DWC Forum – Home Health Care Fee Schedule Comments

Jason Schmelzer                           May 18, 2015
CalChamber
California Coalition on Workers’ Compensation

The California Coalition on Workers’ Compensation (CCWC), the California Chamber of Commerce (CalChamber), and the California State Association of Counties (CSAC) would like to thank you for the opportunity to provide comments on the draft Home Health Care Fee Schedule Regulations. We offer the following observations as the DWC proceeds toward formal rulemaking:

• Limit to Unskilled Care – In order to be consistent with LC 5307.8 our members believe that the entire draft proposal should be reconstituted to apply only to “unskilled” care. Fees for professional services provided by an RN, LVN, or CNN should instead be addressed in the OMFS.

• RFA Requirement – If Home Health Care treatment requests are to be subject to utilization review then an RFA should be required by the regulations to ensure proper documentation and handling of requests for this service.

• Local vs. Statewide Minimum Wage – It is unclear how the regulations will deal with local minimum ordinances on minimum wage. Some local jurisdictions have a substantially higher minimum wage that could drive up the cost of care. The regulations do not address applicability of the local minimum wage to the statewide fee schedule.

• Employee Status of Care Provider – Our membership is deeply concerned about the potential that home health care providers, especially family members of the injured worker, could be found to be the employee of the employer/claims administrator. In the CA IHSS program the home health care providers are hired, directed, and paid by the person receiving the care. Unfortunately, California’s laws on independent contractor status are murky at best. Accordingly, we respectfully request that the DWC take steps to protect CA employers from additional liability and instead seek to construct the program much in the way that IHSS is formulated to protect counties.

SPECIFIC CHANGES
Our organizations recommend the following specific changes to the language:

§ 9789.90 (d) – Definition of “IHSS” – This definition should be revised to limit to “unskilled care” as outlined above.
(d) “IHSS” means In-Home Supportive Services, a program of the State of California, the provisions of which are set forth in California Welfare & Institutions Code sections 12300-12330 and incorporated herein by reference (http://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=WIC&division=9.&title=&part=3.&chapter=3.&article=7). The maximum hours provision of this program, set forth in Welfare & Institutions Code section 12300, subdivision (h)(3), can be exceeded for an injured worker based upon a showing of medical need, if reasonably required to cure or relieve the injured employee from the effects of his or her injury and prescribed by a licensed physician and surgeon, in accordance with Labor Code section 4600, subdivision (h).

(f) “Medicare” means a program of the United States government that provides payment for health care to elderly and disabled persons. The Centers for Medicare and Medicaid Services division of the United States Department of Health and Human Services provides this benefit program to eligible members of the public.

(g) “OWCP” means the United States Department of Labor’s Office of Workers’ Compensation Programs, a program of the United States government providing workers’ compensation benefits to employees of the United States government.

(h) “OWCP fee schedule” means the fee schedule maintained by the United States Department of Labor’s Office of Workers’ Compensation Programs for payment for health care services for injured workers employed by the United States government, which is incorporated by reference (http://www.dol.gov/owep/regs/feeschedule/fee/fee14/fs14_code_rvu_ef.pdf).

§ 9789.91 (b) should be revised to ensure that an in-home assessment is not a necessary requirement for every situation involving home health care.

(b) When needed, an in-home assessment of the injured worker’s need for home health care shall be performed by a qualified registered nurse, physical therapist or occupational therapist employed by a home health care agency. Assessments of an injured worker’s need for home health care will be performed using CMS’s OASIS (Outcome and Assessment Information Set), a group of standard data elements used by CMS to assess patients’ needs for home health care services, which is incorporated by reference (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/HHQIOASISCAAllTimePoint.pdf).

R. M. Turner
May 18, 2015

For this forum, comments must be sent by email to DWCForums@dir.ca.gov. All other forum rules apply to submitting comments. Forum closes on [Sunday] May 17, 2015"
[ I will presume that the intended deadline for comments would be by Monday May 18, 2015, at 5 pm., since that is the next business day since the deadline fell on a Sunday/Holiday. The department had more than adequate time to provide adequate notice and issue the notice to maximize the available time to comment since there has been little public notice on this issue. According to California Civil Code sections 12-13 includes: "The time in which any act provided by law is to be done is computed by excluding the first day and including the last, unless the last day is a holiday, and then it is also excluded. .....13 Whenever any act of a secular nature, other than a work of necessity or mercy, is appointed by law or contract to be performed upon a particular day, which day falls upon a holiday, such act may be performed upon the next business day with the same effect as if it had been performed upon the day appointed ..... 13 (a) Any act required by law to be performed on a particular day or within a specified period of time may be performed (but is not hereby required to be performed) on a special holiday as that term is used in Section 6705 of the Government Code, with like effect as if performed on a day which is not a holiday. 13 (b) Any act required by law to be performed on a particular day or within a specified period may be performed (but is not hereby required to be performed) on a Saturday, with like effect as if performed on a day which is not a holiday."

No notice was issued by the DIR/DWC following (2010) SB 2780, access to other state agencies to the database in order to enforce Medi-Cal/IHSS and linked programs payments adjudicated for Workers’ Compensation applicants. This establishes adjudicated claims for which medical necessity is already established and where continuing/continuity of care may be at issue when a claim is not managed pursuant to the laws and regulations, thus forcing the IW to self procure care. These include but are not limited to the following California based programs which may extend hours or parcel out the cost of caregivers, however they all still fall under Workers’ Compensation as the primary payer. Waiver Personal Care Services (WPCS); IHSS/PSCP; IHSS Residual/PCSP/IPW. EPSDT; Medi-Cal Waiver Program (MCWP) and Case Management Program (CMP). EPSDT provides supplemental services that are prescribed by medical professionals who established the medical necessity of the services, which is considered distinct from IHSS/PSCP services. (ACL 02-43E.) Multipurpose Senior Services Program (MSSP).

This notice: 2015-41, was issued late May 7, 2015 following the 3-25 and 4-22 & 4-29-2015 hearings by the California Senate Oversight Committee on Workers Compensation and Labor Relations, this schedule should have been implemented no later than 7-1-2013, and no action should have been taken on portions of SB 863 which were linked to this issue or were otherwise in conflict with entitlements and other chaptered legislation. Instead, no action was taken, nor public record of the ongoing activities of the “2012 “Working group” until a Public Meeting noticed with approximately 3 days notice and after almost three (3) years time to develop the schedule and enlist the input from the targeted population to develop the schedule. That public meeting conflicted with oral arguments before the California Supreme Court in the case of: S215637 - SOUTH COAST FRAMING v. WORKERS’ COMPENSATION APPEALS BOARD (CLARK) which I and others who would have had input into the process would have attended were it not for this conflict. http://www.courts.ca.gov/28727.htm S215637 - SOUTH COAST
FRAMING v. WORKERS' COMPENSATION APPEALS BOARD (CLARK) This link provides filings in this case where the Injured Worker’s access to medical treatment, and was suffering from chronic/intractable pain the consequence of an industrial Spinal injury, was totally dependant on the notice and medical decisions made by the claims adjustor for the Employer’s Insurance Company because there was no claim for adjudication before the IW, who needed at least case management and assistance with ADLs, in order to insure that he received appropriate medication management and/or a referral to IHSS for home health care/protective supervision, died as a result of his injuries and mental confusion.

I find it further problematic, that there is little if any public notice on the DIR/DWC websites regarding these forums, Governmental oversight hearings and related legislation including but not limited to (2010) SB 2780, (2015) SB 563, SB 542. ..... It was only after the 3-25-2015 hearing that any real action was taken while Injured Workers and their caregivers were denied medically necessary services and/or appropriate pay pursuant to the Labor Code, especially true for those cases where Home Health Care was necessary pursuant to LC 4600(a), the result of inadequate notice and/or other wise were prescribed or adjudicated these or similar services pursuant to California/Federal law.]

<remainder of notice edited for space>

http://www.dir.ca.gov/dwc/ForumDocs/HomeHealth/TextofRegulations.pdf
http://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=WIC&division=9.&title=&part=3.&chapter=3.&article=7
WIC 12300-12330 Welfare and Institutions Code - WIC
DIVISION 9. PUBLIC SOCIAL SERVICES [10000 - 18996] ( Division 9 added by Stats. 1965, Ch. 1784. )
PART 3. AID AND MEDICAL ASSISTANCE [11000 - 15766] ( Part 3 added by Stats. 1965, Ch. 1784. )
CHAPTER 3. State Supplementary Program for Aged, Blind and Disabled [12000 - 12351] ( Chapter 3 repealed and added by Stats. 1973, Ch. 1216. )
ARTICLE 7. In-Home Supportive Services [12300 - 12330] ( Article 7 added by Stats. 1973, Ch. 1216. )
< edited for space please see link>
[BACKGROUND: http://www.leginfo.ca.gov/cgi-bin/displaycode?section=civ&group=03001-04000&file=3509-3548
CIVIL CODE SECTION 3509-3548
“3509. The maxims of jurisprudence hereinafter set forth are intended not to qualify any of the foregoing provisions of this code, but to aid in their just application. ..... 3511. Where the reason is the same, the rule should be the same. ..... 3517. No one can take advantage of his own wrong. 3518. He who has fraudulently dispossessed himself of a thing may be treated as if he still had possession. 3519. He who can and does not forbid that which is done on his behalf, is deemed to have bidden it.
3520. No one should suffer by the act of another.
3521. He who takes the benefit must bear the burden.
3522. One who grants a thing is presumed to grant also whatever is essential to its use. ...... 
3525. Between rights otherwise equal, the earliest is preferred.
3526. No man is responsible for that which no man can control. ...... 
3529. That which ought to have been done is to be regarded as done, in favor of him to whom, and against him from whom, performance is due.
3530. That which does not appear to exist is to be regarded as if it did not exist.
3531. The law never requires impossibilities. ...... 
3541. An interpretation which gives effect is preferred to one which makes void.
3542. Interpretation must be reasonable. ...... 

The Departments of Social Services/Health Care Services cited above and other linked California agencies/departments/entities cited in the RAND report, in addition to “CMS”/”OWCP” and/or may cover some but not all of the home health care services, relevant regulations and case law, have certification forms, some of which are found on the internet, while some are only available upon request such as the Hunt V Kaizer caselaw, ACIN I-03-10 - California Department of Social Services www.dss.ca.gov/lettersnotices/entres/getinfo/acin/2010/I-03_10 .... “Jan 21, 2010 ... SUBJECT: CONLAN II REIMBURSEMENT PROCESS. REFERENCE: ALL COUNTY LETTER NO. 07-11 AND 07-46. The purpose of this” ... or the various “manuals” which I will not list here, but they do affect any schedule.

However, due to some language requirements in some counties, not all workers who speak languages other than English and primarily serve those populations, while they may speak English to some extent, they are not required to read English, and the “manuals” mostly a collection of non-searchable/indexed “Letters” are written only in “English”. This creates problems when an Injured Worker is not given adequate notice, a case is not managed in “good faith” pursuant to the regulations and/or is entitled to collateral entitlements. Failure to give adequate notice can result in an IW being entitled to home health care services/adjudicated to be entitled to home health care services as of the DOI/RFA/Rx and any medical services, including but not limited to continuation/continuity of care pursuant to LC section 4600(a) being presumed “Medically Necessary” and not subject to UR, if providing continuity of care, as defined in the Health & Safety codes, HSC §1367.01 (a), HSC §1367.22 (a)( c) et. Seq., this is consistent with LC 4600, 4610 and ccr t8 9792.
This distinction is important because LC 4600(h) does not require UR nor should it require UR, because URO’s are the exclusive agent of the Employer and their agents and UROs are still subject to the California Medical Practice Act, so many entitled IWs may be forced to self-procure these services when they do not have adequate notice and/or delayed/denied timely receipt of necessary medical care already deemed medically necessary under a presumption of California/Federal law.

These other governmental departments are also adjudicated by means of Administrative Law and the presumptions associated with those disciplines and the presumption of liberal construction in the Client/Consumer/Injured Worker’s favor along with good faith.
In the service and spirit of public policy, certain presumptions, entitlements and other California and Federal laws also apply, and a key to Administrative law, is that it is “expansive” not restricted, in other words, you may provide more but not less services/benefits, and you must provide the means by which to utilize and access these services/benefits and that all California law applies with a few exceptions related to litigation, otherwise, if there is a conflict, it is presumed in the IW’s favor. This is consistent with Workers’ Compensation Law and Regulations. These include but are not limited to the following examples:

LC 4600 et. Seq., uses the term “cure or relieve” and so do the regulations, so there is no question that the California Legislature intended those IWs with catastrophic, complex, terminal, serious, in-operable, intractable pain or other disability which prevents their “cure” or ability to return to work with or without ADA accommodations as a consequence of their injury, and are not meant to be disenfranchised by other portions of California law simply because of a transcription error, to “cure and relieve” as found in LC 4610 as it relates to Utilization Review when the section clearly is pursuant to section 4600 and providing continuity of care, continuing care, as defined in the Health & Safety codes, HSC §1367.01 (a), HSC §1367.22 (a)( c) et. Seq.. With the changes following implementation of SB 863, and without working out the bugs, this is exactly the plight of significantly injured IWs who are now denied medical care including medications and home health care because they are not “cured” and should be getting better and returning to work, no matter how many years they have been disabled, receiving and/or entitled to “necessary medical” care and home health care. The State of California follows the SSA standard for Permanent Disability, a higher standard than Permanent Disability as defined by Workers’ Compensation, this defines the qualification of medical necessity and entitlement to services. Utilization Review, which is not in LC section 4600, is often based upon the instructions of the CA, non-MTUS guidelines, guidelines written by non-medical persons used instead of MTUS, online advertising internet advertising sites such as “drugs.com” rather than a primary source, using the wrong Guidelines or wrong section of MTUS because the “reviewer” is not competent to review the RFA, or following ACOEM guidelines not intended for the specific population and not a part of MTUS. In these cases the benefit goes to the IW. When the law or a regulation is silent, this is not a reason to deny goods or services, and it is handled on a case to case basis and does not require UR at least until URO’s are subject to enforcement and compliance with all California law and do not practice medicine in violation of the Medical Practice act.

When an applicable law/regulation exists in different venues and the IW is entitled in both, then the one with the greatest benefit applies.

Injured Workers are entitled to continuation/continuity of care already presumed medically necessary, and/or is pursuant to the LC, WIC, BPC and HSC §1367.01 (a), HSC §1367.22 (a)( c) et. Seq., this does not require Utilization Review beyond the 1st level of UR, that is: the claims adjustor authorizing the treatment if it is lawfully prescribed pursuant to California law and/or there is informed consent, this does not require the cost of a external URO and usually is accomplished by signing the bottom of the RFA form, entering into an agreement, conveying “Prior authorization” to the PBM or similar vendor. Proof of such stipulations, agreements
and/or payments/performance of contractual obligation should be honored rather than looking for
and/or manufacturing a scenario by which to delay/deny necessary medical treatment. Federal law changed on October 6, 2014, to confirm with the special prescribing requirements for California MD/DOs who are qualified pain management providers of controlled substances. These include “review” by the provider in a good faith “face to face” office evaluation on a schedule determined by the provider, not a delayed “Utilization Review” by a person or entity in violation of the Medical Practice Act or not competent to make such a determination. Prescriptions are required to be issued on special security forms, for one 30 day fill per prescription with refills accomplished by issuing separate dated scripts in-between visits. Please see the MBC link for details. [http://www.mbc.ca.gov/News/2014/09/Rescheduling_Hydrocodone.aspx](http://www.mbc.ca.gov/News/2014/09/Rescheduling_Hydrocodone.aspx) This is continuing/continuity of care already presumed in the HSC §1367.01 (a), HSC §1367.22 (a)(c) et. Seq. and/or LC 4600 et. Seq., which references HSC 1360. These requirements are known by both the department and the various “review” organizations/entities, and yet these statutory presumptions and requirements are violated each and every day, and there is no enforcement as noted in the hearing on 3-25-2015.

Transparency, is a lack of any hidden agendas with all information being available. A degree of disclosure is at a minimum for all verified agreements, practices and dealings, and a required condition for an open and free exchange. Therefore Transparency as referenced in § 9792.25. (A)(1) is expansive, not limiting access to information and means making publically available items such as: adequate notice of meetings, legislation, seeking out the targeted population, hearings including governmental oversight hearings, commission meetings, MEEAC, caselaw, the identities of “reviewers, URO/IMR panels, names of any person handling, or making decisions related to the RFA/UR/IMR/IME, both Medical Directors and Reviewers being licensed in California and/or any state where the Injured Worker, might require, and where the Standard of Care is different, the IW is entitled to the greater benefit including access to the names of the Reviewers. Because of a lack of transparency, and inadequate credentialing Review organizations can circumvent the law and become a safe haven for persons with disciplinary actions, participation in the impaired physicians programs, multiple reported violations which go un-investigated by the department while telling the MBC that any complaint should go to the DIR/DWC for enforcement, or Medical Directors who are not present on premises where determinations are made in the processing of Reviews by non-medical persons or reviewers who are not qualified to review, expedited and/or concurrent reviews and appeals that are ignored. Since programs like the impaired physician’s program is confidential, and accusations are confidential while being investigated, it is imperative that all the names of “reviewers” are supplied to the Medical Board of California, so that they can verify whether or not a reviewer has a history of impairment with the MBC, this verification should also check malpractice histories with the superior courts, URO should not check their own credentials. All entities/governmental entities/departments/litigants are subject to the California Medical Practice Act as found in the BPC, and is enforced by the Department of Consumer affairs and/or the appropriate board, such as the Medical Board of California/ Osteopathic Medicine Board of California where the latest notices for the SCA appear.
Presumptions found in certain California and Federal “ACTS” apply first, and there is no immunity when certain ACTS are violated even by a governmental entity.

These same laws frown on “Underground Regulations” and non-compliance with California law.

I have experience in Social Security, Administrative law, legislation, the laws and regulations related “social services”, ADA and other forms of “client/consumer advocacy”. It is based upon my experience, training and experience with these issues, that are unfamiliar to most in Workers’ Compensation that I add the following comments.

§ 9789.90 Home Health Care - Definitions.

(a) “CMS” means the Centers for Medicare and Medicaid Services, a division of the United States Department of Health and Human Services.

(b) “Home health care agency” means a business entity engaged in the business of providing home health care services. To provide home health care services to injured workers under the California workers’ compensation system, a home health care agency must be licensed by the California Department of Public Health and be Medicare-certified by CMS, or accredited as a home health care agency by the Community Health Accreditation Partner (CHAP) or the Joint Commission on Certification and Accreditation.

(c) “Home health care services” includes the provision of [add: assistance with ADL’s, transportation, accompanying, including but not limited to] medical and other health care services [pursuant to LC sections 4600(a) & HSC section 1367.22 .....] to the injured <or> ill person in their place of residence [add: or where their needs require]. Home health services include <both> [add: but are not limited to] medical and non-medical services deemed to be medically necessary for patients who are [add: without such assistance would be] confined to the home (homebound) [add: or are as a result of their injury/disability homebound] and who require <one or both> [add: any or] all of the following: (1) Skilled care by a licensed medical professional for tasks including, but not limited to, administration of intravenous drugs, dressing changes, occupational therapy, physical therapy, and speech-language pathology services [add: case management or like services, such as interpreters for the cognitively impaired, Protective Supervision (24/7), linked services etc. ] ; and/or (2) Personal care services for tasks and assistance with activities of daily living that do not require skills of a medical professional, such as bowel and bladder care, feeding, bathing, dressing and transfer and assistance with administration of oral medications; and/or (3) Domestic care services such as shopping, cleaning, and laundry that the individual is no longer capable of performing due to the illness or injury that may also be medically necessary in addition to skilled and/or personal care services. Domestic and personal care services do not require specialized training and do not need to be performed by a medical professional. [add: (4) any treatment or service where the claims administrator delays or denies without Utilization Review, withholds medical records, interferes with evaluations, forcing the Injured Worker to self procure or secure the services of another agency or entity.; (5) Any adjudicated award or order involving Medi-Cal, Medicare, IHSS or linked services/programs, including the commencement dates for such services or attempts to procure
services and no adequate notice is given. (6) Any lien for such services, settled will be construed to be acceptance and along with it any penalties or liquidated damages pursuant to law.] (d) “IHSS” means In-Home Supportive Services, a program of the State of California, the provisions of which are set forth in California Welfare & Institutions Code sections 12300-12330 and incorporated herein by reference (http://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=WIC&division=9.&title=3.&chapter=3.&article=7). The maximum hours provision of this program, set forth in Welfare & Institutions Code section 12300, subdivision (h)(3), can be exceeded for an injured worker based upon a showing of medical need, if reasonably required to cure or relieve the injured employee from the effects of his or her injury and prescribed by a licensed physician and surgeon, in accordance with Labor Code section 4600, subdivision (h).  
(f) “Medicare” means a program of the United States government that provides payment for health care to elderly and disabled persons. The Centers for Medicare and Medicaid Services division of the Unites States Department of Health and Human Services provides this benefit program to eligible members of the public. [add: Medicare includes Medicare supplement and part D plans, Medicare Secondary Payers under Medicare Secondary Payer law (42 U.S.C. § 1395y(b)) or any lien for like services.] (g) “OWCP” means the United States Department of Labor’s Office of Workers’ Compensation Programs, a program of the United States government providing workers’ compensation benefits to employees of the United States government. (h) “OWCP fee schedule” means the fee schedule maintained by the United States Department of Labor’s Office of Workers’ Compensation Programs for payment for health care services for injured workers employed by the United States government, which is incorporated by reference (http://www.dol.gov/owcp/regs/feeschedule/fee/fee14/fs14_code_rvu_cf.pdf).

Authority: Sections 133, 4603.5, 5307.1, 5307.3 and 5307.8, Labor Code. Reference: Sections 4600, 5307.1, 5307.8 and 5307.11, Labor Code. [add: (42 U.S.C. § 1395y(b)), HSC §1367.01 (a), HSC §1367.22 (a) (c)]

§ 9789.91 Home Health Care – Eligibility for Services. 
(a) Home health care services shall be provided as medical treatment only if reasonably required to cure or relieve the injured employee from the effects of his or her injury and prescribed by a licensed physician and surgeon, in accordance with Labor Code section 4600, subdivision (h). Home health care services are [Add: not] subject to the utilization review and independent medical review processes set forth in Labor Code sections 4610 and 4610.5, et seq. [Add: in any case where the Injured Worker or their authorized representative was forced to self procure such care pursuant to LC section 4600(a) or California laws related to the administration of Medicaid, Medi-Cal, Medicare, adjudication, these are Grand-fathered; and/or Continuing/continuity of care is entitled pursuant to any California law including but not limited to: HSC §1367.01 (a), HSC §1367.22 (a) (c), 42 U.S.C. § 1395y(b); Until such time as MTUS is adequately amended to include any laws or regulations related to Home Health Care/ADL assistance/ADA assistance/ADA DME/IHSS-linked services or Worker’s Compensation California specific laws and/or regulations, physician certification or similar accepted prescription forms, as the case may be, and all providers, review organizations and/or reviewers/panels members are published, verified as compliant with the California Medical Practice Act by the Medical Board of
California, no Utilization Review will be required of “new” prescriptions that are not
continuing/continuity of care.]
(b) An in-home assessment of the injured worker’s need for home health care <shall> [Add: 
may] be performed by a qualified registered nurse, physical therapist <or> [add: , social worker, 
program team member, case manager if the Injured Worker has consented to such evaluation, 
this is because Case Managers, including Registered Nurses, or evaluators from agencies, while 
considered medical treatment pursuant to Workers’ Compensation are frequently hired as the 
exclusive agent for the claims administrator, to delay or deny medical necessity (see the RIEVE 
v. COVENTRY HEALTH CARE, INC. Case No. SACV 11-1032 870 F.Supp.2d 856 (2012) 
where “case managers” are the “eyes and ears” of the CA and who’s focus is on cost control and 
to “deny necessary medical treatment”); existing IHSS awards and evaluations may be the basis 
upon which additional hours may be added pursuant to § 9789.90 (d) above.] occupational 
therapist employed by a home health care agency [Add: or other social service agency including 
non-profit agencies]. Assessments of an injured worker’s need for home health care will be 
performed using CMS’s OASIS (Outcome and ASsessment Information Set), a group of 
standard data elements used by CMS to assess patients’ needs for home health care services, 
which is incorporated by reference (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-
Assessment-Instruments/HomeHealthQualityInits/Downloads/HHQIOASISCAllTimePoint.pdf) 
[Add: on the direction/discretion of any prescribing MD/DO/Health Care Benefits Plan pursuant 
to California Law, that is, Primary, secondary and/or consulting provider, of the Injured 
Worker’s choice]. [Add: An alternate qualification/eligibility for IHSS type services includes 
persons with disabilities who have met Social Security's medical eligibility criteria to qualify 
automatically qualify IHSS and thus persons who already have either a California Presumptive 
Disability and/or meet the SSDI definition of disability used by Social Security for Adults, 
would not require UR to establish medical necessity by Utilization Review. That definition is: 
The inability to engage in any Substantial Gainful Activity (SGA) due to any medically 
determinable physical or mental impairment which can be expected to result in death or last for a 
continuous period of at least 12 months. A person must not only be unable to do his/her previous 
work but cannot, considering age, education, and work experience, engage in any other kind of 
SGA which exists in the national economy. It doesn't matter whether such work exists in the 
immediate area, or whether a specific job vacancy exists, or whether the worker would be hired 
if he/she applied for work. The worker’s impairment(s) must be the primary reason for his/her 
inability to engage in SGA.” This is a higher qualification for Permanent Disability than using 
the Workers Compensation AMA 5th edition.] 
Authority: Sections 133, 4603.5, 5307.1, 5307.3 and 5307.8, Labor Code. Reference: Sections 
4600, 5307.1, 5307.8 and 5307.11, Labor Code.
§ 9789.92 Home Health Care – Payment Methodology.
(a) To calculate the maximum allowable amount (MAA) for home health care services, apply the 
following formula to the codes and values contained in section 9789.93, Table A, below [Add: 
unless the market wadge is higher, this includes any applicable California Wadge schedule 
and/or payment structure including overtime, breaks, lunch, meal allowances, days off, 
compensation time, wait time, travel time, milage, tolls, credits] :
\[Wru + PRru + MRru \times CF = MAA\]
Where: \( W_{rvu} = \) Work relative value units
\( P_{rvu} = \) Practice expense relative value units
\( M_{rvu} = \) Malpractice relative value units

Table A will be updated periodically in accordance with updates to the Medicare and OWCP home health fee schedules.

(b) Providers shall be entitled to a one hour minimum for each service. For services that exceed one hour, the provider shall be paid in fifteen (15) minute increments, pro rata. Providers will bill using the CMS 1500 form which can be downloaded at the following link (http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS1188854.html) [Add: or any reasonable format for Grand-fathered services pursuant to LC section 4600(a)].

(c) An employer or their insurer shall <not> be liable for household tasks the injured worker’s [Add: including those provided by a] spouse or other member of the injured worker’s household <performed prior to the industrial injury free of charge> [California law allows spouses, parents and family members to perform these types of IHSS-like type services, in other words: http://ca.db101.org/ca/programs/health_coverage/medi_cal/ihss/faqs.htm#_q702 “Can I hire family members to provide my IHSS?

Yes. You can hire relatives, friends, neighbors, and other caregivers to provide you with IHSS.” Since this is the existing California regulation, Workers’ Compensation must at least provide this benefit and not something more restrictive.

Also see http://www.disabilityrightsca.org/pubs/547001-Ch-03.pdf for summary of laws and regulations applicable to IHSS like services, keeping in mind that program limits or hours may not apply to Workers’ Compensation.

“….. If the spouse leaves full-time employment or is prevented from obtaining full-time employment because no other suitable provider is available and, as a result, there is a risk of inappropriate, out-of-home placement or inadequate care, the spouse also may be paid to provide protective supervision and to accompany the disabled recipient as necessary to medical appointments. If the spouse is not able or available, these and the other IHSS services may be provided by others. "Not available" includes time when the spouse is out of the home because of work or for other necessary reasons, or when the spouse is sleeping or meeting the needs of other family members. MPP 30-763.4”] . In addition, an employer shall not be liable for home health care services that are provided more than 14 days prior to the date of the employer’s receipt of the physician's prescription for home health care services, pursuant to Labor Code section 4600, subdivision (h).

[Since this section of LC 4600, is ex-post facto, sometimes many years ex-post facto when there was no anticipation of such a requirement and the findings of case law such as and may affect persons with adjudicated awards, DHCS liens and/or self-procured “Home Health Care, pursuant to LC section 4600(a) which did not require a Prescription or Utilization Review, it is most likely that the 14 days prior to prescription requirement would be unconstitutional]

(d) Any decisions to approve, modify, delay or deny a request for authorization of home health care services are [add: not] subject to the utilization review and independent medical review processes set forth in Labor Code sections 4610 and 4610.5, et seq.
(e) Nothing in this section precludes an agreement for payment of home health care services, made between the provider and the insurer or claims administrator, regardless of whether such payment is less than, or exceeds, the fees set forth in this section.

Authority: Sections 133, 4603.5, 5307.1, 5307.3 and 5307.8, Labor Code.

Reference: Sections 4600, 5307.1, 5307.8 and 5307.11, Labor Code.

Bernardo De La Torre, Esq., President
California Applicants’ Attorneys Association

May 17, 2015

The California Applicants’ Attorneys Association offers the following comments regarding the draft regulations for the Home Health Care Fee Schedule which are currently posted on the DWC Forum.

Senate Bill 863 added Labor Code §5307.8, which requires that the DWC adopt a fee schedule for home health services not covered by Medicare. Home health services range from skilled nursing and therapy services provided by home health agencies or other home care providers to unskilled personal care or chore services that may be provided by family members or other personal care aides.

Initially, the development of the fee schedule should be guided by statute. Labor Code §5307.8 does not give the DWC authority to define the scope and type of home health care services in the fee schedule. The course and scope of the injured workers’ need for home health care services begins with a physician assessment, although a nurse case manager or treating psychologist, may have recommendations to be considered by the prescribing physician which can be reviewed and incorporated into their assessment. A cookie cutter approach to the provision of these services would be disastrous. This proposed draft of the home health care services fee schedule exceeds statutory authority.

§ 9789.90 Home Health Care - Definitions.
The words “who are confined to home (homebound)” should be stricken from subdivision (c).

There are injured workers who require home health care services but are able to leave their home, although in a very infrequent and limited capacity. Being confined to the home is not the legal standard nor a requirement for an injured worker to be eligible for home health care services. A physician may decide under LC 4600 that someone who is not "confined to the home (homebound)" requires home health care as medical treatment. This is a medical necessity issue to be determined by the physician. Therefore, this language exceeds the statutory authority given to the Administrative Director to develop a fee schedule.
Additionally "confined to home (homebound)" is vague and ambiguous. What does this mean? Can the injured worker never leave her/his house without being in jeopardy of having their home health care services terminated?

Subdivision (c)(3) allows domestic care services such as shopping, cleaning, and laundry that the individual is "no longer capable of performing" However, an injured worker may be able to perform some of those tasks but only for a very limited time. As such, the physician may decide that the injured worker needs these services. Therefore, again this language "no longer capable of performing" seeks to restrict the scope of the definition of home health care services which exceeds statutory authority. This language must be stricken.

In subdivision (d) there is a whole sale adoption of numerous code sections from the Welfare and Institutions Code many of which have no bearing on a home health care fee schedule. This approach will cause unnecessary confusion and litigation. Moreover, some of the statutes incorporated could have conflicting provisions with LC 4600. The Administrative Director should cite with specificity which Welfare and Institutions code sections are directly applicable to the fee schedule, and only those sections which are relevant to the fee schedule should be incorporated by reference.

Further, subdivision d) should be amended to be consistent with section 9789.91 to state "that the medical treatment is reasonably required to cure or relieve . . ." and delete “of medical need”.

§ 9789.91 Home Health Care – Eligibility for Services.

With the long inherent delays with UR and IMR, we have a serious concern with subdivision (a) providing that home health care services are subject to the utilization review and independent medical review processes set forth in Labor Code sections 4610 and 4610.5, et seq. When someone is discharged from a hospital and not mobile and discharge instructions come when the person is sent home, what are they going to do while they wait for UR? We recommend that home health care should be authorized until there is a denial, and if there is a denial it should lay out alternate care that would be authorized.

Additionally with regard to adjunct treatment services, such as babysitting, gardening, meal preparations, driving, a UR reviewer is unable to evaluate the need for these services as they have no expertise outside of the application of treatment guidelines. Injured workers are entitled to these services as "necessary and reasonable in order to allow the injured worker to fully comply with the treatment prescribed by the physician."

As a result we recommend that the last sentence of subdivision (a) be stricken as the use of UR and IMR would not be applicable to all types of home health services prescribed. In the alternative, there should be a clarification as to what types of home health care services would be subject to UR, that an alternative to the treatment prescribed be offered if there is a denial, and that services be authorized pending review as the consequences of an injured worker waiting months for home health care services to be authorized could be fatal.
Subdivision (b) demands that the injured worker’s needs for home health services be "performed using CMS's OASIS" There is absolutely no statutory authority for this as the Administrative Director is to ONLY develop a fee schedule pursuant to the statute. Whether the CMS's OASIS is used or any other method would appear to be a medical necessity issue under LC 4600 and 4610. It is up to the requesting physician to support the medical necessity of the requested treatment and this provision would conflict with existing statutes and regulations and must be stricken.

Also, there is no provision as to whom chooses the person to perform an in-home assessment of the injured worker’s need for home health care as provided in subdivision (b). Any assessment must prioritize the injured worker, and be independent of the insurance company, and not be an ancillary service included within an MPN.

Additionally this subdivision allows physical therapists and speech therapists to assess home health care needs but they are not qualified to assess skilled nursing activities which should be assessed by an RN only, particularly in cases of Medication administration, Wound changes, Urinary catheterizations, and NG tube feeds, among other skilled nursing activities.

§ 9789.92 Home Health Care – Payment Methodology.
As required by statute, the rates or fees established shall be adequate to ensure a reasonable standard of services and care for injured employees.
There should be no arbitrary cap imposed on hours of services provided or annual maximum to be paid as each case should be assessed for the individual needs of that injured worker.
If a spouse or family member gives up income from work to take care of their injured family member, this loss of income should be taken into consideration in setting reimbursement rates for family members. Also there should be clear provisions on how family members will be paid or reimbursed for their services.

We recommend that subdivision(c) be amended to add the following underlined language for clarification “(c) An employer or their insurer shall not be liable for household tasks the injured worker’s spouse or other member of the injured worker’s household performed prior to the industrial injury free of charge when performed by the spouse or member of the injured worker's household after the date of injury”

We further recommend that subdivisions (d) be deleted in its entirety for the same reasons set forth above. UR is not applicable to all types of home health services prescribed. In the alternative, there should be a clarification as to what types of home health care services would be subject to UR, that an alternative to the treatment prescribed be offered if there is a denial, and that services be authorized pending review as the consequences of an injured worker waiting months for home health care services to be authorized could be fatal.
Lastly, subdivision (e) should also be deleted in its’ entirety. The Home Health Care Fee Schedule should not be a tale of two worlds. One with rates set by regulations, and one with rates set by private contracts for lesser amounts. There should be one fee schedule with rates clearly regulated and subject to public and transparent rulemaking authority and the public hearing process.

In conclusion, these draft regulations are over reaching and delve into areas not authorized by the statutory authority for a fee schedule. The statutory authority for the fee schedule does not allow for regulation of the definition of medical necessity nor for restricting the scope of home health care services to be provided. Further, as with the consequences of denial of medical care in other areas of the California workers’ compensation system, this fee schedule will also result in significant cost shifting to other public and private health insurance programs, such as Medicare, Medi-Cal, and private group health insurance plans. Injured workers needs for home health care services are often in the most catastrophic injury cases, and with the inevitable denial of these services based on the current focus of this fee schedule, they will have no choice but to obtain this care somewhere else.

Sharon L. Hulbert, Assistant General Counsel  May 15, 2015
Zenith Insurance Company

Zenith appreciates the opportunity to provide comments on the draft Home Health Care regulations.

1. Section 9789.90 (b) currently states that a home health care agency must be “licensed by the California Department of Public Health and be Medicare-certified by CMS, or accredited as a home health care agency by the Community Health Accreditation Partner (CHAP) or the Joint Commission on Certification and Accreditation”.

Under current wording it is not clear if the intent is that the home health care agency is always required to be licensed by the California Department of Public Health and one of the other agencies, or if they can be licensed only by CHAP or the Joint Commission on Certification and Accreditation”. The current sentence structure makes that unclear. Depending on intent, we suggest that the following:

Proposed language if California licensing is always required:

“be licensed by the California Department of Public Health and be meet one of the following requirements: be Medicare-certified by CMS, or be accredited as a home health care agency by either the Community Health Accreditation Partner (CHAP) or the Joint Commission on Certification and Accreditation”.

15
Proposed language if the intent is not to always require California licensing:

“be either (1) licensed by the California Department of Public Health and be Medicare-certified by CMS, or (2) accredited as a home health care agency by either the Community Health Accreditation Partner (CHAP) or the Joint Commission on Certification and Accreditation”.

2. Under 9789.90(c), there is an extra and that needs removed as follows: (2) Personal care services for tasks and assistance with activities of daily living that do not require skills of a medical professional, such as bowel and bladder care, feeding, bathing, dressing, and transfer, and assistance with administration of oral medications; and/or".

3. Under 9789.90(d), the last sentence states that the IHSS must be prescribed by “a licensed physician and surgeon”. We believe this is intended to state by “a licensed physician and/or surgeon.”

4. Under 9789.91(b), “Assessment” in the fourth line should be changed to “Assessment”.

5. Zenith is concerned with the wording in 9789.92(b) and the use of the one hour billing set forth in Table A. The current wording in 9789.92(b) states: “Providers shall be entitled to one hour minimum for each service.” The use of this language opens the provision to potential abuse. "Services" is a broad, undefined term and can be interpreted in many ways. If a physical therapist provides physical therapy to three body parts in one hour, they should not bill a minimum of one hour for each treatment under the theory that each is a separate service. However, it could be argued that each treatment to a different body part is a different service. We assume the intent of this section is to allow the provider to bill a minimum equal to one hour of time for each visit. So regardless of how long the provider is at the injured worker’s home they receive compensation equivalent to at least one hour or more. To accomplish this and avoid misuse of this provision, we suggest aligning this section to the HCPC G definitions. HCPC G codes used in Table A all have descriptions of services they cover. Each description specifically states billing is in 15 minute increments. For example, the description for G0151 states: "Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes". The conversion factor in the HCPC codes is based on the 15 minute increments. If billing under Table A is set out in “hourly increments”, it creates an inherent conflict with the service code description. Therefore, reimbursement and billing should be in 15 minute increments and identify the number of units provided. If the a “minimum” billing time is desired, that should be set out as the number of units of service, for example four 15 minute increments to total an hour. This will keep the California fee table consistent with the G codes being used and also help facility data reporting as the billing increments and G codes will match rather than conflict.

6. Under 9789.92(c), it states that an employer or insurer will not be required to pay for services that were rendered prior to the industrial injury or illness “free of charge”. Zenith suggests removing the words “free of charge”. Essentially, this section is designed to state that if common tasks were performed for the injured person before the injury, then they are not subject to
compensation after the injury as status did not change. Adding the words “free of charge” creates a dispute point opening the door for unnecessary disputes. For example, if a family gives a child an allowance to take out the trash, is that “free of charge”. To avoid unnecessary litigation, Zenith recommends removing the concept “free of charge” from this section.

7. Table A: Please see prior comments in number 5 above in addition to the following comments.

The enabling statute for the Home Health Care Fee Schedule is Labor Code section 5307.8 which reads as follows:

Notwithstanding Section 5307.1, on or before July 1, 2013, the administrative director shall adopt, after public hearings, a schedule for payment of home health care services provided in accordance with Section 4600 that are not covered by a Medicare fee schedule and are not otherwise covered by the official medical fee schedule adopted pursuant to Section 5307.1. The schedule shall set forth fees and requirements for service providers, and shall be based on the maximum service hours and fees as set forth in regulations adopted pursuant to Article 7 (commencing with Section 12300) of Chapter 3 of Part 3 of Division 9 of the Welfare and Institutions Code. No fees shall be provided for any services, including any services provided by a member of the employee’s household, to the extent the services had been regularly performed in the same manner and to the same degree prior to the date of injury. If appropriate, an attorney’s fee for recovery of home health care fees under this section may be awarded in accordance with Section 4906 and any applicable rules or regulations.

Based on the enabling statute, Table A should only deal with unskilled services that are not covered by either Medicare or the OMFS. Please verify that these requirements have been met to avoid conflict between Table A and OMFS. Additionally, certain services seem to be priced high, specifically clinical social workers at $250 an hour. Please compare this to OMFS for comparable professional services to verify that rates are comparable and not overstated. Finally, the rate for a speech language pathologist at $426.963 per hour seems high. Please also review the pricing of that service as compared to comparable services within OMFS.

Robyn Stryd, Assistant Claims Manager
State Compensation Insurance Fund
May 15, 2015

As the revised regulations will require programming as well as publishing and distribution of forms, State Fund recommends that claims administrators be allowed 90 to 120 days from the date of adoption to implement the changes. The following includes recommended changes to the regulatory language. These changes are identified by strikeouts (to remove language) and color/underline (to add language).

§ 9789.90 Home Health Care - Definitions.
Discussion and recommendation:

1. State Fund feels clarification is needed for subsection (c), as indicated below, to provide clarity and consistency. Changes are identified by strikeouts (remove language) and color, underline (add language).

(c) “Home health care services” includes the provision of medical and other health care services to the injured worker or ill person in their place of residence. Home health services include both medical and non-medical services deemed to be medically necessary for patients who are confined to the home (homebound) and who require one or both any or all of the following: (1) Skilled care is provided by a licensed medical professional for tasks including, but not limited to, administration of intravenous drugs, dressing changes, occupational therapy, physical therapy, and speech-language pathology services; and/or (2) Personal care services for tasks and assistance with activities of daily living that do not require skills of a licensed medical professional, such as bowel and bladder care, feeding, bathing, dressing and transfers and assistance with administration of oral medications; and/or (3) Domestic care services such as shopping, cleaning, and laundry that the individual is no longer capable of performing due to the illness or industrial injury that may also be medically necessary in addition to skilled and/or personal care services. Domestic and personal care services do not require specialized training and do not need to be performed by a medical professional.

2. State Fund believes subsection §9789.90 (d) allowing the number of IHSS hours to be exceeded would conflict with Labor Code § 5307.8 because the statute requires the cap to be followed for services not covered under Labor Code § 5307.1.

3. As written, the regulation §9789.90 goes from subsection (d) to subsection (f), eliminating subsection (e). State Fund recommends the regulations be re-lettered to avoid confusion.

§ 9789.91  Home Health Care – Eligibility for Services.

Discussion and recommendation:

1. With respect to section (a), in order to maintain consistency throughout the text of the regulations, State Fund recommends changing the term injured employee in subsection (a) to injured worker.

(a) Home health care services shall be provided as medical treatment only if reasonably required to cure or relieve the injured worker employee from the effects of his or her injury and prescribed by a licensed physician and surgeon, in accordance with Labor Code section 4600, subdivision (h). Home health care services are subject to the utilization review and independent medical review processes set forth in Labor Code sections 4610 and 4610.5, et seq.
2. With respect to section (b), State Fund recommends allowing flexibility to allow the parties to reach an agreement while making it clear if there is no agreement the issue will be reviewed by a professional before the services begin. However, clarification is needed for section (b) as to if an in-home assessment is required for unskilled services and who can request an assessment prior to the primary treating physician submission of a Request For Authorization (RFA). The assessment is medical treatment and as such it is the responsibility of the employer to provide.

3. In section (b) a grammar correction is needed for line four. The word assessment has an unneeded capitalized “s”.

Based upon the above discussion in #2 and 3, we suggest the following changes to subsection (b):

(b) An in-home assessment of the injured worker’s need for home health care shall be obtained by the employer and shall be performed by a qualified registered nurse, physical therapist or occupational therapist employed by a home health care agency, unless the parties agree in writing, as to the extent of the injured workers’ needs. Assessments of an injured worker’s need for home health care will be performed using CMS’s OASIS (Outcome and Assessment Information Set), a group of standard data elements used by CMS to assess patients’ needs for home health care services, which is incorporated by reference (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/HHQIOASISAllTimePoint.pdf).

Authority: Sections 133, 4603.5, 5307.1, 5307.3 and 5307.8, Labor Code. Reference: Sections 4600, 5307.1, 5307.8 and 5307.11, Labor Code.

4. Additional language or subsection should be added to indicate that the Home Health Care agency performing the in-home assessment shall not be the same agency providing the home health care services. This is necessary to prevent potential conflict of interest.

§ 9789.92 Home Health Care – Payment Methodology

Discussion and recommendation:

1. Under §9789.92, it is recommended to specifically indicate to which dates of service or dates of injury the regulations and fee schedule will apply. By doing so, the clarification will avoid argument, in-proper billing dispute resolution process, and unnecessary litigation.

2. State Fund recommends section (b) of this proposed regulation be clarified to indicate whether providers are entitled to a one hour minimum per visit or per service, specifically if an unskilled provider doing domestic or personal care services are able to bill one hour for each type of domestic or personal care service completed. The suggested language change
below will resolve ambiguity in using the word “each.” A provider will be entitled to one hour no matter what type of HHC service is provided. The provider should not be able to charge 1 hour minimum for multiple different services, i.e. 1-hour for feeding, 1-hr for giving medication, 1-hr for cleaning the table, 1-hr for dishes, when all of these services may in fact be accomplished in 1-hr, not 4 hours.

Based upon the reasoning above, we suggest the following changes to subsection (b):

(b) Providers shall be entitled to a one hour minimum for each service. when providing home health care services. For home health care services that exceed one hour, the provider shall be paid in fifteen (15) minute increments, pro rata. Providers will bill using the CMS 1500 form which can be downloaded at the following link (http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms-Items/CMS1188854.html).

3. State Fund further recommends that subsection (b) include language that Providers must also comply with all the billing requirements of Labor Code Section 4603.2 (b)(1).

4. Lastly, with regard to subsection (b), appropriate language should be included to the regulation in an effort to deter fraudulent practice. This language could be based upon the Welfare and Institutions Code section 12301.25 (see sample below).

(a) Notwithstanding any other provision of law, the provider timesheet used to track the work performed by providers of services under this article shall contain both of the following:
(1) A certification to be signed by the provider and the recipient, verifying that the information provided in the timesheet is true and correct.
(2) A statement that the provider or recipient may be subject to civil penalties if the information provided is found not to be true and correct.
(b) A person who is convicted of fraud, as defined by subdivision (a) of section 12305.8 (of the welfare and institutions code), resulting from intentional deception or misrepresentation in the provision of timesheet information under this section shall, in addition to any criminal penalties imposed, be subject to a civil penalty of at least five hundred dollars ($500), but not to exceed one thousand dollars ($1,000), for each violation.

5. With respect to Section (c), State Fund believes the regulation conflicts with Labor Code §5307, which places a restriction on providing any type of home health care services if those
services were being provided to the injured worker before the date of injury. There is no requirement that the home health care services be free of charge prior to the injury, i.e. if the injured worker paid a dry cleaning service to do laundry pre-injury, then that domestic service would not be compensable under LC 5307.8. To avoid this conflict State Fund recommends eliminating the “free of charge” language.

Similarly, the limitation on liability for post-injury HHC services to an injured worker who received the same services pre-injury is not limited to a spouse or member of the employee’s household. The Legislature’s reference to spouse/household member was a specific example: “No fees for any services, including [spouse/household member], to the extent the services had been regularly performed…prior to the DOI.” To avoid, this conflict, State Fund recommends adding in the phrase “or other entity.”

Based on the above discussion, the proposed language below would keep the regulation from conflicting with the statute.

(c) An employer or their insurer shall not be liable for household tasks any home health care services the provided by the injured worker’s spouse, household member, or other entity if those home health care services were provided to the injured worker or other member of the injured worker’s household performed prior to the industrial injury free of charge. In addition, an employer shall not be liable for home health care services that are provided more than 14 days prior to the date of the employer's receipt of the physician's prescription for home health care services, pursuant to Labor Code section 4600, subdivision (h).

§ 9789.93 Table A

Discussion and recommendation:

1. State Fund recommends that Codes S5125 and S5130 be deleted as there are no corresponding definitions within current regulations for those codes.

2. Code S5120 (Chore services) appears to be intended for domestic services provided by a Home Health Care agency and there is a separate code and description WC200 (IHSS-based chore services). It is recommended to change the descriptions to state “Domestic Services (Home Health Care agency-based)” and “IHSS-based domestic services.” This will avoid confusion by providers by having Table A be consistent with 9789.90 (c), will clarify as to which domestic service code should be billed, prevent delays in payment and unnecessary billing disputes.

3. Code S5120 appears to pay less than Code WC200. Clarification in the regulations should be made as to the intent of one code paying higher than another code, specifically if those services are being provided by skilled or unskilled providers.
4. Regarding code WC200 appears to be based on IHSS. If the hourly rate is based on IHSS, there appears to be no support for the $15.37 per hour rate listed in Table A. The current highest IHSS rate in California is $12.81 per hour. Therefore, State recommends the rate for WC200 be $12.81.

Jennifer White
Manager, Medical Bill Review
Promesa Health, Inc.

What is the payment methodology for home health care services not listed in section 9789.93 Table A? For example, home infusion per diem HCPCS codes S9497, S9500-S9504 are not listed in Table A but are not uncommon services in workers compensation. According to section 9789.90 (c) administration of intravenous drugs is considered a home health care service. Providers rendering home infusion IV therapy will be billing a code from S9497, S9500-S9504 along with the medication administered. These S codes are status code I in the PPRRVU table (9789.12.8). Since they are not covered under the physician fee schedule (9789.12) or the proposed home health care fee schedule (9789.90) these would be considered By Report. Will there be a provision added on how to handle By Report home health services? Can these codes be added to Table A?

Jerry Wells, Esq.
Mullen & Filippi

I’ve reviewed the proposed Regs and fee schedule. I agree the hourly fee schedule seems reasonable, but I have concern over language in the Reg, specifically 9789.90(d) wherein IHSS services are defined and the maximum hours for this program are set forth in Welfare & Institutions Code 12300(h)(3). That Code section sets max combined hours at 283 per month, and refers to another section, 12303.4, which sets a tier, based on different criteria, with a MAXIMUM monthly allowance of 195 or 283.

It is my interpretation of the statutes that HHC in WC is bound by those limitations, but the sentence in proposed 9789.90(d) which says “The maximum hours provision of this program…can be exceeded for an injured worker based upon a showing of medical need,
reasonably required to cure or relieve the injured employee from the effects of is or her injury and prescribed by a licensed physician and surgeon, in accordance with Labor Code section 4600… (h)” seems to me to be an effort to circumvent what was intended as a clear ceiling on such benefits.

This seems to suggest that the monthly hours can be whatever a doctor says are reasonably required to cure or relieve, conceivably limited only by the hours in a month (720 for a 30 day month).

Labor Code 5307.8, however, expressly states that with respect to home health care services, “The schedule shall set forth fees and requirements for service providers, and shall be based on the maximum service hours and fees as set forth in regulations adopted pursuant to Article 7 (commencing with Section 12300) of Chapter 3 of Part 3 of Division 9 of the Welfare and Institutions Code.”

I’m not sure why the proposed Reg seems to distinguish between “home health care services” and “IHSS” or in-home supportive care services in its definitions section, unless it’s merely because the IHSS terminology is used in the W&I Code where it’s not in the Labor Code.

Scott Silberman      May 8, 2015
Silberman & Lam, LLP
One problem with subjecting the requests to UR and IMR is that neither seem to have guidelines to follow for home healthcare. Many UR denials say that home care is not part of mtus and more recently we have received denials stating home health is not necessary because the spouse is able to perform these services. However in some cases a spouse or family member quit a job to perform these services. Perhaps a statement that the requests will be subject to UR/IMR once guidelines are adopted would be better.

Also there are long inherent delays with ur/IMR. When someone is discharged from a hospital and not mobile and discharge instructions come when the person is sent home, what are they going to do while they wait for UR? I have never seen a hospital do an Rfa, would that be required? I think that perhaps the home health care should be authorized until there is a denial, and if there is a denial it should lay out alternate care that would be authorized.

Chris Beissert       May 7, 2015
What is the MAA? Maximum Allowable Amount of what? Hours? Money?

Table A: chore services, attendant care, homemaker – what are the definitions?

Also, §9789.91(b) – who chooses the RN to do the in-home assessment?