

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

PUBLIC HEARING

Tuesday, March 11, 2014
Elihu Harris State Office Building Auditorium
1515 Clay Street
Oakland, California

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1 (Time Noted: 10:03 a.m.)

2 MS. OVERPECK: Good morning, everyone. Thank you for
3 coming today. My name's Destie Overpeck. I'm the Acting
4 Administrative Director. This is the public hearing for the
5 Outpatient and Ambulatory Surgical Center Fee Schedule
6 Regulations starting with Section 9789.30, et seq.

7 Please make sure that you have signed in today and
8 indicate if you want to testify.

9 The other staff here today are Dr. Rupali Das, Jarvia
10 Shu, Maureen Gray, our Regulations Coordinator, and Richard
11 Parker, our Court Reporter.

12 When you come up to testify, please give your card to
13 our court reporter. The testimony -- all testimony given today
14 will be taken down by the court reporter.

15 If you have written testimony that you want to also
16 present, please hand it to Maureen Gray.

17 I will call the names for those who have indicated
18 that they want to testify today. If, after we do that, anyone
19 else has come in or changes their mind and decides they do want
20 to say something, that's fine. I'll call you up then.

21 The hearing will continue as long as there are people
22 present who wish to comment on the regulations. However, I'm
23 guessing that the hearing is probably not going to go on too
24 long today given the area of these regulations.

25 Written comments can be given to Maureen today or you

1 can fax, e-mail or deliver them to us until 5:00 p.m. at the
2 Division's office on the 17th floor of this building.

3 The purpose of the hearing is to receive comments on
4 the proposed amendments to the regulation and we welcome any
5 comments that you have about them.

6 All of your comments, both given today orally and
7 given to us in writing, will be considered in determining what
8 revisions, if any, we still need to make to these proposed
9 regulations.

10 Please be sure to restrict your comments to the
11 regulations and any suggestions that you may have for improving
12 them.

13 So with that, let's start. And I will start by asking
14 Amber Ott to begin.

15 AMBER OTT

16 Good morning. My name is Amber Ott. I'm with the
17 California Hospital Association. We appreciate the opportunity
18 to comment on the proposed regulations, and we appreciate that
19 the DWC has recognized the outdated nature of this fee schedule
20 and the need to update it.

21 So I will start out with one of the three primary
22 comments that we have today and that's in regards to the
23 facility only services.

24 So by definition, these services are rarely or never
25 performed in the non-facility setting, meaning the DWC will

1 rely on hospitals to perform these services for injured
2 workers. However, the proposed payments are only at 101.01
3 percent of the amount paid by Medicare. That's the Outpatient
4 Prospective Payment System.

5 So the payment rates under the Medicare program today
6 are insufficient to cover hospital costs. And based on
7 publicly available data from the 2012 Office of Statewide
8 Health Planning and Development -- this is the OSHPD data
9 that's available -- hospitals are only paid 78 percent of their
10 actual costs by the Medicare program. This means a multiplier
11 of 101.01 would bring hospitals to 79 percent of their costs.

12 Unfortunately, this shortfall may result in limited
13 access, making it challenging for injured workers to return to
14 the workforce in a timely manner.

15 In addition, hospitals experience significant payment
16 delays and administrative hurdles with the workers' comp payors
17 when compared to Medicare. At every phase of the revenue
18 cycle, a Medicare claim is significantly more simplified.

19 To begin with, Medicare eligibility is checked online.
20 Whereas, the work comp coverage is checked manually and often
21 the patient isn't able to provide the correct insurance
22 information and they will provide their commercial insurance
23 information instead. Work comp services require an
24 authorization which can sometimes take as long as 18 months to
25 obtain on a contested claim.

1 In addition, Medicare payments are based made -- are
2 paid based on the services provider -- provided and do not
3 require prior authorization. The majority of the work comp
4 claims -- those are non-emergent -- will require
5 preauthorization.

6 And finally, Medicare claims are billed
7 electronically, an automated and seamless process for
8 hospitals. Whereas, most work comp claims must be billed
9 manually and oftentimes require additional information such as
10 itemized billing, implant invoices, operative reports, et
11 cetera.

12 The California Labor Code provides the administrative
13 director the flexibility to adopt different multipliers for
14 selective services as long as the aggregate payments do not
15 exceed 120 percent of what would be payable under Medicare.

16 Due to the increased administrative burdens associated
17 with billing and processing worker comp claims, coupled with
18 the payment shortfalls that are experienced under the Medicare
19 system, the California Hospital Association urges the
20 administrative director to adopt the 120 percent multiplier for
21 facility-only services.

22 The next comment I would like to make is in regards to
23 the other services payment rate. The regulations specify that
24 other services will be paid under the OMFS RBRVS which of
25 course is the Resource-Based Relative Value System. Under the

1 Medicare program the RBRVS payment system is exclusively used
2 to calculate payment for physician services and the OPSS system
3 is used to calculate payment rates for hospitals.

4 Payment rates for hospitals under the OPSS system are
5 typically much higher than those paid to physicians in order to
6 recognize the increased costs associated with maintaining
7 standby capacity for emergencies, greater patient severity in
8 hospital outpatient departments than in office settings and the
9 need for more specialized equipment in the hospital
10 environment.

11 Payment rates for hospitals under the OMFS RBRVS do
12 not consider these factors and are therefore woefully
13 inadequate. In other words, workers' comp carriers will be
14 paying less in total to hospitals for the same services that
15 Medicare would pay. It does not seem appropriate that a
16 workers' comp commercial insurance carrier would be paying less
17 to a hospital than the Medicare program would pay.

18 CHA urges the DWC to adopt the 120 percent of OPSS as
19 the single payment system used to pay for all services provided
20 in the hospital setting. Adopting a single payment system for
21 hospital outpatient services is consistent with the Medicare
22 program rules and will help reduce opportunities for payment
23 errors that may result from having two separate and distinct
24 payment systems for hospital claims.

25 And the final comment that I would like to make is in

1 regards to the therapy cap that exists under the RBRVS system.
2 So therapy services, meaning physical and occupational visits,
3 will fall under the other services reimbursement and be paid
4 per the RBRVS system.

5 However, the system has three distinct caps that will
6 apply to therapy services. So the physical medicine modalities
7 only are capped at two codes on the same visit. Physical
8 medicine procedures or acupuncture codes have no more than 60
9 minutes allowed on one visit and if modalities and procedures
10 are billed, no more than four total codes are allowed on the
11 same visit.

12 These regulations would have a disproportionately
13 negative effect on providers of multiple therapies as compared
14 to free-standing providers of single therapies.

15 It is a common practice at a hospital outpatient
16 department for individuals with significant disabilities to
17 receive several therapy treatments in a single day. Not only
18 is this common, but it is clinically in the best interest of
19 the patient.

20 Capping the number of payable modalities and
21 procedures performed in one visit to no more than four codes
22 requires a prolonged time frame for treatment. By allowing a
23 greater number of modalities and procedures to be performed in
24 a single visit, injured workers can recover from their injuries
25 and return to work sooner.

1 percent of the HOPD rate down to 80.1 percent.

2 Secondly, we want to request that the Division of
3 Workers' Compensation, by way of these regulations, also adopt
4 the same hospital outpatient PPS geographic-adjusted conversion
5 factor utilized by Medicare.

6 And third, we want to -- still seeking to propose and
7 want to bring to the Division's attention the forthcoming RAND
8 Study and our desire to specifically seek an ASC-specific fee
9 schedule for those procedure codes that are not listed as part
10 of the Medicare HOPD payment methodology.

11 So the first point, in terms of our opposition to
12 section -- amendments to Section 9789.30, it does eliminate the
13 alternative payment methodology option which further decreases
14 the fees for a Medicare multiplier of 82 percent down to 80.1
15 percent. As everybody knows, SB 863 from 2012 decreased the
16 maximum allowable reimbursement methodology in rate for an ASC
17 down from 120 percent of the hospital outpatient department for
18 HOPD down to 80 percent.

19 Furthermore, we do know that recently the Workers'
20 Compensation Insurance Rating Bureau, WCIRB, and the --
21 Workers' Compensation Insurance Rating Bureau of California
22 recently published a study showing that the savings from 863
23 regarding workers' compensation were not only 25 percent as
24 originally proposed, but the savings were more in the ballpark
25 of 26 to 28 percent regarding the decline in reimbursement and

1 the savings from 863.

2 So therefore, CASA feels strongly that further
3 reducing the optional alternative ASC fee schedule methodology
4 by even 1.19 percent as proposed by these regulations is
5 unacceptable to ensuring injured workers' access to robust
6 outpatient surgery alternatives such as ASC's.

7 Our second brief comment is with regards to seeking
8 DWC adoption of the Hospital Outpatient PPS geographic-adjusted
9 conversion factor utilized by Medicare.

10 Our own internal research of the existing fee schedule
11 shows that the actual maximum facility fee for ASC's is
12 actually less than the 80 percent maximum allowable by Medicare
13 -- by the Medicare HOPD rate as prescribed by statute and by
14 regulation. The DWC uses a different geographic wage
15 adjustment methodology for Medicare as well as a different
16 conversion factor for determining the ultimate HOPD fee
17 schedule.

18 The difference in the conversion factor is
19 approximately 2.78 percent. This is compared to Medicare's
20 HOPD geographic conversion factor. And the combination of
21 these two differences yields a significant disparity in the fee
22 schedule.

23 For example, we found that in Sacramento County and
24 Placer County and Shasta Counties, they're only realizing 94
25 percent of the actual maximum allowable fee schedule which is

1 currently 80 percent of the HOPD rate. At the same time San
2 Francisco is only realizing a maximum allowable rate of only 96
3 percent.

4 Therefore, CASA is asking the Division to amend these
5 regulations to adopt the same Hospital Outpatient PPS
6 geographic-adjusted conversion factor that's utilized by
7 Medicare.

8 Thirdly, we want to continue to make the Division
9 aware of our desire for an ASC-specific fee schedule for those
10 procedure codes that are not listed as part of the Medicare
11 HOPD payment methodology.

12 Unlisted codes -- unlisted Medicare HOPD procedures
13 may be done in an ASC for the workers' compensation system, but
14 not -- but will not be reimbursed due to lack of a
15 corresponding billing code.

16 As a result, these claims are adjudicated and settled
17 directly by the Workers' Compensation Appeals Board. As a
18 result of no actual fee schedule for these procedures, these
19 payment disputes are not subject to the newly created
20 independent bill review process.

21 Therefore, the existing WCAB process for these
22 unlisted procedure codes increases unnecessary administrative
23 and frictional costs related to these liens.

24 This will become an even larger problem when hospitals
25 de-select many of the implant intensive surgical procedures,

1 such as spine cases, due to retooling of the DRG pass-through
2 and these cases get referred to other sites of service,
3 including the ASC.

4 Included in our comments is a listing of procedure
5 codes which are not currently included in the Medicare HOPD fee
6 schedule that are successfully being performed in many ASC's
7 throughout California and are being reimbursed in the
8 commercial marketplace.

9 You know, we also understand that we're awaiting the
10 final publication of the RAND Study on the migration
11 feasibility of these cases from the inpatient setting to the
12 ASC setting, specifically being reimbursed at 85 percent of the
13 inpatient hospital rate. Pursuant to SB 863, specifically
14 Labor Code Section 5307.1, subdivision (c)(1), the study was
15 required to be published on January 1 of 2013.

16 Based on our conservative internal estimates, this
17 could actually provide at least another 67.5 million dollars in
18 savings, assuming 30 percent of the unlisted procedure codes
19 being performed in the hospital inpatient setting migrate to
20 the ASC environment.

21 Therefore, CASA wants to keep the Division aware of
22 and will be seeking to propose an eventual adoption of the DWC
23 ASC-specific fee schedule for Medicare HOPD unlisted codes at
24 85 percent of the inpatient hospital DRG rate.

25 And I just want to make one or two -- one brief

1 comment around -- commentary on the impact of 863 and ongoing
2 regulations to implement SB 863.

3 We are aware that Berkeley Research Group is
4 continuing their access-to-care study and there was a hearing
5 last week about that. We want to further encourage the
6 Berkeley Research Group and the Division to look at
7 site-of-service data elements into their existing
8 access-to-care analysis. This would compare costs and site of
9 service differential from the ASC, the HOPD, and the inpatient
10 setting.

11 Furthermore, we do know that the WCIRB and the W --
12 and the CWCI cost outcome study that was recently published two
13 weeks ago suggests that there were increased savings with a
14 negligible difference in terms of site of service compared to
15 the ASC and the HOPD. Anecdotally, our members tell us that
16 many of those cases in those data elements was from January 1st
17 to July 1 of 2013. First half of 2013 many of our members were
18 telling us that a lot of those cases were already scheduled
19 prior to 2013 and that many of our facilities at least -- need
20 at least six to nine months to, quote-unquote, get out of the
21 workers' compensation system.

22 Therefore, a clear statistical picture on the cost
23 outcomes and site-of-service differentials will be better
24 realized by the WCIRB and the CWCI after analyzing the entirety
25 of the calendar year 2013 data.

1 that don't exist in the fee schedule yet are being billed by
2 and provided by hospitals. That will be of great assistance.

3 Our primary concern with the proposed regulations
4 largely mirror those of CHA in that the payment methodology
5 proposed in that it's going to utilize part physician fee
6 schedule, part hospital outpatient prospective payment system
7 from Medicare is cumbersome for hospitals and generates
8 inadequate reimbursement as determined by Medicare and through
9 our modeling as well.

10 Specifically, we recognize the DWC's goals to try to
11 lower costs on the system by encouraging utilization at lower
12 cost centers, such as doctors' offices and ambulatory surgical
13 centers, but we think that the DWC's approach to achieving that
14 is unfair on the hospitals. In particular, group health such
15 as HMO's and PPO's have a pretty robust authorization process
16 as already exists in the workers' compensation system. We also
17 see the medical provider networks already established by the
18 DWC.

19 So the infrastructure is actually in place to put the
20 onus on the claims administrator or the payor for health care
21 to only authorize services in the lowest cost setting indeed is
22 appropriate rather than putting the onus on the hospital to
23 simply be aware of and then shut its doors to patients that it
24 can't afford to treat with the payment rates being proposed.

25 In particular, the facility-only services, DWC fully

1 acknowledges that these services can likely only be performed
2 in a facility setting. So I'm not sure how the parallel is
3 drawn between recognizing that these are facility-only services
4 and still telling the facility it doesn't get its maximum
5 reimbursement allowed under the legislation and regulations in
6 the form of a 1.2 multiplier given that the claims
7 administrator has no other option to send these patients to a
8 lower cost setting.

9 The other services in contrast can be performed in a
10 lower cost setting. And again, we would encourage the claims
11 administrator to channel that volume proactively to achieve its
12 own discount rather than the DWC try to accomplish that by --
13 by setting the rates unreasonably low at the -- at the
14 physician's fee schedule allowable.

15 We think that in its -- in its approach to rate
16 setting and really putting the pressure on the hospital to
17 practically turn away patients, the DWC is actually encouraging
18 the opposite of its intended goal. It's going to encourage
19 behavior from the claims administrator the overutilize care
20 because you're getting a significant discount with the
21 hospitals effectively not paying much more or any more than
22 they would pay to have the procedure done in a physician's
23 office and the discount is coming at the expense of the
24 hospital and largely outside of its control.

25 Thank you.

1 MS. OVERPECK: Thank you. Mark Gangl.

2 MR. GANGL: Gangl.

3 MARK GANGL

4 Hi, I'm Mark Gangl with California Service Bureau and
5 we represent a fair number of hospitals in Northern California,
6 particularly or at least my specialty with them is in the
7 workers' comp setting. And I had e-mailed these comments more
8 than testimony yesterday. So you may or may not have them.

9 I guess my first question is, where are the tables and
10 where is the reference to Addendum B? I mean, I have a fair
11 idea which Addendum B we're talking about because there's only
12 one calendar year final 2014 on the CMS website, but it's not
13 in the proposed regulations anywhere.

14 MS. OVERPECK: Okay.

15 MR. GANGL: And there is no table -- Tables A and Tables
16 B.

17 MS. OVERPECK: We did get your e-mail and I'm going to let
18 Jarvia address your question.

19 MR. GANGL: Okay. Thank you.

20 MS. SHU: The Tables A and B will be updated through an
21 administrative order subsequent to this rulemaking process so
22 you'll be using whatever the Table A and B is currently
23 adopted.

24 MR. GANGL: Okay. So for now we will be using the one
25 that was effective what, April 13th?

1 MS. SHU: Correct.

2 MR. GANGL: Or April 1st, 2013.

3 MS. SHU: Correct.

4 MR. GANGL: Okay. And then -- I guess the question is, is
5 there any way that these regulations can clarify how the Q2 and
6 Q3 status code indicators operate? I mean, I have a fair idea,
7 and I kind of outlined it in my e-mail. And it looks like they
8 are heavily reliant on Addendum M which lists the base
9 procedure and then the composite procedure, according to APC
10 groups. And then you have to refer to Addendum A to find out
11 what the composite APC relative weight is as compared to the
12 basic relative weight that you would find in Addendum B. But
13 there's nothing in the regulations that I've ever seen that
14 suggest that. That's just my poking around in the addendums
15 and trying to figure out what it is.

16 And then my other question is, what is the rule that
17 would trigger using the composite rate and how exactly does
18 that work? I mean, my assumption has always been that you
19 would take the highest composite rate of the several procedures
20 that have the Q-status indicator and that would cover all of
21 them. But again, I can't find that anyplace in the
22 regulations. And I've made that pitch to a couple of bill
23 reviewers. They say, oh, no. They're all included services or
24 we ain't paying anything.

25 MS. OVERPECK: Okay. We're -- we'll take that as a

1 comment, but we don't have a response for you right now.

2 MR. GANGL: I honestly didn't think you would. Okay.

3 The other thing is or another thing is urgent care
4 facilities, whether they be part of a -- of a larger hospital
5 group or a standalone facility. They are -- the emergency room
6 codes have urgent care analogs, if you will, the G codes;
7 G03802, 03845. And they aren't reimbursable under either the
8 old physician C schedule. In fact, they didn't exist. And
9 they're not reimbursable under the RBRVS. And so there is no
10 place where those codes can be reimbursed.

11 Although if you were to use the Outpatient Perspective
12 Payment System, they are reimbursable and the fact that the
13 level of facility maintenance and overhead expense is lower in
14 an urgent care setting than it is in a standalone hospital,
15 that's adequately reflected in Medicare and the OPPS, but it's
16 excluded from workers' comp. And frequently the first place
17 that an injured worker is going to be sent is not to the
18 hospital emergency room, but to the closest urgent care
19 facility and the urgent care facilities are not being
20 reimbursed for these visits. So I think something needs to be
21 done about that.

22 And then last, but not least, the rules for -- well,
23 first I'd like to agree that instead of carving out the seventy
24 thousands and the ninety thousands radiology and the physical
25 medicine, et cetera and taking them out of Medicare OPPS and

1 throwing them back into the physician's fee schedule is in some
2 respects counterproductive and it's somewhat confusing.

3 And when we -- exactly how the RBRVS formula is
4 applied to the -- to a facility -- I mean, you've got the --
5 you've got the three cases. You've got a case where there's a
6 technical component, in which case the facility would get the
7 full technical component. And then you've got the other two,
8 the facilities only and then the standalone codes.

9 And the -- the wording in the proposed regulation is a
10 bit vague. And part of my job is working out the -- the logic
11 for adequately pricing or properly pricing so that I can let my
12 hospitals know approximately how much we should expect from a
13 carrier. And frankly, I'm not stupid, but I can't figure it
14 out. So I think that needs to be somehow clarified. And one
15 way would be as done in the RBRVS, you lay out a formula.
16 Here's a formula. Oh, yeah. That's easy enough.

17 So anyway, those are my comments. Any questions?

18 MS. OVERPECK: No. Thank you very much.

19 MR. GANGL: Okay. Thank you.

20 MS. OVERPECK: So I don't see anyone else checked who
21 wanted to testify, but is there anyone here in the audience who
22 would like to come up and say anything?

23 All right. Seeing no hands raised, we will close our
24 hearing.

25 Please remember that your opportunity to file any

1 written comments will stay open until 5:00 p.m. this afternoon
2 and you need to deliver them to DWC who is on the 17th floor of
3 this building.

4 Thank you for coming today and our hearing is now
5 closed.

6 (The proceedings adjourned at 10:36 a.m.)

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R E P O R T E R ' S C E R T I F I C A T E

I, Richard H. Parker, Official Hearing Reporter for the State of California, Department of Industrial Relations, Division of Workers' Compensation, do hereby certify that the foregoing matter is a full, true and correct transcript of the proceedings taken by me in shorthand, and with the aid of audio backup recording, on the date and in the matter described on the first page thereof.

RICHARD H. PARKER,
Official Hearing Reporter
of the State of California,
Workers' Compensation Appeals Board

Dated: March 12, 2014
Fresno, California
/s/