

Title 8, California Code of Regulations, § 9789.30
(Effective March 1, 2008)

(a) For services rendered on or after July 1, 2004, "Adjusted Conversion Factor" means the CMS' conversion factor for calendar year 2003 of \$52.151 x the market basket inflation factor of 1.034 x (0.4 + (0.6 x wage index)).

Effective with the first update occurring in each subsequent calendar year, the "Adjusted Conversion Factor" means the OMFS adjusted conversion factor for the preceding calendar year multiplied by the estimated rate of increase in the market basket for the subsequent calendar year.

For services rendered on or after February 15, 2006, the "Adjusted Conversion Factor" for a rural Sole Community Hospital (SCH) is determined by multiplying the amount determined under section 9789.33(b)(1)(A), for hospitals that do not qualify as a rural SCH hospitals by 1.071.

(b) "Ambulatory Payment Classifications (APC)" means the Centers for Medicare & Medicaid Services' (CMS) list of ambulatory payment classifications of hospital outpatient services.

(c) "Ambulatory Surgical Center (ASC)" means any surgical clinic 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, or 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.

(d) "Annual Utilization Report of Specialty Clinics" means the Annual Utilization Report of Clinics that is filed by February 15 of each year with the Office of Statewide Health Planning and Development by the ASCs as required by Section 127285 and Section 1216 of the Health and Safety Code.

(e) "APC Payment Rate" means CMS' hospital outpatient prospective payment system rate for Calendar Year 2004 as set forth in the Federal Register on November 7, 2003, Volume 68, No. 216, Addendum B, pages 63488 through 63655 conformed to comply with CMS-1471-CN, Federal Register, Volume 68, No. 250 (December 31, 2003), pages 75442 through 75445, and CMS-1371-IFC, Federal Register, Volume 69, No. 3 (January 6, 2004), pages 820 through 844.

Effective with the first update occurring in each subsequent calendar year, the "APC Payment Rate" means CMS' hospital outpatient prospective payment system rate as set forth in its Final Rule in effect as of the date that particular update order becomes effective.

(f) "APC Relative Weight" means CMS' APC relative weight as set forth in CMS' hospital outpatient prospective payment system for the Calendar Year 2004 as set forth in the Federal Register on November 7, 2003, Volume 68, No. 216, Addendum B, pages 63488 through

63655 conformed to comply with CMS-1471-CN, Federal Register, Volume 68, No. 250 (December 31, 2003), pages 75442 through 75445, and CMS-1371-IFC, Federal Register, Volume 69, No. 3 (January 6, 2004), pages 820 through 844.

Effective with the first update occurring in each subsequent calendar year, the "APC Relative Weight" means CMS' APC relative weight as set forth in its Final Rule in effect as of the date that particular update order becomes effective.

(g) "CMS" means the Centers for Medicare & Medicaid Services of the United States Department of Health and Human Services.

(h) "Cost to Charge Ratio for ASC" means the ratio of the facility's total operating costs to total gross charges during the preceding calendar year.

(i) "Cost to Charge Ratio for Hospital Outpatient Department" means the hospital cost-to-charge used by the Medicare fiscal intermediary to determine high cost outlier payments.

(j) "HCPCS" means CMS' Healthcare Common Procedure Coding System, which describes products, supplies, procedures and health professional services and includes, the American Medical Associations (AMA's) Physician "Current Procedural Terminology", Fourth Edition (CPT-4) codes, alphanumeric codes, and related modifiers.

(k) "HCPCS Level I Codes" are the AMA's CPT-4 codes and modifiers for professional services and procedures.

(l) "HCPCS Level II Codes" are national alphanumeric codes and modifiers maintained by CMS for health care products and supplies, as well as some codes for professional services not included in the AMA's CPT-4.

(m) "Health facility" means any facility as defined in Section 1250 of the Health and Safety Code.

(n) "Hospital Outpatient Department" means any hospital outpatient department of a health facility as defined in the California Health and Safety Code Section 1250 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.

(o) "Hospital Outpatient Department Services" means services furnished by any health facility as defined in the California Health and Safety Code Section 1250 and any hospital 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 to a patient who has not been admitted as an inpatient but who is registered as an outpatient in the records of the hospital.

(p) "Market Basket Inflation Factor" means 3.4%, the market basket percentage increase determined by CMS for FY 2004, as set forth in the Federal Register on August 1, 2003, Volume 68, at page 45346, for services rendered on or after July 1, 2004.

Effective with the first update occurring in each subsequent calendar year, the “Market Basket Inflation Factor” is the market basket percentage increase determined by CMS as set forth in its Final Rule, in effect as of the date that particular update order becomes effective.

(q) “Outlier threshold”: Effective with the July 15, 2005 update and update occurring in each subsequent calendar year, the “outlier threshold” means the fixed dollar outlier threshold determined by CMS as set forth in its OPPS Final Rule in effect as of the date that particular update order becomes effective.

~~(q)~~ (r) “Outpatient Prospective Payment System (OPPS)” means Medicare's payment system for outpatient services at hospitals. These outpatient services are classified according to a list of ambulatory payment classifications (APCs).

~~(r)~~ (s) “Sole Community Hospital” (SCH) means a classification designated by CMS to a hospital, in accordance with Title 42 of the Code of Federal Regulations section 412.92.

~~(s)~~ (t) “Total Gross Charges” means the facility's total usual and customary charges to patients and third-party payers before reductions for contractual allowances, bad debts, courtesy allowances and charity care.

~~(t)~~ (u) “Total Operating Costs” means the direct cost 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.

~~(u)~~ (v) “Wage Index” means CMS' wage index for urban, rural and hospitals that are reclassified as described in CMS' 2004 Hospital Outpatient Prospective Payment System (HOPPS), adopted for the Calendar Year 2004, published in the Federal Register on November 7, 2003, Volume 68, No. 216, Addenda H through J, pages 63682 through 63690.

Effective with the first update occurring in each subsequent calendar year, the “Wage Index” is the CMS’ wage index for urban, rural and hospitals that are reclassified as described in its Final Rule in effect as of the date that particular update order becomes effective.

~~(v)~~ (w) “Workers' Compensation Multiplier” means the 120% Medicare multiplier required by Labor Code Section 5307.1, or the 122% multiplier that includes an extra 2% reimbursement for high cost outlier cases.