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

PUBLIC HEARING

Wednesday, June 17, 2015
Elihu Harris State Office Building Auditorium
1515 Clay Street
Oakland, California

DESTIE OVERPECK
Moderator
Administrative Director

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Reported by: Rex Holt, Official Hearing Reporter

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OAKLAND, CALIFORNIA

WEDNESDAY, JUNE 17, 2015, 10:14 AM

ADMINISTRATIVE DIRECTOR DESTIE OVERPECK: Good morning. Thank you for coming today. I'm Destie Overpeck, the Administrative Director for the Division of Workers' Compensation. This is the public hearing for the Outpatient Fee Schedule regulations, specifically section 9789.32. Copies of the proposed regulation and rule-making documents are at the front desk over here. Please be sure to sign in on the sign-in sheet and indicate if you would like to speak today.

Also present is Jarvia Shu, who is the attorney who has worked on these regulations; and Maureen Gray, our regulations coordinator; and Rex Holt, our court reporter. When you come to testify, please give the court reporter a card or something with your name spelled out so he will know who you are. Everything you say will be taken down by the court reporter. If you have anything in writing, you can turn it in to Maureen Gray.

So far we have one individual signed up, and I will call your name in a minute. Before we close today, I will check to make sure if anybody else wishes to speak. We have very few people here so I don't expect this to go on beyond a half an hour. However, any written comments can be given to us by -- up until 5:00 p.m. today by fax or e-mail or hand delivery up

to the 17th floor of this building.

The purpose of this hearing is to receive comments on the proposed amendments, and we welcome any comments you have about them. All comments, both those we receive today orally or any that we receive in writing, will be considered in determining what revisions we may make to the regulation. Please restrict your comment to the subject of the regulation, or suggestions regarding the proposed regulation.

And with that, let's start with Chris Clayton, please.

CHRIS CLAYTON

CHRIS CLAYTON: I'd like to thank the DWC for creating this forum to resolve the payment and coding issues that come to the surface when hospitals are receiving payment pursuant to a Physician Fee Schedule. Yet there are hospitals, and these types of issues are going to occur.

The recommendations and concerns I have related to the proposed regulation are fairly specific. However, I don't think that fix is going to solve a myriad of other issues that occur due to this kind of nuance of paying a hospital like a physician, and I'll get into some of those details later and also in writing if I can.

One item is that the proposed text indicates that it's going to apply to services on or after a to-be-defined date in the future. My recommendation simply would be to strike that and allow it to apply to all service dates seeing that this

problem has existed since the inception of the OMFS RBRVS.

ADMINISTRATIVE DIRECTOR DESTIE OVERPECK: Could you speak a little slowly, especially with acronyms, so that the court reporter can actually hear.

CHRIS CLAYTON: Understood. I'll do my best.

Another provision within the proposed regulations states the HCPCS code used under the OMFS RBRVS shall be used to determine the maximal, allowable amount. In theory, it makes sense. I think, in practice, that language will lead to similar confusion that exists today. It's not specific as to which party is to use that code. For example, is it the hospitals that should be billing with that code or should it be the claims administrator, or their bill-review company, crosswalking the appropriate hospital outpatient code to the corresponding OMFS RBRVS physician code. I recommend that DWC clarify this sentence to require specifically the claims administrator to use the OMFS RBRVS code. Hospitals should continue billing as they would any other payer using hospital codes. Hospitals are not at all accustomed to dealing with physician coding. And billing claims administrators, however, handle physician claims daily. Presumably the claims administrators also should already have on file the corresponding physician code as it was presumably authorized by the claims administrator as requested by the treating physician and also billed by the treating physician.

Thirdly, if a hospital bill with a -- if hospitals bill with a physician code, many of which are not payable under CMS HOPPS, the code will technically not qualify, as in "other service" as defined in the fee schedule, which is defined, in part, as a service payable under OPPS. This is one of the key problems with HCPCS G0463. It's a hospital-specific code that is payable under OPPS. However, the code doesn't exist in the physician's fee schedule. If the hospital bills with a physician code, it's no longer paid under OPPS. Therefore, it's no longer technically another service. I don't believe that's the DWC's intention.

There are other issues beyond, that will be addressed by the proposed regulations, that the DWC is encouraged to take a look at. Specifically, hospital billing codes on the Physician Fee Schedule with a PC/TC indicator of 5, indicating incident 2 codes, defined as "This indicator identifies codes that describe services-covered incident to a physician's service when they are provided by auxiliary personnel employed by the physician and working under his, or her, direct personal supervision, payment may not be made by carriers for these services when they are provided to hospital inpatients or patients in a hospital outpatient department," et cetera, et cetera. The conundrum is if the hospital's code is transformed into a physician code and that code happens to have a PC/TC indicator of 5, under physician rules, it's not

payable. However, under OPPS, the Medicare payment system for hospitals, an example a CPT of 90471 for immunization administration amounts to APC 0437, with a status indicator of S, which is always paid at 100 percent of the APC allowable, in this case around $45 under Medicare's OPPS. This code will go unpaid because, if it were performed by a physician, the Physician's Fee Schedule, Medicare's, that the DWC has adopted, prescribes no payment.

Another example within the RBRVS is the status code B, as in boy, indicating a bundled code, payment for covered services are always bundled into payment for other services not specified. If RVs are shown, they are not used for Medicare payment. If these services are covered, payment is submitted by the payment for the service to which they are incident. An example is CPT 97602, wound care. Under OPPS, this maps to APC 0013, with a status indicator of T, indicating paid at a 100 percent of the APC allowable if it's the highest weighted APC, otherwise paid at 50 percent of the APC allowable, another example of how a hospital is going to get paid for this service under the Medicare OPPS payment system, but as that code translates through to a Physician Fee Schedule, CMS doesn't feel a physician should be paid for the code because it's presumably bundled, a rule that quickly fails when attempting to apply it to a hospital.

Another example is RBRVS status code C, as in Charlie,

indicating carriers price this code. This one is a little bit different, theoretically a carrier could, under the OMFS RBRVS, apply fair pricing to a procedure billed with that code. However, it's our observation, at least on the hospital's side, that these codes often go zero paid because either the carriers don't understand their obligation, cannot find suitable pricing, or just realize that hospitals are probably going to miss the revenue opportunity.

Examples of this are CPT 0283T, as in Thomas, percutaneous, or open, implantation of a neurostimulator electrode arrays, including imaging guidance with the implantation of a pulse generator. This is an extraordinarily costly procedure, and the device that accompanies it is also very costly. Medicare pays these upwards of $27,000 per incident.

Another code is CPT 70559, which is MRI of the brain with, or without, dye. Under OPPS, this one maps to APC 0337, with a status indicator of S, always paid at 100 percent of the APC allowable, typically around $500 under OPPS.

There are nearly 100 radiology codes, CPTs beginning with a 7, that are other services under the fee schedule with a status code of C. Practically speaking, it's not reasonable to anticipate the industry to properly handle these codes.

Finally, we have RBRVS status code X, as in X-ray, indicating a statutory exclusion. These codes represent an

item or service that is not in the statutory definition of physician services. For the fee schedule payment purposes, no RV use or payment amounts are shown for these codes and no payment will be made under the Physician Fee Schedule.

An example is CPT 77424, intraoperative radiation treatment delivery, X-ray, single treatment session. Under OPPS, this one maps to APC 0065, with a status indicator of S, always paid at 100 percent of the APC allowable, in this case around $1200 under Medicare's OPPS. Again, this is a code that's going to be billed by a hospital but is statutorily excluded for payment if billed by a physician because physicians shouldn't be billing with these codes. We're not aware of the corresponding codes that might be billed by a physician in this case.

Other examples would include CPT 86927, fresh frozen plasma thawing, each unit. It's my understanding this is a service that a physician would never perform, and there is likely to be no corresponding physician code.

There are about 1,150 laboratory codes, CPTs beginning with an 8, that fall into this realm, over 1,000 of which have a status indicator of N under OPPS. OPPS rules would indicate that, if a APC-payable procedure is billed, these codes won't separately pay.

However, there are 60 of these lab codes that do have an OPPS status indicator of S or X, which, of course, Medicare

pays at 100 percent of the APC allowable. In the example given, CPT 86927 maps to APC 0438, with a status indicator of S, and always pays just over $100.

This is a subset of the examples of problems -- systemic problems that exist when trying to apply Physician Fee Schedule to hospital reimbursement. In terms of a systemic solution, it's clearly to more holistically subscribe to the outpatient hospital reimbursement mechanism that Medicare prescribes. It's my understanding that DWC is required to follow the relevant rules and payment guidelines of the applicable Medicare payment system and, therefore, wholly abandon the OMFS RBRVS as applicable to physicians. That's it.

ADMINISTRATIVE DIRECTOR DESTIE OVERPECK: Thank you. Does anybody else want to make a comment?

All right. Since no one said yes, we will close our hearing. So, again, a reminder that written comments can be filed until 5:00 p.m. this afternoon, and thank you very much for coming. The hearing is now closed.

(The proceedings ended at 10:30 AM)

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REPORTER'S CERTIFICATE

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

_____
REX HOLT
Official Hearing Reporter
State of California
Workers' Compensation Appeals Board

Dated: June 19, 2015
Oakland, California