpatient fee schedule regulation was adopted in 2004, Medicare allocated 2 percent of the total program payments to outlier payments for the year.	

			Medicare has since lowered this allocation to 1 percent of total program payments to outlier payments this year (78 FR 74826, December 10, 2013; CMS-1601-FC, page 7490). Therefore, in order to conform with changes to Medicare's payment rules, the additional percentage added for outliers was reduced to 121.2% (1.20/.99=1.212) for hospital outpatient departments and 80.81% (0.8/.99=0.80808) for ASCs. The percentage is being lowered across the board as required to achieve proportional consistency across all services. DWC feels the revised multiplier for ASCs is reasonable. The ASC payment levels are approximately 56 percent of the payment rates for comparable hospital outpatient services (MedPAC 2013). Although SB 863 reduces the OMFS allowances for ASC facility services from 120 percent to 80 percent of Medicare Hospital Outpatient Department (HOPD), the ASC	

			allowances (80 percent of Medicare HOPD) are still about 143 percent of the amounts payable under the Medicare fee schedule for ASC services. (RAND Report, *Ambulatory Surgical Services Provided Under California Workers' Compensation*, 2014) Therefore, the 80.81 percent multiplier of Medicare HOPD will still provide a higher payment rate relative to 120 percent of Medicare's ASC fee schedule rates. Medicare's ASC fee schedule reflects the lower costs of performing ambulatory surgery in a freestanding surgical center. The lower costs are well-documented. ASCs can perform procedures more efficiently because they have lower infrastructure costs and concentrate on a narrower range of procedures than hospitals. c. With regards to "eliminating the option to use the alternative payment methodology", after 2007, as a result of a CA Court of Appeal decision (*Capen v.*	

			Shewry, 155 Cal.App.4th 378, Sept. 2007), ASCs with partial or total physician-ownership would no longer be licensed by the California Department of Public Health (CDPH), but would come under the oversight of the Medical Board of California, thereby removing any requirement for these ASCs to report data to the Office of Statewide Health Planning and Development (OSHPD). As a result, CDPH stopped issuing and renewing licenses to all but a small number on non-physician-owned ASCs. Therefore, the number of ASCs providing "Annual Utilization Reports" to OSHPD dropped dramatically in subsequent years. An ASC opting to use the alternative payment methodology is required by section 9789.33(c)(5) to provide the DWC with a completed Annual Utilization Report of Specialty Clinics filed with OSHPD, or equivalent subject to the DWC's audit, for the preceding calendar year. Now,	

			if a physician-owned ASC opts to be paid using the alternative method of payment, the DWC is no longer able to audit the accuracy of the information provided by the ASC to derive its cost-to-charge ratio, making this alternative payment methodology unworkable. A 2014 RAND study, entitled, "*Ambulatory Surgical Services Provided Under California Workers' Compensation: An Assessment of the Feasibility and Advisability of Expanding Coverage* indicates there are over 1,589 ASCs operating in California, of which 1,551 are physician owned. The California Healthcare Almanac indicates that there were 754 free-standing ASCs in California, with 52 licensed by CDPH in 2010. Finally, for the last four annual periods, only 1 ASC elected to use the alternative payment methodology.	
§9789.30(aa)	Payment rate of 80.81% for ASC services	Commenter 6 supports the recalculation of the additional percentage for outlier compensation. Implementation of a WC	Agree. See response to Commenter 2.1, above.	6.3 (Thill, SCIF)

		multiplier to 80.81% for ASC services is reasonable as it encompasses high-cost outlier cases and is consistent with SB 863 reform legislation.		
§9789.30(aa)	Recalculating the additional percentage for outlier compensation.	Commenter 5 supports the recalculation of the additional percentage for outlier compensation for services after the implementation date.	Agree. See response to Commenter 2.1, above.	5.3 (Ramirez, CWCI)
§9789.31(a)	Addenda A, B, D1, D2, E, L, and M	Commenter wants to know if the Addenda comes from a CMS webpage.	Not within the scope of this rulemaking.	3.2 (Gangl, California Service Bureau)
§9789.32(a)	Definition of Emergency Room Visits/Surgical procedures	Commenter states Urgent Care facilities bill using G0380 through G0384, but, there is no fee schedule for urgent care.	Not within the scope of this rulemaking. The G0380-G0384 codes are for hospital type B emergency visits and should not be used for free-standing urgent care facilities. DWC, however, proposes to amend §§9789.32(a) and 9789.39 to include these codes within the definition of hospital emergency room visits. In addition, it is proposed that G0413 (percutaneous skeletal fixation of posterior pelvic bone fracture and/or dislocation, for fracture patterns that disrupt the pelvic ring, unilateral or	3.4 (Gangl, California Service Bureau – written and oral)

			bilateral, (includes ilium, sacroliliac joint and/or sacrum)) be added to the definition of surgical procedures to allow for a facility payment.	
§9789.32(c)(1)(B)	"Other Services" to be paid according to the OMFS RBRVS	Commenter 4 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	Disagree for the following reasons. No access issue has been identified to date using the current payment methodology of applying the pre-2014 OMFS physician fee schedule to calculate the payment rates. The RAND study shows that relative to pre-2014 OMFS allowances, aggregate maximum allowance amounts would increase 48 to 65 percent if the HOPPS fee schedule were used with no multiplier. Recent studies and a news article have found that payment variations need to be addressed because many services have been migrating from physician's offices to the usually higher paid hospital outpatient department settings, as hospital employment of physicians have grown. This shift towards hospital	4.2 (Ott, CHA - written and oral) 7.1 (Clayton, Triage - oral)

		inadequate. WC carriers would be paying less in total for other services provided in a hospital than Medicare would pay for the same service. Commenter 4 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. Commenter 7 states his opinion largely mirror those of CHA, in that the payment methodology proposed is cumbersome for hospitals and generates inadequate reimbursement as determined by Medicare and through our modeling as well. Commenter recognizes the DWC's goals to try to lower costs on the system by encouraging utilization at	outpatient departments settings have resulted in higher spending without significant changes in patient care. The MedPAC (June 2013) report stated that from 2010 to 2011, the share of Medicare E&M office visits in OPDs increased by 9%, the share of echocardiograms provided in OPDs increased by 15%, and the share of nuclear cardiology tests in OPDs increased by 22%. While recognizing payment rates for hospital outpatient services are typically higher due to higher infrastructure and regulatory costs, provision of care should be encouraged to take place in the least costly clinically appropriate setting. MedPAC raised the concern that when a hospital purchases a physician practice, the payment rate for the facility service changes from the RBRVS to the higher hospital outpatient department fee schedule payment rate despite no change in the nature of the actual services.	

		lower cost centers, but commenter thinks that the DWC's approach to achieving that is unfair on the hospitals. In particular, group health such as HMO's and PPO's have a pretty robust authorization process as already exists in the WC system. Commenter also sees the medical provider networks already established by the DWC. So, the infrastructure is actually in place to put the onus on the claims administrator or the payor for health care to only authorize services in the lowest cost setting indeed as appropriate rather than putting the onus on the hospital to simply be aware of and then shut its doors to patients that it can't afford to treat with the payment rates being proposed.		
§9789.32(c)(1)(B)	"Other Services" to be paid according to the OMFS RBRVS	Commenter 5 strongly supports the proposed amendments to make hospital outpatient facility fee payment according to the OMFS RBRVS technical component (TC) or practice	Agree.	5.1 (Ramirez, CWCI) 6.1 (Thill, SCIF)

		expense RVUs with the OMFS RBRVS multiplier because it encourages provision of care in the least costly clinically appropriate setting and "levels the playing field" across hospitals and community-based providers for comparable services. Commenter 6 supports the proposed amendments, and states the implementation of a fee schedule based upon the RBRVS will reduce costs by 7.6% where a CF of 120% of Medicare's allowance is applied, according to the RAND report. The DWC's proposed regulations include a WC multiplier of 121.2% for HOPD services. Given that the previous multiplier was 120% and 122% for high cost outlier cases, this will allow for a smooth transition to and fair reimbursement for HOPD procedures. Adopting the RBRVS for services other than emergency and surgical procedures will		

		prevent services from moving to outpatient settings that would result in a higher reimbursement, and would allow for provision of services in the most appropriate and least costly setting.		
§9789.32(c)(1)(B)	"Other Services" Therapy Caps	Commenter 4 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. Commenter 4 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 4 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 4 feels that capping the number of	Disagree for the following reasons: Therapy services provided in hospital outpatient department settings are currently subject to the same physical therapy caps under the pre-2014 OMFS physician fee schedule. In light of the increases in payment rates that will occur over the transition, a policy change does not appear warranted. Further, if the physical therapy caps were eliminated or relaxed when therapy services are provided in the hospital outpatient setting, this may incentivize shifting the site for therapy services to the hospital outpatient departments.	1.2 (Cotter, HealthBridge) 4.3 (Ott, CHA - written and oral)

		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. Commenter 1 states the legislation will limit progress patients with devastating injuries will be able to make in period of time by limiting daily therapy. Commenter 1 further states the legislation will negatively impact struggling families to be able to make additional appointments with transportation needs and other family burdens.		
§9789.32(c)(1)(B)(i), (ii), and (iii)	Other services payment methodology	Commenter 3 states carving out radiology and physical medicine and throwing them back into the physician's fee schedule is in some respects	Agree and disagree in part. Subdivision (i) sets forth the payment methodology for procedures with a PC/TC. DWC believes the proposed	Commenter 3.5 (Gangl, California Service Bureau – written and oral)

		counterproductive and is somewhat confusing. Commenter recommends providing formulas for subdivisions (i),(ii), and (iii)	regulations are clear without a "formula". DWC believes including a formula for the payment methodology set forth in subdivision (ii) would provide additional clarity, and, thus, subdivision (ii) will be amended accordingly. DWC does not believe subdivision (iii) requires a formula, as it indicates any physician/non-physician professional services billed by the hospital shall be determined according the OMFS RBRVS. The OMFS RBRVS provides a formula in §9789.12.2(b).	
§9789.32(e)	ASC-specific fee schedule for procedures codes no listed as part of the Medicare HOPD.	Commenter 2 proposes eventual adoption by the DWC of an ASC-specific fee schedule for Medicare HOPD unlisted codes at 85% of the inpatient hospital DRG rate.	Not within the scope of this rulemaking.	2.3 (Docherty, CASA - written and oral)
§9789.33(a)	Calculating payment rates for services with status indicator codes Q2 or Q3	Commenter 3 asks this subsection be amended to clarify how and when HCPCS/CPT codes with the status indicators Q2 or Q3 qualify for separate payment, and how the payment would be determined.	Not within the scope of this 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	3.3 (Gangl, California Service Bureau – written and oral)

			determined.	
§§9789.33(b),(c), and (d)	Alternative outlier payment methodology	Commenters 5 and 6 support elimination of the rarely-used alternative outlier payment methodology. Commenter 5 recommends replacing the proposed initial sentence in subdivisions (b)/(c)/(d) "is repealed as of XXX XX, 2014" with "inapplicable for dates of service on or after XXX XX, 2014." Commenter 6 states abolishing the alternative payment methodology simplifies reimbursement for ASCs.	Agree. See response to commenter 2.1 above. Subdivisions (b), (c), and (d) will be amended to state these subdivisions will be inapplicable for dates of service on or after September 1, 2014.	5.3 (Ramirez, CWCI) 6.2 (Thill, SCIF)
§§9789.34 and 9789.35	Tables A and B (§§9789.34 and 9789.35)	Commenter wants to know if there are proposed Tables A and B. If so, where are they found, and if not, when will they be published.	Not within the scope of this rulemaking.	3.1 (Gangl, California Service Bureau – written and oral)