

Title 8, California Code of Regulations §9789.22 - Effective December 1, 2005

(Only the subsections which are amended to conform to the final rule of August 12, 2005, and the correction notice of September 30, 2005 published in the Federal Register which changes the qualifying DRGs for cost outlier cases, for reimbursement of implantable medical devices, hardware, and instrumentation, and when an acute care patient is discharged to a post-acute care provider are printed herein. The new text is underlined. It should be noted, however, in accordance with the Order of the Administrative Director, other subsections which reference the Federal Register or Code of Federal Regulations are also amended (but not printed herein) to incorporate by reference the applicable Federal Register final rule (including correction notices and revisions) and Federal Regulations in effect as of the date this Order becomes effective, to be applied to discharges occurring on or after December 1, 2005.)

(e) Cost Outlier cases.

(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 (f) is excluded from the calculation of costs. 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 (f).

For discharges on or after December 1, 2005: 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 (f) is excluded from the calculation of costs. If an admission for DRGs 496, 497, 498, 519, 520, 531, 532, and 546 qualifies as a cost outlier case, any implantable hardware and/or instrumentation shall be separately reimbursed under subsection (f).

(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.

For discharges on or after December 1, 2005: Implantable medical devices, hardware, and instrumentation for DRGs 496, 497, 498, 519, 520, 531, 532, and 546 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.

(i) Transfers

(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 (i)(1) of this section.

For discharges on or after July 15, 2005: 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, 88, 89, 90, 113, 121, 122, 127, 130, 131, 236, 239, 277, 278, 294, 296, 297, 320, 321, 395, 429, 468, 541 or 542; payment to the transferring hospital shall be made as set forth in subdivision (i)(1) of this section.

For discharges on or after December 1, 2005: 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 qualifying DRGs listed in Table 5 of the Federal Register published on August 12, 2005, (Vol. 70, FR 47278) and entitled "Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates" (CMS-1500-F), which is incorporated by reference and will be made available upon request to the Administrative Director, 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), which is incorporated by reference and will be made available upon request to the Administrative Director,

payment to the transferring hospital shall be made as set forth in subdivision (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% of the amount paid under subdivision (a) of this section, plus 50% of the per diem, set forth in subdivision (i)(1) for each day, up to the full DRG amount.

For discharges on or after December 1, 2005: 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 7, 8, 210, 211, 233, 234, 471, 497, 498, 544, 545, 549, or 550, the payment to the transferring hospital is 50% of the amount paid under subdivision (a) of this section, plus 50% of the per diem, set forth in subdivision (i)(1) for each day, up to the full DRG amount.