

State of California  
Department of Industrial Relations  
**DIVISION OF WORKERS' COMPENSATION**  
455 Golden Gate Avenue, 9th Floor  
San Francisco, CA 94102

**NOTICE OF EMERGENCY REGULATORY ADOPTION**

**Finding of Emergency and Informative Digest**

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

The Administrative Director of the Division of Workers' Compensation, pursuant to the authority of Labor Code sections 59, 133, 5307.1, and 5307.3, proposes to amend section 9789.11 of Article 5.3 of Subchapter 1, Chapter 4.5, of Title 8, California Code of Regulations. This action is necessary in order to implement, on an emergency basis, the provisions of Labor Code Section 5307.1, as amended by Senate Bill 228 (Chapter 639, Stats. of 2003, effective January 1, 2004).

**Finding of Emergency**

The Administrative Director of the Division of Workers' Compensation finds that the proposed regulations attached hereto are necessary for the immediate preservation of the public peace, health and safety or general welfare.

**Statement of Emergency**

The containment of medical costs in the workers' compensation system is critical for the future of California. The cost of medical payments under the State's workers' compensation program has been increasing at a rate much higher than a national index of general health care costs. According to the Workers' Compensation Insurance Rating Bureau, the average estimated medical costs per indemnity claim in California's workers' compensation system rose from \$8,781 in 1992 to \$31,120 in 2002, an increase of 254%. In contrast, medical prices nationally rose only 49% during that same period. Claims administrators have paid physicians almost \$2.1 billion for services rendered to injured workers in 2002, compared to \$1.1 billion in 1995, an 86 percent increase. Hospitals were paid \$1.1 billion for services 2002, a 132% increase over the \$485 million paid in 1995. More dramatically, payments to chiropractors increased in 2002 by 126% percent, from \$104 million in 1995 to \$235 million in 2002.

The rise in medical costs has adversely affected California businesses. According to a recent survey conducted by the California Chamber of Commerce and the California Business Roundtable, the business community believes that workers' compensation insurance is the largest single cost associated with doing business in California. The Rating Bureau reports that insurance premiums for California employers increased from \$5.8 billion to \$14.7 billion, or 153%, between 1995 and 2002. As a result of escalating costs, 27 workers' compensation

insurance companies have gone bankrupt.

In response to increasing medical costs in the workers' compensation system, the Legislature amended Labor Code Section 5307.1 in Senate Bill 228 (Chapter 639, Statutes of 2003, effective January 1, 2004) to make significant changes in the manner by which health care providers are compensated for medical services rendered in cases within the jurisdiction of the California workers' compensation system. Under the amended statute, the maximum reasonable fees for medical services commencing January 1, 2004, other than physician services, are 120 percent of the estimated aggregate fees prescribed in the relevant Medicare payment system. The statute also provides that 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 5 percent. The Legislature's intent in the amended statute was to limit the costs of medical care for injured workers, effective January 1, 2004.

Sections 9789.10 and 9789.11, adopted on an emergency basis in 2004, implemented subdivision (k) of amended Labor Code section 5307.1. Section 9789.11 set forth the payment schedule for physician services in the Official Medical Fee Schedule. For the Calendar Years 2004 and 2005, the maximum reimbursable fees set forth in the existing Official Medical Fee Schedule for physician services were reduced by five (5) percent, although no fees for any procedure were to be reduced to an amount less than paid by the current Medicare payment system for the same procedure.

The emergency adoption of those sections was necessary to give an immediate interpretation from the Division of Workers' Compensation to avoid an increase in medical billing disputes, delays in payments for necessary medical treatment procedures, and an upsurge in litigation before the Workers' Compensation Appeals Board relating to physician fees.

Following the emergency adoption, the Administrative Director conducted a rulemaking action to adopt the physician fee schedule as permanent regulations. The physician fee schedule regulations became permanent July 1, 2004. As a part of that fee schedule, the Administrative Director incorporated by reference, "Table A" into section 9789.11, subdivision (c). Within that Table A, it was discovered that some figures applicable to physical medicine were not calculated in accordance with the intent of the Administrative Director, and some figures were adopted in error. Until all the physical medicine figures in Table A are adopted as calculated in accordance with the intent of the Administrative Director, and until the other errors are corrected, medical providers in the workers' compensation system will not be paid the intended amount for various services, and otherwise unnecessary disputes will continue to arise between providers and payers regarding the payment of bills. The Administrative Director proposes to incorporate by reference a new "Table A" for services rendered on or after the effective date of the regulation. The emergency adoption of the proposed regulation is necessary to prevent disputes and litigation, and to provide a clearly correct payment system for physician services.

The Administrative Director has therefore determined that the emergency adoption of the proposed regulation is necessary for the immediate preservation of the public peace, health and safety or general welfare.

## **Authority and Reference**

The Administrative Director is undertaking this regulatory action pursuant to the authority vested in the Administrative Director by Labor Code sections 59, 133, 4603.5, 5703.1, and 5307.3. Reference is to Labor Code sections 4600, 4603.2 and 5307.1.

## **Informative Digest**

These regulations are required by a legislative enactment –Senate Bill 228 (Chapter 639, Stats. of 2003, effective January 1, 2004).

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.

For physician services, Labor Code section 5307.1, subdivision (k) specifies that maximum reimbursable fees for Calendar Years 2004 and 2005 shall be reduced by five (5) percent from the OMFS 2003 fee schedule amounts. The statute specifies that the Administrative Director has the discretion to reduce individual medical procedures 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. These procedures are represented in the Fee Schedule by separate CPT codes. CPT codes are the procedure codes set forth in the American Medical Association's Physicians' Current Procedural Terminology (CPT) 1997, copyright 1996, American Medical Association, or the Physicians' Current Procedural Terminology (CPT) 1994, copyright 1993, American Medical Association.

The current Table A of Section 9789.11 contains a number of procedure codes with erroneous maximum fees. It also contains some procedure code fees which do not reflect the intent of the Administrative Director.

The Administrative Director now proposes to amend section 9789.11 and Table A included therein. These proposed regulations implement, interpret, and make specific sections 4600, 4603.2, and 5307.1 of the Labor Code as follows:

### **Section 9789.11**

Table A, which is incorporated by reference, contains maximum reasonable fees for several thousand medical procedures. These emergency regulations revise and correct fees for 286 of these medical procedures. A new Table A is adopted for services rendered on or after the effective date of these regulations.

The fees for three procedure codes in the Surgery section are revised to include the 5% reduction which was inadvertently omitted:

62278, 62289, and 64443.

For the following twenty-four Physical Medicine procedure codes, the 5% reduction was eliminated, because it was determined that this reduction would reduce the reimbursement below the level of Medicare:

97012	97022	97112	97612	97631
97014	97024	97116	97614	97650
97016	97026	97250	97616	97721
97018	97028	97520	97618	97752
97020	97110	97530	97620	

For the following three Medicine procedure codes, the 5% reduction was eliminated, because it was determined that this reduction would reduce the reimbursement below the level of Medicare:

90842  
90843  
90844

In the Anesthesia section of Table A, all of the procedure code numbers were revised to the correct five-digit format. These codes are found in the range of 00100 - 01999.

The following six procedure codes were deleted because they represent technical services only and therefore fall within the Clinical Laboratory Fee Schedule and not the Table A physician schedule.

86490  
86510  
86580  
86585  
89350  
89360

The following nine procedure codes were deleted because the services they describe now fall within the Clinical Laboratory Fee Schedule and not the Table A physician schedule.

99000  
99001      99020  
99002      99021  
99017      99026  
99019      99027

The following codes in the Radiology and Pathology sections have been revised to include a correct split between a professional and a technical component:

70010	73225	75710	76930	77750	88300
70015	73500	75743	76936	77761	88302
70030	73525	75746	76938	77763	88304
70170	73530	75774	76941	77777	88305
70190	73590	75790	76942	77778	88307
70332	73615	75801	76945	77781	88309
70336	73620	75803	76946	77782	88311
70350	73700	75805	76950	77783	88312
70360	73720	75807	76965	77784	88313
70370	74000	75809	76975	77789	88314
70371	74150	75810	76986	78460	88318
70373	74181	75820	77261	78472	88319
70390	74190	75825	77263	78478	88321
70450	74210	75880	77280	78481	88323
70540	74320	75885	77310	78483	88325
71010	74327	75893	77315	78580	88329
71036	74329	75961	77321	78647	88331
71040	74340	75962	77326	78650	88332
71060	74350	75980	77328	79000	88342
71100	74355	75984	77331	80500	88346
71250	74400	75992	77332	80502	88347
71550	74445	76000	77334	85060	88348
72010	74450	76010	77336	85097	88349
72125	74470	76061	77401	85102	88355
72141	74475	76066	77402	86077	88356
72170	74485	76070	77403	86078	88358
72192	74710	76075	77404	86079	88362
72196	74740	76080	77406	88104	88365
72200	74742	76086	77407	88106	89100
72240	74775	76090	77408	88107	89105
73000	75552	76093	77409	88108	89130
73010	75600	76095	77411	88125	89132
73040	75605	76150	77412	88160	89136
73050	75662	76350	77413	88161	89140
73085	75665	76355	77414	88162	89141
73090	75671	76360	77417	88172	
73120	75676	76370	77419	88173	
73200	75685	76400	77470	88180	
73220	75705	76506	77600	88182	

For the following five procedure codes, the conversion factor was corrected for typographical errors in Table A:

99065  
99100  
99116  
99135  
99140

Codes 43899 and 48599 were deleted, because they do not exist in the OMFS, and had been included by error.

Codes 35700 and 77416 were added, because they had been inadvertently omitted.

The amounts for codes 57307 and 88099 were revised to correct typographical errors.

### **MATTERS PRESCRIBED BY STATUTE APPLICABLE TO THE AGENCY OR TO ANY SPECIFIC REGULATION OR CLASS OF REGULATIONS**

There are no other matters prescribed by statute applicable to the Division of Workers' Compensation or to any specific regulation or class of regulations.

### **MANDATE ON LOCAL AGENCIES OR SCHOOL DISTRICTS**

The Administrative Director has determined that the proposed regulations will not impose any new mandated programs on any local agency or school district. 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 payors 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 payors, both public and private, and not uniquely to local governments.

### **FISCAL IMPACTS**

Cost to any local agency or school district that is required to be reimbursed under Part 7 (commencing with Section 17500) of Division 4 of the Government Code: None.

The Official Medical Fee Schedule (OMFS) may impose costs on local agencies and school districts. Any such costs, however, will be non-discretionary, because the requirement that every employer must pay for medical treatment for work-related injuries is a statutory obligation. Furthermore, any such costs are non-reimbursable because the requirement on employers to pay for medical treatment for industrially injured employees is not unique to local agencies or school districts and applies to all employers alike, public and private, including the State of California.

Other nondiscretionary costs/savings imposed upon local agencies: None. To the extent that local agencies and school districts are self-insured employers who must pay for medical treatment for industrially injured employees, they will be subject to the same cost impacts as all other self-insured employers in the state.

Costs or savings to state agencies or costs/savings in federal funding to the State: No impact on any federal funding. The changes to the OMFS may have cost and savings impacts on State agencies to the extent that the State agencies are employers. These additional costs or savings, if any, would be the same as for all employers in the state, as they would arise under the obligation for all employers to pay for medical treatment of industrially injured employees. These changes in the OMFS will not result in any costs or savings to the Department of Industrial Relations.