

State of California
DEPARTMENT OF INDUSTRIAL RELATIONS
Division of Workers' Compensation

NOTICE OF MODIFICATION TO TEXT OF
PROPOSED REGULATIONS
(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 modify the text of the following proposed amendments to Title 8, California Code of Regulations:

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 9789.30	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 9789.38	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

PRESENTATION OF WRITTEN COMMENTS AND DEADLINE FOR SUBMISSION OF WRITTEN COMMENTS

Members of the public are invited to present written comments regarding these proposed modifications. **Only comments directly concerning the proposed modifications to the text of the regulations will be considered and responded to in the Final Statement of Reasons.**

Written comments should be addressed to:

Marcela Reyes, Regulations Coordinator
Department of Industrial Relations
Division of Workers' Compensation
Post Office Box 420603
San Francisco, CA 94142

The Division's contact person must receive all written comments concerning the proposed modifications to the regulations no later than **5:00 p.m. on Friday, April 2, 2004**. Written comments may be submitted by facsimile transmission (FAX), addressed to the contact person at (415) 703-4720. Written comments may also be sent electronically (via e-mail), using the following e-mail address: dwcrules@hq.dir.ca.gov.

AVAILABILITY OF TEXT OF REGULATIONS AND RULEMAKING FILE

Copies of the original text and modified text with modifications clearly indicated, and the entire rulemaking file, are currently available for public review during normal business hours of 8:00 a.m. to 5:00 p.m., Monday through Friday, excluding legal holidays, at the offices of the Division of Workers' Compensation. The Division is located at 455 Golden Gate Avenue, 9th Floor, San Francisco, California.

Please contact the Division's regulations coordinator, Ms. Marcela Reyes, at (415) 703-4600 to arrange to inspect the rulemaking file.

The specific modifications proposed include changes to the text of the proposed amendments Title 8, California Code of Regulations, 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 9789.30 (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 9789.38 (Appendix X), Section 9789.40 (Pharmacy), Section 9789.50 (Pathology and Laboratory), Section 9789.60 (Durable Medical Equipment, Prosthetics, Orthotics, Supplies), and Section 9789.70 (Ambulance Services).

DOCUMENTS SUPPORTING THE RULEMAKING FILE

CMS-1471-CN, Federal Register, Volume 68, No. 250 (December 31, 2003), pages 75442 through 75445.

CMS-1371-IFC, Federal Register, Volume 69, No. 3 (January 6, 2004), pages 820 through 844.

Comments from various interested parties concerning the Division's proposed changes have been added to the rulemaking file.

Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173.

Title 42, Code of Federal Regulations, Sections 412.2, 412.23, 412.87, 412.88, and 412.92, revised as of October 1, 2003.

Title 42, Code of Federal Regulations, Sections 419.32, 419.43, 419.64, revised as of January 6, 2004.

FORMAT OF PROPOSED MODIFICATIONS

Proposed Text Noticed for 45-Day Comment Period:

Deletions from the codified emergency regulatory text are indicated by strike-through, thus: ~~deleted language~~.

Additions to the codified emergency regulatory text are indicated by underlining, thus: underlined language.

Proposed Text Noticed for This 15-Day Comment Period on Modified Text:

Deletions from the amended regulatory text, as proposed on January 12, 2004, are indicated by double strike-through under-line, thus: ~~~~deleted language~~~~.

Additions to the amended regulatory text, as proposed on January 12, 2004, are indicated by a double underline, thus: added language.

SUMMARY OF PROPOSED CHANGES

Modifications to Section 9789.10 Physician Services – Definition

Subdivision (d) is amended to include the codes listed in the "Physicians' Current Procedural Terminology (CPT) 1994," copyright 1993, American Medical Association, within the definition of "CPT®." Such codes are utilized in the Physical Medicine section of the OMFS 2003.

Modifications to Section 9789.11 Physician Services Rendered After January 1, 2004

The “General Information and Instructions, Effective for Dates of Service after January 1, 2004,” which is incorporated by reference into Subdivision (a)(1), has been amended. Changes include:

- Page 1 – clarification that licensed hospitals, surgical facilities, and ambulatory surgical centers are entitled to facility fees for the use of the emergency room or operating room.
- Page 2 – express listing of procedures in the Special Services and Reports section of the OMFS 2003 that will not be valid for services rendered after January 1, 2004.
- Page 3 - clarification that any procedure code in the OMFS 2003 that is reimbursed at a rate greater than 100% of the Medicare rate (adopted for Calendar Year 2004) will be reduced up to 5% so that reimbursement will not fall below the Medicare rate.
- Page 4 - requiring that documentation of the actual cost of durable medical equipment may be requested by the payer. Such documentation may include, if applicable, a best or preferred price list.
- Page 4 - clarification that for any supply or material not covered by or listed in the Medicare DMEPOS fee schedule, the maximum reasonable fee paid shall not exceed that set forth in the OMFS 2003. Procedures and formulas for the payment of unlisted supplies or materials are included.
- Page 4 – inclusion of Pharmaceuticals section. Clarification that listed immunizations are reimbursable “By Report” plus a \$15.00 injection fee.
- Page 4 & 5 - clarification that for any pharmacy service or drug not covered by or listed in the relevant Medi-Cal payment system, the maximum reasonable fee paid shall not exceed that set forth in the OMFS 2003. Procedures and formulas for the payment of unlisted pharmacy services or drugs are included.

Subdivision (b) is amended to clarify that any procedure code in the OMFS 2003 that is reimbursed at a rate greater than 100% of the Medicare rate (adopted for Calendar Year 2004) will be reduced up to 5% so that reimbursement will not fall below the Medicare rate.

Subdivision (e) is amended to clarify that except for listed exceptions, pathology and laboratory services will be reimbursed under Section 9789.50.

Modifications to Section 9789.20 General Information for Inpatient Hospital Fee Schedule – Discharge after January 1, 2004

In response to comments, Section 9789.20(d) is amended to specify that the Inpatient Hospital Fee Schedule will be adjusted to conform to Medicare’s mid year updates within 60 days and that the annual updates will be effective every year on October 1. The word “will” is replaced with the word “shall.”

Modifications to Section 9789.21 Definitions for Inpatient Hospital Fee Schedule

Section 9789.21(d): This subdivision is amended to clarify that new technology payments are excluded when determining the composite factor.

Section 9789.21(d)(2)(B) and (D): The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173 (“MMA”) modified the calculation for large urban areas. Therefore, these subdivisions are corrected and the MMA reference is added.

Section 9789.21(d)(2)(E): The MMA modified the calculation for the disproportionate share adjustment factor. Therefore, the MMA reference is added.

Section 9789.21(d)(2)(F): The MMA modified the calculation for the indirect medical education adjustment. Therefore, the MMA reference is added.

Section 9789.21(e): This subdivision is amended to include implantable medical devices (which is referenced in 9789.22(f)).

Section 9789.21(g): This subdivision is edited to provide the correct definition of “cost outlier case.”

Section 9789.21(h): This subdivision is amended to include the payment for new medical services and new technology as part of the “cost outlier threshold.”

Section 9789.21(q)(1): The words “geographic adjustment factor” are replaced with “wage index.”

Modifications to Section 9789.22 Payment of Inpatient Hospital Services

Section 9789.22(b): This subdivision is added to specify that inpatient operating costs and capital-related costs are included in the inpatient hospital fee schedule maximum payment amount.

Section 9789.22(c): This subdivision is added to specify that the maximum payment does not include the cost items specified in Title 42, Code of Federal Regulations, §412(e)(1)(2)(3) and (5). It also provides that the maximum allowable fees for organ and tissue acquisition shall be based on the documented paid cost of procuring the organ or tissue.

After adding subdivisions (b) and (c), the remaining subdivisions have been re-numbered in sequential order, and cross references to the other subdivisions are corrected.

Section 9789.22(e)(3) and (4): The new technology pass-through payment is added to these sections which explain the formula for cost outlier cases.

Section 9789.22(e)(5): The word “once” is replaced by the word “if.”

Section 9789.22(g) and (h): Reference to the Code of Federal Regulations is updated to include the October 1, 2003 revision.

Section 9789.22(i)(1): This subdivision is amended to exclude only the health facilities listed as exempt under Section 9789.22(j).

Section 9789.22(i)(2)(A): This subdivision is amended to include long-term hospitals.

Section 9789.23(i)(2)(B): In response to comments, this section is clarified primarily by removing the word “subsequent.”

Section 9789.23(j)(3) and (5): Reference to the Code of Federal Regulations is updated to include the October 1, 2003 revision. Also, the subdivision incorrect cited Section 412.25 instead of 412.23. This is corrected.

Section 9789.23(j)(6): The reference to the (g)(2) (the transfer policy) is deleted. Although the rehabilitation hospital is exempt, the post acute transfer policy applies to a hospital that discharges to them.

Section 9789.23(j)(8) is added to provide that out of state hospitals are exempt from the maximum reimbursement formula.

Section 9789.23(k) is added for hospitals that are not listed on the Medicare Cost Report.

Modifications to Section 9789.23 Hospital Cost to Charge Ratios, Hospital Specific Outlier Factors, and Hospital Composite Factors

The previous section is deleted and a revised section is provided. The calculations have been corrected to reflect the modifications made by The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, §§401, 402 and 502.

Modifications to Section 9789.30 Hospital Outpatient Departments and Ambulatory Surgical Centers – Definitions

Section 9789.30(a) has been modified to insert the \$ sign before number 52.151.

Section 9789.30(d) has been modified to delete the word “which” and add the word “that.”

Section 9789.30(e) and (f) has been modified to reflect the changes in the federal regulations.

Modifications to Section 9789.31 Hospital Outpatient Departments and Ambulatory Surgical Centers – Adoption of Standards

Section 9789.31(a) has been modified to identify the November 7, 2003 CMS regulation reference number as CMS-1471-FC. The Section has further been modified to reflect that the November 7, 2003 regulation (CMS-1471-FC) setting forth the CMS 2004 HOPPS was changed on December 31, 2003 by CMS-1471-CN, as published in the Federal Register on December 31, 2003, Volume 68, No. 250, pages 75442 through 75445, and on January 6, 2004 by CMS-1371-IFC, as published in the Federal Register on January 6, 2004, Volume 69, No. 3, pages 820 through 844. The Section has been also modified to set forth the CMS website where CMS’ regulations may be accessed.

Modifications to Section 9789.32 Outpatient Hospital Department and Ambulatory Surgical Center Fee Schedule – Applicability

Section 9789.32(a) has been modified to clarify that payment for other services furnished in conjunction with a surgical procedure or emergency room visit shall be in accordance with

subdivision (c) of this Section.

Section 9789.32(c) has been modified to clarify that the maximum allowable fees for services, drugs and supplies furnished by hospitals and ambulatory surgical centers that do not meet the requirements in (a) for a facility fee payment and are not bundled in the APC payment rate for a surgical service or emergency room visit will be determined pursuant to subparts (1)-(7).

Section 9789.32(c)(1) has been deleted.

Section 9789.32(c)(2) and (c)(3) have been renumbered (c)(1) and (c)(2) respectively.

Section 9789.32(c)(5) has been renumbered (c)(4).

Section 9789.32(c)(5) has been added to state that the maximum allowable fees for the technical component of the diagnostic services with a status code indicator "X" shall be determined according to Section 9789.10 and Section 9789.11.

Section 9789.32(g) has been added to reflect that out of state hospital outpatient departments and ambulatory surgical centers are exempt from this fee schedule.

Section 9789.32(h) has been added to state that hospital outpatient departments and ambulatory surgical centers billing for facility fees and other services under this section shall present with their bill the name and physical address of the facility, the facility's Medicare Provider or UPIN (or, in the absence of the Medicare number, the OSHPD Facility Number). The Section further provides that the bill shall include the dates of service, the diagnosis and procedure codes and charges for each service, and the applicable APC codes.

Modifications to Section 9789.33 Hospital Outpatient Departments and Ambulatory Surgical Facilities Fee Schedule – Determination of Maximum Reasonable Fee

Section 9789.33(a)(1) has been amended to include status code indicator "X."

Section 9789.33(a)(3) has been amended to provide that the formula for payment for procedure codes for devices with status code indicator "H" is: Documented paid costs, net of discounts and rebates, plus 10% not to exceed \$250.00, plus any sales tax and/or shipping and handling charges actually paid.

Section 9789(b)(1)(C) has been amended to provide that the formula for payment for procedure codes for devices with status code indicator "H" under the alternative payment methodology in subdivision (b) is: Documented paid costs, net of discounts and rebates, plus 10% not to exceed \$250.00, plus any sales tax and/or shipping and handling charges actually paid.

Section 9789(b)(1)(E) has been added to provide that the formula to determine the maximum allowable payment pursuant to the alternative payment methodology in subdivision (b) for procedure codes for surgical procedures with status code indicator "X" when no APC payment is made for a procedure with status code indicator "S", "T", or "V" is APC relative weight x adjusted conversion factor x 1.20.

Section 9789(b)(3) has been amended to delete the word “standard.”

Section 9789.33(d) has been renumbered Section 9789.33(e). A new Section 9789.33(d) now provides that any ambulatory surgical center that believes its cost-to-charge ratio in connection with its election to participate in the alternative payment methodology for high cost outlier cases under Section 9789.33(b) was erroneously determined because of error in tabulating data may request the Administrative Director for a re-determination of its cost-to-charge ratio. Proposed section 9789.33(d) further provides that the redetermination of its cost-to-charge ratio request shall be in writing, shall state the alleged error, and shall be supported by written documentation. Within 30 days after receiving a complete written request, the Administrative Director shall make a redetermination of the cost-to-charge ratio or reaffirm the published cost-to-charge ratio.

Section 9789.33(e) and (f) have been renumbered Sections 9789.33(f) and (g) respectively. Section 9789.33(f), now Section 9789.33(g), has been modified to clarify 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)(1)-(12). This section has been further modified to move the last sentence to Section 9789.33(h).

Section 9789.33(h) has been added to this section. This section contains the last sentence set forth at section 9789.33(f), now Section 9789.33(g), which has been modified to provide that the maximum allowable fee shall be determined without regard to the cost items specified in 42 C.F.R. § 419.2(c)(1), (2), (3), (4), and (6), as contained in Section 9789.38 Appendix X. This section further provides that cost item set forth at 42 C.F.R. §419(c)(5), as contained in Section 9789.38 Appendix X, is payable pursuant to Section 9789.32(c)(2), and cost items set forth at 42 C.F.R. §419(c)(7) and (8), as contained in Section 9789.38 Appendix X, are payable pursuant to Section 9789.32(c)(3).

Section 9789.33(g) has been renumbered Section 9789.33(i).

Modifications to Section 9789.34 Table A

Section 9789.34 has been modified for clarification to delete the parenthetical phrase contained in the last column of the Table A stating “(before CA WC Adjustment Factor).”

Modifications to Section 9789.35 Table B

Section 9789.35 has been modified for clarification to delete the parenthetical phrase contained in the last column of the Table B stating “(before CA WC Adjustment Factor).”

Modifications to Section 9789.36 Update of Rules to Reflect Changes in the Medicare Payment System.

Section 9789.36 has been modified to state that Sections 9789.30 through 9789.38 shall be adjusted to conform to any relevant changes in the Medicare payment schedule, including mid-year changes, no later than 60 days after the effective date of those changes. The Section has been further modified to state that updates shall be posted on the Division of Workers' Compensation webpage at http://www.dir.ca.gov/DWC/dwc_home_page.htm, and that the

annual updates to the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule shall be effective every year on January 1.

Modifications to Section 9789.38 Appendix X

Section 9789.38 Appendix X: Proposed section 9789.38 sets forth the federal regulations which are incorporated by reference and/or referred to in Sections 9789.30 through 9789.36. The portions of the federal regulations set forth below were amended pursuant to the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub. L. 108-173).

42 C.F.R. § 419.32(d) is modified as follows: (d) Budget neutrality. (1) CMS adjusts the conversion factor as needed to ensure that updates and adjustments under § 419.50(a) are budget neutral. (2) In determining adjustments for 2004 and 2005, CMS will not take into account any additional expenditures per section 1833(t)(14) of the Act that would not have been made but for enactment of section 621 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

42 C.F.R. §419.43(d) is amended to modify the introductory text as follows: (d) outlier adjustment -- (1) General rule. Subject to paragraph (d)(4) of this section, CMS provides for an additional payment for a hospital outpatient service (or group of services) not excluded under paragraph (f) of this section for which a hospital's charges, adjusted to cost, exceed the following: ***

42 C.F.R. §419.43(e) is revised as follows: (e) Budget neutrality. CMS establishes payment under paragraph (d) of this section in a budget-neutral manner excluding services and groups specified in paragraph (f) of this section.

42 C.F.R. §419.43(f) is added to state: (f) Excluded services and groups. Drugs and biologicals that are paid under a separate APC and devices of brachytherapy, consisting of a seed or seeds (including radioactive source) are excluded from qualification for outlier payments.

42 C.F.R. § 419.64: 42 C.F.R. §419.64(d) is amended by revising paragraph (d) as follows: (d) Amount of pass-through payment. (1) Subject to any reduction determined under § 419.62(b), the pass-through payment for a drug or biological as specified in section 1842(o)(1)(A) and (o)(1)(D)(i) of the Act is 95 percent of the average wholesale price of the drug or biological minus the portion of the APC payment CMS determines is associated with the drug or biological. (2) Subject to any reduction determined under § 419.62(b), the pass-through payment for a drug or biological as specified in section 1842(o)(1)(B) and (o)(1)(E)(i) of the act is 85 percent of the average wholesale price, determined as of April 1, 2003, of the drug or biological minus the portion of the APC payment CMS determines is associated with the drug or biological.

42 C.F.R. §419.70 has been deleted as not applicable.

Modifications to Section 9789.40 Pharmacy

Subdivision (b) is added to provide that for a pharmacy service or drug that is not covered by a Medi-Cal payment system, the maximum reasonable fee paid shall not exceed the fee specified in the OMFS 2003. This provision restates the mandate of Labor Code § 5307.1(e).

Modifications to Section 9789.50 Pathology and Laboratory

Subdivision (c) is added to provide that for any pathology and laboratory service not covered by a Medicare payment system, the maximum reasonable fee paid shall not exceed the fee specified in the OMFS 2003. This provision restates the mandate of Labor Code § 5307.1(e).

Modifications to Section 9789.60 Durable Medical Equipment, Prosthetics, Orthotics, Supplies

Subdivision (b) is amended to delete CPT Code 99070 as this code may be utilized to bill for an unlisted service.

Subdivision (c) is added to provide that for durable medical equipment, supplies and materials, orthotics, prosthetics, and miscellaneous supplies and services not covered by a Medicare payment system, the maximum reasonable fee paid shall not exceed the fee specified in the OMFS 2003. This provision restates the mandate of Labor Code § 5307.1(e).

Modifications to Section 9789.70 Ambulance Services

Subdivision (b) is added to provide that for any ambulance service not covered by a Medicare payment system, the maximum reasonable fee paid shall not exceed the fee specified in the OMFS 2003. This provision restates the mandate of Labor Code § 5307.1(e).