

## OMFS Update for Inpatient Hospital Services (Effective for discharges occurring on or after December 1, 2005)

### 1. Data Sources

- a. The Medicare FY06 update to the inpatient prospective payment system was published on August 12, 2005 in the Federal Register (Vol. 70 FR 47278) and is entitled " Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates; Final Rule" (CMS-1500-F). A correction to the final rule was published on September 30, 2005, in the Federal Register (Vol. 70 FR 57161), and is entitled "Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates; Correction" (CMS-1500-CN). These documents are available at <http://www.cms.hhs.gov/providers/hipps/frnotices.aspfrnotices.asp>.
- b. The factors to determine composite rate are available on the CMS website at <http://www.cms.hhs.gov/providers/hipps/ippspufs.asp> The public use file used to calculate the composite rates is entitled "Impact File for IPPS FY 2006 Final Rule." The file contains wage data posted on the CMS website as of August 17, 2005.

### 2. Composite Rate Calculation

- a. Update to the standardized amount. L.C. 5307.1(g)(1)(A)(i) provides that the annual inflation adjustment for inpatient hospital facility fees shall be determined solely by the estimated increase in the hospital market basket. Thus, in lieu of using the Medicare FY06 rates to determine the updated OMFS amounts, the estimated increase in the hospital market basket was applied to the FY05 OMFS rates.
- b. OMFS rate for operating costs
  - i. Based on a provision of the Medicare Modernization Act (MMA), all hospitals are paid the same standard rate for operating costs (based on the rate for hospitals located in large urban areas). The FY05 rate was \$ 4,569.83. The estimated increase in the market basket is 3.7%. The FY06 standard rate under the OMFS is \$ 4,738.91 ( $\$4,569.83 \times 1.037$ ).
  - ii. The MMA provides that if a hospital's wage index is less than 1.0, the labor-related share is .62 of the standard rate. If the wage index is 1.0 or higher, the labor-related share is .697. The wage-adjusted standard rate is determined as follows:
    1. If  $WIGRN \geq 1.0$ , wage-adjusted rate =  $\$ 4,738.91 \times (.697 \times WIGRN + .303)$
    2. If  $WIGRN < 1.0$ , wage-adjusted rate =  $\$ 4,738.91 \times (.62 \times WIGRN + .38)$

- iii. The wage-adjusted operating rate is further adjusted for any additional payments for teaching and serving a disproportionate share of low-income patients.  
Adjusted operating rate = wage-adjusted standard rate x (1 + DSHOP + TCHOP)
  - c. OMFS rate for capital-related costs
    - i. The estimated increase in the capital market basket is 0.8%. The FY06 standard capital rate is \$420.06 ( $\$416.73 \times 1.008$ ). The standard capital rate is further increased 3% for hospitals located in large urban areas.
    - ii. The standard capital is adjusted for the capital geographic adjustment factor, teaching, and for serving low-income patients.  
Adjusted capital rate =  $\$420.06 \times \text{WICGRN} \times (1 + \text{DSHCPG} + \text{TCHCPG})$  [x 1.03 if large urban].
  - d. The standard composite rate is the sum of the OMFS rate for operating costs and the OMFS rate for capital-related costs.
  - e. Sole community hospitals (PTYPE = 16) receive the higher of the standard composite rate or a composite rate based on a hospital-specific rate for operating costs plus the OMFS rate for capital-related costs. The hospital-specific rate for operating costs is the higher of OLDHSPPS or HSP96. When the hospital-specific composite rate is higher than the standard composite rate, the amount is shown in italics.
- 3. Cost-to-charge ratio (CCR) used to determine outlier payments is the sum of the operating and capital cost-to-charge ratios.  $\text{CCR} = \text{OPCCR} + \text{CPCCR}$
- 4. Hospital-specific outlier threshold
  - a. The standard outlier threshold is \$23,600.
  - b. The standard outlier threshold is allocated to operating and capital components and adjusted for geographic location as follows:
    - i. If  $\text{WIGRN} > 1.0$ , operating outlier threshold =  $\$23,600 \times \text{OPCCR}/\text{CCR} \times (\text{WIGRN} \times .697 + .303)$
    - ii. If  $\text{WIGRN} < 1.0$ , operating outlier threshold =  $\$23,600 \times \text{OPCCR}/\text{CCR} \times (\text{WIGRN} \times .62 + .38)$
    - iii. Capital outlier threshold =  $\$23,600 \times \text{CPCCR}/\text{CCR} \times \text{WICGRN}$
    - iv. Hospital-specific outlier threshold = operating outlier threshold + capital outlier threshold
- 5. Listing of Hospitals
  - a. Any hospital that has become a certified critical access hospital (CAH), but is not reflected in the development of this table, should notify DWC.

- b. Any other hospital that does not appear on the Medicare impact file should contact the Division of Workers' Compensation and provide the information needed to determine a composite rate.
6. DRG Relative Weights: Revised DRG relative weights were published on August 12, 2005 in the Federal Register (Vol. 70 FR 47617) as "TABLE 5--LIST OF DIAGNOSIS-RELATED GROUPS, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)." Section 9789.24. Diagnostic Related Groups, Relative Weights, Geometric Mean Length of Stay is revised to reflect these changes effective with discharges occurring on or after December 1, 2005.
7. Maximum Allowable Fees: To determine the standard payment rate, the hospital-specific composite rate would be multiplied by the DRG relative weight and 1.20 multiplier. Additional payments will be made for high cost outlier cases and for certain pass-through costs in accordance with the regulations.
8. For purposes of determining whether a case qualifies as a cost outlier case, section 9789.22(e)(5) is amended to conform to updates to the DRGs which were published on August 12, 2005 in the Federal Register (Vol. 70 FR 47278) and is entitled " Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates" (CMS-1500-F), and the correction notice published on September 30, 2005 in the Federal Register (Vol. 70 FR 57161), and is entitled "Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates; Correction" (CMS-1500-CN). A new DRG 546 (spinal fusions except cervical with curvature of the spine or malignancy) is created. The new DRG 546 will be composed of all noncervical spinal fusions previously assigned to DRGs 497 and 498 that have a principal or secondary diagnosis of curvature of the spine or a principal diagnosis of a malignancy.
9. For purposes of reimbursing for implantable medical devices, hardware, and instrumentation, section 9789.22(f) is amended to conform to updates to the DRGs which were published on August 12, 2005 in the Federal Register (Vol. 70 FR 47278) and is entitled " Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates" (CMS-1500-F), and the correction notice published on September 30, 2005 in the Federal Register (Vol. 70 FR 57161), and is entitled "Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates; Correction" (CMS-1500-CN). A new DRG 546 (spinal fusions except cervical with curvature of the spine or malignancy) is created. The new DRG 546 will be composed of all noncervical spinal fusions previously assigned to DRGs 497 and 498 that have a principal or secondary diagnosis of curvature of the spine or a principal diagnosis of a malignancy.

10. Acute Care Transfers: Section 9789.22(i)(2)(A) is amended to conform to updates to the qualifying DRGs when an acute care patient is discharged to a post-acute care provider, which were published on August 12, 2005 in the Federal Register (Vol. 70 FR 47278) and is entitled " Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates" (CMS-1500-F), and the correction notice published on September 30, 2005 in the Federal Register (Vol. 70 FR 57161), and is entitled "Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates; Correction" (CMS-1500-CN). These documents are available at <http://www.cms.hhs.gov/providers/hipps/>. Table 5 lists how the transfer policy will apply when an acute care patient in a particular DRG is transferred to a post-acute care provider.

Section 9789.22(i)(2)(B) is amended to conform to updates to the DRGs which were published on August 12, 2005 in the Federal Register (Vol. 70 FR 47278) and is entitled " Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates" (CMS-1500-F), and the correction notice published on September 30, 2005 in the Federal Register (Vol. 70 FR 57161), and is entitled "Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates; Correction" (CMS-1500-CN). DRG 209 is deleted and replaced with new DRG 544 (major joint replacement and reattachment of lower extremity) and new DRG 545 (revision of hip and knee replacement). In addition to the above changes, DRGs 7, 8, 233, 234, 471, 497, 498, 549, 550 are now subject to payment in accordance with this section.

11. Section 9789.22 is further amended by Order of the Administrative Director as described in paragraph 12, below. In particular, the subsections which reference the Federal Register or Code of Federal Regulations are amended to incorporate by reference the Federal Register, August 12, 2005, Vol. 70 FR 47278) entitled "Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates"-CMS-1500-F, and the correction notice published on September 30, 2005 in the Federal Register (Vol. 70 FR 57161), and is entitled "Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates; Correction"-CMS-1500-CN, to be applied to discharges occurring on or after December 1, 2005.

12. Pursuant to Labor Code section 5307.1(g)(2), the Administrative Director of the Division of Workers' Compensation orders that to the extent references to the Federal Register or Code of Federal Regulations are made in any sections starting from section 9789.20 through 9789.24 of Title 8 of the California Code of Regulations, said section is hereby amended to incorporate by reference the applicable Federal Register final rule (including correction notices and revisions) and Federal Regulations in effect as of the date the Order becomes effective, to be applied to discharges occurring on or after December 1, 2005.