

**STATE OF CALIFORNIA  
DEPARTMENT OF INDUSTRIAL RELATIONS  
Division of Workers' Compensation**

**NOTICE OF PROPOSED RULEMAKING**  
**(Adoption of Emergency Regulations)**

**Subject Matter of Regulations: Workers' Compensation –  
Official Medical Fee Schedule – Services Rendered After January 1, 2004**

**TITLE 8, CALIFORNIA CODE OF REGULATIONS**  
**SECTIONS 9789.10 – 9789.110**

**NOTICE IS HEREBY GIVEN** that the Administrative Director of the Division of Workers' Compensation, pursuant to the authority vested in him by Labor Code Sections 59, 129, 129.5, 133, 5307.1, 5307.3, and 5318 proposes to adopt the proposed regulations described below after considering all comments, objections, and recommendations regarding the proposed action. The below sections were adopted as emergency regulations and became effective January 2, 2004.

**PROPOSED REGULATORY ACTION**

The Department of Industrial Relations, Division of Workers' Compensation, proposes to adopt Article 5.3 of Chapter 4.5, Subchapter 1, of Title 8, California Code of Regulations, commencing with Section 9789.10:

Section 9789.10	Physician Services – Definition
Section 9789.11	Physician Services Rendered After January 1, 2004
Section 9789.20	General Information for Inpatient Hospital Fee Schedule – Discharge after January 1, 2004
Section 9789.21	Definitions for Inpatient Hospital Fee Schedule
Section 9789.22	Payment of Inpatient Hospital Services
Section 9789.23	Hospital Cost to Charge Ratios, Hospital Specific Outlier Factors, and Hospital Composite Factors
Section 9789.24	Diagnostic Related Groups, Relative Weights, Geometric Mean Length of Stay
Section 9789.30	Hospital Outpatient Departments and Ambulatory Surgical Centers - Definitions
Section 9789.31	Hospital Outpatient Departments and Ambulatory Surgical Centers – Adoption of Standards
Section 9789.32	Outpatient Hospital Department and Ambulatory Surgical Center Fee Schedule – Applicability
Section 9789.33	Hospital Outpatient Departments and Ambulatory Surgical Facilities Fee Schedule – Determination of Maximum Reasonable Fee
Section 9789.34	Table A
Section 9789.35	Table B
Section 9789.36	Update of Rules to Reflect Changes in the Medicare Payment System
Section 9789.37	DWC Form 15 Election for High Cost Outlier
Section 9789.38	Appendix X
Section 9789.40	Pharmacy
Section 9789.50	Pathology and Laboratory

Section 9789.60	Durable Medical Equipment, Prosthetics, Orthotics, Supplies
Section 9789.70	Ambulance Services
Section 9789.80	Skilled Nursing Facility [Reserved]
Section 9789.90	Home Health Care [Reserved]
Section 9789.100	Outpatient Renal Dialysis [Reserved]
Section 9789.110	Update of Rules to Reflect Changes in the Medicare Payment System

## PUBLIC HEARING

A public hearing has been scheduled to permit all interested persons the opportunity to present statements or arguments, oral or in writing, with respect to the subjects noted above, on the following dates:

**Date:** March 11, 2004  
**Time:** 10:00 am to 5:00 PM or conclusion of business  
**Place:** Gov. Hiram W. Johnson State Office Building, Auditorium  
455 Golden Gate Avenue  
San Francisco, California 94102

**The State Office Building and its Auditorium are accessible to persons with mobility impairments. Alternate formats, assistive listening systems, sign language interpreters, or other type of reasonable accommodation to facilitate effective communication for persons with disabilities, are available upon request. Please contact the State Wide Disability Accommodation Coordinator, Adel Serafino, at 1-866-681-1459 (toll free), or through the California Relay Service by dialing 711 or 1-800-735-2929 (TTY/English) or 1-800-855-3000 (TTY/Spanish) as soon as possible to request assistance.**

Please note that public comment will begin promptly at 10:00 a.m. and will conclude when the last speaker has finished his or her presentation. If public comment concludes before the noon recess, no afternoon session will be held.

The Administrative Director requests, but does not require that, any persons who make oral comments at the hearings also provide a written copy of their comments. Equal weight will be accorded to oral comments and written materials.

## WRITTEN COMMENT PERIOD

Any interested person, or his or her authorized representative, may submit written comments relevant to the proposed regulatory action to the Department of Industrial Relations, Division of Workers' Compensation. The written comment period closes at **5:00 p.m., on March 11, 2004**. The Department of Industrial Relations, Division of Workers' Compensation will consider only comments received at the Department of Industrial Relations, Division of Workers' Compensation by that time. Equal weight will be accorded to oral comments presented at the hearing and written materials.

Submit written comments concerning the proposed regulations prior to the close of the public comment period to:

Marcela Reyes  
Regulations Coordinator  
Department of Industrial Relations

Division of Workers' Compensation  
Post Office Box 420603  
San Francisco, CA 94142

Written comments may be submitted by facsimile transmission (FAX), addressed to the above-named contact person at (415) 703-4720. Written comments may also be sent electronically (via e-mail) using the following e-mail address: [dwcrules@dir.ca.gov](mailto:dwcrules@dir.ca.gov).

Unless submitted prior to or at the public hearing, Ms. Reyes must receive all written comments no later than 5:00 p.m. on March 11, 2004.

## **AUTHORITY AND REFERENCE**

The Administrative Director is undertaking this regulatory action pursuant to the authority vested in the Administrative Director by Labor Code Sections 127, 133, 4603.5, 5307.1, 5307.3, 5307.6, and 5318.

Reference is to Labor Code Sections 139.2, 4061, 4061.5, 4062, 4600, 4603.2, 4620, 4621, 4622, 4625, 4628, 4650, 5307.1, 5307.6, 5318, and 5402.

## **INFORMATIVE DIGEST AND POLICY OVERVIEW**

Section 5307.1 of the Labor Code, as amended by Senate Bill 228, requires the Administrative Director to adopt and revise periodically an official medical fee schedule that establishes, except for physician services, the reasonable maximum fees paid for all medical services rendered in workers' compensation cases. 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 (administered by the Center for Medicare & Medicaid Services of the United States Department of Health and Human Services) and Medi-Cal payment systems.

Beginning January 1, 2004, and continuing until the above Medicare-based fee schedule is adopted, the maximum reasonable fees for medical services (except for physician services) must be 120 percent of the estimated aggregate fees prescribed in the relevant Medicare payment system for the same class of services. Services paid at this rate include, but are not limited to, hospital inpatient services and services performed in an ambulatory surgical center or hospital outpatient department. The maximum reasonable fee for pharmacy and drug services that are not otherwise covered by a Medicare fee schedule payment for facility services must be 100 percent of the fees prescribed in the relevant Medi-Cal payment system. Fees for medical services and pharmacy services and drugs shall be adjusted to conform to any relevant change in the Medicare and Medi-Cal payment systems.

For the Calendar Years 2004 and 2005 the maximum reimbursable fees set forth in the existing Official Medical Fee Schedule for physician services must be reduced by five (5) percent. The Administrative Director has the discretion to reduce individual medical procedures (reflected in the Fee Schedule by separate CPT codes) by amounts different than five percent, but in no event shall a procedure be reduced to an amount that is less than that paid by the current Medicare payment system for the same procedure.

Prior to the adoption of the Medicare-based fee schedule, for any treatment, facility use, product, or service not covered by a Medicare payment system, including acupuncture services, or for a pharmacy service or drug not covered by a Medi-Cal payment system, the maximum reasonable fee must not

exceed the fee specified in the existing Official Medical Fee Schedule.

The Administrative Director now proposes to adopt administrative regulations governing payment under the Official Medical Fee Schedule for medical services rendered after January 1, 2004. These proposed regulations implement, interpret, and make specific Section 5307.1 of the Labor Code as follows:

**1. Section 9789.10**

This section provides definitions for key terms relating to physician services rendered after January 1, 2004 to ensure that their meaning will be clear to the regulated public. The key terms include:

(a) “Basic value” is defined to identify the value unit for an anesthesia procedure that used to determine the maximum reimbursable fee for a service involving the administration of anesthesia.

(b) “CMS” is defined to identify the Center for Medicare & Medicaid Services of the United States Department of Health and Human Services.

(c) “Conversion factor,” or “CF,” is defined to clarify the factor that is multiplied by the listed relative value unit of each individual procedure code in the Official Medical Fee Schedule to determine the maximum reimbursable physician fee. The conversion factor is necessary to calculate the 5% reduction in fees for physician services rendered after January 1, 2004, as mandated by Labor Code § 5307.1(k) and implemented by Section 9789.11.

(d) “CPT<sup>®</sup>” is defined to identify the licensed procedure coding system created by the American Medical Association and utilized in the Official Medical Fee Schedule.

(e) “Medicare rate” is defined as the Calendar Year 2004 physician fee schedule established by CMS. As mandated by amended Labor Code § 5307.1(k), the Medicare rate is used as the base by which the 5% reduction in physician fees will be determined.

(f) “Modifying units” is defined to identify the anesthesia modifiers and qualifying circumstances that are used to determine the maximum reimbursable fee for a service involving the administration of anesthesia.

(g) “Official Medical Fee Schedule” is defined to identify the maximum reimbursable fees for all medical services, goods, and treatment rendered after January 1, 2004. The Official Medical Fee Schedule consists of proposed Article 5.1 of Chapter 4.5, Title 8, California Code of Regulations (commencing with Section 9789.10).

(h) “Official Medical Fee Schedule 2003” (or “OMFS 2003”) is defined to identify the maximum reimbursable fees for all medical services, goods, and treatment rendered *before* January 1, 2004. The Official Medical Fee Schedule 2003 was adopted pursuant to Labor Code § 5307.1, in effect on December 31, 2003.

(i) “Percent reduction calculation” is defined to clarify the factor that is to be used for the purpose of applying the percentage reduction in fees for physician services rendered after January 1, 2004, as mandated by amended Labor Code § 5307.1(k) (effective January 1, 2004) and implemented by Section 9789.11.

(j) “Physician services” is defined to identify the medical treatment procedures whose maximum reimbursable fees, set forth in the Official Medical Fee Schedule 2003, are subject to the 5% reduction mandated by Labor Code § 5307.1(k) and implemented by Section 9789.11.

(k) “RVU” is defined to identify the relative value unit for a particular procedure, set forth in the Official Medical Fee Schedule 2003, which is used to determine the maximum reimbursable fee for a physician service.

(l) “Time value” is defined to identify the unit of time indicating the duration of an anesthesia procedure, set forth in the Official Medical Fee Schedule 2003, which is used to determine the maximum reimbursable fee for a service involving the administration of anesthesia.

## 2. Section 9789.11

This section sets forth the formula for determining the maximum reimbursable fees for physician services rendered after January 1, 2004. Amended Labor Code § 5307.1(k) requires that such fees, set forth in the Official Medical Fee Schedule 2003, be reduced by 5%. However, the Administrative Director has the discretion to adjust individual procedure codes by different amounts, provided that no resulting fee drops below the current Medicare rate for the same procedure.

(a) This subdivision provides that, except for the “General Information and Instructions” section, the ground rules set forth in the Official Medical Fee Schedule 2003 are applicable to physician services rendered after January 1, 2004. A new “General Information and Instructions” section is incorporated by reference.

(b) This subdivision establishes that for physician services rendered after January 1, 2004, the maximum reimbursable fees for each procedure set forth in the Official Medical Fee Schedule 2003 shall be reduced up to 5%, except for procedures that are reimbursed at or below the current Medicare rate.

(c) For the convenience of the regulated public, this subdivision consists of a table, “Table A - OMFS Physician Services Fees for Services Rendered after January 1, 2004,” incorporated by reference, setting forth each individual procedure code, its corresponding relative value, conversion factor, assigned percent reduction calculation (between 0 and 5.0%), and maximum reimbursable fee.

**NOTE: On January 7, 2004, subsequent to the approval of the OMFS Emergency Regulations, the Centers for Medicare and Medicaid Services issued an interim final rule implementing the provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108-173. The Act required changes to the relative value units that will result in increases in Medicare payments for physician fee schedule services for Calendar Year 2004. The interim final rule, found at 69 Federal Register No. 4, pages 1084 through 1267, applies this mandate. The Division recognizes that CMS’ changes to the relative value units may affect the Division’s computation of the percent reduction calculation set forth in “Table A- OMFS Physician Services Fees for Services Rendered after January 1, 2004.” The Division will review its estimation of the 2004 Medicare rates, taking into consideration the new relative value units, and correct the percent reduction calculations as necessary. Any corrections will be available prior to the March 11, 2004 public hearing.**

(d) This subdivision sets forth the formulas for determining the 5% reduction in maximum reimbursable fees for physician and anesthesia services. For physician services, the relative value unit for each procedure code is multiplied by the applicable conversion factor, which is then multiplied by Notice of Proposed Rulemaking – OMFS (011204)

the assigned percent reduction calculation (between 0 and 5%) to produce the maximum reimbursement fee before the application of the OMFS 2003 ground rules. For anesthesia services, the base unit for each procedure is added to a modifying unit (if any) and time value, and then multiplied by the conversion factor  $\times 95\%$ .

(e) This subdivision identifies the physician service procedure codes in the Pathology and Laboratory section of the OMFS 2003 that will be subject to the 5% reduction in maximum reimbursable fees required by amended Labor Code § 5307.1 and implemented by Section 9789.11.

### **3. Section 9789.20**

This regulation sets forth that the Inpatient Hospital Fee Schedule applies to services with a date of discharge after January 1, 2004, that the schedule will be adjusted to conform to relevant changes in the Medicare payment schedule no later than 60 days after the effective date of those changes, and that updates will be posted on the Division's website.

### **4. Section 9789.21**

Amended Labor Code § 5301.7 provides that all fees by a hospital for inpatient services shall be in accordance with the fee-related structure and rules of the relevant Medicare payment systems and that the maximum reasonable fees shall be 120 percent of the estimated aggregate fees prescribed in the Medicare payment system before the application of the inflation factor set forth in the statute. This regulation sets forth the definitions of terms used in the inpatient fee schedule regulations and the formulas needed in order to determine the maximum payment for medical services. The definition of "Composite factor" in Subdivision (d)(3) has been amended to reflect the changes that have been made to Section 9789.23 since the adoption of the emergency regulations.

### **5. Section 9789.22**

Amended Labor Code 5301.7 provides that all fees by a hospital for inpatient services shall be in accordance with the fee-related structure and rules of the relevant Medicare payment systems and that the maximum reasonable fees shall be 120 percent of the estimated aggregate fees prescribed in the Medicare payment system before the application of the inflation factor set forth in the statute. This regulation provides the basic procedures for the payment of inpatient services: the formula to determine the maximum payment for inpatient medical services, the requirement for health facilities to provide specific information in their bills to allow payers to determine the maximum payment, the formula for cost outlier cases, an exception for implantable hardware, a new technology pass-through, a modified factor for sole community hospitals, an explanation of how payment for transfers will be calculated, exemptions for certain types of hospitals, and the procedure for a request for redetermination.

### **6. Section 9789.23**

This section is a table that provides the Medical Provider Number, the hospital name, the Inpatient Hospital Operating Cost to Charge Ratio, Capital Cost to Charge Ratio, Total Cost to Charge Ratio, Hospital Specific Outlier, and Composite Factors. These factors are used to determine the amount of the outliers, to determine if the provider is entitled to an outlier, and to determine the maximum payment for inpatient medical services. The cost to charge ratios have been added to the table since the adoption of the emergency regulations at the request of the public. This table replaces the prior Section 9789.23 which instead had columns entitled "provider," "hospital name," "composite factor," "adjusted composite factor," and "hospital specific outlier factor."

**7. Section 9789.24**

This section is a table that provides the DRGs (diagnosis related groups), relative weights and geometric length of stay. These factors are used in the formula to determine the maximum payment for inpatient medical services.

**8. Section 9789.30**

This section provides definitions for key terms relating to medical services provided by hospital outpatient departments and ambulatory surgical centers after January 1, 2004. The key terms include:

(a) “Adjusted Conversion Factor” is defined to identify CMS’ conversion factor for 2003 of 52.151 x the market basket inflation factor of  $1.034 \times (0.4 + (0.6 \times \text{wage index}))$ .

(b) “Ambulatory Payment Classifications (APC)” is defined to identify the list of ambulatory payment classifications of hospital outpatient services used by Centers for Medicare & Medicaid Services (CMS).

(c) “Ambulatory Surgical Center (ASC)” is defined to identify any surgical clinic as defined in the California Health and Safety Code Section 1204 (b)(1), any ambulatory surgical center that is certified to participate in the Medicare program under Title XVIII (42 U.S.C. § 1395 et seq.) of the federal Social Security Act, or any surgical clinic accredited by an accrediting agency as approved by the Licensing Division of the Medical Board of California pursuant to Health and Safety Code Sections 1248.15 and 1248.4.

(d) “Annual Utilization Report of Specialty Clinics” is defined to identify the Annual Utilization Report of Clinics which is filed by February 15 of each year with the Office of Statewide Health Planning and Development by the ASCs as required by Section 127285 and Section 1216 of the Health and Safety Code.

(e) “APC Payment Rate” is defined to identify CMS’ hospital outpatient prospective payment system rate for Calendar Year 2004 as set forth in the Federal Register on November 7, 2003, Volume 68, No. 216, Addendum B, pages 63488 through 63655.

(f) “APC Relative Weight” is defined to identify CMS’ APC relative weight as set forth in CMS’ hospital outpatient prospective payment system for the Calendar Year 2004 as set forth in the Federal Register on November 7, 2003, Volume 68, No. 216, Addendum B, pages 63488 through 63655.

(g) “CMS” is defined to identify the Centers for Medicare & Medicaid Services of the United States Department of Health and Human Services.

(h) “Cost to Charge Ratio for ASC” is defined as the ratio of the facility’s total operating costs to total gross charges during the preceding calendar year.

(i) “Cost to Charge Ratio for Hospital Outpatient Department” is defined to identify the hospital cost-to-charge ratio used by the Medicare fiscal intermediary to determine high cost outlier payments.

(j) “HCPCS” is defined to identify CMS’ Healthcare Common Procedure Coding System, which describes products, supplies, procedures and health professional services and includes, the American Medical Associations (AMA’s) Physician “*Current Procedural Terminology*” Fourth Edition, (CPT-4) codes, alphanumeric codes, and related modifiers.

(k) “HCPCS Level I Codes” is defined to identify the AMA’s CPT-4 codes and modifiers for professional services and procedures.

(l) “HCPCS Level II Codes” is defined to identify the national alphanumeric codes and modifiers maintained by CMS for health care products and supplies, as well as some codes for professional services not included in the AMA’s CPT-4.

(m) “Health Facility” is defined to identify any facility as defined in Section 1250 of the Health and Safety Code.

(n) “Hospital Outpatient Department” is defined to identify any hospital outpatient department as defined in the California Health and Safety Code Section 1250 and any hospital outpatient department that is certified to participate in the Medicare program under Title XVIII (42 U.S.C. SEC. 1395 et seq.) of the federal Social Security Act.

(o) “Hospital Outpatient Department Services” is defined to refer to services furnished by any health facility as defined in the California Health and Safety Code Section 1250 and any hospital that is certified to participate in the Medicare program under Title XVIII (42 U.S.C. SEC. 1395 et seq.) of the federal Social Security Act to a patient who has not been admitted as an inpatient but who is registered as an outpatient in the records of the hospital.

(p) “Market Basket Inflation Factor” is defined to identify the market basket percentage increase determined by CMS for FY 2004, 3.4%, as set forth in the Federal Register on August 1, 2003, Volume 68, at page 45346.

(q) “Outpatient Prospective Payment System (OPPS)” is defined to identify Medicare’s payment system for outpatient services at hospitals. These outpatient services are classified according to a list of ambulatory payment classifications (APCs).

(r) “Total Gross Charges” is defined as the facility’s total usual and customary charges to patients, and third-party payers before reductions for contractual allowances, bad debts, courtesy allowances and charity care.

(s) “Total Operating Costs” is defined as the direct cost incurred in providing care to patients. Included in operating cost are: salaries and wages, rent or mortgage, employee benefits, supplies, equipment purchase and maintenance, professional fees, advertising, overhead, etc. It does not include start up costs.

(t) “Wage Index” is defined to identify CMS’ wage index for urban, rural and hospitals that are reclassified as described in CMS’ 2004 Hospital Outpatient Prospective Payment System (HOPPS), adopted for the Calendar Year 2004, published in the Federal Register on November 7, 2003, Volume 68, No. 216, Addenda H through J, pages 63682 through 63690.

(u) “Workers’ Compensation Multiplier” means the 120% Medicare multiplier required by Labor Code § 5307.1, or the 122% multiplier that includes an extra 2% reimbursement for high cost outlier cases.

## **9. Section 9789.31**

In this section the Administrative Director adopts and incorporates by reference the following standards:

(a) In this subdivision the Administrative Director incorporates by reference, the Centers for Medicare & Medicaid Services (CMS) 2004 Hospital Outpatient Prospective Payment System (HOPPS), adopted for the Calendar Year 2004, published in the Federal Register on November 7, 2003, Volume 68, No. 216, Addenda A through J, pages 63478 through 63690 as follows:

- (1) Addendum A, “List of Ambulatory Payment Classifications (APCs) with Status Indicators, Relative Weights, Payment Rates, and Copayment Amounts Calendar Year 2004.”
- (2) Addendum B, “Payment Status by HCPCS Code and Related Information Calendar Year 2004.”
- (3) Addendum D1, “Payment Status Indicators for Hospital Outpatient Prospective Payment System.”
- (4) Addendum D2, “Code Conditions.”
- (5) Addendum E, “CPT Codes Which Would Be Paid Only As Inpatient Procedures.”
- (6) Addendum H, “Wage Index For Urban Areas.”
- (7) Addendum I, “Wage Index For Rural Areas.”
- (8) Addendum J, “Wage Index For Hospitals That Are Reclassified.”

(b) In this subdivision the Administrative Director incorporates by reference the American Medical Associations’ Physician “*Current Procedural Terminology*,” 2004 Edition.

(c) In this subdivision the Administrative Director incorporates by reference CMS’ 2004 Alphanumeric “*Healthcare Common Procedure Coding System (HCPCS)*.”

## **10. Section 9789.32**

This Section sets forth the applicability of the hospital outpatient department and surgical center fee schedule.

(a) This subdivision provides that Sections 9789.30 through 9789.38 are applicable to the maximum allowable fees for emergency room visits and surgical procedures rendered after January 1, 2004. The subdivision defines emergency room visits based on CPT codes 99281-99285 and surgical procedures based on CPT codes 10040-69990. The subdivision further provides that a facility fee is payable only for the specified emergency room and surgical codes and for supplies, drugs, devices, blood

products and biologicals that are an integral part of the emergency room visit or surgical procedure. Subparts (a)(1) through (a)(3) set forth when a supply, drug, device, blood product and biological are considered an integral part of an emergency room visit or surgical procedure. The first sentence of subdivision (a) of proposed Section 9789.32 has been corrected to reflect the proper proposed sections referenced as Sections 9789.30 through 9789.38.

(b) This subdivision provides that Sections 9789.30 through 9789.38 apply to any hospital outpatient department as defined in the California Health and Safety Code Section 1250 and any hospital outpatient department that is certified to participate in the Medicare program under Title XVIII (42 U.S.C. § 1395 et seq.) of the federal Social Security Act and any ASC as defined in the California Health and Safety Code Section 1204(b)(1), any ambulatory surgical center that is certified to participate in the Medicare program under Title XVIII (42 U.S.C. § 1395 et seq.) of the federal Social Security Act, and any surgical clinic accredited by an accrediting agency as approved by the Licensing Division of the Medical Board of California pursuant to Health and Safety Code Sections 1248.15 and 1248.4, performing procedures and services on an outpatient basis. The first sentence of subdivision (b) of proposed Section 9789.32 has been corrected to reflect the proper proposed sections referenced as Sections 9789.30 through 9789.38.

(c) This subdivision provides that the maximum allowable fees for services and supplies furnished by hospitals and ambulatory surgical centers that do not meet the requirements in Section 9789.33(a) for a facility fee payment will be determined pursuant to subparts (c)(1) through (c)(7).

(d) This subdivision provides that only hospitals may charge or collect a facility fee for emergency room visits. It further provides that only hospitals and ambulatory surgical centers as defined in Section 9789.30(c) and Section 9789.30(m) may charge or collect a facility fee for surgical services provided on an outpatient basis.

(e) This subdivision provides that hospital outpatient departments and ambulatory surgical centers will not be reimbursed for procedures on the inpatient only list, Addendum E, except that pre-authorized services rendered are payable at the pre-negotiated fee arrangement. The subdivision further provides that the pre-authorization must be provided by an authorized agent of the claims administrator to the provider, and the fee agreement and pre-authorization must be memorialized in writing prior to performing the medical services.

(f) This subdivision provides that critical access hospitals and hospitals that are excluded from acute PPS are exempt from this fee schedule.

## **11. Section 9789.33**

This section sets forth the formulas for maximum allowable payment for services rendered after January 1, 2004 by hospital outpatient departments and ambulatory surgical centers.

(a) This subdivision provides the formula to determine the maximum allowable payment for outpatient facility fees for hospital emergency room services or for surgical services performed after January 1, 2004 at a hospital outpatient department or at an ambulatory surgical center. This subdivision further provides that a 1.22 factor shall be used in lieu of an additional payment for high cost outlier cases.

(1) This subpart provides that the formula to determine the maximum allowable payment for outpatient facility fees for hospital emergency room services or for surgical services performed

after January 1, 2004 at a hospital outpatient department or at an ambulatory surgical center for procedures with codes with status code indicators “S”, “T” or “V” is:  $(APC \text{ relative weight} \times \$52.151) \times (.40 + .60 \times \text{applicable wage index}) \times \text{inflation factor of } 1.034 \times 1.22$ .

(A) This subpart provides that Table A in Section 9789.34 contains an “adjusted conversion factor” which incorporates the standard conversion factor, wage index and inflation factor. It further provides that the maximum payment for ASCs and non-listed hospitals can be determined using the following formula:  $APC \text{ relative weight} \times \text{adjusted conversion factor} \times 1.22$ .

(B) This subpart provides that Table B in Section 9789.35 contains an “adjusted conversion factor” which incorporates the standard conversion factor, wage index and inflation factor. It further provides that the maximum payment for the listed hospitals can be determined using the following formula:  $APC \text{ relative weight} \times \text{adjusted conversion factor} \times 1.22$ .

(2) This subpart provides that the formula to determine the maximum reasonable fee for procedure codes for drugs and biologicals with status code indicator “G” is  $APC \text{ payment rate} \times 1.22$ .

(3) This subpart provides that the formula to determine the maximum reasonable fee for procedure codes with status code indicator “H” is documented paid costs, net of discounts and rebates, plus 10%.

(4) This subpart provides that the formula to determine the maximum reasonable fee for procedure codes for drugs and biologicals with status code indicator “K” is  $APC \text{ payment rate} \times 1.22$ .

(b) This subdivision provides for an alternative payment methodology in lieu of the maximum allowable fees set forth under subdivision (a).

(1) This subpart provides that the standard payment formulas pursuant to the alternative payment methodology in lieu of the maximum allowable fees set forth under subdivision (a).

(A) This subpart provides that the formula to determine the maximum allowable payment pursuant to the alternative payment methodology in lieu of the maximum allowable fees set forth under subdivision (a) for procedure codes with status code indicators “S”, “T” or “V” is:  $(APC \text{ relative weight} \times \$52.151) \times (.40 + .60 \times \text{applicable wage index}) \times \text{inflation factor of } 1.034 \times 1.20$ .

(B) This subpart provides that the formula to determine the maximum allowable payment pursuant to the alternative payment methodology in lieu of the maximum allowable fees set forth under subdivision (a) for procedure codes for drugs and biologicals with status code indicator “G” is  $APC \text{ payment rate} \times 1.20$ .

(C) This subpart provides that the formula to determine the maximum allowable payment pursuant to the alternative payment methodology in lieu of the maximum allowable fees set forth under subdivision (a) for procedure codes with status code indicator “H” is documented paid costs, net of discounts and rebates, plus 10%.

(D) This subpart provides that the formula to determine the maximum allowable payment pursuant to the alternative payment methodology in lieu of the maximum allowable fees set forth under subdivision (a) for procedure codes for drugs and biologicals with status code indicator “K” is APC payment rate x 1.20.

(2) This subpart provides that the additional payment formula for a high cost outlier case pursuant to the alternative payment methodology in lieu of the maximum allowable fees set forth under subdivision (a) is [(Facility charges x cost-to-charge ratio) - standard payment x 2.6] x .50.

(3) This subpart provides that in determining the additional payment, the facility’s charges and standard payment for devices with status code indicator “H” shall be excluded from the computation.

(c) This subdivision sets forth the requirements which must be met in order to qualify for the alternative payment methodology.

(1) This subpart provides that the facility that is seeking reimbursement for high cost outlier cases is required to file a DWC Form 15 “Election for High Cost Outlier,” contained in Section 9789.37. The completed form must be filed before March 1 of each year. The election becomes effective on April 1 of the same year and remains effective for a one-year period.

(2) This subpart provides that if the facility does not file a timely election satisfying the requirements set forth in this subdivision and Section 9789.37, payment is determined under subdivision (a).

(3) This subpart provides that if a hospital does not participate under Medicare, the maximum allowable fees applicable are determined under subdivision (a).

(4) This subpart requires that the cost-to-charge ratio applicable to a hospital participating in the Medicare program are determined based on the hospital’s cost-to-charge used by the Medicare fiscal intermediary to determine high cost outlier payments under 42 C.F.R. § 419.43(d), which is incorporated by reference and contained in Section 9789.38 - Appendix X. This subpart further provides that the cost-to-charge ratio being used by the intermediary for services furnished on February 15 of the year the election is filed is to be included on the hospital’s election form.

(5) This subpart provides that the cost-to-charge ratio applicable to an ambulatory surgery center is the ratio of the facility’s total operating costs to total gross charges during the preceding calendar year. The facility’s election form as contained in Section 9789.37 must include a completed Annual Utilization Report of Specialty Clinics filed with Office of Statewide Health Planning and Development (OSHPD) for the preceding calendar year, which is incorporated by reference. The facility’s election form shall further include the facility’s total operating costs during the preceding calendar year, the facility’s total gross charges during the preceding calendar year, and a certification under penalty of perjury signed by the Chief Executive Officer and a Certified Public Accountant, as to the accuracy of the information. Upon request from the Administrative Director, an independent audit may be conducted at the expense of the ASC. (Note: While ASCs may not typically file Annual Utilization Report of Specialty Clinics with OSHPD, any ASC

applying for the alternative payment methodology must file the equivalent, subject to audit by the Division of Workers' Compensation.) A copy of the Annual Utilization Report of Specialty Clinics may be obtained at OSHPD's website or upon request to the Administrative Director.

(6) This subpart provides that before April 1 of each year the AD will post a listing of those facilities that have elected to be paid under this paragraph and the facility-specific cost-to-charge ratio that shall be used to determine additional fees allowable for high cost outlier cases. The subpart further provides that the list shall be posted on the Division of Workers' Compensation or is available upon request to the Administrative Director.

(d) This subdivision provides that the OPSS rules (42 C.F.R § 419.44 and Status Indicators in Addendum A) regarding reimbursement for multiple procedures are incorporated by reference as set forth in Section 9789.38 - Appendix X.

(e) This subdivision provides that the OPSS rules in 42 CFR §§ 419.62, 419.64, and 419.66 regarding transitional pass-through payments for innovative medical devices, drugs and biologicals are incorporated by reference, as contained in Section 9789.38 - Appendix X, except that payment for these items is made pursuant to subdivisions (a) or (b) as applicable.

(f) This subdivision provides that the payment determined under subdivisions (a) and (b) include reimbursement for all of the included cost items specified in 42 CFR § 419.2(b), which is incorporated by reference, as contained in Section 9789.38 Appendix X. This subdivision further provides that all of the cost items specified in 42 C.F.R. § 419.2(c)1-6 are included in the maximum allowable payment rate and are incorporated by reference as contained in Section 9789.38 Appendix X.

(g) This subdivision provides that the maximum allowable fees are determined without regard to the provisions in 42 C.F.R. § 419.70 as contained in Section 9789.38 - Appendix X.

## **12. Section 9789.34**

This Section contains Table A, setting forth the "adjusted conversion factor," which incorporates the standard conversion factor for payment of facility fees provided by the ambulatory surgical centers and non-listed hospitals. The table lists the MSA Code, the urban and rural areas, the counties, the applicable wage index, and the "adjusted conversion factor" before the California Workers' Compensation adjustment factor for payment of facility fees provided by the ambulatory surgical centers and non-listed hospitals. The "adjusted conversion factor" is based on the following formula:  $\$52.151 \times (.40 + .60 \times \text{applicable wage index}) \times \text{inflation factor of } 1.034$ . The regulated public will be able to use the table to obtain the appropriate "adjusted conversion factor." The "adjusted conversion factor" is required in order to calculate the maximum allowable facility fee payment for facility fee services provided by the ambulatory surgical centers and non-listed hospitals based on the applicable formula pursuant to proposed Section 9789.33, subdivisions (a) or (b).

## **13. Section 9789.35**

This Section contains Table B, setting forth the "adjusted conversion factor," which incorporates the standard conversion factor for payment of facility fees provided by hospital outpatient departments. The table lists the provider number, the name of the hospital, the operating wage index, and the "adjusted conversion factor" before the California Workers' Compensation adjustment factor for payment of facility fees provided by the hospital outpatient departments. The "adjusted conversion

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factor” is based on the following formula:  $\$52.151 \times (.40 + .60 \times \text{applicable wage index}) \times \text{inflation factor of } 1.034$ . The regulated public will be able to use the table to obtain the appropriate “adjusted conversion factor.” The “adjusted conversion factor” is required in order to calculate the maximum allowable facility fee payment for facility fee services provided by the ambulatory surgical centers based on the applicable formula pursuant to proposed Section 9789.33, subdivisions (a) or (b).

**14. Section 9789.36**

This Section provides that Sections 9789.30 through 9789.38 will be adjusted to conform to any relevant changes in the Medicare payment system as required by law. It further provides that the Administrative Director will determine the effective date of the change and issue an order informing the public of the change and the effective date, and the order will be posted on the Division’s Internet Website.

**15. Section 9789.37**

This Section sets forth the form which will be used when electing to participate in the alternative payment methodology for high cost outlier cases under Section 9789.33(b) in lieu of the maximum allowable fees set forth pursuant to Section 9789.33(a). The facility electing to elect the high cost outlier payment methodology must file this form with the Administrative Director by March 1 of each year providing the requested information. The hospital outpatient departments must include in the form the cost-to-charge ratio being used by the Medicare fiscal intermediary to determine high cost outlier payments. The ASCs shall include in the form the facility’s total operating costs during the preceding calendar year, the facility’s total gross charges for the preceding calendar year. The facility’s election form shall further include a completed Annual Utilization Report of Specialty Clinics filed with Office of Statewide Health Planning and Development (OSHPD) for the preceding calendar year, which is incorporated by reference. (Note: While ASCs may not typically file Annual Utilization Report of Specialty Clinics with OSHPD, any ASC applying for the alternative payment methodology must file the equivalent, subject to audit by the Division of Workers’ Compensation.) A copy of the Annual Utilization Report of Specialty Clinics may be obtained at OSHPD’s website or upon request to the Administrative Director. The facility’s election form shall further include a certification under penalty of perjury signed by the Chief Executive Officer and a Certified Public Accountant, as to the accuracy of the information and attachment(s). Upon request from the Administrative Director, an independent audit may be conducted at the expense of the ASC.

**16. Section 9789.38**

This Section sets forth the Medicare federal regulations which have been incorporated by reference and/or referred to in the outpatient fee schedule regulations in numerical order.

**17. Section 9789.40**

This section provides that the fees for pharmacy services rendered after January 1, 2004 will be paid at 100% of the fees prescribed in the relevant Medi-Cal payment system. The Division will provide the means by which providers and payers can access current and past Medi-Cal rates.

**18. Section 9789.50**

This section provides that the maximum reimbursable fee for pathology and laboratory services rendered after January 1, 2004 shall not exceed 120% of the rate for the same procedure code in the Notice of Proposed Rulemaking – OMFS (011204)

CMS' Clinical Diagnostic Laboratory Fee Schedule applicable to California. The section identifies specific codes in the Special Services and Reports section of the OMFS 2003 that are eliminated based on the change to the CMS fee schedule.

**19. Section 9789.60**

This section provides that for services, equipment, or good provided after January 1, 2004, the maximum reimbursable fee for durable medical equipment, supplies and materials, Orthotics, prosthetics, and miscellaneous supplies and services shall not exceed 120% of the rate for the same procedure code in the CMS' Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS) Fee Schedule, applicable to California and as updated in the October 2003 quarterly update. The section identifies specific codes in the Special Services and Reports section of the OMFS 2003 that are eliminated based on the change to the CMS fee schedule.

**20. Section 9789.70**

This section provides that the maximum reimbursable fee for ambulance services rendered after January 1, 2004 shall not exceed 120% of the applicable fee set forth in CMS' Ambulance Fee Schedule, applicable to California.

**21. Section 9789.80**

This section is reserved for future rulemaking regarding the maximum reimbursable fees for skilled nursing facilities.

**22. Section 9789.90**

This section is reserved for future rulemaking regarding the maximum reimbursable fees for home health care.

**23. Section 9789.100**

This section is reserved for future rulemaking regarding the maximum reimbursable fees for outpatient renal dialysis.

**24. Section 9789.110**

Pursuant to amended Labor Code § 5307.1(g), this section provides that the OMFS shall be adjusted to reflect any relevant changes in the Medicare and Medi-Cal payment systems. The Administrative Director shall determine the effect date of the change and issue an order informing the public of the change and the effective date. Any order issued by the Administrative Director under this section must be posted on the Division of Workers' Compensation Internet Website.

## **STATE MANDATED LOCAL COSTS; REIMBURSEMENT**

The Administrative Director has determined that the proposed regulations will not impose any new mandated program on local agencies and school districts. The California Supreme Court has determined that an increase in workers' compensation benefit levels does not constitute a new State mandate for the purpose of local mandate claims because the increase does not impose unique requirements on local governments. See County of Los Angeles v. State of California (1987) 43 Cal.3d

46. The potential costs imposed on all public agency employers and payers by these proposed regulations, although not a benefit level increase, are similarly not a new State mandate because the regulations apply to all employers and payers, both public and private, and not uniquely to local governments.

## **DETERMINATION OF DISCRETIONARY COSTS ON LOCAL AGENCIES**

The proposed regulations may impose discretionary costs on local agencies and school districts. Any such costs, however, will be non-discretionary because the requirement that every employer comply with the requirements of California's workers' compensation laws is a statutory obligation. Furthermore, any such costs are non-reimbursable because the requirement for employers and payers to comply with California's workers' compensation laws is not unique to local agencies or school districts and applies to all employers and payers alike, public and private, including the State of California.

## **COST OR SAVINGS TO STATE AGENCIES**

The proposed regulations may impose costs on State agencies to the extent that the State is an employer, and to the extent that the State may be a provider of medical services. (State government accounts for about 3% of the occupational injuries and illnesses.) Any such costs are, however, are non-reimbursable since the requirement on an employer to comply with California's workers' compensation laws is not unique to State agencies and applies to all employers and payers alike, public and private.

## **COST OR SAVINGS IN FEDERAL FUNDING TO STATE**

The proposed regulations will not affect any federal funding.

## **SIGNIFICANT STATEWIDE ADVERSE ECONOMIC IMPACT ON BUSINESS**

The Administrative Director has concluded that the amended regulations will not have a significant statewide adverse economic impact on businesses, including the ability of California businesses to compete with businesses in other states.

## **POTENTIAL COST IMPACT ON REPRESENTATIVE PRIVATE PERSONS OR DIRECTLY AFFECTED BUSINESSES**

The Administrative Director has determined that the amended regulations will not have a significant adverse economic impact on representative private persons or directly affected businesses. The entities directly affected by the regulations, which govern payments for medical services provided to injured workers after January 1, 2004 include: (1) health care providers, including but not limited to physicians, pharmacists, inpatient and outpatient facilities, who bill for procedures covered under the Official Medical Fee Schedule; (2) employers who are large and financially secure enough to be permitted to self-insure their workers' compensation liability and who administer their own workers' compensation claims; (3) private insurance companies which are authorized to transact workers' compensation insurance in California; and (4) third party administrators which are retained to administer claims on behalf of self-insured employers or insurers.

## **ECONOMIC IMPACT ON SMALL BUSINESSES**

The economic impact on small business is primarily due not to the regulations but to the legislative enactments that link medical bill reimbursements to specific outside payment systems, such

as Medicare and Medi-Cal. The regulations are to clarify legislative mandates to adopt Medicare and Medi-Cal fee schedules. Small self-insureds and third party claims administrators will have small initial costs for revising and updating computer systems, average cost per business being \$1000. Physicians offices may have to purchase updated OMFS groundrules for medical fee schedules; current version of schedule costs \$38. Businesses can download copies of pricing or ways to determine pricing for specific services from DWC website.

## **ASSESSMENT OF EFFECTS ON JOB AND/OR BUSINESS CREATION, ELIMINATION OR EXPANSION**

The Administrative Director has determined that the proposed regulations will likely have no net effect on the creation or elimination of existing jobs/businesses within California, or affect the expansion of current California businesses.

## **IMPACT ON HOUSING COSTS**

The proposed regulations will have no effect on housing costs.

## **CONSIDERATION OF ALTERNATIVES**

In accordance with Government Code section 11346.5(a)(13), the Administrative Director must determine that no reasonable alternative considered or that has otherwise been identified and brought to the Administrative Director's attention would be more effective in carrying out the purpose for which the actions are proposed or would be as effective and less burdensome to affected private persons than the proposed action.

The Administrative Director invites interested persons to present statement or arguments with respect to alternatives to the proposed regulations at the scheduled hearing or during the written comment period.

## **AVAILABILITY OF INITIAL STATEMENT OF REASONS, TEXT OF PROPOSED REGULATIONS, RULEMAKING FILE AND DOCUMENTS SUPPORTING THE RULEMAKING FILE / INTERNET ACCESS**

An Initial Statement of Reasons and the text of the proposed regulations in plain English have been prepared and are available from the contact person named in this notice. The entire rulemaking file will be made available for inspection and copying at the address indicated below.

As of the date of this notice, the rulemaking file consists of the notice, the initial statement of reasons, the proposed text of the regulations, and the Form 399. Also included are documents incorporated by reference, and studies and documents relied upon in drafting the proposed regulations.

In addition, the Notice, Initial Statement of Reasons, and proposed text of regulations may be accessed and downloaded from the Division's website at [www.dir.ca.gov](http://www.dir.ca.gov).

Any interested person may inspect a copy or direct questions about the proposed regulations and any supplemental information contained in the rulemaking file. The rulemaking file will be available for inspection at the Department of Industrial Relations, Division of Workers' Compensation, 455 Golden Gate Avenue, 9th Floor, San Francisco, California, between 9:00 a.m. and 4:30 p.m., Monday through Friday. Copies of the proposed regulations, initial statement of reasons and any information contained in the rulemaking file may be requested in writing to the contact person.

## **CONTACT PERSON**

Nonsubstantive inquiries concerning this action, such as requests to be added to the mailing list for rulemaking notices, requests for copies of the text of the proposed regulations, the Initial Statement of Reasons, and any supplemental information contained in the rulemaking file may be requested in writing at the same address. The contact person is:

Marcela Reyes  
Regulations Coordinator  
Department of Industrial Relations  
Division of Workers' Compensation  
Post Office Box 420603  
San Francisco, CA 94142  
E-mail: [mreyes@dir.ca.gov](mailto:mreyes@dir.ca.gov)

The telephone number of the contact person is (415) 703-4600.

## **BACKUP CONTACT/PERSON CONTACT PERSON FOR SUBSTANTIVE QUESTIONS**

In the event the contact person is unavailable, or to obtain responses to questions regarding the substance of the proposed regulations, inquiries should be directed to the following backup contact persons:

Jackie Schauer ([jschauer@dir.ca.gov](mailto:jschauer@dir.ca.gov))  
George Parisotto ([gparisotto@dir.ca.gov](mailto:gparisotto@dir.ca.gov))  
Destie Overpeck ([doverpeck@dir.ca.gov](mailto:doverpeck@dir.ca.gov))  
Minerva Krohn ([mkrohn@dir.ca.gov](mailto:mkrohn@dir.ca.gov))  
Division of Workers' Compensation  
Post Office Box 420603  
San Francisco, CA 94142

The telephone number of the backup contact persons is (415) 703-4600.

## **AVAILABILITY OF CHANGES FOLLOWING PUBLIC HEARING**

If the Administrative Director makes changes to the proposed regulations as a result of the public hearing and public comment received, the modified text with changes clearly indicated will be made available for public comment for at least 15 days prior to the date on which the regulations are adopted.

## **AVAILABILITY OF THE FINAL STATEMENT OF REASONS**

Upon its completion, the Final Statement of Reasons will be available and copies may be requested from the contact person named in this notice or may be accessed on the website: [www.dir.ca.gov](http://www.dir.ca.gov)

## **AUTOMATIC MAILING**

A copy of this Notice, the Initial Statement of Reasons, and the text of the regulations, will automatically be sent to those interested persons on the Administrative Director's mailing list.

If adopted, the regulations as amended will appear in Article 5.3 of Chapter 4.5, Subchapter 1, of Title 8, California Code of Regulations, commencing with Section 9789.10.