

**Title 8, California Code of Regulations
Chapter 4.5, Division of Workers' Compensation
Subchapter 1**

Administrative Director – Administrative Rules

(Plain Text is Emergency Regulation Proposed for Permanent Adoption,
Deletions from the codified emergency regulatory text are indicated by strike-through,
thus: ~~deleted language~~.)

Additions to the codified emergency regulatory text are indicated by underlining, thus:
underlined language.)

Deletions from the amended regulatory text, as proposed on January 12, 2004, are
indicated by double strike-through underline, thus: ~~deleted language~~.)

Additions to the amended regulatory text, as proposed on January 12, 2004, are indicated
by a double underline, thus: added language.)

Deletions from the amended regulatory text, as proposed on March 18, 2004, are
indicated by italics with double strike-through double under-line, thus: ~~*deleted language*~~.)

Additions to the amended regulatory text, as proposed on March 18, 2004, are indicated
by a dotted underline, thus: *added language*.)

Article 5.3

Official Medical Fee Schedule – Services Rendered after January 1, 2004

Section 9789.21. Definitions for Inpatient Hospital Fee Schedule.

- (a) “Average length of stay” means the geometric mean length of stay for a diagnosis-related group assigned by CMS.
- (b) “Capital outlier factor” means fixed loss cost outlier threshold x capital wage index x large urban add-on x (capital cost-to-charge ratio/total cost-to-charge ratio).
 - (1) The capital wage index, also referred to as the capital geographic factor (GAF), is specified in the Federal Register of October 6, 2003 (correcting the rule published on August 1, 2003) at Vol. 68, page 57736, Table 4A for urban areas, Table 4B on page 57743 for rural areas, and Table 4C on page 57744 for reclassified hospitals, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.
 - (2) The “large urban add-on” is indicated by the post-reclassification urban/rural location published in the Payment Impact File at positions 229-235. As stated in Title 42, Code of Federal Regulations, Section 412.316(b), as it is in effect on November 11, 2003, the “large urban add-on” is an additional 3% of what would otherwise be payable to the health facility.
 - (3) “Fixed loss cost outlier threshold” means the Medicare fixed loss cost outlier threshold for inpatient admissions. The fixed loss cost outlier

threshold for FY 2004 is \$31,000 as published in the Federal Register of August 1, 2003 at volume 68, number 148 at page 45477.

- (c) “CMS” means the Centers for Medicare & Medicaid Services of the United States Department of Health and Human Services.
- (d) “Composite factor” means the factor calculated by the administrative director for a health facility by adding the prospective operating costs and the prospective capital costs for the health facility, excluding the DRG weight and any applicable outlier and new technology payment, as determined by the federal Centers for Medicare & Medicaid Services (CMS) for the purpose of determining payment under Medicare.
 - (1) Prospective capital costs are determined by the following formula:
 - (A) Capital standard federal payment rate x capital geographic adjustment factor x large urban add-on x [1 + capital disproportionate share adjustment factor + capital indirect medical education adjustment factor]
 - (B) The “capital standard federal payment rate” is \$414.18 as published by CMS in the Federal Register of October 6, 2003 (correcting the publication of August 1, 2003), at Vol. 68, page 57735, Table 1D, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.
 - (C) The “capital geographic adjustment factor” is published in the Payment Impact File at positions 243-252.
 - (D) The “large urban add-on” is indicated by the post-reclassification urban/rural location published in the Payment Impact File at positions 229-235. As stated in Title 42, Code of Federal Regulations, Section 412.316(b), effective November 11, 2003, the “large urban add-on” is an additional 3% of what would otherwise be payable to the health facility.
 - (E) The “capital disproportionate share adjustment factor” is published in the Payment Impact File at positions 117-126.
 - (F) The “capital indirect medical education adjustment factor” (capital IME adjustment) is published in Payment Impact File at positions 202-211.
 - (2) Prospective operating costs are determined by the following formula:
 - (A) [(Labor-related national standardized amount x operating wage index) + nonlabor-related national standardized amount] x [1 + operating disproportionate share adjustment factor + operating indirect medical education adjustment]

- (B) The “labor-related national standardized amount” is \$3,136.39 ~~for large urban areas and \$3,086.73 for other areas~~, as published by the federal Centers for Medicare & Medicaid Services in the Federal Register of October 6, 2003 (correcting the publication of August 1, 2003), at Vol. 68 page 57735, Table 1A, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director and as modified by Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, §401, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.
- (C) The “operating wage index” is published in the Payment Impact File at positions 253-262.
- (D) The “nonlabor-related national standardized amount” is \$1,274.85 ~~for large urban areas and \$1,254.67 for other areas~~, as published by CMS in the Federal Register of October 6, 2003 (correcting the publication of August 1, 2003), at Vol. 68, page 57735, Table 1A, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director and as modified by Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, §401, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.
- (E) The “operating disproportionate share adjustment factor” is published in the Payment Impact File at positions 127-136 and as modified by Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, §402, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.
- (F) The “operating indirect medical education adjustment” is published in the Payment Impact File at positions 212-221 and as modified by Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, §502, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.
- (G) For sole community hospitals, the operating component of the composite rate shall be the higher of the prospective operating costs determined using the formula in (2) or the hospital-specific rate published in the Payment Impact File at positions 137-145.
- (3) A table of composite factors for each health facility in California is contained in Section 9789.23. The sole community hospital composite factors that incorporate the operating component specified in subdivision (d)(2)(G) are listed in italics in the column headed “~~Adjusted~~ Composite Factor (SCH)” set forth in Section 9789.23.

- (e) “Costs” means the total billed charges for an admission, excluding non-medical charges such as television and telephone charges, ~~and charges for Durable Medical Equipment for in home use, charges for implantable medical devices, hardware, and/or instrumentation reimbursed under subdivision (e) (f) of Section 9789.22,~~ multiplied by the hospital's total cost-to-charge ratio.
- (f) “Cost-to-charge ratio” means the sum of the hospital specific operating cost-to-charge ratio and the hospital specific capital cost-to-charge ratio. The operating cost-to-charge ratio for each hospital is published in the Payment Impact File at positions 161-168. The capital cost-to-charge ratio for each hospital is published in the Payment Impact File at positions 99-106.
- (g) “Cost outlier case” means a hospitalization for which the hospital's costs, as defined in subdivision (e) above, ~~exceeds the Inpatient Hospital Fee Schedule payment amount by the hospital's outlier factor. If costs exceed the cost outlier threshold, the case is a cost outlier case.~~
- (h) “Cost outlier threshold” means the sum of the Inpatient Hospital Fee Schedule payment amount, the payment for new medical services and technologies reimbursed under subdivision (g) of Section 9789.22, and ~~plus~~ the hospital specific outlier factor.
- (i) “Diagnosis Related Group (DRG)” means the inpatient classification scheme used by CMS for hospital inpatient reimbursement. The DRG system classifies patients based on principal diagnosis, surgical procedure, age, presence of comorbidities and complications and other pertinent data.
- (j) “DRG weight” means the weighting factor for a diagnosis-related group assigned by CMS for the purpose of determining payment under Medicare. Section 9789.24 lists the DRG weights and geometric mean lengths of stay as assigned by CMS.
- (k) “FY” means the CMS fiscal year October 1 through September 30.
- (l) “Health facility” means any facility as defined in Section 1250 of the Health and Safety Code.
- (m) “Inpatient” means a person who has been admitted to a health facility for the purpose of receiving inpatient services. A person is considered an inpatient when he or she is formally admitted as an inpatient with the expectation that he or she will remain at least overnight and occupy a bed, even if it later develops that such person can be discharged or is transferred to another facility and does not actually remain overnight.
- (n) “Inpatient Hospital Fee Schedule maximum payment amount” is that amount determined by multiplying the DRG weight x hospital composite factor x 1.20.
- (o) “Labor-related portion” is that portion of operating costs attributable to labor costs, as specified in the Federal Register of October 6, 2003 (correcting the publication of August

1, 2003), at Vol. 68, page 57735, Table 1A, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

- (p) “Medical services” means those goods and services provided pursuant to Article 2 (commencing with Section 4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code.
- (q) “Operating outlier factor” means $((\text{fixed loss cost outlier threshold} \times ((\text{labor-related portion} \times \text{wage index}) + \text{nonlabor-related portion})) \times (\text{operating cost-to-charge ratio} / \text{total cost-to-charge ratio}))$.
 - (1) The wage index, also referred to as operating wage index in the Payment Impact File at positions 253–262, is specified as the ~~geographic adjustment factor~~ wage index at Federal Register of October 6, 2003 (correcting rule published on August 1, 2003) at Vol. 68, page 57736, Table 4A for urban areas; Table 4B on page 57743 for rural areas, and Table 4C on page 57744 for reclassified hospitals, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.
 - (2) The nonlabor-related portion is that portion of operating costs attributable to nonlabor costs as defined in the Federal Register of October 6, 2003 (correcting the publication of August 1, 2003), at Vol. 68, page 57735, Table 1A, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.
- (r) “Outlier factor” means the sum of the capital outlier factor and the operating outlier factor. A table of hospital specific outlier factors for each health facility in California is contained in Section 9789.23.
- (s) “Payment Impact File” means the FY 2004 Prospective Payment System Payment Impact File (October 2003 Update) (IMPFIL04) published by the federal Centers for Medicare & Medicaid Services (CMS), which document is hereby incorporated by reference. The description of the file is found at http://cms.hhs.gov/providers/hipps/impact_rcd_lay.pdf. The file is accessible through <http://cms.hhs.gov/providers/hipps/ippspufs.asp>. A paper copy of the Payment Impact File, with explanatory material, is available from the Administrative Director upon request. An electronic copy is available from the Administrative Director at http://www.dir.ca.gov/DWC/dwc_home_page.htm ..
- (t) “Professional Component” means the charges associated with a professional service provided to a patient by a hospital based physician. This component is billed separately from the inpatient charges.

Authority: Sections 133, 4603.5, 5307.1, and 5307.3, Labor Code.

Reference: Sections 4600, 4603.2, 5307.1, and 5318, Labor Code.

Section 9789.22. Payment of Inpatient Hospital Services.

- (a) Maximum payment for inpatient medical services shall be determined by multiplying 1.20 by the product of the health facility's composite factor and the applicable DRG weight. The fee determined under this subdivision shall be a global fee, constituting the maximum reimbursement to a health facility for inpatient medical services not exempted under this section. However, preadmission services rendered by a health facility more than 24 hours before admission are separately reimbursable.
- ~~(b)~~ The maximum payment for inpatient medical services includes reimbursement for all of the inpatient operating costs specified in Title 42, Code of Federal Regulations, Section 412.2(c), effective date October 1, 2002 and revised as of October 1, 2003, which is incorporated by reference and will be made available upon request to the Administrative Director, and the inpatient capital-related costs specified in Title 42, Code of Federal Regulations, Section 412.2(d), effective date October 1, 2002 and revised as of October 1, 2003, which is incorporated by reference and will be made available upon request to the Administrative Director.
- ~~(c)~~ The maximum payment shall ~~not take into account~~ include the cost items specified in Title 42, Code of Federal Regulations, Section 412.2(e) (1), (2), (3), and (5), revised as of October 1, 2003, which is incorporated by reference and will be made available upon request to the Administrative Director. The maximum allowable fees for cost item set forth at 42 C.F.R. §412.2(e)(4), “the acquisition costs of hearts, kidneys, livers, lungs, pancreas, and intestines (or multivisceral organs) incurred by approved transplantation centers,” shall be based on the documented paid cost of procuring the organ or tissue.
- ~~(b)(d)~~ Health facilities billing for fees under this section shall present with their bill the name and address of the facility, the facility's Medicare ID number, and the applicable DRG codes. The billings shall include the principal and secondary diagnoses and surgical procedures. They shall also set forth the patient characteristics, including the DRG weight, the charges, the costs for new technology, and the length of stay.
- ~~(e)(c)~~ Cost Outlier cases. Inpatient services for cost outlier cases, shall be reimbursed as follows:
- (1) Step 1: Determine the Inpatient Hospital Fee Schedule maximum payment amount (DRG weight x 1.2 x hospital specific composite factor).
 - (2) Step 2: Determine costs. Costs = (total billed charges x total cost-to-charge ratio).
 - (3) Step 3: Determine outlier threshold. Outlier threshold = (Inpatient Hospital Fee Schedule payment amount + hospital specific outlier factor ± any new technology pass-through payment determined under Section 9789.22(g)).

- (4) If costs exceed the outlier threshold, the case is a cost outlier case and the admission is reimbursed at the Inpatient Hospital Fee Schedule payment amount + new technology pass-through payment determined under Section 9789.22(g) + (0.8 x (costs - cost outlier threshold)).
- (5) For purposes of determining whether a case qualifies as a cost outlier case under this subdivision, charges for implantable hardware and/or instrumentation reimbursed under subsection ~~(d)(f)~~ is excluded from the calculation of costs. ~~Once~~ If an admission for DRGs 496, 497, 498, 519, 520, 531 and 532 qualifies as a cost outlier case, any implantable hardware and/or instrumentation shall be separately reimbursed under subsection ~~(d)(f)~~.
- ~~(d)(f)~~ Implantable medical devices, hardware, and instrumentation for DRGs 496, 497, 498, 519, 520, 531 and 532 shall be separately reimbursed at the provider's documented paid cost, plus an additional 10% of the provider's documented paid cost, net of discounts and rebates, not to exceed a maximum of \$250.00, plus any sales tax and/or shipping and handling charges actually paid. For purposes of this subdivision, a device is an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar related article, including a component part, or accessory which is: (1) recognized in the official National Formulary, or the United States Pharmacopoeia, or any supplement to them; (2) intended for use in the cure, mitigation, treatment, or prevention of disease; or (3) intended to affect the structure or any function of the body, and which does not achieve any of its primary intended purposes through chemical action within or on the body and which is not dependent upon being metabolized for the achievement of any of its primary intended purposes.
- ~~(e)(g)~~ “New technology pass-through”: Additional payments will be allowed for new medical services and technologies as provided by CMS and set forth in Title 42, Code of Federal Regulations Sections 412.87 (effective September 7, 2001 and revised as of October 1, 2003), Section 412.88 (effective September 7, 2001 and amended August 1, 2002 and August 1, 2003 and revised as of October 1, 2003), which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.
- ~~(f)(h)~~ Sole Community Hospitals: If a hospital meets the criteria for sole community hospitals, under Title 42, Code of Federal Regulations § 412.92(a), effective October 1, 2002 and revised as of October 1, 2003, and has been classified by CMS as a sole community hospital, its payment rates are determined under Title 42, Code of Federal Regulations § 412.92(d), effective October 1, 2002 and as revised as of October 1, 2003, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

~~(e)~~(i) Transfers

- (1) Inpatient services provided by a health facility transferring an inpatient to another hospital are exempt from the maximum reimbursement formula set forth in subdivision (a). Maximum reimbursement for inpatient medical services of a health facility transferring an inpatient to another hospital shall be a per diem rate for each day of the patient's stay in that hospital, not to exceed the amount that would have been paid under Title 8, California Code of Regulations §9789.22(a). However, the first day of the stay in the transferring hospital shall be reimbursed at twice the per diem amount. The per diem rate is determined by dividing the maximum reimbursement as determined under Title 8, California Code of Regulations §9789.22(a) by the average length of stay for that specific DRG. However, if an admission to a health facility transferring a patient is exempt from the maximum reimbursement formula set forth in subdivision (a) because it satisfies one or more of the requirements of Title 8, California Code of Regulations §9789.22(~~e~~) or ~~(h)~~(j), this subdivision shall not apply. Inpatient services provided by the hospital receiving the patient shall be reimbursed under the provisions of Title 8, California Code of Regulations §9789.22(a).
 - (2) Post-acute care transfers exempt from the maximum reimbursement set forth in subdivision (a).
 - (A) When an acute care patient is discharged to a post-acute care provider which is a rehabilitation hospital or distinct part rehabilitation unit of an acute care hospital or a long-term hospital, and the patient's discharge is assigned to one of the following qualifying DRGs: 12, 14, 24, 25, 89, 90, 113, 121, 122, 130, 131, 236, 239, 243, 263, 264, 277, 278, 296, 297, 320, 321, 429, 462, 483, or 468; payment to the transferring hospital shall be made as set forth in subdivision ~~(e)~~(i)(1) of this section.
 - (B) When an acute care patient is discharged to a post-acute care provider and the patient's discharge is assigned to one of the following qualifying DRGs 209, 210 or 211, the payment to the transferring hospital is 50% ~~for~~ ~~the first day is half~~ of the payment amount paid under subdivision (a) of this section, plus 50% of the per diem, set forth in subdivision ~~(e)~~(i)(1) for each ~~subsequent~~ day, up to the full DRG amount.
- ~~(h)~~(j) The following are exempt from the maximum reimbursement formula set forth in subdivision (a) and are paid on a reasonable cost basis.
- (1) Critical access hospitals;
 - (2) Children's hospitals that are engaged in furnishing services to inpatients who are predominantly individuals under the age of 18.

- (3) Cancer hospitals as defined by Title 42, Code of Federal Regulations, Section 412.253(f), effective date October 1, 2002 and as revised as of October 1, 2003, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.
 - (4) Veterans Administration hospitals.
 - (5) Long term care hospitals as defined by Title 42, Code of Federal Regulations, Section 412.253(e), effective date October 1, 2002 and as revised as of October 1, 2003, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.
 - (6) Rehabilitation hospital or distinct part rehabilitation units of an acute care hospital or a psychiatric hospital or distinct part psychiatric unit of an acute care hospital, ~~except as provided in subdivision (g)(2).~~
 - (7) The cost of durable medical equipment provided for use at home is exempt from this Inpatient Hospital Fee Schedule. The cost of durable medical equipment shall be paid pursuant to Section 9789.60.
 - (8) Out of state hospitals.
- (k) A health facility that is not listed on the Medicare Cost Report should notify the Administrative Director and provide in writing the following information: OSHPD Licensure number, Medicare provider number, physical location, number of beds, and, if applicable, average FTE residents in approved training programs. If a hospital has been in operation for more than one year, information should also be provided on the percentage of inpatient days attributable to Medicaid patients.
- ~~(l)~~(l) Any health care facility that believes its composite factor or hospital specific outlier factor was erroneously determined because of an error in tabulating data may request the Administrative Director for a re-determination of its composite factor or hospital specific outlier factor. Such requests shall be in writing, shall state the alleged error, and shall be supported by written documentation. Within 30 days after receiving a complete written request, the Administrative Director shall make a redetermination of the composite factor or hospital specific outlier factor or reaffirm the published factor.

Authority: Sections 133, 4603.5, 5307.1, 5307.3, and 5318, Labor Code.

Reference: Sections 4600, 4603.2, 5307.1, and 5318, Labor Code.

Section 9789.32. Outpatient Hospital Department and Ambulatory Surgical Center Fee Schedule – Applicability.

(a) Sections 9789.30 through 9789.368 shall be applicable to the maximum allowable fees for emergency room visits and surgical procedures rendered after January 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 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 assigned to the same APC as the emergency room visit or surgical procedure and has a status indicator H or,~~

~~(2)(3)~~ 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 9789.368 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 the technical component of the diagnostic services shall be determined according to Section 9789.10 and Section 9789.11.~~

~~(2)(1)~~ The maximum allowable fees for ~~the~~ professional ~~component of~~ medical services that are not included in the APC payment rate for emergency room visits and

~~surgical procedures, and~~ which are performed by physicians and other licensed health care providers shall be paid according to Section 9789.10 and Section 9789.11.

- ~~(3)(2)~~ (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.
- ~~(4)(3)~~ (3) The maximum allowable fee for drugs ~~not otherwise covered by a Medicare fee schedule payment for facility service~~ shall be 100% of the fee prescribed by Medical pursuant to Labor Code Section 5307.1 subdivision (a), or, where applicable, Section 9789.40.
- ~~(5)(4)~~ (4) The maximum allowable fee for clinical diagnostic tests shall be determined according to Section 9789.50.
- ~~(5)~~ (5) The maximum allowable fees for non-surgical ~~the technical component of the diagnostic~~ 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 ~~procedure~~ 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. ~~and the applicable APC codes~~

Authority: Sections 133, 4603.5, 5307.1, and 5307.3, Labor Code.

Reference: Sections 4600, 4603.2, and 5307.1, Labor Code.

Section 9789.33. Hospital Outpatient Departments and Ambulatory Surgical Facilities Fee Schedule – Determination of Maximum Reasonable Fee.

(a) For Services rendered after January 1, 2004, the maximum allowable payment for outpatient facility fees for hospital emergency room services or for surgical services performed at a hospital outpatient department or at an ambulatory surgical center shall be determined based on the following. The 1.22 factor shall be used in lieu of an additional payment for high cost outlier cases.

(1) ~~Procedure codes~~ CTP codes 99281-99285 and CPT codes 10040-69990 with status code indicators "S", "T", "X" or "V":

(APC relative weight x \$52.151) x (.40 + .60 x applicable wage index) x inflation factor of 1.034 x 1.22

(A) Table A in Section 9789.34 contains an "adjusted conversion factor" which incorporates the standard conversion factor, wage index and inflation factor. The maximum payment rate for ASCs and non-listed hospitals can be determined as follows:

APC relative weight x adjusted conversion factor x 1.22

(B) Table B in Section 9789.35 contains an "adjusted conversion factor" which incorporates the standard conversion factor, wage index and inflation factor. The maximum payment rate for the listed hospitals can be determined as follows:

APC relative weight x adjusted conversion factor x 1.22

(2) Procedure codes for drugs and biologicals with status code indicator "G":

APC payment rate x 1.22

(3) Procedure codes for devices with status code indicator "H":

Documented paid costs, net of discounts and rebates, plus 10% not to exceed \$250.00, plus any sales tax and/or shipping and handling charges actually paid.

- (4) Procedure codes for drugs and biologicals with status code indicator “K”:

APC payment rate x 1.22

- (b) Alternative payment methodology. In lieu of the maximum allowable fees set forth under (a), the maximum allowable fees for a facility meeting the requirements in subdivisions (c)(1) through (c)(5) will be determined as follows:

- (1) Standard payment:

- (A) ~~Procedure codes~~ CTP codes 99281-99285 and CPT codes 10040-69990 with status code indicators “S”, “T”, “X” or “V”:

(APC relative weight x \$52.151) x (.40 + .60 x applicable wage index) x inflation factor of 1.034 x 1.20

- (B) Procedure codes for drugs and biologicals with status code indicator “G”:

APC payment rate x 1.20

- (C) Procedure codes for devices with status code indicator “H”:

Documented paid costs, net of discounts and rebates, plus 10% not to exceed \$250.00, plus any sales tax and/or shipping and handling charges actually paid.

- (D) Procedure codes for drugs and biologicals with status code indicator “K”

APC payment rate x 1.20

- ~~(E) Procedures codes for surgical procedures with status code indicator “X” when no APC payment is made for a procedure with status code indicator “S”, “T”, or “V”:~~

APC relative weight x adjusted conversion factor x 1.20

- (2) Additional payment for high cost outlier case:
[(Facility charges x cost-to-charge ratio) – (standard payment x 2.6)] x .50

- (3) In determining the additional payment, the facility’s charges and ~~standard~~ payment for devices with status code indicator “H” shall be excluded from the computation.

- (c) The following requirements shall be met for election of the alternative payment methodology:
- (1) A facility seeking to be paid for high cost outlier cases under subdivision 9789.33(b) must file a written election using DWC Form 15 “Election for High Cost Outlier,” contained in Section 9789.37 with the Division of Workers’ Compensation, Medical Unit (Attention: OMFS-Outpatient), P.O. Box 8888, San Francisco, CA 94128. The form must be ~~filed~~ post-marked by March 1 of each year and shall be effective for one year commencing with services furnished on or after April 1 of the year in which the election is made.
 - (2) The maximum allowable fees applicable to a facility that does not file a timely election satisfying the requirements set forth in this subdivision and Section 9789.37 shall be determined under subdivision (a).
 - (3) The maximum allowable fees applicable to a hospital that does not participate under the Medicare program shall be determined under subdivision (a).
 - (4) The cost-to-charge ratio applicable to a hospital participating in the Medicare program shall be the hospital’s cost-to-charge ratio used by the Medicare fiscal intermediary to determine high cost outlier payments under 42 C.F.R. § 419.43(d), which is incorporated by reference, as contained in Section 9789.38 Appendix X. The cost-to-charge ratio being used by the intermediary for services furnished on February 15 of the year the election is filed shall be included on the hospital’s election form.
 - (5) The cost-to-charge ratio applicable to an ambulatory surgery center shall be the ratio of the facility’s total operating costs to total gross charges during the preceding calendar year. Total Operating Costs are the direct costs incurred in providing care to patients. Included in operating cost are: salaries and wages, rent or mortgage, employee benefits, supplies, equipment purchase and maintenance, professional fees, advertising, overhead, etc. It does not include start up costs. Total gross charges are defined as the facility’s total usual and customary charges to all patients and third-party party payers before reductions for contractual allowances, bad debts, courtesy allowances and charity care. The facility’s election form, as contained in Section 9789.37 shall include a completed Annual Utilization Report of Specialty Clinics filed with Office of Statewide Health Planning and Development (OSHPD) for the preceding calendar year, which is incorporated by reference. The facility’s election form shall further include the facility’s total operating costs during the preceding calendar year, the facility’s total gross charges during the preceding calendar year, and a certification under penalty of perjury signed by the Chief Executive Officer and a Certified Public Accountant, as to the

accuracy of the information. Upon request from the Administrative Director, an independent audit may be conducted at the expense of the ASC. (Note: While ASCs may not typically file Annual Utilization Report of Specialty Clinics with OSHPD, any ASC applying for the alternative payment methodology must file the equivalent, subject to the Division of Workers' Compensation's audit.) A copy of the Annual Utilization Report of Specialty Clinics may be obtained at OSHPD's website at <http://www.oshpd.ca.gov/HID/HID/clinic/util/index.htm#Forms> or upon request to the ~~Administrative Director at:~~ Division of Workers' Compensation, Medical Unit (Attention: OMFS-Outpatient), P.O. Box ~~420603~~ 8888, San Francisco, CA 941~~4228~~.

- (6) Before April 1 of each year the AD shall post a list of those facilities that have elected to be paid under this paragraph and the facility-specific cost-to-charge ratio that shall be used to determine additional fees allowable for high cost outlier cases. The list shall be posted on the Division of Workers' Compensation website: http://www.dir.ca.gov/DWC/dwc_home_page.htm or is available upon request to the ~~Administrative Director at:~~ Division of Workers' Compensation, Medical Unit (Attention: OMFS-Outpatient), P.O. Box ~~420603~~ 8888, San Francisco, CA 941~~4228~~.
- (d) Any ambulatory surgical center that believes its cost-to-charge ratio in connection with its election to participate in the alternative payment methodology for high cost outlier cases under Section 9789.33(b) was erroneously determined because of error in tabulating data may request the Administrative Director for a re-determination of its cost-to-charge ratio. Such request shall be in writing, shall state the alleged error, and shall be supported by written documentation. Within 30 days after receiving a complete written request, the Administrative Director shall make a redetermination of the cost-to-charge ratio or reaffirm the published cost-to-charge ratio.
- ~~(d)~~(e) The OPPS rules in 42 C.F.R. § 419.44 regarding reimbursement for multiple procedures are incorporated by reference as contained in Section 9789.38 Appendix X.
- ~~(e)~~(f) The OPPS rules in 42 C.F.R. §§ 419.62, 419.64, and 419.66 regarding transitional pass-through payments for innovative medical devices, drugs and biologicals shall be incorporated by reference, as contained in Section 9789.38 Appendix X, except that payment for these items shall be in accordance with subdivisions (a) or (b) as applicable.
- ~~(f)~~(g) The payment determined under subdivisions (a) and (b) include reimbursement for all of the included cost items specified in 42 CFR § 419.2(b)(1)-(12), which is incorporated by reference as contained in Section 9789.38 Appendix X.
- (h) The maximum allowable fee shall be determined without regard to ~~In addition, all of the~~ cost items specified in 42 C.F.R. § 419.2(c)~~1-6~~ (1), (2), (3), (4), and (6), as contained in Section 9789.38 Appendix X, ~~are included in the maximum allowable payment rate and~~

~~are incorporated by reference as contained in Section 9789.38 Appendix X. Cost item set forth at 42 C.F.R. §419(c)(5), as contained in Section 9789.38 Appendix X, is payable pursuant to Section 9789.32(c)(2). Cost items set forth at 42 C.F.R. §419(c)(7) and (8), as contained in Section 9789.38 Appendix X, are payable pursuant to Section 9789.32(c)(3).~~

~~(g)(i)~~ The maximum allowable fees shall be determined without regard to the provisions in 42 C.F.R. § 419.70.

Authority: Sections 133, 4603.5, 5307.1, and 5307.3, Labor Code.

Reference: Sections 4600, 4603.2, and 5307.1, Labor Code.