

**STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
Division of Workers' Compensation**

STATEMENT OF REASONS FOR ADOPTION OF REGULATIONS

TITLE 8, CALIFORNIA CODE OF REGULATIONS, SECTION 9792.1

Subject Matter of Regulations: Workers' Compensation – Payments for Inpatient Hospital Services

NOTICE IS HEREBY GIVEN in compliance with Labor Code Section 5307.4, that the Administrative Director of the Division of Workers' Compensation, pursuant to the authority vested in the Administrative Director by Labor Code Sections 5307.1(a)(1) and 5307.4, has severed a portion of the rulemaking proposal noticed on August 11, 2000, and adopted amendments to Title 8 of the California Code of Regulations, Section 9792.1. Section 9792.1 concerns fees for inpatient hospital services in workers' compensation cases.

The amendments adopted concern reimbursement for the costs of implantable instrumentation and hardware for spinal related surgeries under DRGs 496-500. This adoption does not conclude the rulemaking proceeding. The remainder of the rulemaking proceeding concerning the proposed cost outlier methodology and other issues will continue.

The amended regulations will be effective for admissions that occur on or after April 13, 2001.

BACKGROUND TO THE REGULATORY PROCEEDING

Labor Code Section 5307.1 requires the Administrative Director of the Division of Workers' Compensation (Division) to "adopt and revise, no less frequently than biennially, an official medical fee schedule which shall establish reasonable maximum fees paid for medical services provided pursuant to (Division 4 of the Labor Code)." The Official Medical Fee Schedule (OMFS) was last revised effective April 1, 1999.

One portion of the OMFS applies just to hospital inpatient services. The Inpatient Hospital Fee Schedule component of the OMFS establishes a maximum "global fee" for services made in connection with particular "diagnosis related groups" (DRGs). DRGs are codes used to group related types of procedures for reimbursement purposes.

The maximum global fee for a specific procedure at a specific facility is determined by multiplying 1.20 by the product of the health facility's composite factor, (a factor that is based on the unique cost and service differentials applicable to specific individual facilities), and the applicable DRG weight (or revised DRG weight if a revised weight has been adopted by the Administrative Director).

The Administrative Director has learned from both the payor and provider communities that the DRG weights for the five spine related surgical DRGs produce reimbursement levels pursuant to the fee schedule that are so low that some facilities are actively discouraging, and in some cases even preventing, surgeons from performing these procedures on an inpatient basis at their facilities. This may pose a threat to access to health care for seriously injured workers.

The DRGs in question are as follows:

- DRG 496 Combined Anterior/Posterior Spinal Fusion
- DRG 497 Spinal Fusion with CC ¹
- DRG 498 Spinal Fusion without CC
- DRG 499 Back and Neck Procedures except Spinal Fusion with CC
- DRG 500 Back and Neck Procedures except Spinal Fusion without CC

As indicated in the documents relied upon (and contained in the rulemaking file), the Division received numerous complaints that the reimbursement levels for DRGs 469 through 500 are inadequate at least in part due to the expenses incurred by hospitals in procuring the hardware or instrumentation that is used in some spinal surgery procedures. Recent technological advances in orthopedic spine-related surgery often utilize instrumentation and hardware such as pedicle screws, titanium screws and plates, interbody fixation cages and implantable bone growth stimulators which are extremely expensive. The California Medical Association reports that hardware costs can run anywhere from approximately \$1,500 to \$14,000 per surgery. The Administrative Director has been informed that the reimbursement levels under the current spine related DRG groups often do not cover even the implanted hardware costs for some of these procedures, thereby forcing hospitals to choose between losing money on these procedures or refusing to allow these procedures to be performed in their facilities.

Because of this disparity between procedure costs and fee schedule reimbursement levels, the Administrative Director has been informed that some hospitals are refusing to allow complex spinal surgeries to be scheduled in their facilities. This may create access problems for injured workers in need of complex surgical procedures.

The regulatory amendments were initially the subject of a public comment period from August 11 to September 28, 2000. Public hearings were conducted in Los Angeles and San Francisco, California.

The amended regulations were filed with the Secretary of State on March 14, 2001, and will take effect on the 30th day thereafter – April 13, 2001.

SPECIFIC REASON FOR REGULATORY ADOPTION

The current rulemaking action was commenced in order to adopt interim relief that appeared to be needed in relation to claims by providers of inadequate reimbursement for very costly admissions, especially spinal surgeries falling under DRGs 496-500 in the Inpatient Hospital Fee Schedule. The regulations as originally proposed concerned reimbursement for implantable hardware and instrumentation and the adoption of a cost outlier methodology.

In light of comments received to date, the Administrative Director has severed from the rulemaking and adopted the modified proposal concerning reimbursement for the costs of implantable hardware and instrumentation costs under the spinal surgery codes DRG 496-500. The regulations, as adopted, provide that for DRGs 466-500, the cost of the implantable hardware will be excluded from the DRG payment and subject to a separate payment of actual documented paid cost, plus 10% of documented paid cost (to a maximum of \$250), plus sales tax, shipping and handling actually paid. This action is an interim solution to immediately mitigate a portion of the spinal surgery code issues addressed in the rulemaking; the regulations will specify that the implantable hardware amendments will “sunset” as of

¹ Complicating Condition(s).

12/30/01. The remainder of the rulemaking proceeding will continue to allow refinement of the proposed cost outlier methodology and other issues addressed in the rulemaking proposals.

As this is intended to be an interim solution to the fee issues concerning the spinal surgeries under DRGs 496-500, the Administrative Director has adopted a sunset date of December 31, 2001, for the implantable hardware provisions.

FACTUAL BASIS FOR REGULATORY ACTION

Section Adopted: Section 9792.1(c)(8)

Problem addressed by adoption:

The adoption of Section 9792.1(c)(9) excludes the cost of implantable hardware and instrumentation for spinal related surgeries, DRGs 496 through 500, from the global DRG computed fee where the admission occurs on or after the effective date of the regulations. The cost of implantable hardware and/or instrumentation for DRGs 496 through 500, where the admission occurs on or after the effective date of the regulations, will be separately reimbursed at documented cost, plus 10% of documented cost, up to a maximum of \$250.00, plus any sales tax and/or shipping and handling charges actually paid.

The regulation adopted allows separate reimbursement in addition to the DRG computed fee for both the documented costs of the instrumentation and hardware for these specified DRGs and a portion of the facility's overhead costs in acquiring the instrumentation and hardware.

Reason for Adoption:

The Administrative Director has learned that the costs of the implantable hardware and instrumentation such as titanium cages used in spinal surgeries in DRGs 496 through 500 often exceed the total maximum global fee computed under the fee schedule.

With respect to the costs of instrumentation and hardware, for example, the titanium cages used in some spinal fusion procedures are very expensive. The Division has reviewed data provided by hospitals and payors that suggests that total hospital costs for instrumentation and hardware alone for these DRGs are substantially higher in some cases than the total maximum global reimbursement rate for the entire hospitalization. The Division has received information that the current reimbursement levels have led some facilities to refuse to allow these procedures to be performed, threatening injured workers' access to these procedures.

Although the Administrative Director believes that it is necessary to allow separate reimbursement for instrumentation and hardware for the specified DRGs, the Administrative Director also feels that in order to avoid costly and time consuming billing disputes, it is necessary to regulate the maximum allowable additional reimbursement for these items.

Section Amended: Section 9792.1(e)

Problem Addressed:

The amendment to Section 9792.1 makes it clear that the newly adopted subsection (c)(8) is not retroactive to April 1, 1999.

Reason for Adoption:

Some providers who submitted comments on the regulations asked that the regulations be made retroactive to the initial April 1, 1999, effective date of the fee schedule in order to reimburse them for the economic losses they claimed to have under the fee schedule. The Administrative Director determined that is necessary to clarify in Section 9792.1(e) that the newly adopted provisions concerning reimbursement for implantable instrumentation and hardware are not retroactive in order to forestall any attempt by a provider to seek increased reimbursement by claiming retroactive application of this provision. (It should be noted that providers may be paid fees in excess of the fee schedule pursuant to Labor Code § 5307.1(b) if the fee is reasonable, and accompanied by an itemization and justification.)

Section Adopted: Section 9792.1(f)

Problem Addressed:

The adoption of Section 9792.1(f) provides a sunset date for the newly adopted provision concerning reimbursement for implantable instrumentation and hardware. At the suggestion of the Office of Administrative Law, this section has been grammatically but non-substantively changed from the modified text released for public comment in order to improve the section’s clarity.

Reason for Adoption:

Since this is intended to be an interim solution to the fee issues in relation to the spinal surgeries under DRGs 496-500, the Administrative Director determined it is necessary to adopt a sunset date of December 31, 2001, for the implantable hardware provisions.

EFFECTIVE DATE

The amendments to Section 9792.1 will take effect on April 13, 2001.

**MAILING OF STATEMENT OF REASONS FOR ADOPTION OF REGULATION
and TEXT OF REGULATION**

As required by Labor Code Section 5307.4(d), this Statement of Reasons for Amendment of Regulations, and the text of the amended and adopted regulations, 8 CCR Section 99792.1, are being mailed to all persons on the Administrative Director’s mailing list, to all persons who requested notice of regulatory proceedings and to every facility on the Office of Statewide Health Planning and Development’s listing of California hospitals.

Dated: _____

RICHARD P. GANNON
Administrative Director

California Code of Regulations
Title 8, Division 1, Chapter 4.5, Subchapter 1, Article 5.5

§9792.1 - Payment of Inpatient Services of Health Facilities.

(a) Maximum reimbursement 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 or revised DRG weight if a revised weight has been adopted by the administrative director. 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) 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.

(c) The following are exempt from the maximum reimbursement formula set forth in subdivision (a):

- (1) Inpatient services for admissions where the length of stay exceeds the day outlier threshold established by the Health Care Financing Administration for the diagnosis-related group.
- (2) Inpatient services for the following diagnoses: Psychiatry (DRGs 424-432), Substance Abuse (DRGs 433-437), Organ Transplants (DRGs 103, 302, 480, 481, 495), Rehabilitation (DRG 462 and inpatient rehabilitation services provided in any rehabilitation center that is authorized by the Department of Health Services in accordance with Title 22, §§ 70301 - 70603 of the California Code of Regulations to provide rehabilitation services), Tracheostomies (DRGs 482, 483), and Burns (DRGs 456-460, 472, 475).
- (3) Inpatient services provided by a Level I or Level II trauma center, as defined in Title 22, California Code of Regulations sections 100260, 100261, to a patient with an immediately life threatening or urgent injury.
- (4) Inpatient services provided by a health facility for which there is no composite factor.
- (5) Inpatient services provided by a health facility located outside the State of California.
- (6) The cost of durable medical equipment provided for use at home.

(7) Inpatient services provided by a health facility transferring an inpatient to another hospital. 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 §9792.1(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 §9792.1(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 §9792.1(c)(1) through (c)(5), subdivision (c)(7) 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 §9792.1(a).

(8) Implantable hardware and/or instrumentation for DRGs 496 through 500, where the admission occurs on or after April 13, 2001. Implantable hardware and/or instrumentation for DRGs 496 through 500, where the admission occurs on or after April 13, 2001, shall be separately reimbursed at the provider's documented paid cost, plus an additional 10% of the provider's documented paid cost not to exceed a maximum of \$250.00, plus any sales tax and/or shipping and handling charges actually paid.

(d) Any health care facility that believes its composite factor was erroneously determined because of an error in tabulating data may request the Administrative Director for a re-determination of its composite 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 reaffirm the published composite factor.

(e) This section, except as provided in subsection (c)(8), shall apply to covered inpatient hospital stays for which the day of admittance is on or after April 1, 1999.

(f) Subsection (c)(8) shall remain in effect only through December 31, 2001, and shall not apply to admissions occurring on or after January 1, 2002.

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

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