

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

FINAL STATEMENT OF REASONS

Subject Matter of Adopted Amendments to Regulations: Workers' Compensation – Payments for Medical Treatment and Medical-Legal Services

The Administrative Director of the Division of Workers' Compensation, pursuant to the authority granted by Labor Code Sections 127, 133, 5307.1, 5307.3 and 5307.6, has adopted amendments to the Official Medical Fee Schedule ("OMFS"), (a document that is incorporated by reference into Title 8, California Code of Regulations, Section 9791.1) and Title 8, California Code of Regulations, Sections 9791.1, 9792.5, 9793 and 9795. Sections 9791.1 and 9792.5 concern fees for medical treatment in workers' compensation cases. Sections 9793 and 9795 concern fees for medical-legal expenses in workers' compensation cases.

AN IMPORTANT PROCEDURAL NOTE ABOUT THIS RULEMAKING:

The OMFS and the Medical-Legal Fee Schedule ("MLFS") "establish or fix rates, prices, or tariffs" within the meaning of Government Code Section 11340.9(g) and are therefore not subject to Article 5 of the Administrative Procedure Act (commencing at Government Code Section 11346.)

The rulemaking proceeding that resulted in the adoption of amendments to the OMFS and MLFS was conducted under the Administrative Director's rulemaking power under Labor Code Sections 5307.1, 5307.3 and 5307.6. The regulatory proceeding was subject to the procedural requirements of Labor Code Sections 5307.1 and 5307.4. This Final Statement of Reasons was prepared to comply with the procedural requirements of Labor Code Section 5307.4 and for the convenience of the regulated public to assist the regulated public in analyzing the amendments that were adopted after this non-APA rulemaking proceeding.

PROBLEMS ADDRESSED BY THE REGULATORY PROCEEDING:

Labor Code Section 5307.1 requires the Administrative Director of the Division of Workers' Compensation to "adopt and revise, no less frequently than biennially, an official medical fee schedule which shall establish reasonable maximum fees paid for medical services provided pursuant to [Division 4 of the Labor Code]." The OMFS was last revised effective April 1, 1999 and required minor technical revisions, clarifications and the correction of typographical errors.

SPECIFIC PURPOSE OF REGULATORY ACTION

Labor Code Section 5307.1 requires the Administrative Director of the Division of Workers' Compensation to "adopt and revise, no less frequently than biennially, an official medical fee schedule

which shall establish reasonable maximum fees paid for medical services provided pursuant to [Division 4 of the Labor Code]." The Official Medical Fee Schedule is incorporated by reference into Section 9791.1 as it is an extremely large document that cannot be published in its entirety in the Code of Regulations. The Official Medical Fee Schedule [OMFS] was last revised effective April 1, 1999.

The adopted amendments to the OMFS and related sections of the regulations make technical revisions, clarifications and correct typographical errors.

Labor Code Section 5307.6 requires the Administrative Director to "adopt and revise a fee schedule for medical-legal expenses as defined by Section 4620 ... at the same time he or she adopts and revises the medical fee schedule pursuant to Section 5307.1." As the OMFS was revised to make technical revisions, clarifications and corrections of typographical errors, it was appropriate to make technical revisions, clarifications and corrections of typographical errors in the medical-legal fee schedule at the same time.

STATE REIMBURSABLE MANDATE

The Administrative Director of the Division of Workers' Compensation has determined that the regulations as adopted do not impose any new mandated programs or increased service levels on any local agency or school district.

Additionally, 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. (County of Los Angeles v. State of California, 43 Cal.3d 46 (1987)). The potential costs imposed on all public agency employers and payors by these 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.

COST OR SAVINGS TO LOCAL AGENCIES, SCHOOL DISTRICTS AND STATE AGENCIES

The regulations as adopted impose no direct or indirect costs on any local agency or school district that will require reimbursement under Part 7 (Commencing with Section 17500) of Division 4 of the Government Code.

The regulations as adopted impose no nondiscretionary direct or indirect costs or savings on any local agency or school district. To the extent that local agencies and school districts are self-insured employers who must reimburse physicians or other providers for medical treatment for industrially injured employees, they will be subject to the same cost impacts as all other employers in the state. These impacts are discussed in more detail in the Economic and Fiscal Impact Statement in the rulemaking file.

COST OR SAVINGS IN FEDERAL FUNDING TO STATE

None. The regulations do not affect any federal funding.

POTENTIAL ECONOMIC IMPACT ON BUSINESS

The Administrative Director finds that adoption of these regulations has economic impact on businesses, both adverse and beneficial. These impacts are discussed in more detail in the Economic and Fiscal Impact Statement in the rulemaking file.

The Administrative Director finds that adoption of these regulations will not have a significant impact on the ability of California businesses to compete with businesses in other states.

COST IMPACT ON PRIVATE PERSONS AND BUSINESSES:

To the extent that representative private persons or businesses must reimburse physicians or other providers for medical treatment for industrially injured employees, they will be subject to the same cost impacts as all other employers in the state. These impacts are discussed in more detail in the Economic and Fiscal Impact Statement in the rulemaking file.

Generally an overall financial benefit will accrue to medical providers as the clarification of regulatory provisions should reduce the number of disputes over the cost and payment for medical services. In specific cases, some medical providers will get slightly higher reimbursements for their services, while others will get slightly less.

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

The Administrative Director has determined that the regulations do not affect the creation or elimination of jobs within the State of California, the creation of new businesses or the elimination of existing jobs within the State of California, or the expansion of existing businesses within the State of California.

UPDATED INFORMATIVE DIGEST

1. Amendments to the Official Medical Fee Schedule, (a Document Incorporated by Reference into Title 8, CCR Section 9791.1).

Labor Code Section 5307.1 requires the Administrative Director of the Division of Workers' Compensation to "adopt and revise, no less frequently than biennially, an official medical fee schedule which shall establish reasonable maximum fees paid for medical services provided pursuant to [Division 4 of the Labor Code]." The Official Medical Fee Schedule incorporated by reference into Section 9791.1 is an extremely large document that cannot be published in its entirety in the Code of Regulations. The Official Medical Fee Schedule [OMFS] was last revised effective April 1, 1999.

The adopted amendments to the OMFS and related sections of the regulations make technical revisions, clarifications and corrections of typographical errors as follows:

General Information and Instructions for Use Section:

a. Services Covered – Page 1

The existing section clarifies the application of the OMFS for the regulated public.

The first adopted amendment changed the reference to accrediting agencies in the second paragraph of the section from “the Accreditation Association for Ambulatory Health Care (AAAHC)” to “any 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.”

The second adopted amendment inserted the following text after the second paragraph in the “Services Covered” section on page 1 of the OMFS:

No facility except those specified in the immediately preceding paragraph may charge or collect a facility fee for services provided on an outpatient basis.

b. Fee Computation and Billing Procedures – Page 3

The existing section informs the regulated public how the conversion factors used in the OMFS are adjusted and where they are listed in the OMFS.

The adopted amendment corrected an erroneous reference in the first paragraph on page 3 of the OMFS for the location of the current conversion factors from Appendix B to Appendix C.

c. Supplies and Materials – Page 4

The existing section identifies what supplies and materials are or are not separately reimbursable.

The first adopted amendment inserted the following text after the asterisked paragraph on page 4 of the OMFS:

The following formulas only apply to health care providers such as physicians, physical therapists, Physician Assistants and Nurse Practitioners, dispensing items from their office or outpatient surgery facility.

The second adopted amendment inserted the following text at the end of existing subsection (1): “not to exceed the provider's usual and customary charge for the item.”

The third adopted amendment, inserted the following text at the end of existing subsection (2): “not to exceed the provider's or retailer's usual and customary charge for the item.”

d. Reports

Consultation Reports – Page 7

The existing section identifies which consultation reports are separately reimbursable. The adopted amendment inserted the following text after the three bulleted sections on page 7 of the OMFS:

- A report by a consulting physician where the claim does not meet the criteria of a “contested claim” as set forth in 8 CCR § 9793(b).
- A consultation code may not be billed when care or any part of care has been clearly transferred by the primary treating physician to another physician. (See definition of Referral under the Evaluation and Management Section page 11.)

e. Missed Appointments – Page 8

The existing section sets forth the procedure for identifying missed appointments.

The adopted amendment inserted the following text after the first sentence on page 8 of the OMFS:

This code applies to both treatment and consultation appointments. For Medical-Legal missed appointments use the appropriate code from the Medical-Legal Fee Schedule - CCR 9795 (see Appendix C).

Evaluation and Management Section:

Levels of E/M Services – Page 13

The existing section sets forth the procedure for identifying the appropriate level of evaluation and management services.

The adopted amendment replaced the third underlined section of the second full paragraph on page 13 of the OMFS with the following text:

The physician's interpretation of the results of diagnostic tests/studies (i.e. professional component) with preparation of either a separate distinctly identifiable signed written report or a separate distinctly identifiable section of an overall report (i.e. PR-2, PR-3, Narrative Report or Doctor's First Report of Injury) may also be reported separately, using the appropriate CPT code with the modifier -26 appended.

Anesthesia Section

Other Modifiers – Page 82

The existing section sets forth optional modifier codes used for identifying various anesthesia related services and procedures.

The adopted amendment deleted Modifier - 51 on page 82 of the OMFS.

Radiology and Nuclear Medicine Section

Modifiers – Page 351

The existing section sets forth modifier codes used for identifying various radiology and nuclear medicine related services and procedures.

The adopted amendment inserted the following text at the end of the first paragraph on page 351 of the OMFS:

Modifier - 29 for global procedures (those procedures where one provider is responsible for both the professional and technical component) has been deleted. If a provider is billing for a global service, no modifier is necessary.

Pathology and Laboratory Section

Modifiers – Page 394

The existing section sets forth modifier codes used for identifying various pathology and laboratory related services and procedures.

The adopted amendment inserted the following text at the end of the first paragraph on page 394 of the OMFS.

Modifier - 29 for global procedures (those procedures where one provider is responsible for both the professional and technical component) has been deleted. If a provider is billing for a global service, no modifier is necessary.

Medicine Section

a. Modifiers – Page 451

The existing section sets forth modifier codes used for identifying various medicine related services and procedures.

The adopted amendment inserted the following text at the end of the first paragraph on page 451 of the OMFS:

Modifier - 29 for global procedures (those procedures where one provider is responsible for both the professional and technical component) has been deleted. If a provider is billing for a global service, no modifier is necessary.

b. Central Nervous System Assessment – Page 498

The existing section sets forth the appropriate CPT code for reporting and billing for services related to the development of cognitive skills.

The adopted amendment corrected the erroneous reference in the first sentence on page 498 of the OMFS, concerning the development of cognitive skills, from CPT 97770 to 97799.

Physical Medicine Section

Specific Billing Instructions – Page 503

The existing section sets forth the fee schedule for physical medicine services.

The adopted amendment corrected the erroneous reference in the fifth bulleted paragraph on page 503 of the OMFS from California Code of Regulations Section 9785(c) to Section 9785(f).

Physical Medicine – Page 505

The adopted amendment inserted the following text after the third sentence and just above the section heading for “MODALITIES” on page 505 of the OMFS:

The appropriate physical medicine code for the use of a transcutaneous electrical nerve stimulator (TENS unit) is 97014.

Manipulative Treatment Section – Page 510

Specific Billing Instructions – Page 510

The existing section sets forth the fee schedule for Osteopathic manipulative treatment.

After considering the public comments received, the Division withdrew the proposed amendment for further study and discussion during the next full revision of the OMFS. The proposed language would have deleted the statement in the second paragraph of the Osteopathic Manipulation section that the Physical Medicine and Rehabilitation ground rules apply to osteopathic manipulative treatment codes.

Orthotics and Prosthetics Section - Pages 534 through 546

The existing section sets forth the fee schedule for orthotics services and devices.

The adopted amendment added the prosthetics section that was inadvertently omitted from the current Official Medical Fee Schedule.

2. Amendments to Section 9791.1- the Official Medical Fee Schedule.

The existing section incorporates by reference the OMFS as revised April 1, 1999.

The adopted amendment updates the section and incorporates by reference the amendments to the OMFS made in this rulemaking proceeding.

As noted above, in order to give the regulated public time to train their staff and implement the amendments set forth below, the Division will ask the Office of Administrative Law for the adopted amendments to have an effective date of *thirty (30) days* after their filing with the Secretary of State. The Office of Administrative Law will fill in the effective date, currently shown by asterisks (*) for the month and day, as thirty (30) days after the date on which the amendments as adopted were filed with the Secretary of State.

3. Amendments to Section 9792.5 - the Official Medical Fee Schedule.

The existing section sets forth the requirements for timely payment or objection to billings for medical treatment subject to the fee schedule, and provides for increased fees and interest for untimely objections and/or payment.

The adopted amendment to subsection (a)(1) conforms this section to the provisions of Sections 9785, 9786, 9792.5, 9793, and 9794. These sections use the term “claims administrator” instead of “employer.”

The adopted amendment to subsection (a)(5) conforms this section to the legislature’s amendment of Labor Code Section 4603.2(b) (Chapter 124, Stats. 1999,) to include both employee and/or employer selected treating physicians by cross-referencing the definition of the term “treating physician” to the definition of “primary treating physician” provided by Section 9785(a)(1).

The adopted amendments to subsections (b), (d) and (e) conform these subsections to the legislature’s amendment of Labor Code Section 4603.2(b) (Chapter 124, Stats. 1999,) to require that if a medical billing or a portion thereof is contested, denied, or considered incomplete, the physician shall be notified, in writing, that the billing is contested, denied, or considered incomplete, within 30 working days after receipt of the billing by the employer.

The adoption of the second paragraph of subsection (b) clarifies that, for purposes of this Section, treatment that is “provided or authorized by the treating physician selected by the employee or designated by the employer” includes but is not limited to treatment provided by a “secondary physician” as that term is defined by section 9785(a)(2).

The repeal of subsection (f) eliminates a conflict with the provisions of Labor Code Section 4603.2, which establishes that interest on a properly documented bill accrues from the date of receipt of the bill. Existing subsection 9792.5(g) was renumbered to conform to the repeal.

The addition of Labor Code Section 4603.5 to the authority note informs the regulated public that this section gives the Administrative Director the authority to issue regulations to carry out the requirements of Article 2, Chapter 2, Part 2 of Division 4 of the Labor Code. This article deals with medical and hospital treatment.

The addition of Labor Code Section 5307.1 to the reference note informs the regulated public that this section contains rules integral to establishing fee levels payable under the OMFS.

B. REVISIONS TO THE MEDICAL-LEGAL FEE SCHEDULE

Labor Code Section 5307.6 requires the Administrative Director to “adopt and revise a fee schedule for medical-legal expenses as defined by Section 4620 ... at the same time he or she adopts and revises the medical fee schedule pursuant to Section 5307.1.” As the OMFS was revised to make technical revisions, clarifications and corrections of typographical errors, it was appropriate to make technical revisions, clarifications and corrections of typographical errors in the medical-legal fee schedule at the same time.

1. Amendments to Section 9793 - the Medical-Legal Fee Schedule.

The existing section sets forth the definitions of terms concerning medical-legal expenses and comprehensive medical-legal evaluations.

The adopted amendment to subsection (f) corrects a technical error and conforms this subsection to Section 9795(c) / ML 101 which provides that a follow-up medical-legal evaluation is to be performed within 9 months, not one year.

The non-substantive adopted amendment to subsection (i) corrects the cross-reference in light of the repeal of Section 9785.5, and the inclusion of its requirements into Section 9785(a)(1) as amended effective January 1, 1999.

2. Amendments to Section 9795 - the Medical-Legal Fee Schedule.

The existing section sets forth the reasonable level of fees for medical-legal expenses, follow-up, supplemental and comprehensive medical-legal evaluations and medical-legal testimony.

The adopted amendment to Section 9795(b) clarifies that the all-inclusive fee for each medical-legal evaluation procedure includes reimbursement for any transcription services used in the preparation of a medical-legal report.

The adopted amendment to subsection (d) provides that the –93 interpreter modifier does not apply to ML 101. Where Modifier –93 is applicable, the value of the procedure is multiplied by 1.1 to compensate the doctor for the increased time necessary for the examination. Since ML 101 is a timed code, the length of time to perform the exam is already accounted for in the higher fee resulting from the commensurately longer evaluation attributable to translation time.

A. REVISIONS TO THE OFFICIAL MEDICAL FEE SCHEDULE

1. AMENDMENTS TO THE OFFICIAL MEDICAL FEE SCHEDULE ITSELF.

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**AN IMPORTANT NOTE CONCERNING THE EFFECTIVE
DATE OF THE ADOPTED AMENDMENTS TO THE OMFS**

In order to give the regulated public time to train their staff and implement the adopted amendments set forth below, the Division will ask the Office of Administrative Law for the adopted amendments to have an effective date of *thirty (30) days* after their filing with the Secretary of State. The Office of Administrative Law will fill in the effective date as *thirty (30) days* after the date on which the amendments as adopted are filed with the Secretary of State.

The effective dates for the adopted amendments set forth below will be made available on the Division's website (http://www.dir.ca.gov/workers'_comp.html) as soon as their effective date is received from the Office of Administrative Law.

a. GENERAL INFORMATION AND INSTRUCTIONS FOR USE SECTION:

Section Amended: Services Covered

Specific Purpose of Amendments:

The first adopted amendment changed the reference to accrediting agencies in the second paragraph of the section from “the Accreditation Association for Ambulatory Health Care (AAAHC)” to “any 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.”

The second adopted amendment inserted the following text after the second paragraph in the “Services Covered” section on page 1 of the OMFS of the OMFS:

No facility except those specified in the immediately preceding paragraph may charge or collect a facility fee for services provided on an outpatient basis.

Factual Basis that Amendments were Necessary:

The first amendment adopted was needed to update the out-of-date language that only recognized the Accreditation Association for Ambulatory Health Care. Under the current Health and Safety Code provisions, the California Medical Board approves a variety of accreditation agencies.

The second amendment adopted was required because some providers that lack the appropriate license or certification are charging a facility fee. The original intent behind this provision when the OMFS was adopted was that only licensed or certified facilities could charge a facility fee. This amendment was necessary to achieve the original intent of the provision. Portions of the regulated community expressed confusion on this point. Clarification was therefore needed.

Section Amended: Fee Computation and Billing Procedures

Specific Purpose of Amendment:

The adopted amendment changed an erroneous reference in the first paragraph on page 3 of the OMFS for the location of the current conversion factors from Appendix B to Appendix C.

Factual Basis that Amendment was Necessary:

The adopted amendment was required to correct an erroneous cross-reference.

Section Amended: Supplies and Materials

Specific Purpose of Amendments:

The first amendment adopted inserted the following text after the asterisked paragraph on page 4 of the OMFS:

The following formulas only apply to health care providers such as physicians, physical therapists, Physician Assistants and Nurse Practitioners, dispensing items from their office or outpatient surgery facility

The second adopted amendment inserted the following text at the end of existing subsection (1): “not to exceed the provider’s usual and customary charge for the item.”

The third adopted amendment, inserted the following text at the end of existing subsection (2): “not to exceed the provider’s usual and customary charge for the item.”

Factual Basis that Amendments Were Necessary:

The first adopted amendment was necessary to clarify that the reimbursement formulas were only intended to apply to medical providers and not wholesale or retail vendors or suppliers. Portions of the regulated community expressed confusion on this point. Clarification was therefore needed.

The second and third adopted amendments were necessary to clarify that the respective additional storage and handling charges permitted for supplies and materials and dispensed durable medical equipment may not exceed the provider's usual and customary charge for the item. **

Section Amended: Consultation Reports.

Specific Purpose of Amendment:

The adopted amendment inserted the following text after the three bulleted sections on page 7 of the OMFS:

- A report by a consulting physician where the claim does not meet the criteria of a “contested claim” as set forth in 8 CCR § 9793(b).
- A consultation code may not be billed when care or any part of care has been clearly transferred by the primary treating physician to another physician. (See definition of Referral under the Evaluation and Management Section page 11.)

Factual Basis that Amendment was Necessary

The first portion of this amendment was necessary to clarify that a report that does not meet the “contested claim” criteria for payment as a medical-legal expense is subject to the OMFS, not the medical-legal fee schedule. Portions of the regulated community expressed confusion on this point. Clarification was therefore needed.

The second portion of this amendment was necessary to clarify that when an injured worker’s care has been transferred, in whole or in part, by the Primary Treating Physician to another physician, a consultation code and report may not be charged by the physician to whom care has been transferred. Portions of the regulated community expressed confusion on this point. Clarification was therefore needed.

Section Amended: Missed Appointments

Specific Purpose of Amendment

The adopted amendment inserted the following text after the first sentence on page 8 of the OMFS:

This code applies to both treatment and consultation appointments. For Medical-Legal missed appointments use the appropriate code from the Medical-Legal Fee Schedule - CCR 9795 (see Appendix C).

Factual Basis that Amendment was Necessary

This amendment was necessary to achieve the original intent of this provision that the missed appointment code applies to both treatment and consultation appointments. Portions of the regulated community expressed confusion on this point. Clarification was therefore needed.

b. EVALUATION AND MANAGEMENT SECTION:

Section Amended: Levels of E/M Services

Specific Purpose of Amendment:

The adopted amendment replaced the third underlined section of the second full paragraph on page 13 of the OMFS with the following text:

The physician's interpretation of the results of diagnostic tests/studies (i.e. professional component) with preparation of either a separate distinctly identifiable signed written report or a separate distinctly identifiable section of an overall report (i.e. PR-2, PR-3, Narrative Report or Doctor's First Report of Injury) may also be reported separately, using the appropriate CPT code with the modifier -26 appended.

Factual Basis that Amendment was Necessary:

This amendment was necessary to clarify that the professional services component for a diagnostic test or other study, (e.g. an x-ray), is reimbursable without a separate interpretive report addressing only the test or study. Some bill review companies interpreted the existing provision to require a separate interpretive report, and refused to pay the professional services component where the interpretive report is included as a component part in another report.

The original intent behind the section was to allow either a separate and distinctively identifiable section incorporated into a required physicians' report, or, at the provider's option, a separate report. Portions of the regulated community expressed confusion on this point, and litigation resulted. Clarification was therefore needed.

c. ANESTHESIA SECTION

Section Amended: Other Modifiers.

Specific Purpose of Amendment:

The adopted amendment deleted Modifier - 51 on page 82 of the OMFS.

Factual Basis that Amendment was Necessary:

This amendment was necessary to correct an error in the original adoption of the OMFS. Anesthesia is a time based code, and its reimbursement is not affected by the number of procedures performed.

d. RADIOLOGY AND NUCLEAR MEDICINE SECTION

Section Amended: Modifiers.

Specific Purpose of Amendment:

The adopted amendment inserted the following text at the end of the first paragraph on page 351 of the OMFS:

Modifier - 29 for global procedures (those procedures where one provider is responsible for both the professional and technical component) has been deleted. If a provider is billing for a global service, no modifier is necessary.

Factual Basis that Amendment was Necessary:

This amendment was necessary to clarify for the regulated public that modifier – 29 has been deleted from both CPT and the OMFS. Some payors still require providers to bill using this no longer valid modifier. Portions of the regulated community expressed confusion on this point. Clarification was therefore needed.

e. PATHOLOGY AND LABORATORY SECTION

Section Amended: Modifiers.

Specific Purpose of Amendment:

The adopted amendment inserted the following text at the end of the first paragraph on page 394 of the OMFS.

Modifier - 29 for global procedures (those procedures where one provider is responsible for both the professional and technical component) has been deleted. If a provider is billing for a global service, no modifier is necessary.

Factual Basis that Amendment was Necessary:

This amendment was necessary to clarify for the regulated public that modifier – 29 has been deleted from both CPT and the OMFS. Some payors are still requiring providers to bill using this no longer valid modifier. Portions of the regulated community expressed confusion on this point. Clarification was therefore required.

f. MEDICINE SECTION

Section Amended: Modifiers.

Specific Purpose of Amendment:

The adopted amendment inserted the following text at the end of the first paragraph on page 451 of the OMFS.

Modifier - 29 for global procedures (those procedures where one provider is responsible for both the professional and technical component) has been deleted. If a provider is billing for a global service, no modifier is necessary.

Factual Basis that Amendment was Necessary:

This amendment was necessary to clarify for the regulated public that modifier – 29 has been deleted from both CPT and the OMFS. Some payors are still requiring providers to bill using this no longer valid modifier. Portions of the regulated community expressed confusion on this point. Clarification was therefore necessary.

Section Amended: Central Nervous System Assessment

Specific Purpose of Amendment:

The adopted amendment corrected the erroneous reference in the first sentence on page 498 of the OMFS, concerning the development of cognitive skills, from CPT 97770 to 97799.

Factual Basis that Amendment was Necessary:

This amendment was necessary to correct a technical error in the OMFS as originally adopted. There is no CPT code 97770. The appropriate CPT code in the existing OMFS for the development of cognitive skills is CPT code 97799.

g. PHYSICAL MEDICINE SECTION

Specific Purpose of Amendments:

The first adopted amendment (on page 503) corrected the erroneous reference in the fifth bulleted paragraph from California Code of Regulations Section 9785(c) to Section 9785(f).

The second adopted amendment (on page 505) inserted the following text after the third sentence and just above the section heading for “MODALITIES”:

The appropriate physical medicine code for the use of a transcutaneous electrical nerve stimulator (TENS unit) is 97014.

Factual Basis that Amendments were Necessary:

The first adopted amendment was necessary to conform the OMFS to amendments in Title 8, Cal. Code of Regs., Section 9785. The amendments were effective January 1, 1999. The erroneous cross-reference was confusing to the regulated public. Correction was therefore needed.

The second adopted amendment was necessary to clarify for the regulated public that the appropriate physical medicine code for using a transcutaneous electrical nerve stimulator (TENS unit) in a physical medical provider’s office is 97014. Some providers incorrectly use surgical code 64550. Surgical code 64550 is the appropriate code for a transcutaneous nerve stimulation (TENS unit) during a surgical procedure. Clarification was therefore needed.

i. ORTHOTICS AND PROSTHETICS

Section Adopted: Prosthetics Maximum Reimbursement Rates

Specific Purpose of Amendment:

The adopted amendment adopted the prosthetics section that was inadvertently omitted from the Official Medical Fee Schedule when it was revised effective April 1, 1999.

Factual Basis that Amendment was Necessary:

The prosthetics maximum reimbursement section was inadvertently omitted from the current Official Medical Fee Schedule. Some payors were therefore refusing to pay providers' billings on the grounds that there was no prosthetics schedule in effect. In addition, when these disputes reached the WCAB, the WCAB had no fee schedule to guide them by providing a baseline for determining a reasonable fee.

2. SECTION AMENDED: SECTION 9791.1 - THE OFFICIAL MEDICAL FEE SCHEDULE.

Specific Purpose of Amendment:

The adopted amendment to Section 9791.1 incorporates by reference the Official Medical Fee Schedule as revised as of the effective date of the amendments adopted in this rulemaking proceeding.

Factual Basis that Amendment was Necessary:

The adopted amendment to Section 9791.1 was required to properly incorporate by reference the amendments to the OMFS that were adopted in this rulemaking. The Official Medical Fee Schedule is an extremely large document that cannot be published in its entirety in the Code of Regulations.

In order to give the regulated public notice that the OMFS has the legal effect of a regulation, it has been incorporated by reference into Section 9791.1 in accordance with the provisions of Title 1, CCR Section 20(c)(1-5). These sections set forth the procedure by which a document may properly be incorporated by reference.

3. SECTION AMENDED: SECTION 9792.5 - THE OFFICIAL MEDICAL FEE SCHEDULE.

Specific Purpose of Amendments:

The adopted amendment to section 9792.5(a)(1) conforms this section to the provisions of Sections 9785, 9786, 9792.5, 9793, and 9794. These sections all use the term "claims administrator" instead of "employer."

The adopted amendment to Section 9792.5(a)(5) conforms this section to the legislature's amendment of Labor Code Section 4603.2(b) (Chapter 124, Stats. 1999,) to include both employee and/or employer selected treating physicians by cross-referencing the definition of the term "treating physician" to the definition of "primary treating physician" provided by Section 9785(a)(1).

The adopted amendments to Section 9792.5(b), (d) and (e) conform these sections to the legislature's amendment of Labor Code Section 4603.2(b) (Chapter 124, Stats. 1999,) to require that if a medical billing or a portion thereof is contested, denied, or considered incomplete, the physician shall be notified, in writing, that the billing is contested, denied, or considered incomplete, within 30 working days after receipt of the billing by the employer.

The adoption of the second paragraph of Section 9792.5(b) clarifies that, for purposes of this section, treatment which is provided or authorized by the treating physician includes but is not limited to treatment provided by a “secondary physician” as that term is defined by section 9785(a)(2).

Section 9792.5(f) was repealed to eliminate a conflict with the provisions of Labor Code Section 4603.2. Existing subsection 9792.5(g) was renumbered to conform to the repeal.

The addition of Labor Code Section 4603.5 to the authority note informs the regulated public that this section gives the Administrative Director the authority to issue regulations to carry out the requirements of Article 2, Chapter 2, Part 2 of Division 4 of the Labor Code. This article deals with medical and hospital treatment.

The addition of Labor Code Section 5307.1 to the reference note informs the regulated public that this section contains rules integral to establishing fee levels payable under the OMFS.

Factual Basis that Amendments were Necessary:

The adopted amendment to Section 9792.5(a)(1) was necessary to improve the clarity of Section 9792.5, and conforms this section to the provisions of Sections 9785, 9786, 9792.5, 9793, and 9794. These sections all use the term “claims administrator” instead of “employer.”

The adopted amendments to Section 9792.5, subsections (a)(5), (b), (d), (e) and (f) were required to conform these sections to recent statutory changes.

The adoption of the second paragraph of Section 9792.5(b) was required to clarify that, for purposes of this Section, treatment which is provided or authorized by the treating physician includes but is not limited to treatment provided by a “secondary physician” as that term is defined by section 9785(a)(2). This was necessary to carry out the requirements of Labor Code Section 4603.2(b) that these payment rules apply to treatment that is either provided by or authorized by the treating physician. The term “treating physician” can include both primary and secondary treating physicians.

The repeal of Section 9792.5(f) was required by the Court of Appeal’s opinion in Boehm & Associates v. WCAB, (Lopez) (1999) 76 Cal. App. 4th 513. Existing subsection 9792.5(g) was renumbered to conform to the repeal.

The addition of Labor Code Section 4603.5 to the authority note was necessary to inform the regulated public that the Administrative Director has the authority to issue regulations to carry out the requirements of Article 2, Chapter 2, Part 2 of Division 4 of the Labor Code. This article deals with medical and hospital treatment.

The addition of Labor Code Section 5307.1 to the reference note was necessary to inform the regulated public that this section contains rules integral to establishing fee levels payable under the OMFS.

B. REVISIONS TO THE MEDICAL-LEGAL FEE SCHEDULE

1. SECTION AMENDED: SECTION 9793 - THE MEDICAL-LEGAL FEE SCHEDULE.

Specific Purpose of Amendment:

The adopted amendment to Section 9793(f) corrects a technical error and conforms this subsection to Section 9795(c)/ML 101 which provides that a follow-up medical-legal evaluation is to be performed within 9 months, not one year.

The adopted non-substantive amendment to Section 9793(i) conforms the cross-reference to the repeal of Section 9785.5, and the inclusion of its requirements into Section 9785(a)(1) as amended effective January 1, 1999.

Factual Basis that Amendment was Necessary:

The adopted amendment to Section 9793(f) was required to correct a technical error and conform this subsection to Section 9795(c)/ML 101.

The adopted amendment to Section 9793(i) was required to conform this section to a recent change in the regulations to which it cross-references.

2. SECTION AMENDED: SECTION 9795 - THE MEDICAL-LEGAL FEE SCHEDULE.

Specific Purpose of Amendment:

The adopted amendment to Section 9795(b) clarifies that the all-inclusive fee for each medical-legal evaluation procedure includes reimbursement for any transcription services used in the preparation of a medical-legal report.

The adopted amendment to Section 9795(d) provides that the –93 interpreter modifier does not apply to ML 101. Where Modifier –93 is applicable, the value of the procedure is multiplied by 1.1 to compensate the doctor for the increased time necessary for the examination. Since ML 101 is a timed code, the length of time to perform the exam is already accounted for in the higher fee resulting from the commensurately longer evaluation attributable to translation time.

Factual Basis that Amendment was Necessary:

The amendment to Section 9795(b) was necessary to prevent dual reimbursement for any transcription services used in the preparation of a medical-legal report.

The amendment to Section 9795(d) was necessary to prevent dual reimbursement for the additional evaluation time required for a patient who requires an interpreter.

C. A CHANGE WITHOUT REGULATORY EFFECT

A Non-Substantive Change to the “Services covered” Section on Page 1 of the OMFS

The revised text of the “services covered” section on page 1 of the OMFS submitted for a 15-day public comment period inadvertently showed the words “surgical clinic accredited by” as proposed for deletion. This was a typographical error, and the inadvertent deletion of the words “surgical clinic accredited by” has been corrected.

In addition, to improve the clarity of the text as amended, the word “an” has been inserted in front of the newly adopted phrase “accrediting agency as approved by the Licensing Division of the Medical Board of California.”

The complete and correct sentence as amended is as follows:

Nothing contained in this schedule shall preclude any hospital as defined in subdivisions (a), (b), or (f) of Section 1250 of the Health and Safety Code, or any surgical facility which is licensed under subdivision (b) of Section 1204 of the Health and Safety Code, or any ambulatory surgical center that is certified to participate in the Medicare program under Title XIX (42 U.S.C. Sec. 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, from charging and collecting a facility fee for the use of the emergency room or operating room of the facility.

This change is a non-substantive change within the meaning of Section 40, Title 1 California Code of Regulations as it does not materially alter the requirements, rights, responsibilities, conditions, or prescriptions contained in the original text. This change was made in order to improve the clarity of the regulation as adopted.

CONSIDERATION OF ALTERNATIVES

The Administrative Director considered all comments submitted during the two public comment periods, and made modifications based on those comments to the regulations as initially proposed. The Administrative Director has now determined that no alternatives proposed by the regulated public or otherwise considered by the Division of Workers' Compensation would be more effective in carrying out the purpose for which these regulations were proposed, nor would they be as effective and less burdensome to affected private persons and businesses than the regulations that were adopted.

SUMMARY OF COMMENTS RECEIVED AND RESPONSES THERETO CONCERNING THE REGULATIONS ADOPTED

The comments of each organization or individual are addressed in the following charts as they relate to each section of the regulations as proposed and as finally adopted.

The two public comment periods were as follows:

Initial 45-day comment period on proposed regulations:

July 20 through September 13, 2001.

15-day comment period on modifications to proposed text:

February 1 through February 22, 2002.

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