Title 8, California Code of Regulations §9789.22 – Effective January 1, 2008

(Only the subsections which are amended to conform to the Medicare FY 2008 update to the inpatient prospective payment system, published on August 22, 2007 in the Federal Register (Vol. 72, No. 162, FR 47130), entitled, "Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates; Final Rule" (CMS-1533-FC), correction published on October 10, 2007 in the Federal Register (Vol. 72, FR 57634), entitled, "Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates; Correction" (CMS-1533-CN2), correction published on November 6, 2007 in the Federal Register (Vol. 72, FR 62585), entitled, "Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates; Correction" (CMS-1533-CN3), and the notice to the final rule published on November 27, 2007 in the Federal Register (Vol. 72, No. 227, FR 66580), entitled, "Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and CY 2008 Payment Rates, the Ambulatory Surgical Center Payment System and CY 2008 Payment Rates, the Hospital Inpatient Prospective Payment System and FY 2008 Payment Rates; and Payments for Graduate Medical Education for Affiliated Teaching Hospitals in Certain Emergency Situations Medicare and Medicaid Programs; Hospital Conditions of Participation; Necessary Provider Designations of Critical Access Hospitals" (CMS-1392-FC, CMS-1533-F2, and CMS-1531-IFC2)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 additional notices, 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 January 1, 2008.)

(e) Cost Outlier cases. Inpatient services for cost outlier cases, shall be reimbursed as follows:

(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).

For discharges on or after January 1, 2008: 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) are excluded from the calculation of costs. If an admission for DRGs 028, 029, 030, 453, 454, 455, 456, 457, 458, 459, 460, 471, 472, and 473 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.

For discharges on or after January 1, 2008: Implantable medical devices, hardware, and instrumentation for DRGs 028, 029, 030, 453, 454, 455, 456, 457, 458, 459, 460, 471, 472, and 473 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.

For discharges on or after December 1, 2006: 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 addendum to the notice published on October 11, 2006, (Vol. 71, FR 59886) and entitled “Medicare Program;

Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates: Final Fiscal Year 2007 Wage Indices and Payment Rates After Application of Revised Occupational Mix Adjustment to Wage Index" (CMS-1488-N), 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.

For discharges on or after March 1, 2007: 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 addendum to the notice published on October 11, 2006 (Vol. 71, FR 59886), and entitled "Medicare Program; Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates: Final Fiscal Year 2007 Wage Indices and Payment Rates After Application of Revised Occupational Mix Adjustment to Wage Index" (CMS-1488-N), which is incorporated by reference and will be made available upon request to the Administrative Director, and Correction of Notice published on January 5, 2007 (Vol. 72, No. 3, FR 569), and entitled, "Medicare Programs; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Final Fiscal Year 2007 Wage Indices and Payment Rates After Application of Revised Occupational Mix Adjustment to the Wage Index; Corrections" (CMS-1488-CN2), 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.

For discharges on or after January 1, 2008: 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 addendum to the final rule published in the Federal Register on August 22, 2007, (Vol. 72, FR 47130) and entitled "Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates; Final Rule" (CMS-1533-FC) which is incorporated by reference and will be made available upon request to the Administrative Director, and correction published in the Federal Register on October 10, 2007, (Vol. 72, FR 57634) and entitled "Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates; Correction" (CMS-1533-CN2), 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.

For discharges on or after December 1, 2006: 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, 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.

For discharges on or after March 1, 2007: 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.

For discharges on or after January 1, 2008: When an acute care patient is discharged to a post-acute care provider and the patient's discharge is assigned to one of the qualifying DRGs designated with a “yes” in the “FY08 Final Rule Special Pay DRG” column in Table 5 of the addendum to the final rule published in the Federal Register on August 22, 2007, (Vol. 72, FR 47130) and entitled “Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates; Final Rule” (CMS-1533-FC), which is incorporated by reference and will be made available upon request to the Administrative Director, and correction published in the Federal Register on October 10, 2007, (Vol. 72, FR 57634) and entitled “Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates; Correction” (CMS-1533-CN2), which is incorporated by reference and will be made available upon request to the Administrative Director, 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.