Regulation Section	Issue	Comment	Response	Commenter	
9789.12.1 (Scope and applicability of the physician fee schedule	Inform which version of the physician fee schedule should be used by date of service	Commenter requests a specific instruction regarding prior OMFS ground rules should be provided to ensure payer and adjudication consistency. It is important to specify that all prior OMFS ground rules are superseded by the new fee schedule and ground rules for dates of service after adoption of the fee schedule.	Disagree. The regulation proposal is quite clear about the dates applicable to the fee schedule. Proposed section 9789.12.1(a) provides that for treatment rendered of or after 1/1/2014, sections 9789.12-9789.19 apply (proposed new physician fee schedule). For services rendered prior to 1/1/2014, the fees shall be determined in accordance with the fee schedule in effect at the time the service was rendered.	18.8 (Okun & Crowell)	
9789.12.1 (Scope and applicability of the physician fee schedule	Subsection (a) contracted fees	Commenter recommends adding the following to subsection (a): "The Physician Fee Schedule shall not govern fees for services covered by a contract setting such fees as permitted by Labor Code section 5307.11 except to the extent that contracted fees are predicated on Physician Fee Schedule allowances." The commenter recommends this change to clarify that contract fees are not precluded from being based on Physician Fee Schedule allowances. Commenter recommends the following for subsection (b): "Maximum fees for services of a physician or non-physician practitioner are governed by the Physician Fee Schedule, ~~regardless of specialty,~~ for services performed within his or her scope of practice...~~However~~, Osteopathic Manipulation Codes...". Commenter states the maximum fees in an RBRVS-based fee schedule sometimes differs by type of provider.	Subsection (a): Disagree. The acting AD does not see a necessity to provide this additional language. Basic contract concepts would allow parties to consider a fee schedule as the benchmark for their contracted allowed amounts. Subsection (b): Disagree. The section states that the maximum fees are governed by the fee schedule regardless of specialty, but does not say that the fees are the same for each specialty. The provisions that vary by provider type are specified in the rule (e.g. only psychiatrists receive the mental health HPSA bonus, NPs/PAs are subject to the 85% payment level unless "incident to" a physician's service, etc.)	31.7 (Ramirez)	

Regulation Section	Issue	Comment	Response	Commenter	
9789.12.2 (Calculation of reasonable fees for services other than anesthesia)	Use of GPCIs v. State-wide GAF	Commenter 7 supports the use of Medicare GPCIs for each region. Commenters 6, 9, 18, 31, 38, 40, 42 oppose using the GPCI localities and instead recommend use of a single state-wide GPCI. Commenter 18 states using the severely outdated CA local GPCI will create significant administrative burdens on multi-clinic providers and unfairly harm providers in misclassified and miscalculated areas. Implementation of a single state-wide GPCI will result in a more streamlined conversion from OMFS to RBRVS for both multi-clinic providers and payers alike. Commenter 31 states the current GPCI areas in CA are illogical and are neither fair nor successful and they de-compensate where the population is sparse. While HPSAs may provide some relief, addressing the disincentives that create and exacerbate this problem by establishing a single state-wide GPCI for WC is a better solution and is more efficient than creating or exacerbating health professional shortage areas then compensating for them. Adopting a single GPCI will also eliminate the billing abuse associated with multiple GPCIs. (e.g. a provider reports an incorrect service location by entering a 3rd party biller zip code on the form to increase reimbursement). Commenter 31 suggests amending 9789.12.2 by adding the following: <u>The California state-wide Geographic Practice Cost Index (GPCI) is 1.082 and shall be used in calculations of maximum reasonable fees.</u>	Agree in part. The Medicare California 9-locality GPCIs would add administrative complexity as the fee schedule is being transitioned to the RBRVS. In addition, there is momentum at the federal level to refine the GPCIs, including work on the structure and number of localities, and revision of the GPCI calculation for physician work. See Medicare Payment Advisory Commission Report to the Congress, June 2013, Chapter 8. Based on the totality of comments received, the DWC will amend the regulations to use statewide GAFs calculated by RAND rather than the Medicare 9-locality GAFs. The revised regulations propose one statewide GAF for anesthesia. The revised proposal will utilize separate statewide GAFs for each RVU component, work, practice expense, and malpractice expense and. (See RAND Report: *Implementing a Resource-Based Relative Value Scale Fee Schedule for Physician Services* , chapter 6.) For services other than anesthesia, computing statewide average GAF for each RVU component creates values that are more sensitive to the geographic variation in cost of different procedures. The proposed statewide GAFs for 2014 are listed in section 9789.19.	6.3 (Suchil); 7.2 (Rothenberg); 9(Brackensiek); 14(Marston); 18.4 (Okun & Crowell); 31.1 and 31.8 (Ramirez); 33.2 (Merz & Schmelzer); 38(Broyles); 40(Madden); 42(Blink)	
Cont'd	Con'td	Commenter 33 states the locality GPCIs runs contrary to the legislative intent of SB 863, which clearly and explicitly states a preference for a single statewide GAF in lieu of Medicare's locality-specific approach.			
9789.12.2	Site of service	Commenter 7 supports the site of service differential. Commenter 12 states revisions to the fee schedule should address the current disparity in payments for identical services delivered in a physician's office versus a hospital outpatient facility.	Agree. The issue of equalizing payments for some procedures no matter the site of service will be explored as part of the hospital outpatient fee schedule.	7.4 (Rothenberg); 12.6 (Mumbauer)	

Regulation Section	Issue	Comment	Response	Commenter	
9789.12.5 Conversion Factors	Transition CFs to Single CF	Commenter 7, 12, 31 support the CF phased in over four years to a single CF as proposed. Commenters 8, 9, 15 state they are concerned about the impact of going to a single CF and the specific impact on radiology reimbursement with the overall limitation of the 120% of the estimated aggregate Medicare payments in 2012. The continued reduction in reimbursement for imaging services will impair the ability of the radiology community to continue to upgrade and replace equipment. Reducing access to freestanding imaging center might drive patients to more costly facilities like hospitals. Commenter 9 wants separate CF for radiology. Commenter 24 requests multiple conversion factors based on the AD's authority under LC 5307.1(b). Commenter 12 supports the use of a single CF for all services as opposed to different ones for different disciplines, which could lower reimbursement for therapy services compared to current Medicare rates thereby negatively affecting patient access. Commenter 31 notes that the 2013 MedPAC report on physician and other health care providers examines the availability of Medicare providers and concludes that beneficiary access to physicians and other health professional services is stable and similar to access for privately insured individuals ages 50 to 64.	Agree, with using multiple CF during the 4 yr. transition phasing down to 1 CF for anesthesia and 1 CF for all other services. Regarding the potential shift to more costly hospitals: the June 2013 MedPAC report to Congress identified certain procedures where the outpatient fee schedule payment rates could be *reduced* so that payments are equal whether a service is provided in a freestanding physician's practice or in an OPD. The services studied included cardiac imaging services, such as echocardiography and cardiac nuclear tests. The study did not suggest increasing the rates under the physician fee schedule, because it found the services included in the study are frequently performed in physician's offices, which indicates that they are likely safe and appropriate to provide in a freestanding office and that the physician fee schedule payment rates are adequate to ensure access. (p. 28). The regulation proposes to transition to a single conversion factor in 2017 as this is consistent with the Medicare methodology of aligning payment with resources used. If multiple CFs are used the logic of the relativity inherent in the relative value scale is undermined.	7.1 (Rothenberg); 9(Brakensiek - oral); 13(Parker); 8.1 (Achermann); 12.2 (Mumbauer); 15(Hauscarriague); 24(Gerlach - oral); 31.2 (Ramirez)	
Cont'd		Cont'd. Commenter 31 states since physicians are accessible to treat patients under an RBRVS fee schedule for 100% of Medicare, commenter is confident they will continue to treat WC patients at 20% more than Medicare allowances.	Cont'd. In addition, it is noted that under the "default" RBRVS schedule, LC section 5307.1 transitions to one CR.		

Regulation Section	Issue	Comment	Response	Commenter	
9789.12.5 (Conversion Factors	Transition CFs to Single CF, suggested revisions to the language	Commenter suggests subsection (b)(1) include the following language: "…the maximum allowable amount based on the resource-based relative value scale at 120 percent of the Medicare conversion factor in effect in July 2012, as adjusted by the Medicare Economic Index annual adjustment factors, and any annual Relative Value Scale Adjustment Factors, provided that the adjusted conversion factor does not cause estimated aggregate fees to exceed 120 percent of the estimated aggregate fees allowed for the same class of services in the relevant Medicare payment system. Similar language is suggested for subsection (c). These revisions are recommended to ensure that adjustments to the CFs and other factors affecting payment amounts do not result in estimated aggregate fees that exceed 120% of the estimated aggregate fees paid by Medicare for the same class of services, as required by LC 5307.1(b). Commenters 37, 38 request DWC adopt a policy that reaches the upper limit of 120% to include all of those things that would be appropriate to include in the 120% and not only be looking at 1/2 to 2/3 of the picture, but as much of the services that are rendered that are appropriate to include at 120%.	Disagree. The acting AD does not see the need to add this language as LC 5307.1 subdivision (a)(2) sets forth the criteria the physician fee schedule must meet, and anchors the maximum to 120% of *July 2012 Medicare,* adjusted for MEI and relative value scale adjustment. The revised proposal will reorganize subdivision (b) for improved clarity relating to the transition period.	31.9 (Ramirez); 34.1 (Thill & Hauscarriague); 37(Azevedo); 38(Broyles)	
9789.12.5 Conversion Factors	Transition CFs to Single CF	Commenter requests the conversion factors for E/M services during the transition period proceed at least as fast as they were intended to be in SB 863.	Disagree. The CF in the proposed fee schedule reflect the recent RAND study which used more recent data and a larger database. The RAND CFs are more accurate than the SB 863 CFs.	42(Blink)	
9789.12.5 Conversion Factors	Stop-Loss to reimbursement rates	Commenter 20 states the proposed surgical CFs will cause shoulder, knee, and spine orthopaedic practices to see a 25-30% reduction in their reimbursement, due to many E&M services performed by specialists are not reimbursable, reductions in diagnostic imaging, loss of ability to bill an additional 10% when an interpreter is needed, prohibition on billing consultations/consultation reports, prohibition on billing another service on the same day as an injection, reductions in assistant surgeon fees, prohibition on billing supplies, pharmaceutical dispensing fees, patient educational materials, and likely inability to bill prolonged service codes. Commenter 21 stated COA conducted an internal study of 25 orthopaedic practices over a 1 year period which included the actual mix of CPT codes billed by each practice. Commenter 21 found there will be a 30% to 40% reduction at the end of the transition for surgeons that predominantly perform arthroscopic knee and shoulder procedures, and a 20% - 30% reduction on a very time and risk intensive procedure, such as a total knee replacement.	The July 2013 RAND report shows an overall decrease in 2017 of 20.1% for surgical codes, and an overall decrease of -8.7% for the surgery specialty. Each physician practice will experience a different level of decrease (or increase) depending on the mix of services included in the practice. Some codes will decrease compared to current reimbursement, while other codes such as evaluation and management codes, will increase compared to current reimbursement. The 4-year transition period helps to buffer the affect of the decreases to various codes. The values for the codes are the Relative Value Units set by Medicare in light of a the resources required for each procedure, with input from the American Medical Association's Relative Value Update Committee, and many specialty societies. In addition, for workers' compensation, Labor Code section 5307.1 provides that the maximum shall not exceed 120% of Medicare (as of July 2012 Medicare rate, with inflation.) This additional 20% also serves to buffer changes experienced due to the conversion from the antiquated OMFS to the new resource-based schedule.	20.3(Anderson & Besh); 21.0(Anderson, same Anderson as in commenter 20)	

Regulation Section	Issue	Comment	Response	Commenter	
9789.12.6(a) (HPSA Bonus Payment)	HPSAs	Commenter cites the language in 9789.12.6(a) pertaining to HPSA bonus payment. Commenter then states, the proposed rules are silent as to whether a single GAF will be assigned or if GPCIs will be applied. Due to the lack of updating of the regions, commenter recommends applying a single GAF until such time the regions are reviewed and revised. Should the Division proceed with 1 statewide GAF, commenter requests consideration be given to reducing or removing the 10% increase for HPSA depending on the increase that will be derived from the application of a statewide figure.	Agree that the Division should adopt statewide GAFs at this time (See discussion above re Section 9789.12.2.) Disagree that the HPSA bonus payment should be reduced or eliminated. The 10% primary care and mental health HPSA bonus payments are designed to provide incentive in the health professional shortage areas, and the adoption of statewide GAFs for anesthesia and All Other (3 GAFs at the RVU component level) does not eliminate the need for these payments that support access to care.	6.3(Suchil)	
9789.12.6(a) (HPSA Bonus Payment)	HPSA regulation	Commenters recommend deleting this section, if the acting AD decides to adopt a statewide GPCI. Commenter 42 states HPSAs warrant further study, because HPSAs are geared toward general medicine, emphasizing internal medicine, pediatrics, OB/GYN, and family practice which do not necessarily reflect the kinds of services needed for treating WC patients. Commenter 42 recommends further study.	Disagree. See response to Commenter 6.3 on section 9789.12.6(a), above. The US Dept. of Health & Human Services, CMS publication Med Learn Network HPSA Fact Sheet states: "HPSAs are geographic areas, or populations within geographic areas, that lack sufficient health care providers to meet the health care needs of the area or population. HPSAs identify areas of greater need throughout the U.S. so that limited resources can be directed to those areas. Areas are designated as HPSAs by the Health Resources and Services administration (HRSA) based on census tracts, townships, or counties. Designations are made for primary care, dental, and mental health." http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/HPSAfctsht.pdf The health provider shortage could very well impact workers' compensation patients. (Note that the Division is not adopting the additional, temporary, Primary Care Incentive Program under the Affordable Care Act, which targets bonuses for primary care physicians such as those providing geriatric, pediatric, and family medicine.)	31.10 (Ramirez); 42(Blink)	
9789.12.7 (CMS' RVU file)	Proposed payment rate for services paid under the physician fee schedule.	Commenter(s) support the proposed payment rate for physical therapy. Commenter 18 states RBRVS accurately reflects the true resources that go into the delivery of healthcare, and ensures that scarce resources are more fairly distributed. Commenter 18 states this approach is proven to align provider reimbursement with timely return-work and focused, higher quality medical care.	Agree. The Medicare RBRVS values assigned to services subject to the physician fee schedule are the result of rigorous study and analysis by experts in the field (Medicare and AMA/Specialty Society RVS Update Committee (RUC)). The RBRVS more accurately reflects the resources needed to provide a service than the current physician fee schedule which is based on decades old "usual, customary, and reasonable" payment systems.	1.1 (Lerg); 2.1 (Jewell); 3.1 (Patel); 4.1 (Lee); 5.1 (Jaro); 10.1 (Holcomb); 18.1 (Okun & Crowell); 19.1 (Lerg); 22.1 (Brandt); 26.1 (Katz); 27.1 (Wasielewski); 29.1 (Cupples); 30.1 (Barroga)	

Regulation Section	Issue	Comment	Response	Commenter	
9789.12.7 (CMS' RVU file)	Proposed RBRVS payment rate for services	Commenter states the RVU takes into account clinical management only, and does not account for disability management. WC administrative overhead is higher than in Medicare, employers want their injured worker seen more frequently, and workers' compensation is inherently adversarial.	Disagree. There are similar requirements in Medicare for a person injured outside of the work place, that would need similar disability management to assist the injured person to return to functioning. The proposed physician fee schedule rate is set at 120% of Medicare to account for the extra costs incurred in the workers' compensation system. In addition, there is separate payment for PR-2 Primary Treating Physician Progress Reports and PR-4 Primary Treating Physician Permanent and Stationary Report.	20(Besh - oral)	
9789.12.10 (Coding: CPT 4th Ed.)	CPT - Use the most recent edition	Commenter states the reference to the 4th edition of the CPT should be changed to the most recent publication, and updated annually.	Agree in part. Agree that the coding should be updated annually. Section 9789.12.10 refers to section 9789.19 for the version of the CPT by date of service, and will be updated each year. Disagree that section 9789.12.10 should not reference the "Fourth Edition". The Fourth Edition was first published by AMA in 1977. The yearly publications since that time are all "fourth edition", but also designate the year of publication, e.g. CPT-4 2013. If the AMA publishes a fifth edition at some point in the future the Division can amend the regulation. The yearly updates of the CPT Fourth Edition will be referenced in section 9789.19.	23.5 (Francis)	
9789.12.11 (E/M: Coding-New Patient; Documentation)	E&M documentation	Regarding the 1995 and 1997 E&M documentation guidelines, commenter 20 stated, the phrase "but not a combination of the two guidelines" to be confusing. It is unclear whether this would be on the same date of service or the same injury, etc. Commenter 20 believes it would be clearer to state: "To properly document and determine the appropriate level of evaluation and management service, providers must use either one of the following guidelines: (1) The 1995 Documentation Guidelines... (2) The 1997 Documentation Guidelines... Providers may not use a combination of the two guidelines on the same date of service." Commenter 31 recommends the AD adopt and require the use of either the 1995 or the 1997 Guidelines rather than both guidelines. If the Director does not accept the recommendation to adopt only one, we recommend requiring the provider to document for each E&M billing the Guideline utilized.	Agree that there should be clarification made to the proposed regulations regarding the E&M documentation guidelines, but the Division proposes language other than that suggested by the commenter. The Division proposes language clarifying that the medical provider may not use a combination of the two guidelines *for a patient encounter.* This follows the Medicare terminology, and is more appropriate than the "date of service" since each patient encounter is independently documented. The Acting AD also adds language to clarify that it is the provider's choice of which guideline to use by stating that a medically necessary service documented according to either guideline shall be paid at the documented level of service.	20.5 (Anderson & Besh); 31.11 (Ramirez)	

Regulation Section	Issue	Comment	Response	Commenter	
9789.12.12 (Consultation Services Coding)	Consultation reports are bundled into the underlying E&M visit code and are not separately payable, except that a report will be separately reimbursable where the consultation is requested by the WCAB or the AD, and a report will be separately reimbursable where the consultation is requested by a QME or AME in the context of a medical-legal evaluation.	Commenter 18 states the role of consultation reports in WC differs dramatically from Medicare. The expectation in WC is that consulting physicians submit a report containing not only his opinion, but also the detailed mechanism of injury, objective findings, causation, and detailed treatment plan/opinions for future care in the case. The provider is required to issue a work status to determine duty status. Converting this service to a Medicare environment means requesting the provider to provide a 1 page summary simply outlining recommendations, instead of a comprehensive evaluation document provided to support treatment, claim compensability, and billing. The E&M codes in 2014 shows a decline in reimbursement. Commenter recommends separate payment be maintained for consultation reports by adopting a single flat fee reimbursement for the WC codes (consultation, PR3, and PR4) to avoid the issue of duplicate denials for multiple report pages due to the utilization of the same code for multiple lines. Commenter 20 states their understanding of the Legislative intent was to continue to recognize and allow for the billing of consultation CPT codes and consultation reports because communications are unique and central to WC system and in ultimately evaluating and resolving disability impairment issues. The specialty consultation report is often used as substantial medical evidence to advance or resolve treatment issues. Commenter 16 states the proposed regulation is inconsistent with LC 5307.1(a)(2)(B), which formally recognizes the	RAND's revised working paper (WR-993-1DIR, July 2013), found that paying separately for reports that would otherwise be bundled under Medicare rules is estimated to be 81% of the current OMFS payments ($24.96 M of the $30.82 M in RAND's analysis file), for reports billed under CPT code 99080. Medicare redistributed the savings of eliminating the use of consultation codes by redistributing the savings to the new and established office visits, and the initial hospital and initial nursing facility visits. According to the 2010 Medicare PFS, this redistribution of savings resulted in approximately a 6% increase in the new and established office visits and a 0.3% increase in the initial hospital and nursing facility visits. The increase in these E&M visits is reflected in all procedures that have E&M as part of their global period, such as global surgery. If Medicare rules for consultations and related reports are not adopted, an offsetting adjustment would need to be made to limit aggregate fees to 120% of payment under July 2012 Medicare (adjusted for inflation.) Commenter 20 states and commenter 41 implies no reimbursement is allowed for the consultation report. This is not accurate. The medical consultation reports are paid for in the underlying E&M visit, and separate payment will be made for the extra work required to produce WC specific reports required	14(Marston); 16(Helm); 18.2 (Okun & Crowell); 20.1 (Anderson & Besh); 23.2 (Francis); 28(Cattolica - oral); 35.1 (Honor); 40(Madden); 41(McLaughlin); 43(Rondeau)	
Cont'd	Con'td	Cont'd. the importance of consultation codes. Section 9789.12.12 prohibits specialists from billing the consultation codes and the consultation report code when the consult is requested by the treating physician. Commenter 20 states the use of prolonged codes will not work because specialists may be spending only an additional 15-20 minutes of additional time, which would not qualify them to bill using the prolonged service code. For many of the reasons stated above, commenter 23 strongly objects to the elimination of consultation codes. Commenter 35 opposes the adoption of the Medicare rule that visit codes are to be used instead of consultation codes. Commenter states that use of office visit codes would be to unreasonably apply a Medicare rule to a workers' compensation situation where it doesn't apply. Elimination of separate payment for consultation reports other than those requested by AD, WCAB, AME or QME would eliminate payment for medically necessary reports that are also needed to assist parties in making appropriate medical decisions. Commenter 41 states LC 4616.3 and 4616.4 provide the injured worker has the right to ask for a MPN 2nd and 3rd opinion, and there's no requirement the opinion be the treating doctor in the end.	Cont'd. by the WCAB, or by an AME or QME in the context of a medical-legal exam. The treating physician may still request a consultation from a specialist, by using the appropriate E&M code. Medicare determined the physician work is clinically similar, and OIG found that the consultation codes may be overvalued relative to the E&M codes for initial hospital care and new patient office/outpatient visits. There is no basis for believing WC is different for medical consultations. Regardless, proposed 9789.12.12 allows for using a code for prolonged service with direct patient contact in addition to the E&M code if warranted under CPT guidelines. The acting AD continues to believe the proposed regulation achieves the best balance by following Medicare payment ground rules and paying separately only for WC-specific consultation reports. The regulation would pay for the extra work required to produce WC specific reports, lessening the potential for access issues. There would be no requirement to adjust for budget neutrality or eliminate duplicate payment. The acting AD believes she is following the direction of SB 863, by determining when it is appropriate to differ from Medicare ground rules. The acting AD believes the specific needs in the WC community will be met by paying for the extra work required to produce WC specific reports.		

Regulation Section	Issue	Comment	Response	Commenter	
Cont'd	Cont'd	Cont'd.	Cont'd. The "consultation code" bundling rules should apply equally to consultations inside or outside the MPN.		
9789.12.12 (Consultation Services Coding)	Maximum fees for physicians performing consultation services shall be determined utilizing the appropriate RVU for a patient E&M visit and the RVUs for prolonged service codes if warranted under CPT guidelines.	Commenter states elimination of CPT code 99358 for non-face-to-face prolonged services per Medicare reimbursement rules will result in a significant reduction in critical information required for case disposition.	The face-to-face prolonged service codes have status code A and are separately payable as long as they meet CPT guidelines. However, the non-face-to face prolonged service codes have status code B; therefore payment for them is subsumed in the payment for the services to which they are incident. It should be noted that the workers' compensation fees will be approximately 20% higher than Medicare fees, to accommodate additional time when treating workers' compensation patients. Deviation from the Medicare payment policy would require a budget neutrality adjustment.	14(Marston); 18.3 (Okun & Crowell)	
9789.12.12 (Consultation Services Coding)	Application of the Medicare consultation coding policy	Commenter supports the use of Medicare's consultation coding policy because Medicare increased general E&M service reimbursement in exchange for the reimbursement previously allowed under consultation codes.	Agree.	31.12 (Ramirez)	
9789.12.12 (Consultation Services Coding)	Prolonged service codes, consultation codes and reports	Commenter states prolonged service codes and consultation codes should be recognized and reimbursed.	Agree in part, in that prolonged service codes for direct patient contact will be reimbursed when CPT guidelines are met. See above response to comments by Marston et al. Disagree with the suggestion to utilize the consultation codes. See above response to comments by Marston et al.	42(Blink)	
9789.12.13 (Correct Coding Initiative)	NCCI edits	Commenter supports the application of NCCI edits to WC bills except where payment ground rules differ from Medicare ground rules.	Agree.	31.13 (Ramirez)	
9789.12.14 (CA specific codes)	California specific codes needs to be expanded.	Commenter urges the list of CA-specific codes be expanded as it does not cover many typical reports that are unique to CA WC. Examples of reports that would not be "bundled" in any fee for other procedures are: supplemental reports requested by a party from the treating physician, consultation reports from physicians in the MPN, or outside the MPN if the employee is legally entitled to treat outside the MPN, regarding medical issues outside of the medical expertise of the treating physician, and 2nd and 3rd opinion consultation reports from physician's in the MPN requested by the injured worker. In view of the need for these reports, and the level of complexity required in the reporting by the physicians, commenter strongly recommends these types of reports be eligible for separate reimbursement. At minimum, commenter urges consultation reports by physicians in an MPN, or outside the MPN if the employee is legally entitled to treat outside the MPN, as well as 2nd or 3rd physician opinions be included in the CA specific codes.	Disagree. Reports requested by a party from the primary treating physician fall within the title 8 section 9785 (f) rule which defines a "progress report", PR-2. For example, "supplemental reports requested by a party" would fall within the section 9785 (f)(7) definition of a progress report which includes a report issued when: "The claims administrator reasonably requests appropriate additional information that is necessary to administer the claim. “Necessary” information is that which directly affects the provision of compensation benefits as defined in Labor Code Section 3207. " The PR-2 is separately payable using code WC002, and the maximum fee is set forth in section 9789.19. As explained in responding to comments pertaining to section 9789.12.12, costs for medical consultation reports are included in the visit codes, and to pay separately would result in duplicate payment in many cases. The visit code reimbursement was raised to account for the reporting of the consultant's opinion. The "consultation code" bundling rules should apply equally to consultations inside or outside the MPN.	24.1 (Gerlach)	

Regulation Section	Issue	Comment	Response	Commenter	
9789.12.14 (CA specific codes)	Page limits on reports; Payment amounts	Commenter 24 states the WC003, WC005, WC006, WC007, and the maximum page limit of 7 pages on WC004 is arbitrary. If the page limitations are to be retained, the language should be clarified to specify from whom the mutual agreement to go over the page limit must be obtained. 9789.19 has rates for WC006 when 9789.12.14 has this code reserved for the future. WC007 fails to consider when a treating physician requests a medical specialty consultation or consultations outside his or her medical expertise. Commenter states under the proposed regulations consulting physicians would not be paid to determine if the medical symptoms are related to the work injury, what the appropriate treatment might be if necessary. Commenter states an injured worker has the right to obtain a 2nd or 3rd opinion from within the MPN on issues of diagnosis or recommended medical treatment. Commenter recommends a "complexity factor(s) be added to the CA specific codes to account for the complex analysis of multiple issues, including medical-legal causation, medical treatment issues, apportionment, and/or whole person impairment. Commenter 28 states the proposed regulation will reimburse physician reports at the rates set in 1999. Commenter recommends all treatment and consulting reports be reimbursed commensurate with their probative value. Commenter 31 recommends paying $69 fee for P&S reports and eligible consultation reports.	Disagree. The 7-page limit has been in place for many years and there is no evidence that the number of reimbursable pages is inadequate. The section 9789.19 provision for exceeding page limits with mutual agreement provides a mechanism for increased payment where the parties agree a lengthier report is needed. These page limits have been in place with the current physician fee schedule ground rules and there have been no issues the acting AD is aware of that would cause her to change the number of pages allotted without empirical evidence to support such a change. The term "mutual agreement" does not need further definition. Agree that there is a discrepancy between section 9789.12.14 regarding WC006 [Reserved] and section 9789.19. Section 9789.19 will be revised to delete the payment rate for WC006. Disagree with the suggestion to expand WC007 to provide separate payment for reports where a consultation is requested by the primary treating physician. As explained in responding to comments pertaining to section 9789.12.12, costs for medical consultations and reports, no matter who is the requester, are included in the visit codes, and to pay separately would result in duplicate payment in many cases.	24.2 (Gerlach); 28 (Cattolica - oral); 31.5 and 31.15, 31.16 (Ramirez)	
Cont'd	Con'td	Cont'd. In Feb. 2013, CWCI analyzed the payment amounts for all 99080 reports in the ICIS database with dates of service between 1/1/2011 and 6/30/2012, and found that the average payment for these reports was $68.80. Commenter 31 also recommends deleting WC008, WC009, WC010, and WC011, because these services are rarely used, are part of another service, or can be reported under an existing or proposed code.	Cont'd. Disagree with the suggestion to increase WC-specific codes by a complexity factor. There is no empirical evidence in which to justify application of "complexity factors" at this time. It should be noted for WC-specific reports, the rates were increased by the estimated MEI. A more in-depth study will need to be performed to determine what the "probative value" of the WC-specific reports are before revising the payment rates. To do so, without empirical evidence would be arbitrary. Commenter 31 suggests based on their data, the average payment for P&S and consultation reports (CPT code 99080) is $68.80. The acting AD cannot comment on this suggested payment rate without seeing the data and knowing what the average is for different types of reports, the code 99080 is currently used for a variety of reports: P&S reports, consultation reports, and also where "... a claims administrator or its authorized agent requests that a provider complete a form that is not legally mandated or submit information in excess of that required pursuant to Title 8, California Code of Regulations Section 9785." Disagree with deleting WC008, WC009, WC010, and WC011, as these services are separately payable and there is no existing CPT code that describes the services.		

Regulation Section	Issue	Comment	Response	Commenter	
9789.12.14 (CA specific codes)	Subsection (a)(1) does not pay for the Doctor's First Report	Commenter states the DFR is unique to WC. It provides a primary treating physician shall render opinions on all medical issues necessary to determine an employee's eligibility to compensation in the manner prescribed by 9785(e), (f), and (g). Commenter believes the physician should be adequately reimbursed.	The acting AD recognizes the concern for separately payable DFR reports. However, the DFR has not been a payable report since its inception. It should be noted that the new patient E&M codes have a significantly higher payment rate than the rate for an established patient. The Division has provided that the physician may charge a "new patient" visit for the first visit for *each* new injury, in recognition of the extra work of addressing a new injury, even if it occurs to what would otherwise be classified as an "established patient".	24.3 (Gerlach)	
9789.12.14 (CA specific codes)	Reports not included in the CA-specific list	Commenter states Physician's Return-to-work, voucher report, and request for authorization [RFA] are not included in the list of separately payable reports.	The Return to Work and Voucher Report (8 CCR section 10133.36) is prepared by the first physician (primary treating physician, QME, or AME), who finds the employee to be permanent and stationary. It is a mandatory *attachment* to the first medical report finding that the employee suffers permanent partial disability and is P&S. (section 9785(h), (i).) The form contains information that is normally part of a P&S report. The form merely helps to organize the information and make it easier for the physician to document his/her findings relating to the employee's work restrictions. As such, this is part of preparing the P&S report and does not warrant separate payment. The Request for Authorization for Medical Treatment is not a stand alone "report", but is a form that calls attention to the request for authorization of treatment, so that the request is easily identifiable for expeditious handling. As part of treatment, the physician formulates a treatment plan and requests authorization for the treatment. The RFA form does not establish any new duties, it merely helps to organize the information and make it easier for the physician to convey the request for authorization. It is not separately reimbursable; payment related to requesting authorization is bundled into the E&M codes, (note new patient code is paid higher than	24.4(Gerlach); 28(Cattolica - oral)	

Regulation Section	Issue	Comment	Response	Commenter	
Cont'd	Cont'd	Cont'd.	Cont'd. established patient), and also, payment for the PR-2 for established patients. It should also be noted that the E&M fees will be increasing substantially under the RBRVS.		
9789.12.14 (CA specific codes)	CA-specific codes and BR codes should be included in the calculations for the 120% aggregate cap.	Commenter states the WC specific codes and BR codes should be included in the calculations for aggregate estimated fees. If DWC decides not to bundle payment for P&S reports or consultation reports into the underlying service, reimburse the reports at a flat average fee. Delete the proposed CA specific codes for services that are rarely used, that are part of another service, or that can be reported under another existing or proposed code. Commenter states the reports are within the "same class of services in the relevant Medicare payment system" specified in (b) that "may not exceed 120 percent of the estimated aggregate fees paid for the same class of services in the relevant Medicare payment system." Commenter further states if the AD decides to continue to make PTP progress reports and/or discharge reports separately reimbursable, it is important to clarify in the regulations that the fee is billable by and reimbursable to only the PTP, as it is currently. This will prevent unnecessary disputes over whether the fee is payable to other providers.	Disagree. The proposed regulations contemplate bundling many medical reports into the underlying service, as is done in Medicare. However, specified WC-specific reports are paid for separately because these are unique to the WC system. For the physician fee schedule, the statute requires the maximum shall not exceed 120% of estimated annualized aggregate fees prescribed in the Medicare physician payment system as it appeared in July 2012, adjusted for inflation. For services that aren't covered by Medicare, the statute provides that "any service provided that is not covered under Medicare shall be included at its rate of payment established by the AD." There is nothing in the statute that requires the services that are not covered by Medicare to be within the 120% of July 2012 cap. These regulations set the fee payable for the PR-2, however, it is a different regulation, section 9795, that regulates the usage of the form. WC005 should be kept so the reports can be tracked separately, which will be helpful in evaluating the implementation of the new fee schedule and assessing the need for changing report fees.	31.5 (Ramirez)	

Regulation Section	Issue	Comment	Response	Commenter	
9789.12.15 (CA-specific Modifier)	California specific modifier	Commenter recommends DWC continue with the modifier -93, interpreter services required at the time of evaluation. Treating a number of patients who do not understand English is also more unique to a WC than Medicare. Now that DWC has enacted interpreter regulations to more clearly define when an interpreter can be billed, commenter believes it is reasonable to continue to allow the additional reimbursement for the physician when an interpreter is utilized.	Disagree. Commenter provides no empirical basis for their conclusion that more non-English speaking patients are seen in WC as opposed to Medicare. In addition, it may very well take more time to explain and discuss medical issues with the elderly than a younger injured worker. Allowing additional payment would require a budget neutral adjustment in order to stay within the 120% of Medicare cap.	20.5 (Anderson & Besh)	
9789.13.1 (Supplies)	Separate payment for routinely bundled supplies is not allowed. Splints and casting materials are separately payable in addition to the procedure.	Commenter 18 states removing reimbursement for dispensed "by report" supplies will result in either direct payment by patients in violation of law or direct reimbursement by employers. In many cases these types of supplies are dispensed outside of an E/M environment such as in the rehabilitation department and as such cannot be considered inclusive in the E/M code, as proposed. Commenter states it is unreasonable to expect the provider and illegal to expect the patient to bear cost of therapeutic and treatment items that belong in the WC system. For example, home exercise rehabilitation equipment i.e. exercise balls, theraban, and shoulder rehab kits, and theraputty (A9300) for home use. These supplies fall outside of the DMEPOS fee schedule. Commenter 35 states that the regulation should indicate how non-bundled supplies should be reimbursed. Commenter states that rules related to dispensed DME should be reproduced in the physician fee schedule or in the DMEPOS fee schedule.	Under Medicare, which the proposed regulation adopts, with certain exceptions, supplies and materials are not separately payable, because the practice expense RVUs include the cost of supplies for procedures performed in an office. There is no need for a formula as the supplies are bundled, and for those that are not bundled such as splints and casting materials, the maximum fees are specified in a document incorporated by reference. 9789.19. Supplies are not payable for procedures performed in a facility because the facility is reimbursed for these costs in the facility fee. The injured worker would not be responsible for the costs. If this type of exercise equipment (A9300) is considered reasonably required to cure or relieve the injured worker from the effects of his or her injury, it shall be provided by the employer. (Labor Code 4600). Exercise equipment is not considered by Medicare, however, it should be provided for in the DMEPOS fee schedule, not the physician fee schedule. Other dispensed DME items are also to be covered by the DMEPOS fee schedule, not by the physician fee schedule.	14(Marston); 18.5 (Okun & Crowell); 35.2 (Honor); 40(Madden); 42(Blink)	
9789.14 (Reimbursement for Reports, duplicate reports, chart notes)	PR-3, Permanent and Stationary Report reimbursement amount	Commenter states he agrees with COA's proposal to reimburse permanent and stationary reports at 80% of a basic Med-Legal (ML-102) report. This will reduce billing disputes, fairly compensate providers for submitting ratable reports, and may reduce the need for subsequent medical-legal reports.	Disagree. Commenter is requesting a reimbursement of $500 for a P&S report. ML-102 is assigned 50 RVs. Each relative value is equal to (50 RVs * $12.50)*.8 = $500. Commenter provides no factual basis for a P&S report warranting a payment of $500. The proposed regulations provides for a reimbursement of up to $179.49 absent mutual agreement. Commenter proposes a huge increase in reimbursement with no factual justification. Revision of the payment methodology for separately payable WC-specific reports would require a more in-depth study.	12.3 (Mumbauer)	

Regulation Section	Issue	Comment	Response	Commenter	
9789.15.3 (Qualified non-physician anesthetist services)	Role of mid-level practitioners.	Commenter 23 is seeking clarification of the role of mid-level practitioners as contained in this proposed section. Subsection (a) refers to "anesthesia assistants", but it is the commenter's understanding the official term is "anesthesiologist assistant." Anesthesiologist assistants are recognized and certified at the national level. The proposed regulation should be amended to reflect the proper name for this type of practitioner. Commenter 25 requests section 9789.15.3(a) be revised to use the term "certified anesthesiologist assistants" instead of "anesthesia assistants". Commenter 23 states subsection (b) states anesthesia services furnished by a qualified non-physician anesthetist shall be paid according to the physician fee schedule. Commenter states this appears to be inconsistent with how all other non-physician practitioners are paid under the proposed rule. Commenter 25 recommends section 9789.15.3(b) be revised to state, "Anesthesia services furnished by a qualified non-physician anesthetist shall be paid according to ~~the physician fee schedule~~ section 9789.15.1"	Agree with commenter 25's suggested language; the acting AD will revise subdivision (a) to reference "certified anesthesiologist assistant" instead of "anesthesia assistant". Agree in part insofar as the current language may be confusing. Subdivision (c) of section 9789.15.3 actually provides that the payment methodology for qualified non-physician anesthetist services is pursuant to sections 9789.15.3 and section 9789.18.1. Section 9789.18.1 states in pertinent part, "The maximum reasonable fee for physician and non-physician practitioner anesthesia services shall be calculated as follows: [Base unit + Time Unit] * CF = Base Maximum Fee". However, the acting AD does not see the necessity of keeping subdivision (b) of section 9789.15.3, as it does not seem to serve any purpose and may be causing confusion. Subdivision (b) will be deleted to improve clarity.	23.3 (Francis); 25.1, 15.2 (Sybert)	
9789.15.4 (Physical Medicine, Chiropractic, Acupuncture MPPR and pre-authorization)	Application of the Medicare MPPR and application of caps that are presumed reasonable limitations on reimbursement for services provided at one visit unless pre-authorized and pre-negotiated fee arrangement has been obtained.	Commenters are against the proposed application of the Medicare MPPR and cap. Commenters 1, 10, 22, 27, 29, 30 suggest that if MPPR is applied it should the Medicare 2012 MPPR, instead of the current year MPPR. Commenter 7 is opposed to the MPPR only, because the CPT codes already account for duplication. Commenters 7, 26 state, the MPPR is based on the assumption that duplication exists in the PE portion of therapy codes billed on the same day. However, therapy codes are unlike most CPT codes in that the PE for a typical visit is spread out among multiple codes since multiple services are typically provided to a patient during a visit. In other words, CPT recognized that services are billed through multiple codes and valued the existing codes correctly to account for efficiencies in PE. If the DWC insists on using the MPPR, we bring to your attention that in 2012, the Medicare MPPR for therapy services was 20% of the PE unit value, not 50%, and since this fee schedule is based on 2012 Medicare reimbursement, the 20% value should be used. Commenter 11 opposes because any redundancies have already been reviewed and eliminated through the AMA HCPAC and RUC process. The % reduction is arbitrary and unsupported by available data; and the policy could deny patient access.	Disagree. At the end of the 4-year transition (2017), physical therapy, acupuncture, and chiropractic specialties will experience a 64.7%, 9.2%, and 22.3% increase, respectively, in payment rates from the current OMFS after the proposed MPPR and soft caps are applied. (RAND Report, *Implementing a Resource-Based Relative Value Scale Fee Schedule for Physician Services* , 2013, Table 5.3.) Deviating from the Medicare MPPR would require an adjustment to the level of reimbursement for other services in order to stay within the 120% aggregate cap. Medicare addressed the issue of potential redundancies in their FY 2011 PFS final rule, beginning on p. 73232. Medicare noted that AMA RUC examined several services billed 90% or more of the time together as part of its potentially misvalued service initiative and, in several cases, created one code to describe the complete service, with a value that reflects the expected efficiencies. But, Medicare asserts, in most cases it has not created one code to describe a complete therapy service, in part because many of the core therapy codes are timed codes based on increments of treatment time. Due to different methodologies used for considering the median number of services furnished to a patient in a session, Medicare determined that despite the AMA RUC's consideration of multiple services for valuation, the	1.2 (Lerg); 2.2 (Jewell); 4.2 (Lee); 7.8 (Rothenberg); 10.2 (Holcomb); 11.1 (Willmarth); 12.1 (Mumbauer); 19.2 (Lerg); 22.2 (Brandt); 26.2 (Katz); 27.2 (Wasielewski); 29.2 (Cupples); 30.2 (Barroga)	

Regulation Section	Issue	Comment	Response	Commenter	
Cont'd	Cont'd	Cont'd	Cont'd. therapy code combinations as actually reported by practitioners would typically have some additional duplication in the PE.Thus, while the PFS values may reflect some efficiencies in the PE for certain code combinations based on the AMA RUC approach to valuation, the actual efficiencies are not fully recognized in the PE inputs for the most commonly reported therapy code combinations, nor are they necessarily recognized in the many other common code combinations that were not considered by the AMA RUC as the typical case. Regarding commenters request to stay with 2012 MPPR, LC 5307.1(a)(2)(A)(iii) sets the baseline for transitioning from the current OMFS to not more than 120% of Medicare in 2017. DWC does not believe it is the intent of the statute to freeze in place any of the Medicare ground rules adopted by the DWC for the fee schedule. The Division believes the "July 2012 Medicare" was intended to avoid the application of the "Sustainable Growth Rate" (which would create a large decrease in the conversion factor) if the statute had merely benchmarked the workers' compensation schedule to "120% of Medicare." Section 633 of the American Taxpayer Relief Act of 2012 increased the MPPR on selected therapy services to 50% for both office and institutional settings, effective April		
Cont'd.	Cont'd.	Cont'd.	Cont'd. 1, 2013. It is assumed Congress thoroughly studied this matter before passing legislation setting the reduction to 50%.		
9789.15.4 (Physical Medicine, Chiropractic, Acupuncture MPPR and pre-authorization), cont'd.	Application of the Medicare MPPR and application of caps that are presumed reasonable limitations on reimbursement for services provided at one visit unless pre-authorized and pre-negotiated fee arrangement has been obtained. Cont'd	Commenter 11 also states CPT definitions and values were developed to assure that various health care practitioners would have access to multiple codes within their scopes of practice but allow for differentiation of service delivery based on each profession. The Medicare MPPR is based on the assumptions that all codes require the same amount of labor, set up, equipment and supply costs, or that use of the same code by different disciplines in the same day translates to duplication of services. Even within a distinct discipline, the labor, set up, equipment, and supplies may be completely different between two codes. Ex. 97110 and 97535. Commenter is equally perplexed why the MPPR is also applied to acupuncture and chiropractic manipulation. Commenter fails to see how aspects of the PE for OT services could possibly be redundant with the PE for acupuncture services for example. Commenter is concerned this will have a chilling effect on the use of best practices and move intervention to methods based more on payment guidelines. Ex. A patient may benefit from intensive therapy on 1 day rather than multiple times in a week.	Commenter does not state how frequently sets of codes such as 97110 and 97535 are billed for the same patient during the same visit. The Medicare 2011 final rule, (75 FR 73170; Nov. 29, 2010; CMS-1503-FC, p. 73232), Medicare found the duplicate labor activities in PE were: clean room/equipment, education /instruction /counseling /coordinating home care; greet patient/provide gowning; obtain measurements. Examples of duplications are found in the Medicare 2011 FR, Table 19, p. 73234. The Medicare 2011 final rule also addressed the issue of applying the MPPR across therapy disciplines, such as occupational therapy, and speech language pathology. It was argued these services are separate and distinct interventions furnished independently by individually licensed professionals, each of which is certified to provide unique and specialized services that do not cross discipline service lines. It was further argued that each discipline involves entirely different skills, equipment, supplies, and treatment goals, and separate disciplines are often located in different treatment settings.	11.1 (Willmarth)	

Regulation Section	Issue	Comment	Response	Commenter	
Cont'd	Con'td		Medicare stated that although it would be uncommon for services to be furnished to a single patient by different therapy disciplines and billed by a single provider on the same date of service, Medicare found there would be some overlap in the PE in this circumstance. In particular, Medicare found the PE overlaps include greeting the patient, obtaining vital signs, and post-visit phone calls. Similar to therapy codes, acupuncture are also timed codes. By analogy, there is reasonable to believe acupuncture and chiropractic services would provide similar duplicate labor activities in PE.		
9789.15.4 (Physical Medicine, Chiropractic, Acupuncture MPPR and pre-authorization)	Application of the Medicare MPPR and application of caps that are presumed reasonable limitations on reimbursement for services provided at one visit unless pre-authorized and pre-negotiated fee arrangement has been obtained.	Commenter supports the elimination of the current cascade system for therapy services.	Agree.	7.3 (Rothenberg)	
9789.15.4 (Physical Medicine, Chiropractic, Acupuncture MPPR and pre-authorization)	Application of the Medicare MPPR and application of caps that are presumed reasonable limitations on reimbursement for services provided at one visit unless pre-authorized and pre-negotiated fee arrangement has been obtained.	Commenters 1, 2, 3, 4, 7, 10, 19, 20, 22, 27, 29, 30 request clarification of the policy on paying for evaluations and treatment on the first visit. Commenter 5 states there is confusion regarding reimbursement for treatment/procedures provided on the day of evaluation. Are these charges supposed to be reimbursed when billed on the evaluation day? Commenter 26 states the integrity and value of evaluative/assessment codes should be maintained and not further reduced because of the clinical skill and labor that composes the code.	Disagree. Responding to the comment regarding reimbursement for treatment evaluations, §9789.15.4(b)(2) places an overall time limitation on a visit for physical medicine modality, procedure, or acupuncture codes. It is noted that a number of the physical medicine modality codes are not timed codes either. Responding to commenter 5: The proposed regulation section 9789.15.4 is clear in stating the soft cap and MPPR is applicable to only certain "always therapy" codes, and are not applicable to any other codes such as E&M visit codes. A FAQ may be helpful in the future, but, there is no necessity to amend the proposed regulatory section. Commenter 26 is not clear in identifying the specific codes he is concerned about, and therefore, it is not possible for the acting AD to respond further.	1.3 (Lerg); 2.4 (Jewell); 3.3 (Patel); 4.4 (Lee); 5.3 (Jaro); 7.7 (Rothenberg); 10.4 (Holcomb); 19.3; (Lerg); 20.5; (Lerg); 22.4 (Brandt); 26.3 (Katz); 27.4 (Wasielewski); 29.4 (Cupples); 30.4 (Barroga)	

Regulation Section	Issue	Comment	Response	Commenter	
9789.15.4 (Physical Medicine, Chiropractic, Acupuncture MPPR and pre-authorization)	Application of the Medicare MPPR and application of caps that are presumed reasonable limitations on reimbursement for services provided at one visit unless pre-authorized and pre-negotiated fee arrangement has been obtained.	Commenters are opposed to applying a cap to therapy services. Commenter 11 states the cap envisioned in this proposal is an inappropriate solution to assure correct utilization and payment for therapy services. The amount and duration of therapy services should be driven by the therapist's clinical reasoning and judgment in light of the injured workers' needs. The cap will limit access to appropriate care and will negatively impact therapy outcomes. Commenter 11 appreciates that the proposal includes a pre-authorization process by which the caps may be exceeded, but is troubled that it appears that this exception would be driven by a negotiated fee arrangement rather than the injured worker's need for therapy services. Commenter 11 also believes that the authorized agent of the claims administrator should be required to consult with a licensed therapist about the appropriate amount of duration of therapy. Commenter 12 recommends eliminating the definition of a procedure as a 30 minute encounter, and use the Medicare definition of 15 minutes, and further the ground rules be revised to permit up to 4 procedures. Commenter 35 recommends allowing six total modalities and procedures rather than four.	The presumptive fee cap on the number of procedures reimbursed without prior authorization is necessary to guard against excessive payment for physical medicine procedures. The acting administrative director has determined Medicare's annual payment cap would not be appropriate for workers' compensation, but a per-visit "soft cap" on the number of procedures is a reasonable and necessary measure to avoid excessive payment for physical medicine procedures. The cap incorporates the typical number of procedures/modalities expected to be provided to a patient in one session. The Medicare 2011 PFS final rule discusses the AMA RUC methodology which considered all claims for therapy services paid under the Medicare PFS, and determined the median number of services is three (two therapeutic procedures and one therapeutic modality). Medicare considers the median number of four services (because in their methodology, they do not include claims for a single therapy service.)	11.2 (Willmarth); 12.4 (Mumbauer); 35.4 (Honor)	
Cont'd	Cont'd	Cont'd.	Cont'd. Medicare, however, found the scenarios utilized by the AMA RUC were an incomplete representation of the usual combinations of services reported when therapy services are furnished in a practitioner's office. For example, Medicare found the most common combination of therapy CPT codes in CY 2009 PFS claims data consisted of an average of 3.5 services which were comprised of some combination of one or more units of a single therapeutic procedure CPT code and one or more units of a single modality CPT code, rather than 3 total units of service. In addition, it should be noted that one commenter (7) stated the "proposed limits on procedures and modalities billed per visit appear to be reasonable given current billing patterns...". Responding to commenter 12, requesting allowance to bill up to 4 procedures: Section 9789.15.4 for treatment consisting of *modalities only* there is a 2 code cap; nor more than 60 minutes on the same visit; and where both modalities and procedures are billed, no more than 4 codes total on the same visit. Therefore, the proposed regulation will allow billing for up to 4 procedures, as requested by the commenter. In response to commenter 12's request that DWC follow Medicare definition of 15 minute units: Section 9789.15.4 of proposed regulation does not deviate from Medicare's definition of a time unit.		

Regulation Section	Issue	Comment	Response	Commenter	
9789.15.4 (Physical Medicine, Chiropractic, Acupuncture MPPR and pre-authorization)	Application of the Medicare MPPR and application of caps that are presumed reasonable limitations on reimbursement for services provided at one visit unless pre-authorized and pre-negotiated fee arrangement has been obtained.	Commenter supports the policy that the DWC is not proposing to use the Medicare therapy caps, as they are inappropriate to the workers' comp. environment.	Agree. The current annual Medicare dollar cap on therapy services is not appropriate for workers' compensation.	7.5 (Rothenberg)	
9789.15.4 (Physical Medicine, Chiropractic, Acupuncture MPPR and pre-authorization)	Application of the Medicare MPPR and application of caps that are presumed reasonable limitations on reimbursement for services provided at one visit unless pre-authorized and pre-negotiated fee arrangement has been obtained.	Commenter states the proposed limits on procedures and modalities billed per visit appear to be reasonable given current billing patterns.	Agree.	7.6 (Rothenberg)	
9789.15.4 (Physical Medicine, Chiropractic, Acupuncture MPPR and pre-authorization)	Application of the Medicare MPPR and application of caps that are presumed reasonable limitations on reimbursement for services provided at one visit unless pre-authorized and pre-negotiated fee arrangement has been obtained.	Commenter states that the OMFS rule that testing codes found in the medicine section and physical medicine section are limited to once per each 30 days unless otherwise authorized should be continued.	Disagree. The testing codes should be billable where they are medically necessary. Commenter did not submit any data to support the recommendation of a once in 30 day limit.	35.3 (Honor)	
9789.16.1 (Surgery, global fee)	Post-op E&M visits during the global surgery period	Commenters 20 state, based on a time analysis of 211 patients, the orthopaedic surgeon spends an additional 9 minutes of the 1st post-op visit and 10 additional minutes on each subsequent post-op visit. If the post-op visit is a level 3 visit, the CPT code anticipates that the surgeon is spending 15 minutes with the patient. Spending an addition 9-10 minutes nearly doubles the time the surgeon spends with an injured worker as compared to time spent with a Medicare patient. Commenters 20 state the 1st post-op visit involves the surgeon discussing expectations for return-to-work, resulting in more time spent with the injured worker on each post-op visit. The commenter finds Medicare's timed file to be very confusing. Commenter recommends clarifying all post-op visits while the injured worker is in the hospital would not be separately reimbursable, and one post-op visit after discharge would not be separately reimbursable. Thereafter, the surgeon would be allowed to bill the appropriate level of E&M. Finally, commenter recommends clarifying that AMA CPT code 99024 would be used to track the number of non-compensated E&M post-surgical visits. Commenter 21 (same as one of the #20 commenters) further clarified the nature of the time analysis discussed above. Commenter tracked 211 of her patients seen in commenter's office over a 5 month period. Commenter 21 completed a spreadsheet which broke the time spent into medical assistant rooming time, MD face to face time, MD non face to	As discussed in the ISOR, the acting AD determined that the rule to be adopted for WC should diverge from Medicare in 2 respects: The PR-2 should be separately payable if it occurs during the global period, and E&M services should be separately payable for those visits during the global period that are in excess of the number of visits included in the Medicare physician time file for the surgical procedure code. Commenter states it is the amount of time per visit that is longer for injured workers and compared to Medicare patients. The acting AD cannot comment on commenter's time analysis, as she has not seen the data or methodology. However, surveying 211 patients from one orthopaedic surgeon's office cannot be considered evidence-based, but, more anecdotal. (See the AMA's Medicare RBRVS, The Physician's Guide 2013, chapters, 4, 5, 6, a document relied upon, for a description of the methods to determine RVUs, including survey methods to ensure statistical soundness.) It should be noted that the RAND study indicated that "empirical data are not available to decompose the global RVUs into separate and appropriate RVUs for the surgery from the post-operative E&M services" (RAND Report, 2013, page 73) because of the practices of bundling global surgical payments. But, there is evidence that the valuation of E&M services included in the global surgery RVUs is overvalued.	16(Helm); 20.2 (Anderson & Besh); 20.2 (Anderson, same as in 20); 23.4(Francis)	

Regulation Section	Issue	Comment	Response	Commenter	
Cont'd	Cont'd	Cont'd. face time after the visit and medical assistant check out time. Commenter 23 believes limiting E&M services during the global period to the physician time file is both inappropriate and inconsistent with the statute.	Cont'd. A July 20, 2013, Washington Post article stated, every year, the Medicare system publishes its time estimates for every service, which are based on AMA surveys. When the Washington Post analyzed the records for doctors who work in outpatient surgery clinics in Florida, it found that "the time estimates made by Medicare and the AMA appear significantly exaggerated. If the AMA time estimates are correct, then 41 percent of gastroenterologists, 23 percent of ophthalmologists and 17 percent of orthopedic surgeons were typically performing 12 hours or more of procedures in a day, which is longer than the typical outpatient surgery center is open, the Post found in the Florida data. Additionally, if the AMA estimates are correct, more than 3 percent of ophthalmologists and internists and more than 2 percent of orthopedic surgeons are squeezing more than 24 hours of procedures into a single day....The finding that doctors are working much more quickly than AMA assumes is supported by research by MedPAC that shows that the actual times of surgery were quite a bit less than the AMA-Medicare estimates. Using operating room logs, researchers calculated the average times of 60 key surgeries and invasive diagnostic procedures. For all but two of the procedures, the AMA estimates were longer."		
Cont'd	Cont'd	Cont'd.	Cont'd. The Post also noted, "Between 2003 and 2013, the AMA and Medicare have increased the work values for 68 percent of the 5,700 codes analyzed by The Post, while decreasing them for only 10 percent." The Medicare Physician Fee Schedule 2013 Final rule and a May 2012 OIG report ("Musculoskeletal Global Surgery Fees Often Did Not Reflect the Number of Evaluation and Management Services Provided" A-05-09-0053) found the overvaluation occurring for E&M services furnished during the global period. So, combined with the additional 20% payment over Medicare (to account for WC-specific needs) and the overvaluation of E&M services in the global surgery payment, any additional time requirements for E&M visits for WC patients should be adequately reimbursed.		

Regulation Section	Issue	Comment	Response	Commenter	
9789.16.4	Surgery-Global Fee: circumstances allowing E&M code during the global period	Commenter 35 suggests that instead of using the number of visits in the physician time file to set the base standard for additional payments, all E/M services, including required separately reimbursable reports, which are required under section 9785 should be paid during the global period. In addition, any evaluation or reports requested by the parties during the global period should be separately payable.	Agree in part. DWC agrees with commenter regarding reports, insofar as the Progress Reports required by section 9785 are separately reimbursable during the global period. Disagree with commenter's suggestion that all E&M services during the global period should be separately payable. It is necessary to adopt the Medicare global surgery periods in order to properly price surgical services under the RBRVS system since the "surgical package" is a fundamental aspect of the development of the relative value unites for the procedures that are assigned a global period of 10 or 90 days. Allowing additional separate payment during the global period would result in duplicate payment.	35.5 (Honor)	
9789.16.6 (Surgery - Bilateral Surgeries)	Payment for bilateral surgeries	Commenter supports adoption of the Medicare rule allowing 100% reimbursement for the primary (highest ranked) procedure and 50% reimbursement for the second through fifth procedures as proposed in the regulations, By Report for more than 5 procedures. This multiple procedure rule is integral to the Medicare payment system and the valuation of the surgical procedures.	Agree.	20.4 (Anderson & Besh)	
9789.17.1 (Radiology Diagnostic Imaging Multiple Procedures)	Application of the Medicare MPPR to specified diagnostic imaging procedures to be applied to the professional component (PC) and technical component (TC) of the procedure	Commenter 8 states their specialty has opposed the extension by Medicare of applying MPPR reductions to the professional component that has been recently adopted by Medicare. They agree there can be cost reductions on the technical side for multiple procedures, but the same elements of cost reduction do not apply to the professional or interpretative/report aspect of those imaging procedures. Commenter 8 opposes the application of the MPPR to the professional component of these imaging procedures. Commenter 8 argues the CMS policy is flawed because it relies on incomplete data and over-generalized findings. Commenter 8 criticizes a Feb. 2011 MedPAC report and 2009 GAO report, discounting their findings. Commenter 43 refers to a 2002 position paper authored by the American College of Radiology to CMS and IMPAQ with respect to extending MPPR to PC. The transcript also refers to an August 2012 ACR sponsored paper.	Disagree with the suggestion that the acting AD should depart from the Medicare's rule applying the MPPR to the professional component. It is true that the 2009 GAO report did cite an analysis of behavior related to only one imaging code, CT of abdomen and pelvis, as the basis of their recommendation to expand the current MPPR to the professional component; this service pair accounted for the largest share of spending across all imaging service pairs. The report also admitted that they “could not estimate savings from an MPPR for the physician work component of all service pairs because the RUC had not reviewed these services and the data required for this analysis were missing”(page 14). However, the acting administrative director finds the GAO report does a good job of justifying their recommendation for the MPPR expansion to the professional component: “Of a total of 18 minutes allotted for interpretation of the second (lower-priced) service, 8 minutes were allotted for activities such as reviewing the patient’s prior medical history before the service and reviewing the final report and following up with the referring physician after the service. Since time spent on these activities was already included in the first (higher-priced) service, we discounted the fee for the lower-priced service by 44 percent” (page 14).	8.2 (Achermann) 43(Rondeau)	

Regulation Section	Issue	Comment	Response	Commenter	
Cont'd	Cont'd	Cont'd	Cont'd. GAO provides additional justification for reduced work of reviewing studies of contiguous body parts: "a practicing radiologist we interviewed stated that when two CT scans of contiguous body areas (e.g., the abdomen and pelvis) are taken at the same time, the total number of actual CT images reviewed is lower than if each scan were performed separately. This is because an abdominal CT generally includes margins of the pelvis and vice versa, and the images of these overlapping margins are examined only once by the radiologist" (page 15). While this is an anecdotal quote, the acting AD believes it is illustrative of the overall issue. The reduction in professional work (intra-service and post-service) may not be as great if two completely different types of imaging studies are interpreted, for example, a CT of the head and an X-ray of the ankle. However, there is likely to be some efficiency of scale in most cases, especially in the pre-service component (reviewing medical records, previous studies).		
Cont'd	Cont'd	Cont'd	Cont'd. Additionally, the categorization of some procedures is somewhat arbitrary, e.g., the distinction of chest CT from abdomen CT, and is implied on page 15 of the GAO report as quoted above, and there is no absolute reason that these should be distinct procedures. The reduction in professional work (intra-service and post-service) may not be as great if two completely different types of imaging studies are interpreted, for example, a CT of the head and an X-ray of the ankle. However, there is likely to be some efficiency of scale in most cases, especially in the pre-service component (reviewing medical records, previous studies). Additionally, the categorization of some procedures is somewhat arbitrary, e.g., the distinction of chest CT from abdomen CT, and is implied on page 15 of the GAO report as quoted above, and there is no absolute reason that these should be distinct procedures. Although the data on which the MPPR application to professional work may have been based on limited data and there is always the potential that this policy might change in the future if justified by new and expanded data, based on the MedPac and GAO reports, the acting AD can find no justification for varying from Medicare policy of applying the MPPR to professional codes.		

Regulation Section	Issue	Comment	Response	Commenter	
Cont'd	Cont'd	Cont'd	Cont'd. Moreover, the acting AD can identify no reason why the MPPR policy should apply differently to cases involving ill or injured workers (i.e., to workers' compensation).Based on this assessment, acting AD had decided to follow its current proposal of applying the MPPR to the professional component for radiology services. Finally, electronic film technology has reduced the effort needed to review multiple studies, which suggests another reason for applying Medicare's MPPR policy.		
9789.19	Update Table	Commenter 35 recommends increasing the proposed payment for the PR-2, set at $11.78, to the same value as the first page of other reports, $38.25. Commenter states that the reimbursement rate does not reflect the amount of work required to prepare them, even in light of the increase in the E&M rate.	Disagree. Payment levels for the E&M codes are being increased substantially, by 39.5 percent in aggregate by 2017. In Medicare reports are bundled into the E&M payment. Although it is appropriate in workers' compensation to pay separately for the Progress Report since it does involve workers' compensation-specific requirements, there is no justification for more than tripling the fee. This is especially true in light of the substantial E&M payment levels.	35.6 (Honor)	
LC section 5307.1(a)(2)(A); LC section 4620	Authority and requirement of AD to adopt a physician fee schedule. Med-Legal services should be carved out.	Commenter 9 states the AD has authority to carve out diagnostic services related to a medical-legal report and have these services paid for under a different fee schedule based on LC section 5307.1(a)(2)(A). Commenter states this LC section authorizes the AD to define which physician services are subject to the RBRVS fee schedule. Commenter 20 states they believe consultation reports requested by the WCAB, AD, or QME/AME are intended to resolve a Medical-Legal dispute; and, thus these costs should be considered Medical-Legal costs - not OMFS - physician services. This would apply to all services performed to resolve a disputed issue including diagnostic imaging ordered by AMEs/QMEs.	Agree that the AD has discretion in defining which physician services are subject to the RBRVS physician fee schedule. Disagree with the suggestion to pay diagnostic services related to medical-legal evaluations under a different fee schedule. There is no evidence why a diagnostic test should be paid differently just because it is performed for medical-legal purposes. The medical-legal regulation at title 8, CCR § 9794 (a)(1) provides in pertinent part that "x-rays, laboratory services and other diagnostic tests shall be billed and reimbursed in accordance with the official medical fee schedule adopted pursuant to Labor Code Section 5307.1." Disagree. Consultations requested by a QME/AME or requested by the WCAB or AD should not be priced by the Medical-Legal Fee Schedule. The Medical-Legal Fee Schedule, §9795, specifies that the physician fee schedule under Labor Code §5307.1 is applicable to reports by treating or consulting physicians as follows: "Reports by treating or consulting physicians, other than comprehensive, follow-up or supplemental medical-legal evaluations, regardless of whether liability for the injury has been accepted at the time the treatment	9 (Brakensiek); 20.6 (Anderson & Besh)	

Regulation Section	Issue	Comment	Response	Commenter	
Cont'd	Cont'd	Cont'd. Commenter 20 urges the DWC to ensure that these costs are not included in the 120% aggregate pool of 2012 Medicare funds.	Cont'd. was provided or the report was prepared, shall be subject to the Official Medical Fee Schedule adopted pursuant to Labor Code Section 5307.1 rather than to the fee schedule set forth in this section."Agree that separately payable workers' compensation reports are not within the 120% aggregate cap. The proposed regulations consider that the separately payable consultation reports requested by the WCAB, AD, or QME/AME are included in the fee schedule at the rate adopted by the AD and are not subject to the 120% aggregate cap. The RAND Report, page 21, recognizes this as follows: "Because these are WC-related reports that are not Medicare-covered services, the 120-percent limitation on aggregate fees is not affected by the separate payments for the reports. This assumption affects the impact analysis but does not affect the budget-neutral CFs."		
LC section 5307.1(a)(2)(A)(iii)	Percentage increase over transition period	Commenter states, "...according to the RAND report we are currently paying at 111 percent of Medicare. The Labor Code provides that payments can be made up to 120 percent, yet the same RAND report shows that starting with the recommended 2014 conversion factors there will be an increase of up to almost 30 percent by 2017, and with no end in sight to further upward movement.	RAND has since revised their working paper, and RAND has now determined the OMFS is 116 percent of Medicare and in 2017 the RBRVS physician fee schedule will be 120% of Medicare as permitted by SB 863. The RAND working paper contained an error where there was a double application of the inflation factor when determining the maximum allowed amounts, which produced results that overstated the total maximum allowed amounts and affected the net impact of implementing the RBRVS. In 2017 there will be an increase of 11.9 percent.	6.1 (Suchil)	

Regulation Section	Issue	Comment	Response	Commenter	
LC section 5307.1(a)(2)(A)(iii)	120% of Medicare aggregate cap	Commenter 6 states, "Further, this increase does not appear to include the cost of a number of reports that the RAND report suggests be held outside of the up to 120 percent cap, as Medicare does not make separate payment for them. This may not comply with the intent of the Legislature's cap for California workers' compensation being set at up to 120 percent of Medicare. We recommend that all codes, whether Medicare, OWCP or California specific, be included in the calculations to determine the capped total figure. Commenters 20 and 23 are concerned about what treatments and services fall under the 120% cap. Commenter 31 states the proposed regulation is within the upper limit permitted by LC 5307.1(a)(2)(A), but above the upper limit imposed by LC section 5307.1(b), which states in pertinent part, the AD may adopt different CFs, DRGs, etc., from those used in the Medicare payment system, provided the estimated aggregate fees do not exceed 120% of the estimated aggregate fees paid for the same class of services in the relevant Medicare payment system". Commenter further states that annual adjustment factors described in LC 5307.1(g) rapidly escalate the CF beyond the 120% of Medicare limit. Commenter 33 recommends that the DWC adopt an OMFS based on RBRVS that is consistent with the SB 863 cost savings estimates advertised to and relied upon by employers at the time the reforms were passed.	Disagree. Given the language of SB 863, the acting AD believes that workers' compensation specific services that are not paid for under the Medicare physician fee schedule are not subject to the 120% of Medicare aggregate cap. LC 5307.1(a)(2)(iii), states that for purposes of calculating maximum reasonable fees, any service provided to injured workers that is not covered under the Medicare program shall be included at its rate of payment established by the AD, pursuant to subdivision (d). Subdivision (d) states for services not covered by a Medicare payment system, the AD shall establish maximum fees for that item, provided that maximum fee shall not exceed 120% of the fees paid by Medicare for services that require comparable resources. If workers' compensation-specific services were brought under the 120% cap, then the other services would need to be reduced below 120% of Medicare. The Division does not believe that is the legislative intent. It is noteworthy that under the "default" RBRVS fee schedule, beginning 2017 the statute specifies that the conversion factor would be 120% of the 2012 Medicare conversion factor as updated for inflation (MEI) and any relative value scale adjustment factor.	6.2 (Suchil); 20.8 (Anderson & Besh); 23.1 (Francis); 31.4 (Ramirez); 33.1 (Merz & Schmelzer); 34.2 (Thill & Hauscarriague)	
LC section 5307.1(a)(2)(A)(iii)	120% of Medicare aggregate cap	Commenter states it is unclear what treatments and services fall under the 120% cap, and urges additional funding needs to be incorporated under the cap to account for WC specific services. (e.g. acupuncture, after-service hours, chart notes, reports, duplication of x-rays and scans, work hardening and conditioning, functional capacity assessment, amongst others.)	Disagree. The proposed regulations clearly identify the WC-specific services (e.g. WC-specific codes) and identify when separate payment will be payable.	16(Helm)	
LC section 5307.1(a)(2)(A)(iii)	120% of Medicare aggregate cap	Commenter states the 120% multiplier is too low, and other states with low multipliers have failed.	Disagree. There is no evidence provided to substantiate commenter's statement. The acting AD does not have discretion to exceed the 120% multiplier set forth in Labor Code section 5307.1.	9(Brackensiek - oral)	

Regulation Section	Issue	Comment	Response	Commenter	
General	Future updates - payment rates	Commenter(s) request DWC post actual reimbursement per code for each region and/or to have a per visit fee schedule calculator on the DWC website. Commenter 7 explains WC TPAs and other payers have little or no experience with the Medicare fee schedule. This is a complex system, made even more complex by the use of the MPPR (which is another reason to not have it as part of the fee schedule). Commenter 7 can easily foresee that payers, in attempting to implement the MPPR, may reduce entire codes by the MPPRs percentage factor, not just the PE portion of the code. This is further complicated by the changing CF and unit values each year. Providers will have a very hard time arguing that they were paid incorrectly unless there is a neutral and authoritative site that shows the fees per CPT code, and how they are correctly reduced per visit under the MPPR, and that is unique to the geographic region. The American Physical Therapy Assn. has a Medicare fee schedule calculator on their website which incorporates the GPCIs and MPPR which the DWC could use as a model (using the DWC's CFs of course). This will assist payers implementing the fee schedule correctly, and providers in knowing what they should be paid, and reduce complaints to the DWC. Commenter 26 is concerned with the amount of provider education that will be offered throughout the transition. The transition is unclear with regard to how practitioners will be advised to extrapolate a formula which allows providers to calculate provider payments.	Disagree. This would add extensive additional administrative burden on the DWC and could be misleading to the public. The regulations set forth a clear formula for the base maximum allowable fee for a procedure, but then groundrules may be applicable that affect the actual payment rate. Therefore a chart of fees by procedure code could be misleading since the actual maximum payable amount may be different, for example it may be paid at 85% if performed by a non-physician practitioner, or it may receive a 10% bonus if performed by a physician in a Health Professional Shortage Area, or it may be subject to a multiple procedure reduction. In order to facilitate implementation of the fee schedule DWC will also consider hosting webinars, and posting training materials or FAQs on the website.	1.4 (Lerg); 2.3 (Jewell); 3.2 (Patel); 4.3 (Lee); 5.2 (Jaro); 7.9 (Rothenberg); 10.3 (Holcomb); 19.4 (Lerg); 20.7 (Anderson & Besh); 22.3 (Brandt); 26.4 (Katz); 27.3 (Wasielewski); 29.3 (Cupples); 30.3 (Barroga)	
General	Controlling Radiology Benefit Managers (RBMs)	Commenter states RBMs control referrals of WC patients for imaging services. There is lack of transparency, and typically pay less than the OMFS. Commenter recommends DWC require the actual provider of the service be paid and that the RBM be compensated for the actual services provided, e.g. authorization, review, etc.	The Division appreciates the concern regarding this issue, but this comment is outside the scope of this fee schedule	8.3 (Achermann)	
General	Additional UR mechanism for imaging services.	Commenter recommends DWC adopt the American College of Radiology's Appropriateness Criteria that are widely accepted evidence-based utilization guidelines. This can serve as an alternative to traditional RBM and provide pre-authorization.	The Division appreciates the suggestion, but his comment is outside the scope of this fee schedule. Evidence-based treatment guideline are adopted in the Medical Treatment Utilization Schedule. The letter has been referred to Division staff working on the MTUS for consideration.	8.4 (Achermann)	

Regulation Section	Issue	Comment	Response	Commenter	
General	PPO Discounts coupled with a limitation of 120% cap	Commenter states PPO discounts widely prevalent in the WC system leaves little choice and frequently no negotiating leverage in either accepting these discounts, or not seeing injured workers. Coupled with a limitation to 120% of Medicare fees, most providers will see a draconian reduction in reimbursement, which will undoubtedly affect access to care.	Disagree. Transition from the current OMFS to 120% of July 2012 Medicare, plus inflation adjustments, will not result in a reduction to the system costs. Instead, there will be an overall increase in payments from the OMFS which is currently estimated at 116% of Medicare, to 120% of Medicare. What will occur is a redistribution of payments for procedures based on the relative resources needed to perform the procedure. The current OMFS based reimbursement on outdated historical charges, which tend to undervalue E&M services relative to procedures. Overvaluing a service provides an incentive for unnecessary utilization while undervaluing a service could raise access issues. The RBRVS reflects the resources (costs) required to furnish services and provides neutral incentives for providing services. The PPO discounts currently exist, and therefore, should not have any significant impact if they continue to exist when the physician fee schedule transitions to a RBRVS based system.	12.2 (Mumbauer)	
General	Identifying over-utilized services	Commenter 12 urges DWC to look at work already done both in private and public sectors to identify commonly over-utilized services such as advanced imaging, diagnostic procedures, sleep studies, and laboratory services. Commenter 12 makes reference to the 2013 MedPAC report that highlighted concerns regarding the continued over-utilization of medical imaging.	Agree, DWC will consider any findings of MedPAC and Medicare as they address this issue. The redistribution of payments by service type will occur when the physician fee schedule transitions to the RBRVS, which will lower payments to some services that have been historically overvalued and increase payments to services, such as E&M, that have been undervalued.	12.8 (Mumbauer)	
General	Post-injury drug screening services	Commenter 18 states many employers and payers in WC require mandatory post-injury drug screening to be billed on the initial CMS1500 claim to the payer. There is no such need in a Medicare environment. There is no CPT code for this type of service in the proposed OMFS. Commenter recommends these services be billed and reimbursed with clear coding and reimbursement language. Recommend that either CPT 80101 be priced and retained for these services, or allow the use of CPT 89999 with a delineated fee. Commenter 33 recommends broadening the scope of the proposed regulation to include a fee schedule for drug testing. Commenter 42 states, drug screening "should be reimbursed appropriately."	Disagree. Drug screening should be paid for through the pathology and clinical laboratory fee schedule. Medicare does not recognize CPT 80101, and lists it as status code I. Medicare uses HCPCS G-codes instead of CPT 80101 for drug screening. The proposed regulation section 9789.19 states CPT codes 80100 to 80104 are not to be used and references the clinical lab fee schedule in section 9789.50. There does not appear to be a CPT code "89999" in the 2013 CPT. Disagree. The acting AD believes the clinical laboratory fee schedule adequately covers maximum fees for drug testing. Commenter has not presenter any details on what he deems "appropriate."	14(Marston); 18.6 (Okun, Crowell); 33.3 (Merz & Schmelzer) 42(Blink)	

Regulation Section	Issue	Comment	Response	Commenter	
General	After-hours codes	Commenter states after-hours reimbursement codes should be retained to encourage after-hours work comp clinic access and reduce usage of costly inefficient emergency rooms. Commenter recommends retention of an after-hours reimbursement methodology utilizing current CPT code with OWCP RVU data to keep consistency with proposed fee schedule methodology.	Disagree. DWC believes CPT codes 99050 - 99060 are the relevant codes commenter is referring to. These codes have a status code "B", which indicates payment for these services are always bundled into payment for other services not specified. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident. If the DWC were to pay separately for these after-hour visits, an adjustment would need to be made to account for duplication of payment made in the service they are incident to (more than likely the E&M codes). Moreover, there would need to be an offsetting reduction in overall payment so that the schedule does not exceed the cap of 120% of July 2012 Medicare. DWC does not discern a need to depart from this Medicare bundling rule.	18.7 (Okun, Crowell)	
General	Third Party Administrators discounting	Commenter is concerned with the ability for TPAs to enter into contracts with WC insurers and reimburse providers at a lower rate than that of the adopted OMFS. Commenter recommends the proposed fee schedule address how TPA are able to negotiate/discount payments to providers within the WC system.	The acting AD believes this request is outside the scope of the physician fee schedule regulations. In addition, the Labor Code section 5307.11 specifies that a "health care provider…and a contracting agent, employer, or carrier may contract for reimbursement rates different from those in the fee schedule adopted and revised pursuant to Section 5307.1."	26.5 (Katz) 39(Langton)	
General	Pass RBRVS as an emergency regulation, convene a thorough review of the entire body of new ground rules	Commenter requests the RBRVS physician fee schedule be passed as an emergency regulation, subjecting the regulation to review and improvement over the course of the 1st 6 mos. or even the entire 12 months of 2014. In conjunction, commenter wishes to participate in a thorough review of the entire body of new ground rules with the intent that the theoretic be replaced with the practical as soon as possible	Disagree. This regulatory proceeding is being conducted under the acting AD's rulemaking power under LC sections 133, 4603.5, 5307.1, and 5307.3. This regulatory proceeding is subject to the procedural requirements of LC section 5307.4. The acting AD believes the regulatory procedure currently being followed allows for much more public participation before the regulation is adopted, than if this regulation were to be adopted as an emergency regulation. Under the Administrative Procedure Act emergency regulation procedure, there is no public participation at all before the regulations would be adopted. The acting AD does not believe the proposed ground rules are "theoretic", as those Medicare ground rules that have been adopted in the proposed regulation have been thoroughly studied and vetted before Medicare adopted them. Where appropriate, the acting AD has diverged from the Medicare ground rules. The acting AD will continue to review and observe the impacts of implementing the proposed ground rules.	28(Cattolica - oral)	

Regulation Section	Issue	Comment	Response	Commenter	
General	Additional costs to the WC system	Commenter states the proposed physician fee schedule is a $344 million potential cost increase for the system. Such a large increase was not factored into the reform calculations, and, if adopted as currently proposed, the RBRVS fee schedule will overwhelm the total projected net cost reductions.	Disagree. The comment is based on the June RAND working paper which had 2 major errors and some minor errors, which estimated a greater impact to the system and what the estimated impact is. (See RAND July working paper, Appendix E which describes the errors and changes made to correct these errors for the RAND Report issued in August 2013.) The June 2013 RAND working paper estimated a 19.6% overall increase from the current physician fee schedule. After correction of the prior errors, the 2013 RAND report finds an estimated 11.9% overall increase from the current physician fee schedule.	31.3 (Ramirez)	
General	Hospital outpatient facility fees	Commenter recommends DWC continue to restrict outpatient facility fee payments to only hospital emergency departments, hospital outpatient surgery departments and ASCs. Reimburse medical services that are appropriately provided in other outpatient settings under the Physician fee schedule. Restrict payments to ASCs to surgeries on Medicare's ASC list of covered procedures.	Not relevant to physician fee schedule, but, will note for possible revision of the hospital outpatient and ASC fee schedules.	31.6 (Ramirez)	
General	Implementation Period	Commenters recommend providing stakeholders with 60-90 days of lead time to prepare systems and staff for the transition to the new fee schedule.	The Division is trying to provide as much implementation time as possible. However, stakeholders can and should be preparing now for an RBRVS system as the "default" fee schedule under Labor Code section 5307.1 would go into effect January 1, 2014 if the AD did not complete the rulemaking by that time. Since the regulations proposed in this rule are by and large consistent with Medicare, with limited divergence, the work of preparing for the "default" overlaps with preparation to implement the proposed regulations. The Division aims to have the regulations in place as soon as possible prior to 1/1/2014 to reduce the possibility of the need for extra effort which would be required if the default were in effect prior to the regulations.	33.4 (Merz & Schmelzer) 38(Broyles)	

Regulation Section	Issue	Comment	Response	Commenter	
General	Adoption of RBRVS fee schedule	Commenter recommends the Division adopt the RBRVS Medicare fee schedule model only if it also institutes a more effective system that gives providers recourse for non-compliant processing as well as incorrectly paid bills. The proposed fee schedule is much more complex than Medicare and the current OMFS. If claims administrators cannot pay correct fees now, commenter is concerned about what will happen under the Medicare-modeled RBRVS system. The proposed fee schedule is orders of magnitude more complicated than Medicare.	Disagree. SB 863 mandates a transition to the RBRVS-based physician fee schedule. There are processes in place for providers to appeal disputed billing/payments. The premise of the proposed RBRVS physician fee schedule is to follow Medicare, and only diverge where the WC experience differs from Medicare experience. Even with some level of divergence from Medicare fee schedule policies, the proposed WC fee schedule is far less complicated than Medicare's thousands of pages of ground rules, and payment policies that are developed by the Medicare local contractors. The Division is completely at a loss to understand commenter's contention that the proposed fee schedule is "orders of magnitude more complicated" than Medicare. There are no facts to support this statement. There will of course be a "learning curve" for all parties involved as they become accustomed to the new fee schedule. However, there are many improvements that will streamline billing and payment, such as updated coding and relative value units, and a clear set of current ground rules. If the "default" schedule were to go into effect on 1/1/2014, each provider and payer would need to discern which Medicare rules are applicable, and how to calculate the fees.	32.1(Montgomery)	
Cont'd.	Cont'd.	Cont'd.	Cont'd. The regulations and the documents incorporated provide a comprehensive, and finite, set of rules to determine the maximum reasonable fees.		
General	Consequences of the RBRVS adoption for the second review and IBR processes	Commenter states the consequences of RBRVS adoption for the second review and IBR processes are bleak if such adoption happens without addressing compliance issues. The second review system's record for getting providers paid is abysmal. Second review is not working.	The comments do not address the substance of the proposal and are outside the scope of the proposed regulations.	32.2(Montgomery)	
General	IBR process	Commenter states the IBR process, while promising in theory, is so far unproven in its ability to get bills paid. To complicate things, IBR was set up to handle payment disputes, not compliance issues. Commenter proposes a separate IBR process to deal specifically and exclusively with non-compliance issues and mismanagement of bills (ICR - Independent Compliance Review).	The comments do not address the substance of the proposal and are outside the scope of the proposed regulations.	32.3(Montgomery)	
General	e-billing	Commenter states successful implementation of e-billing will be even more crucial with the RBRVS schedule. WC e-billing system is barely out of its infancy and experiences considerable growing pains.	The comments do not address the substance of the proposal and are outside the scope of the proposed regulations.	32.4(Montgomery)	

Regulation Section	Issue	Comment	Response	Commenter	
General	Parity for responsibility for compliance	Commenter states before or concurrently with adoption of this fee schedule, more of the compliance burden should be shifted back onto claims administrators. Commenter states there is a lack of parity with claims administrators with respect to the consequences of non-compliance with DWC's regulations.	The comments do not address the substance of the proposal and are outside the scope of the proposed regulations.	32.5(Montgomery)	
General	Support for transition to RBRVS	Commenter supports the transition from OMFS to the RBRVS, because it will be updated, and will pay adequate reimbursement rates to front line primary treating physicians	Agree.	37(Azevedo); 38(Broyles); 40(Madden)	
General	Training	Commenter encourages education to stakeholders (e.g. PTs) for the 4-year transition.	Agree.	39(Langton)	
General	Ground Rules for 2015	Commenter states ground rules should be analyzed for 2015. Using the same ground rules in Medicare doesn't make sense for the things that are important to WC.	Disagree in part. The acting AD believes many ground rules established by Medicare are also appropriate for the WC system. The acting AD has adopted only certain, and not all, ground rules from Medicare.	42(Blink)	