

## **Title 8, California Code of Regulations §9789.32**

**(Effective March 1, 2008)**

(a) Sections 9789.30 through 9789.38 shall be applicable to the maximum allowable fees for emergency room visits and surgical procedures rendered on or after July 1, 2004. For purposes of this section, emergency room visits shall be defined by CPT codes 99281-99285 and surgical procedures shall be defined by CPT codes 10040-69990. A facility fee is payable only for the specified emergency room and surgical codes and for supplies, drugs, devices, blood products and biologicals that are an integral part of the emergency room visit or surgical procedure. A supply, drug, device, blood product and biological is considered an integral part of an emergency room visit or surgical procedure if:

(1) the item has a status code N or Q and is packaged into the APC payment for the emergency room visit or surgical procedure (in which case no additional fee is allowable) or,

(2) the item is furnished in conjunction with an emergency room visit or surgical procedure and has been assigned Status Code G, H or K.

Payment for other services furnished in conjunction with a surgical procedure or emergency room visit shall be in accordance with subdivision (c) of this Section.

(b) Sections 9789.30 through 9789.38 apply to any hospital outpatient department as defined in Section 9789.30(n) and any hospital outpatient department that is certified to participate in the Medicare program under Title XVIII (42 U.S.C. SEC. 1395 et seq.) of the federal Social Security Act and any ASC as defined in the California Health and Safety Code Section 1204, subdivision (b)(1), any ambulatory surgical center that is certified to participate in the Medicare program under Title XVIII (42 U.S.C. SEC. 1395 et seq.) of the federal Social Security Act, and any surgical clinic accredited by an accrediting agency as approved by the Licensing Division of the Medical Board of California pursuant to Health and Safety Code Sections 1248.15 and 1248.4, performing procedures and services on an outpatient basis.

(c) The maximum allowable fees for services, drugs and supplies furnished by hospitals and ambulatory surgical centers that do not meet the requirements in (a) for a facility fee payment and are not bundled in the APC payment rate for a surgical service or emergency room visit will be determined as follows:

(1) The maximum allowable fees for professional medical services which are performed by physicians and other licensed health care providers shall be paid according to Section 9789.10 and Section 9789.11.

(2) The maximum allowable fees for organ acquisition costs and corneal tissue acquisition costs shall be based on the documented paid cost of procuring the organ or tissue.

(3) The maximum allowable fee for drugs not otherwise covered by a Medicare fee schedule payment for facility services shall be 100% of the fee prescribed by Medi-Cal pursuant to Labor Code Section 5307.1 subdivision (a), or, where applicable, Section 9789.40.

(4) The maximum allowable fee for clinical diagnostic tests shall be determined according to Section 9789.50.

(5) The maximum allowable fees for non-surgical ancillary services with a status code indicator "X" shall be determined according to Section 9789.10 and Section 9789.11.

(6) The maximum allowable fee for durable medical equipment, prosthetics and orthotics shall be determined according to Section 9789.60.

(7) The maximum allowable fee for ambulance service shall be determined according to Section 9789.70.

(d) Only hospitals may charge or collect a facility fee for emergency room visits. Only hospital outpatient departments and ambulatory surgical centers as defined in Section 9789.30(n) and Section 9789.30(c) may charge or collect a facility fee for surgical services provided on an outpatient basis.

(e) Hospital outpatient departments and ambulatory surgical centers shall not be reimbursed for procedures on the inpatient only list, Section 9789.31(a)(5), Addendum E, except that pre-authorized services rendered are payable at the pre-negotiated fee arrangement. The pre-authorization must be provided by an authorized agent of the claims administrator to the provider. The fee agreement and pre-authorization must be memorialized in writing prior to performing the medical services.

(f) Critical access hospitals and hospitals that are excluded from acute PPS are exempt from this fee schedule.

(g) Out of state hospital outpatient departments and ambulatory surgical centers are exempt from this fee schedule.

(h) Hospital outpatient departments and ambulatory surgical centers billing for facility fees and other services under this Section shall present with their bill the name and physical address of the facility, the facility's Medicare Provider Number or UPIN (or, in the absence of the Medicare number, the OSHPD Facility Number). The bill shall include the dates of service, the diagnosis and current HCPCS codes and charges for each billed service, including HCPCS codes for any items and services that are packaged into the APC payment for a significant procedure.