June 8, 2016

The California Applicants' Attorneys Association (CAAA) appreciates the opportunity to comment on the proposed Home Health Care Services Fee Schedule that is currently posted on the DWC website, for a first 15 day comment period ending June 8, 2016.

CAAA has previously provided comments on the fee schedule for the DWC Forum and at the public hearing on November 30, 2015.

We now offer the following specific comments concerning the current proposed modifications to the text of the regulations.

§ 9789.90 Home Health Care - Definitions.

Section 9789.90, subdivisions (b), (d) and (e) now provide reference to the Medical Treatment Utilization Schedule ("MTUS") and the "home health services" topic (which is contained within the proposed Chronic Pain Medical Treatment Guidelines, pages 88 and 89). These guidelines were the subject of a public comment period ending December 19, 2015, and a public hearing on September 1, 2015. To our knowledge these guidelines have not been finalized or approved.

CAAA's primary concern provided in our comments to the proposed revisions to the Chronic Pain Treatment Guidelines was specifically with regard to the restrictive definition of Home Health Care Services set forth on pages 88 and 89 and the changes related to the definition of "homebound" as a threshold eligibility requirement to obtain services:

"Homebound is defined as "confined to the home". To be homebound means: The individual has trouble leaving the home without help (e.g., using a cane, wheelchair, walker, or crutches; special transportation; or help from another person) because of the occupational illness or injury
OR
Leaving the home isn't recommended because of the occupational illness or injury
AND
the individual is normally unable to leave home and leaving home is a major effort (CMS, 2014)."

Initially, we previously recommended that the general reference to CMS 2014 be deleted from page 89 of the Chronic Pain guidelines. Our concern is that this reference could create enough ambiguity that medically necessary home health care services which would otherwise be authorized may be denied by a UR or IMR reviewer.

We also urged that the restrictive definition of "homebound" not be adopted in the MTUS as it would unnecessarily narrow the obligation to provide attendant care to many injured workers.

While we recognize that the current version of the MTUS is not the subject of comment at this time, we observe that the MTUS Chronic Pain Management Treatment Guideline currently being applied by UR and IMR reviewers to determine eligibility for Home Health Care Services is not consistent with the requirements of Labor Code Section 5307.27.

Labor Code Section 5307.27 requires that the MTUS be evidence based, peer reviewed and based on nationally recognized standards of care. The current reference to "home health care services" and "homebound" in the MTUS does not meet any of these required standards. CMS 2014 sets forth payment eligibility criteria for the federal government run Medicare health insurance program. These are not evidence based treatment guidelines.

CAAA fears that limiting eligibility for home health care services with an unduly restrictive MTUS and definition of "homebound" will inevitably result in the denial of home health care services to the most vulnerable injured worker population.

What about the stroke victim who can "easily" leave the house but has cognitive and mental deficiencies which prevent them from taking care of their hygiene, medical needs, and daily chores? Or the paranoid, agoraphobic worker with PTSD who gets out of the house upon his psychiatrist's recommendations but has intermittent episodes where they do not leave the house, fail to take medications and don't eat properly? Or the severe migraine sufferer who can function normally when they do not have headaches, but when the headaches come on they become light sensitive for several days or weeks in a row and cannot get out in daylight or drive at night?

We proposed that the goal of revising the chronic pain guidelines should be to expand and possibly introduce other Evidence Based Medicine treatment

modalities to provide as many treatment options for injured workers and their treating physicians as possible. Restricting eligibility requirements for home health care services needed by the most seriously injured workers may prove not only catastrophic to the worker, but to their family, their employer, and other social welfare programs. Such a restrictive definition will undoubtedly cause increased frictional costs which will prove more expensive to the employer in the long run.

We also previously strongly recommended that the added language in the Chronic Pain Medical Treatment Guidelines defining "homebound" be deleted, as well as the overall eligibility requirement that a worker be "homebound" to obtain services, as it is derived from CMS 2014.

Based on the above CAAA further believes that the reference to the MTUS in the proposed revisions to the home health care services fee schedule is misplaced and should be deleted in its entirety.

First, the MTUS continues to be subject to revision and a blanket reference to it in these fee schedule regulations bars any meaningful comments as we don't know what future revisions are contemplated in the area of home health care services.

Second, the MTUS does not provide any guidance on home health care services for the most catastrophically injured workers or the terminally ill. We fear that limiting the definition of home health care services to what is in the MTUS will inevitably result in the denial of home health care services to the most vulnerable injured worker population. A cookie cutter approach to the provision of these services would be disastrous. While the MTUS may provide guidance in limited circumstances for soft tissue injuries, or a brief convalescence following surgery, it should not define in all cases the definition of home health care services.

The development of the home health care fee schedule must be guided by statute. Labor Code §5307.8 does not give the DWC authority to define the scope and type of home health care services in the fee schedule. The course and scope of the injured workers' need for home health care services should not be defined by the fee schedule or a restrictive definition in the MTUS. To ignore this will result in a home health care services fee schedule which exceeds statutory authority and increases frictional costs for employers with devastating consequences to injured workers. To the extent this proposed draft of the home health care services fee schedule exceeds statutory authority, we do object. The proposed Home Health Care Fee Schedule should only set forth a methodology for payment and maximum

allowable rates for payment for the full range of home health care services that may be required by injured workers.

§ 9789.91 Home Health Care – Eligibility for Services.

In our previous comments we had recommended that the fee schedule regulations provide that home health care shall be authorized until there is a UR denial, and if there is a denial, the determination shall lay out alternate care to be provided.

We recognize that in response to our request language in subdivision (b) was stricken as the use of UR and IMR is not applicable to all types of home health services prescribed.

We suggested there should be a clarification as to what types of home health care services would be subject to UR, that an alternative to the treatment prescribed be offered if there is a denial, and that services be authorized pending UR review as the consequences of an injured worker waiting months for home health care services to be authorized could be fatal.

We continue to urge that further consideration for limitations on UR of home health care services be part of policy discussions on future changes to the UR process although outside the scope of the implementation of this fee schedule.

Additionally, family members should be included in the billing methodology and rates in the fee schedule. Admittedly, family members may not be qualified to perform every service required. Providing for ancillary agreements between the insurance company and family members in subdivision (d) seems counter to the goal of reducing litigation.

CAAA proposes the following language for subdivision (d) (2): An injured worker may use, and the employer or its insurer will pay for, a provider (who is not employed by a home care organization or home health care agency and who may be a family member of the injured worker), if the individual : (1) performs non-medical services, i.e., personal care or chore services and (2) the provider has the skills necessary to provide the home health care services required by the injured worker as determined by an in-home nurse assessment and/or prescription.

The rates set forth in Section 9789.93 Table A should continue to provide for chore services and home health aide services which would allow payment to family care givers and individuals not employed by a home health care agency for chore

services or attendant care services. All of the other rates on this table are for skilled services that these designated persons would not be qualified to be paid for unless they happened to be a registered nurse, dietician, clinical social worker, qualified physical or occupational therapist, speech pathologist, or certified nurse assistant.

Employers and claims administrators are protected by these regulations.

Protections should also be in these regulations for personal care givers and family caregivers as to the rates they will be reimbursed for their services.

§ 9789.92 Home Health Care – Payment Methodology& Billing Rules.

As required by statute, the rates or fees established for home health care services shall ***be adequate to ensure a reasonable standard of services and care for injured employees.***

There should be no arbitrary cap imposed on hours of services provided or annual maximum to be paid as each case should be assessed for the individual needs of that injured worker.

We believe that specific comments on the adequacy of the rates set forth in Section 9789.93 Table A are best addressed by the current providers of home health care services.

However we must comment on section 9789.92, subdivision (b) (1).This subdivision provides for a 4 unit minimum to be applied to the provision of home health care services, which is only one hour. Additional time beyond the 4 units is to be billed in 15 minute increments

CAAA recommends that a 2-hour or 8 unit minimum be allowed in subdivision (b)(1) as this would better incentivize providers to partake in providing home health care services with the limitations of the fee schedule. Home health care agencies have to pay overhead and travel, and at a one hour minimum they would lose money sending someone for a one hour job. By analogy, the interpreter fee schedule has a two hour minimum in place per §9795.3(b)(2) and interpreters are paid for travel.

As far as travel, § 9789.92 subdivision (d) (4) now precludes payment for travel to and from an injured worker's home to provide home health care services. We again recommend, to be consistent with the interpreter fee schedule, that travel time be

paid for home health care providers with similar limitations. §9795.3(b) (3) allows payment for an interpreter's travel if the distance is greater than 25 miles "between the interpreter's place of business and the place where the service is rendered." Eligible travel time is paid at the "rate of $5.00 per quarter hour or portion thereof." We believe with the ever increasing traffic congestion in the San Francisco Bay Area, Los Angeles, and other urban areas that payment for travel time is essential for home health care providers who must travel to perform their work. Therefore, we recommend that subdivision (b) (4) be deleted and that rates for travel time be added to 9789.3, Table A, as set forth above.

Our final comments are with regard to Section 9789.92, subdivision (d) which states that "Nothing in this section precludes an agreement for payment of home health care services, made between an employer or its claims administrator and the provider, regardless of whether such payment is less than, or exceeds, the fees set forth in this section."

The home health care fee schedule should not be a tale of two worlds. One with rates set by regulations, and one with rates set by private contracts not subject to public scrutiny for "lesser" amounts. We urge that subdivision (d) be deleted in its' entirety. There should be one fee schedule with rates clearly regulated and subject to public and transparent rulemaking authority and the public hearing process. To do otherwise may result in a "wild west" of hidden and unregulated fee contracts, which was clearly not intended by the authors of Senate Bill 863. As required by statute, the rates or fees established for home health care services shall ***be adequate to ensure a reasonable standard of services and care for injured employees.*** Private contracts with "lesser" fees will not satisfy this statutory mandate.

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