Issue	Comment	Response	Commenter
Support for adopting Medicare MSA-based locality GPCIs	**Commenter 4** completely supports the Division's adoption of a public policy recognizing that fee schedules which control reimbursement for medical services provided in California's workers' compensation system should reflect geographic differences in the cost of delivering those services. The chosen tool to implement that policy, Medicare's "GPCI" factor(s) takes advantage of the work already accomplished to adjust for those geographic differences. Commenter 4 strongly believes reimbursement for all medical services should be calculated to take into account the cost of doing business in the locale where those services are delivered. **Commenter 5** states, "On behalf of the more than 43,000 members of the California Medical Association (CMA) and the California Occupational Medicine Physicians (COMP), an	Agree that Medicare MSA-based locality GPCIs should be adopted. The proposed revised payment localities are consistent with the objective of providing allowances that reflect resources required to provide a service in a particular geographic area, resulting in improved payment accuracy. A recent RAND memo determined the OMFS statewide fee schedule is paying relatively more in low cost areas and less in high cost areas than either Medicare or commercial payers.	4.1, 4.6 – Stephen Cattolica, Legislative Advocate, representing California Society of Industrial Medicine and Surgery (CSIMS), California Neurology Society (CNS), California Society of Physical Medicine and Rehabilitation (CSPM&R), Independent Physical Therapy Association of California (iPTCA), California Workers' Compensation Interpreters'Association (CWCIA) – written and oral testimony 5.1 – Stacey Wittorff, Legal Counsel, Center for Legal Affairs, California Medical Association (CMA) and Ron Crowell, MD, President, California Occupational Medicine Physicians (COMP) 6.1 – Basil Besh, MD, President, California Orthopaedic Association

	association of more than 120 occupational clinics in California who are on the front lines of treating injured workers, we are writing in support of the proposed regulation changes to the physician fee schedule to use Medicare's locality-specific geographic adjustment factors. We have consistently advocated for the use of Medicare payment localities and geographic adjustment factors (gaf) instead of one statewide geographic adjustment factor, as this approach better captures the varying differences in practice economic conditions and local costs. In 2015, Congress passed the "Protecting Access to Medicare Act," which included a locality structure change to update Medicare physician geographic payments in California to ensure they accurately reflect local costs to provide care (office rent, employee wages, and		7.1 Ron Crowell, MD, President, California Occupational Medicine Physicians (COMP) 8.1 Thomas Novelli, One Call Care Management (oral testimony)

	professional liability insurance). The new law changed California's locality structure from nine county-based localities to 27 Metropolitan Statistical Areas (MSAs) as defined by the Office of Management and Budget (OMB). Medicare currently organizes hospitals into MSA regions. In 2017, the Centers for Medicare and Medicaid Services (CMS) issued the implementing regulations for California's new Medicare physician payment localities. The law requires CMS to phase–in the new payments from 2017-2021 with full implementation in 2022. This new approach provides an increased ability for payment to more precisely match the economic factors in each of the 27 localities. These changes will also help to maintain access to care for injured workers in the impacted California regions. We hear from our members on the continued challenges of providing high quality care to		

	injured workers. One challenge is competing with other sectors of the healthcare marketplace where workers are being recruited away from occupational clinics to higher paying jobs in hospitals and clinics. This approach will align the Medicare physician and hospital payment regions as recommended by the Institute of Medicine so they can compete equally. We believe moving to the MSA locality-based structure will help physicians and clinics better compete to retain employees and continue to provide high quality care. For these reasons we are in support of the proposed regulation change." **Commenter 6** states, "Some years ago, COA was part of a medical coalition that urged the Centers for Medicare and Medicaid Services (CMS) to update their GCPIs to more accurately reflect the practice costs in areas throughout California. At that time, areas		

	that have become very high cost areas to practice medicine were included in Region 99 – the lowest practice costs in the state. This was clearly inappropriate. Because CMS has adjusted their GCPIs to more accurately reflect practice costs, we now support the use of the Medicare GCPIs for California's Workers' Compensation Physician Fee Schedule. We do ask, however, that the adjustments be phased in as Medicare is doing to provide the least amount of disruption and fluctuation in reimbursement rates for physicians." **Commenter 7** states they are writing in support of the proposed regulation changes to the physician fee schedule to use Medicare's locality-specific geographic adjustment factors.		

	"During the discussion on regulations related to the implementation of SB 863 back in 2013 and 2014, we advocated for the use of the nine Medicare payment localities for the statewide geographic adjustment factor. Our belief was this approach would better capture the varying differences in practice economic conditions and local costs. The Division decided to pass regulations using the average statewide geographic adjust factor for the physician fee schedule. This decision was partially based on their assessment that the Medicare payment localities had not been updated in more than 15 years which resulted in substantial differences in payment between bordering urban counties. In 2017, Medicare changed its locality structure from nine to 27 localities under their Metropolitan Statistical Area (MSA) based locality structure. This new approach provides an increased ability		

	for payment to more precisely match the economic factors in each of the 27 localities. We hear from our clinics on the continued challenges of recruiting and maintaining staff to provide high quality care to injured workers. One challenge is competing with other sectors of the healthcare marketplace where workers are being recruited away from occupational clinics to higher paying jobs in hospitals and clinics. We believe moving to the MSA locality-based structure will help our clinics better compete to retain employees and continue to provide high quality care. For these reasons we are in support of the proposed regulation change." **Commenter 8** states they appreciate, and generally support, DWC's efforts to ensure payment accuracy within the workers' compensation programs, specifically by transitioning to		

	a GPCI-based model, away from the state geographic factors. This is something that Medicare has done and with the same mission in mind. And really ensuring that providers have timely access and are paid accurately is something that's agreed and generally supported by all stakeholders.		
Provider access in rural areas	**Commenter 1** recommends against replacement of the average statewide GAF with the Medicare GPCIs because the reformulated payments will result in lowered payments in localities where it is already difficult to find physicians to treat injured workers. **Commenter 2** states the potential for provider access may be further exacerbated in rural parts of California if providers in those areas perceive that the GPCI adjustments don't accurately reflect their cost of doing business and/or result in reductions in reimbursement rates over the current OMFS rates. Most would agree that lack of providers in rural areas	Disagree. The purpose of the GPCI is to improve payment accuracy by accounting for the differences in input prices that providers face in different geographic localities. The current statewide GAFs make no adjustment for differences in costs of maintaining a practice across geographic areas. A recent RAND memo determined the OMFS statewide fee schedule is paying relatively more in low-cost areas and less in high-cost areas than either Medicare or commercial payers. The statewide GAFs are contrary to the objective of the RBRVS which is to align the OMFS allowances with resources required to provide medical care to injured workers.	1.1 Stacy L. Jones, Senior Research Associate, CWCI 2.2 Jason Schmelzer representing CCWC, California Coalition on Workers' Compensation, California Chamber of Commerce, League of California Cities, RCRC, California Manufacturers & Technology Association, American Insurance Association, Property Casualty Insurers Association of America, California Association of Joint Powers Authorities 3.1 Karen Sims, Assistant Claims Operations Manager, Claims Medical

	is a problem in and of itself, not a reflection of any fee schedule. Payer's experience given a limit of available provider workforce is to contract directly with those providers at a higher rate than current OMFS to secure good treating providers in their MPNs. During that last OMFS adjustment, it has been reported that several providers ceased accepting workers' compensation due to continued reporting of lower reimbursement rates. Many of these were in rural areas. As noted, some MPNs had to agree to a reimbursement rate above OMFS in order to maintain that providers and this is not reflected in MPN certification. In heavily populated areas, provider access is seldom a problem and reimbursement at OMFS without Geo-Coding has not been an issue. We agree that reimbursement rates matter to providers, regardless of where the practice in the state."	RAND found, "MSA-based payment localities … would reduce payments in rural areas and small MSAs and could therefore affect the access. Conversely, the statewide fee schedule could be affecting access in higher-cost urban areas. By more accurately reflecting the differences in the cost of maintaining a practice across geographic areas, access should not be adversely affected and could be improved in the higher cost areas. In lower cost areas, the issue is less the adequacy of the allowances than the adequacy of the physician workforce. The OMFS already addresses access in underserved areas by providing an additional 10-percent payment for physician and other practitioner services provided in primary care health professional shortage areas or to mental health practitioners in mental health shortage areas." According to the *2018 Medicare RBRVS – The Physician's Guide*, published by the American Medical Association (AMA), application of Medicare GPCIs	and Regulatory Division, State Compensation Insurance Fund 4.3, 4.8 – Stephen Cattolica, Legislative Advocate, representing California Society of Industrial Medicine and Surgery (CSIMS), California Neurology Society (CNS), California Society of Physical Medicine and Rehabilitation (CSPM&R), Independent Physical Therapy Association of California (iPTCA), California Workers' Compensation Interpreters'Association (CWCIA) – written and oral testimony 8.2 – Thomas Novelli, One Call Care Management (oral testimony) 9.1 Don Schinske, Cal Capitol Group (oral testimony)

	Commenter 3 states, the proposed regulations will result in substantial reduction in OMFS allowance for physicians in most rural areas, where there is already an established provider shortage. This creates a disincentive for physicians to practice in rural areas, and inevitably shift physician concentration from the low cost areas into the high cost areas, as physicians seek to relocate to areas with more business and higher pay. Physicians in rural areas may be discouraged from accepting WC cases due to the lowered reimbursement rate, denying injured workers the benefit to seek medical treatment within a reasonable distance. **Commenter 4** is completely supportive of the proposed regulation to adopt Medicare's MSA-based locality GPCIs. Notwithstanding this support, commenter states providers in rural areas will experience lower reimbursement and will likely experience even worse	was studied by the General Accounting Office (GAO) in 2005. The study reported that GPCIs have a negligible impact on physicians' decisions to locate in rural areas citing that a spouse's employment opportunities, quality of local schools, and the availability of other physicians within the area to share in their delivery of care (i.e. taking call) have just as much of an impact. While commenter 2 correctly points out that some MPNs have negotiated reimbursement at a higher rate than what is in the OMFS, nothing in these proposed regulations precludes this practice from continuing. Comments from professional organizations representing physicians and other non-physician practitioners have expressed their support for the proposed transition to MSA locality-based GPCIs, with some advising the Division of Workers' Compensation to be sensitive to possible impacts on access in rural areas. The	

	access to care. Commenter clarifies, "[i]n this context we do not equate proximity-how close one might reside to a provider-with access-the ability to be seen and treated by that same provider. MPN over-selectivity, administrative burdens and most recently, an overbearing regulatory burden have already taken their toll on true access to care." Commenter 4 urges the Division to "ramp up its access study rather than waiting for the annual study to be done. To monitor the WCIS system on a transactional basis to ensure that care is not further eroding in rural areas because of implementation of the "GPCIs." **Commenter 8** states, given the complexity and some of the challenging administrative considerations with this, DWC is urged to proceed cautiously and occasionally check in with providers, especially in rural areas that may be subject to steeper payment rate cuts than others and the other MSAs.	Division understands the value and importance of being sensitive to any possible impacts on access to medical care for injured workers. Commenters in support of the transition to Medicare's MSA-based locality GPCIs were submitted on behalf of the following organizations and entities: • California Society of Industrial Medicine and Surgery (CSIMS) • California Neurology Society (CNS) • California Society of Physical Medicine and Rehabilitation (CSPM&R) • Independent Physical Therapy Association of California (iPTCA) • California Workers' Compensation Interpreters'Association (CWCIA) • California Medical Association (CMA) • California Occupational Medicine Physicians (COMP)	

	Commenter states that over time, in Medicare, that sometimes these shocks can be a little more significant than people give consideration to. Rural providers, especially, should be checked to make sure that there is no access issues for patients. In many cases there are not many providers in some of these rural areas and states. **Commenter 9** states, there will be some minor areas -- small areas that experience a decrease in reimbursement here. The Statement of Reasons is unclear whether the effects on access had been analyzed or looked at. After all, the rationale for RBRVS is it's obviously based on the cost of operating. That said, there is never going to be a challenge with access in San Francisco; whereas, when you get out into the rural areas, go up to Alturas or Susanville, you may be looking at service being provided by a family doctor or general practitioner who receives work comp	• California Orthopaedic Association • One Call Care Management It should also be noted that during the 2013 rulemaking — which proposed the transition to a RBRVS-based physician fee schedule — CWCI, American Insurance Association (AIA), and State Compensation Insurance Fund (SCIF) commented that if the statewide GAFs were adopted, then, the HPSA 10-percent bonus should not be adopted. No evidence-based finding has been provided by CWCI, AIA, or SCIF to support the argument that the rural areas now need both higher pay resulting from the statewide GAFs — to the detriment of urban areas that are underpaid — and geographic HPSA bonuses in order to retain access in rural areas. The commenter for AIA, dated, July 10, 2013, stated, "[s]hould the Division proceed with one statewide GAF, we request that consideration be given to	

	patients as a convenience to their existing patients. You would hate to have any of them just say, you know -- given the existing reporting challenges and paperwork associated with handling work comp, you would hate to see them drop it now just because of a five or ten percent reduction. Commenter would hope that, as DWC looks at these types of changes to the fee schedule, that access is a component of that analysis.	reducing or removing the 10 percent increase for the Health Professional Shortage Areas (HPSA) depending on the increase that will be derived from the application of a statewide figure." The August 19, 2013, comment by SCIF, stated "[t]he proposed regulations [§ 9789.12.6 Health Professional Shortage Area Bonus Payment] will allow a physician who provide services in a Health Professional Shortage Area (HPSA) to receive a 10% bonus payment. All physicians, including psychiatrists, are eligible for this additional payment, if the location in which they provide services is designated as a HPSA by the Health Resources and Services Administration. … State Fund recommends postponing the 10% bonus payment at this time. The conversion factor that has been assigned to these services should be sufficient to attract providers who are doing business in HPSA-designated areas. After the implementation of the RB-RVS Fee Schedule, the DWC	

		may reevaluate the need for HPSA payments if increased payments are needed to encourage providers to accept workers' compensation patients in HPSA-eligible areas." The July 17, 2013, comment by CWCI, stated, "[a]dopt a single California-wide GPCI instead of multiple GPCIs and HPSAs."	
Proper Implementation of the use of GPCIs	Commenter states, proper payment under the proposed use of GPCIs requires the service provider include the correct address and ZIP code for where the service actually took place. Additional clarification will be required for physicians who provide services from remote locations (e.g. radiologists interpreting digital scans and radiography from a location that differs from where the scan or x-ray occurred; laboratory services; telehealth services; telephonic conferences, etc.).	Agree. The Division proposes to further amend the regulations to include guidance for determining the "payment locality" in application of GPCI values.	1.2 Stacy L. Jones, Senior Research Associate, CWCI
Administrative costs	**Commenter 2** states, there are significant administrative differences that make the alignment highly problematic for all parties and opens	Notice taken. Adopting Medicare's new MSA-based payment localities furthers the objective of the RBRVS to provide allowances that reflect	2.1 Jason Schmelzer representing CCWC, California Coalition on Workers' Compensation, California Chamber of

	additional avenues for abuse and fraud. There are considerable challenges with implementing the proposed a geographic based fee schedule. For example, many providers have multiple offices. It is nearly impossible to systematically correlate the correct provider address with where the treatment was delivered to accurately determine the correct geo-zip fee schedule. The administrative costs for payers and providers to convert payment systems to align to the new GPCI structure would be significant. Even a routine update to the OMFS would require both provider and payers systems to incur programming changes to align accurately. The overarching change to a completely new reimbursement structure is infinitely more complex to administer for everyone involved and difficult at best to processed payments accurately and timely.	the resources required to provide a service and will improve payment accuracy. The Division also proposes to further amend the regulations to include guidance for determining the "payment locality" in application of GPCI values. The Division, however, will remain sensitive to this concern — and especially — to any permanent impacts that become evident.	Commerce, League of California Cities, RCRC, California Manufacturers & Technology Association, American Insurance Association, Property Casualty Insurers Association of America, California Association of Joint Powers Authorities 3.4 Karen Sims, Assistant Claims Operations Manager, Claims Medical and Regulatory Division, State Compensation Insurance Fund

	Commenter 3 states, the proposed change will increase bill review and process time as an extra layer of complexity is introduced. The reimbursement for each billing code will now be different depending on the provider's location zip code. Additional time and resources are also needed for claims administrator to verify the actual location of where the service is performed. Also, the potential litigation cost on billing zip code disputes must also be taken into consideration.		
Payment for physician reports	Commenter suggests consideration should be given to whether physician reports will continue to be paid based on universal flat fees, or whether geographic factors will be included in payment calculations for this type of physician service.	Commenter's suggestion falls within the broader topic of physician reporting requirements and payment policies in the California workers' compensation system; and is outside the scope of this rulemaking. The broader issue of physician reporting payment policies will likely be considered for a future rulemaking.	1.3 Stacy L. Jones, Senior Research Associate, CWCI
Explanation of Review/Remittance Advice Guidelines	Commenter suggests the proposed regulation should be coordinated with any revisions	The address including the ZIP code for each service code must be included on the bill to allow	1.4 Stacy L. Jones, Senior Research Associate, CWCI

	to the Explanation of Review/Remittance Advice Guidelines if the service location zip code will be required to explain the payment calculation, in order to avoid conflicts and Independent Bill Review (IBR) costs.	the payer to determine the appropriate payment locality. The location in which the service was furnished is entered on the ASC X12 professional claim format (Loop 2310C; Service Facility Location Name, including segment N4 Service Facility Location City, State, Zip Code, is required when the location is different than that carried in Loop ID-2010AA (Billing Provider).) For paper bills, the service facility location is required to be entered in item 32 on the paper CMS1500 form if the service location is different than the billing provider location. The DWC's rulemaking agenda for this year includes update of the Medical Billing and Payment Guide, including the Explanation of Review/Remittance Advice regulations. DWC will be updating to current CARC and RARC codes. In the meantime, the payer may use DWC Bill Adjustment Reason Code G5 (and CARC 162/RARC M118, N202): "This charge was adjusted for the reasons set forth in the attached letter."	

Conflicts with MSA GPCI and MPN geographic service areas	Commenter is concerned about the potential for individual MPN geographic service areas (as defined by geo-coding to meet access requirements) conflict or overlap with the MSA GPCI. Thereby creating an added layer of complexity to administering an MPN or adjudicating MPN provider bills accurately.	Disagree. An MPN Geographic Service Area is the geographic area in which the DWC has confirmed there are a sufficient number of medical providers to meet MPN access standards during a review of an MPN original application, modification or reapproval. Payments for MPN medical provider services will either be the maximum amounts set by the OMFS or the amounts set pursuant to contract. There are no MPN statues or regulations that address the amount that must be paid to MPN providers. Therefore, there are no regulatory or statutory conflicts or overlap between an MPN's geographic service area and the proposed amendments to the OMFS. They are completely separate issues. One deals with MPN access standards and the other deals with payment to the providers. The administrative complexities mentioned by the commenter voluntarily arise because of the contracts negotiated between the MPN and its providers.	2.3 Jason Schmelzer representing CCWC, California Coalition on Workers' Compensation, California Chamber of Commerce, League of California Cities, RCRC, California Manufacturers & Technology Association, American Insurance Association, Property Casualty Insurers Association of America, California Association of Joint Powers Authorities
Impacts on Medical Provider Networks	**Commenter 2** states, "Payers experience given a limit of	Disagree. While commenter 2 correctly points out that some	2.2 Jason Schmelzer representing CCWC,

	available provider workforce is to contract directly with those providers at a higher rate that current OMFS to secure good treating providers in their MPN's. During the last OMFS adjustment, it has been reported that several providers ceased accepting workers' compensation due to continued reporting an lower reimbursement rates. Many of these were in rural areas. As noted, some MPN's had to agree to a reimbursement rate above OMFS in order to maintain the providers and this is not reflected in MPN certification." **Commenter 3** states, "[a]s physicians in the rural areas look to move into the more "profitable" counties or stop accepting workers' compensation cases altogether, some MPNs may no longer meet the strict access standards established under Title 8, CCR, §9767.5. In such cases, the employers must relinquish control over the care of the injured workers and the quality	MPNs have negotiated reimbursement at a higher rate than what is in the OMFS, nothing in these proposed regulations precludes this practice from continuing. Regarding commenter 3's comment regarding MPN access standards: Access to medical care in rural areas is an issue DWC is mindful of, and, therefore, already has regulations in place when there is a demonstrated lack of providers in these areas. Pursuant to Title 8, CCR section 9767.5(b), MPNs may apply for and be approved to have an "alternative access standard" which expands the access standards according to the availability of providers in the area. Many MPNs have already been approved to have "alternative access standards" including SCIF's MPN. As long as there are available MPN providers in the expanded alternative access standard, the employer maintains control over the care of the injured workers and the quality of care expected	California Coalition on Workers' Compensation, California Chamber of Commerce, League of California Cities, RCRC, California Manufacturers & Technology Association, American Insurance Association, Property Casualty Insurers Association of America, California Association of Joint Powers Authorities 3.2 Karen Sims, Assistant Claims Operations Manager, Claims Medical and Regulatory Division, State Compensation Insurance Fund

	care expected from an MPN will be sacrificed."	from an MPN will not be sacrificed.	
HPSA bonus	Commenter states, "…physicians in rural areas who will qualify for the Geographic Health Professional Shortage Area (HPSA) 10-percent bonus payment under the proposed regulations would have received the same 10-percent bonus payment under the current regulations. The decrease in payments in rural areas will not be offset by the 10-percent bonus payment. The proposed regulations would in fact adversely affect this incentive because it would undercut the total amount a physician is paid in the underserved area. The Initial Statement of Reasons concludes that physicians in rural counties were overpaid, while physicians in urban counties were underpaid. However, the Initial Statement of Reasons does not indicate how much on	Disagree. The purpose of the GPCI is to improve payment accuracy by accounting for the differences in input prices that providers face in different geographic localities. The current statewide GAFs make no adjustment for differences in costs of maintaining a practice across geographic areas. A recent RAND memo determined the OMFS statewide fee schedule is paying relatively more in low-cost areas and less in high-cost areas than either Medicare or commercial payers. The statewide GAFs are contrary to the objective of the RBRVS which is to align the OMFS allowances with resources required to provide medical care to injured workers. RAND found, "MSA-based payment localities … would reduce payments in rural areas and small MSAs and could therefore affect the access. Conversely, the statewide fee	3.3 Karen Sims, Assistant Claims Operations Manager, Claims Medical and Regulatory Division, State Compensation Insurance Fund

	average the physicians in rural counties were overpaid, and whether that was a direct effect of the incentive program built into the system to serve underserviced areas. After all, it is the legislative intent to provide increase payments to encourage "access in underserved areas."	schedule could be affecting access in higher-cost urban areas. By more accurately reflecting the differences in the cost of maintaining a practice across geographic areas, access should not be adversely affected and could be improved in the higher cost areas. In lower cost areas, the issue is less the adequacy of the allowances than the adequacy of the physician workforce. The OMFS already addresses access in underserved areas by providing an additional 10-percent payment for physician and other practitioner services provided in primary care health professional shortage areas or to mental health practitioners in mental health shortage areas." According to the *2018 Medicare RBRVS – The Physician's Guide*, published by the American Medical Association (AMA), application of Medicare GPCIs was studied by the General Accounting Office (GAO) in 2005. The study reported that GPCIs have a negligible impact on physicians' decisions to locate in rural areas citing that a	

		spouse's employment opportunities, quality of local schools, and the availability of other physicians within the area to share in their delivery of care (i.e. taking call) have just as much of an impact. Comments from professional organizations representing physicians and other non-physician practitioners have expressed their support for the proposed transition to MSA locality-based GPCIs, with some advising the Division of Workers' Compensation to be sensitive to possible impacts on access in rural areas. The Division understands the value and importance of being sensitive to any possible impacts on access to medical care for injured workers. Commenters in support of the transition to Medicare's MSA-based locality GPCIs were submitted on behalf of the following organizations and entities:	

		• California Society of Industrial Medicine and Surgery (CSIMS) • California Neurology Society (CNS) • California Society of Physical Medicine and Rehabilitation (CSPM&R) • Independent Physical Therapy Association of California (iPTCA) • California Workers' Compensation Interpreters'Association (CWCIA) • California Medical Association (CMA) • California Occupational Medicine Physicians (COMP) • California Orthopaedic Association • One Call Care Management It should also be noted that during the 2013 rulemaking — which proposed the transition to a RBRVS-based physician fee schedule — commenter 3, State Compensation Insurance Fund (SCIF), stated the HPSA 10-	

		percent bonus should not be adopted. No evidence-based finding has been provided by any commenters, including SCIF, to support the argument that the rural areas now need both higher pay resulting from the statewide GAFs — to the detriment of urban areas that are underpaid — and geographic HPSA bonuses in order to retain access in rural areas. In particular, the August 19, 2013, comment by SCIF, stated "[t]he proposed regulations [§ 9789.12.6 Health Professional Shortage Area Bonus Payment] will allow a physician who provide services in a Health Professional Shortage Area (HPSA) to receive a 10% bonus payment. All physicians, including psychiatrists, are eligible for this additional payment, if the location in which they provide services is designated as a HPSA by the Health Resources and Services Administration. … State Fund recommends postponing the 10% bonus payment at this time. The conversion factor that has been	

		assigned to these services should be sufficient to attract providers who are doing business in HPSA-designated areas. After the implementation of the RB-RVS Fee Schedule, the DWC may reevaluate the need for HPSA payments if increased payments are needed to encourage providers to accept workers' compensation patients in HPSA-eligible areas."	
Extend geographic adjustments policy	Commenter strongly urges the Division to take immediate steps to consistently administer this policy across all provider types and all Medical Services whether they be delivered under labor code 4600 or as a medical-legal expenses. The division should install these fundamental reimbursement factors or a properly configured version of them in every applicable service and fee schedule - to treatment modalities of all kinds, interpreting services, diagnostic testing and others. Commenter states, the ability to do so is already within the regulatory authority of the	Comment is outside the scope of the current rulemaking.	4.2, 4.7 - Stephen Cattolica, Legislative Advocate, representing California Society of Industrial Medicine and Surgery (CSIMS), California Neurology Society (CNS), California Society of Physical Medicine and Rehabilitation (CSPM&R), Independent Physical Therapy Association of California (iPTCA), California Workers' Compensation Interpreters'Association (CWCIA)

	Administrative Director, just as instituting the current proposal and the other, on-going adjustments to the various fee schedules that have taken place recently.		
Timeliness of reimbursement	Commenter states, "[a]s with their comments regarding access to care, the timeliness of reimbursement is not directly affected by the current proposal." Commenter states there were months and months of error-filled reimbursement from 2006, the last time physicians experienced raises such as currently proposed in urban areas. At that time, there was no eBilling and no IBR. However, commenter urges the division to issue a newsline warning payers to not delay paying what is owed.	Notice taken.	4.5 - Stephen Cattolica, Legislative Advocate, representing California Society of Industrial Medicine and Surgery (CSIMS), California Neurology Society (CNS), California Society of Physical Medicine and Rehabilitation (CSPM&R), Independent Physical Therapy Association of California (iPTCA), California Workers' Compensation Interpreters'Association (CWCIA)