

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION
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NOTICE OF EMERGENCY REGULATORY ADOPTION

Updated Finding of Emergency and Updated 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 adopt changes to the Official Medical Fee Schedule (OMFS) on an emergency basis, in order to ensure that OMFS fees do not fall below revised fee levels adopted by the Centers for Medicare & Medicaid Services of the United States Department of Health and Human Services (CMS) which became effective January 1, 2005.

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

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(8 C.C.R. § 9789.11)

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 OMFS 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). After adoption of the Table A it became apparent that the table needed some revisions and corrections. These revisions and corrections were adopted as emergency regulations effective January 14, 2005. The Centers for Medicare & Medicaid Services of the United States Department of Health and Human Services (CMS) has adopted changes to its fee schedule for physicians' services. These changes were published November 15, 2004, in the Federal Register, and became effective January 1, 2005. In order to ensure that the fees in the OMFS do not fall below Medicare fees as updated January 1, 2005, the OMFS must be amended immediately. It is now necessary to adopt an emergency regulation to keep in force the Table A effective January 14, 2005 and to adopt a new Table A to be effective for services on or after May 14, 2005.

Until all the necessary changes are adopted to Table A, 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 readopt the Table A effective January 14, 2005 and incorporate by reference a new "Table A" for services rendered on or after May 14, 2005.

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.

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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 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. Table A of title 8 CCR section 9789.11 was adopted as an emergency regulation effective January 1, 2004 and subsequently adopted on a permanent basis effective July 1, 2004 to set forth physician fees.

The Table A of Section 9789.11 effective July 1, 2004 was supplemented by a revised and corrected table by the emergency adoption of Table A effective January 14, 2005. These emergency regulations readopt that Table A for services rendered on or after January 14, 2005. These regulations also adopt a new Table A for services on or after May 14, 2005 to carry out the statutory directive that OMFS fees not fall below the Medicare fee for the same procedure, as Medicare has revised its physician fees for 2005.

The Administrative Director now adopts amendments to section 9789.11 to adopt Table A effective January 14, 2005 and Table A effective May 14, 2005 on an emergency basis. These proposed regulations implement, interpret, and make specific sections 4600, 4603.2, and 5307.1 of

the Labor Code as follows:

**Changes in Table A effective January 14, 2005.
Section 9789.11**

Table A, which is incorporated by reference, contains maximum reasonable fees for several thousand medical procedures. These emergency regulations readopt the Table A which was adopted for services on or after the effective date of January 14, 2005, which revised and corrected fees for 286 of these medical procedures.

The fees for three procedure codes in the Surgery section are revised, effective January 14, 2005, 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, effective January 14, 2005, 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, effective January 14, 2005, 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, effective January 14, 2005. These codes are found in the range of 00100 - 01999.

The following six procedure codes were deleted, effective January 14, 2005, 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
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The following nine procedure codes were deleted, effective January 14, 2005, because the services they describe now fall within the Clinical Laboratory Fee Schedule and not the Table A physician schedule.

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99000	99001	99002	99017	99019	99020
99021	99026	99027			

The following codes in the Radiology and Pathology sections were revised, effective January 14, 2005, to include a correct split between a professional and a technical component:

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

88348	88356	88365	89105	89136
88349	88358	89100	89130	89140
88355	88362		89132	89141

For the following five procedure codes, the conversion factor was corrected, effective January 14, 2005, for typographical errors in Table A:

99065	99100	99116	99135	99140
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Codes 43899 and 48599 were deleted, effective January 14, 2005, because they do not exist in the OMFS, and had been included by error.

Codes 35700 and 77416 were added, effective January 14, 2005, because they had been inadvertently omitted.

The amounts for codes 57307 and 88099 were revised, effective January 14, 2005, to correct typographical errors.

Changes in Table A effective May 14, 2005.

A second new Table A, incorporated by reference, is adopted for services rendered on or after May 14, 2005. This second Table A revises and corrects fees for nine of these medical procedures, and adjusts fees for 105 medical procedures so that they do not fall below Medicare in light of CMS' fee increases for those procedures which became effective January 1, 2005.

The fees for the following procedure codes are revised, effective May 14, 2005, to reflect changes in CMS' physician's fee schedule which became effective January 1, 2005:

11740	27600	28126	31725	54318	67808
19001	27601	28140	32815	54450	67916
20910	27665	28153	32905	60512	67923
20972	27686	28160	32940	61340	68530
21400	27730	28193	36420	61520	68770
21493	27732	28250	36489	61530	68850
21925	27752	28261	36493	61583	70553
24560	27824	28285	36533	61596	80502
25455	27825	28286	36860	61888	88180
25565	28050	28300	42100	63301	88349
25600	28060	28302	47505	64726	90842
25622	28080	28305	47553	65900	91032
26765	28100	28308	50020	67025	92265
27035	28104	28455	50205	67028	92284
27060	28108	28576	50578	67120	93721
27071	28110	28645	50961	67121	93722
27517	28120	31720	53200	67345	94770

96115 99183 99311

The fees for the following nine procedure codes are revised, effective May 14, 2005, to include the 5% reduction which was inadvertently omitted in previous iterations of the Table A:

88028 88036 88045 88140 88155
88029 88037 88130 88150

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 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.

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 Division of Workers Compensation

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.