*8 CCR 9789.22 As of December 1, 2009*
*(The underlined text reflects amendments made in accordance with the administrative director Orders effective November 29, 2004, July 15, 2005, December 1, 2005, December 1, 2006, March 1, 2007, April 1, 2007, and January 1, 2008, and by the orders of the acting administrative director effective December 1, 2008 and December 1, 2009.)*

§ 9789.22. Payment of Inpatient Hospital Services

(a) Maximum payment 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. 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) The maximum payment for inpatient medical services includes reimbursement for all of the inpatient operating costs specified in *Title 42, Code of Federal Regulations, Section 412.2(c),* effective date October 1, 2002 and revised as of October 1, 2003, which is incorporated by reference and will be made available upon request to the Administrative Director, and the inpatient capital-related costs specified in *Title 42, Code of Federal Regulations, Section 412.2(d),* effective date October 1, 2002 and revised as of October 1, 2003, which is incorporated by reference and will be made available upon request to the Administrative Director.

(c) The maximum payment shall include the cost items specified in *Title 42, Code of Federal Regulations, Section 412.2(e)(1),* (2), (3), and (5), revised as of October 1, 2003, which is incorporated by reference and will be made available upon request to the Administrative Director. The maximum allowable fees for cost item set forth at *42 C.F.R. §412.2(e)(4),* "the acquisition costs of hearts, kidneys, livers, lungs, pancreas, and intestines (or multivisceral organ) incurred by approved transplantation centers," shall be based on the documented paid cost of procuring the organ or tissue.

(d) 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. The billings shall include the principal and secondary diagnoses and surgical procedures. They shall also set forth the patient characteristics, including the DRG weight, the charges, the costs for new technology, and the length of stay.

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

(1) Step 1: Determine the Inpatient Hospital Fee Schedule maximum payment amount (DRG weight x 1.2 x hospital specific composite factor).

(2) Step 2: Determine costs. Costs = (total billed charges x total cost-to-charge ratio).

(3) Step 3: Determine outlier threshold. Outlier threshold = (Inpatient Hospital Fee Schedule payment amount + hospital specific outlier factor + any new technology pass-through payment determined under Section 9789.22(g)).

(4) If costs exceed the outlier threshold, the case is a cost outlier case and the admission is reimbursed at the Inpatient Hospital Fee Schedule payment amount + new technology pass-through payment determined under Section 9789.22(g) + (0.8 x (costs - cost outlier threshold)).

(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, as modified in the Federal Register of August 12, 2005 (CMS-1500-F; 70 FR 47278) on page 47308, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director: 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, as indicated in the Crosswalk from CMS DRGs to Medicare Severity DRGs, FY 2008 Final Rule, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director: 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 Medicare Severity 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, as modified in the Federal Register of August 12, 2005 (CMS-1500-F; 70 FR 47278) on page 47308, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director: 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, as indicated in the Crosswalk from CMS DRGs to Medicare Severity DRGs, FY 2008 Final Rule, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director: Implantable medical devices, hardware, and instrumentation for Medicare Severity 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.

(g) "New technology pass-through": Additional payments will be allowed for new medical services and technologies as provided by CMS and set forth in *Title 42, Code of Federal Regulations Sections 412.87* (effective September 7, 2001 and revised as of October 1, 2003), Section 412.88 (effective September 7, 2001 and amended August 1, 2002 and August 1, 2003 and revised as of October 1, 2003), which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

For discharges on or after November 29, 2004, additional payments will be allowed for new medical services and technologies as provided by CMS and set forth in *Title 42, Code of Federal Regulations Sections 412.87* (effective September 7, 2001 and revised October 1, 2003 and amended as of October 1, 2004), Section 412.88 (effective September 7, 2001 and amended August 1, 2002 and August 1, 2003 and revised October 1, 2003 and amended as of October 1, 2004), which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

For discharges on or after January 1, 2008, additional payments will be allowed for new medical services and technologies as provided by CMS and set forth in *Title 42, Code of Federal Regulations Sections 412.87* (effective September 7, 2001 and revised October 1, 2003 and

amended as of October 1, 2004), Section 412.88 (effective September 7, 2001 and amended August 1, 2002 and August 1, 2003 and revised October 1, 2003 and amended October 1, 2004 and as of October 1, 2007), which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

For discharges on or after December 1, 2008, additional payments will be allowed for new medical services and technologies as provided by CMS and set forth in *Title 42, Code of Federal Regulations Sections 412.87* (effective September 7, 2001 and revised October 1, 2003 and amended October 1, 2004 and as of October 1, 2008), Section 412.88 (effective September 7, 2001 and amended August 1, 2002 and August 1, 2003 and revised October 1, 2003 and amended October 1, 2004 and as of October 1, 2007), which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

For discharges on or after December 1, 2009, additional payments will be allowed for new medical services and technologies as provided by CMS and set forth in *Title 42, Code of Federal Regulations Sections 412.87* (effective September 7, 2001 and revised October 1, 2003 and amended October 1, 2004, October 1, 2008, and as of October 1, 2009), Section 412.88 (effective September 7, 2001 and amended August 1, 2002 and August 1, 2003 and revised as of October 1, 2003 and amended October 1, 2004 and as of October 1, 2007), which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

(h) Sole Community Hospitals: If a hospital meets the criteria for sole community hospitals, under *Title 42, Code of Federal Regulations §412.92(a)*, effective October 1, 2002 and revised as of October 1, 2003, and has been classified by CMS as a sole community hospital, its payment rates are determined under *Title 42, Code of Federal Regulations § 412.92(d)*, effective October 1, 2002 and as revised as of October 1, 2003, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

For discharges on or after December 1, 2005, if a hospital meets the criteria for sole community hospitals, under *Title 42, Code of Federal Regulations §412.92(a)*, effective October 1, 2002 and revised October 1, 2003 and amended as of October 1, 2005, and has been classified by CMS as a sole community hospital, its payment rates are determined under *Title 42, Code of Federal Regulations § 412.92(d)*, effective October 1, 2002 and revised October 1, 2003 and amended as of October 1, 2005, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

For discharges on or after December 1, 2008, if a hospital meets the criteria for sole community hospitals, under *Title 42, Code of Federal Regulations §412.92(a)*, effective October 1, 2002 and revised October 1, 2003 and amended as of October 1, 2005, and has been classified by CMS as a sole community hospital, its payment rates are determined under *Title 42, Code of Federal Regulations § 412.92(d)*, effective October 1, 2002 and revised October 1, 2003 and amended October 1, 2005 and as of October 1, 2008, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

(i) Transfers

(1) Inpatient services provided by a health facility transferring an inpatient to another hospital are exempt from the maximum reimbursement formula set forth in subdivision (a). 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 §9789.22(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 §9789.22(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 §9789.22(j)*, this subdivision 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 §9789.22(a).*

(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, as specified in the Federal Register of October 7, 2004 (CMS-1428-CN2, 69 FR 60242) beginning on page 60246, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director: 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 designated with a “yes” in “FY06 Final Rule Post-acute Care DRG” column in Table 5 of the Federal Register published on August 12, 2005, (CMS-1500-F; Vol. 70, FR 47278), beginning on page 47617; and the correction notice published on September 30, 2005 in the Federal Register (CMS-1500-CN; Vol. 70, FR 57161), beginning on page 57163, which documents are hereby 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 designated with a "yes" in the "FY 07 Final Rule Post -acute Care DRG" column in Table 5 of the addendum to the notice published on October 11, 2006, (CMS-1488-N; Vol. 71, FR 59886), beginning on page 60013, which document is hereby 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 designated with a "yes" in the "FY 07 Final Rule Post -acute Care DRG" column in Table 5 of the addendum to the notice published on October 11, 2006 (CMS-1488-N; Vol. 71, FR 59886), beginning on page 60013; and Correction of Notice published on January 5, 2007 (CMS-1488-CN2; Vol. 72, No. 3, FR 569), beginning on page 573, which documents are hereby 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 Medicare Severity DRGs designated with a "yes" in the "FY08 Final Rule Post-Acute DRG" column in Table 5 of the addendum to the final rule published in the Federal Register on August 22, 2007, (CMS-1533-FC; Vol. 72, FR 47130), beginning on page 47539; and correction published in the Federal Register on October 10, 2007, (CMS-1533-CN2; Vol. 72, FR 57634), on page 57727, which documents are hereby 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, 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 Medicare Severity DRGs designated with a "yes" in the "FY09 Final Rule Post-Acute DRG" column in Table 5 of the addendum to the final rule published in the Federal Register on August 19, 2008, (CMS-1390-F; Vol. 73 FR 48434), beginning on page 48899, which document is hereby 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, 2009: 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 qua-

lifying Medicare-Severity DRGs designated with a “yes” in the “FY 2010 Final Rule Post-Acute DRG” column in Table 5 of the addendum to the final rule published in the Federal Register on August 27, 2009, (CMS-1406-F; Vol. 74 FR 43754), beginning on page 44126, which document is hereby 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 as specified in the Federal Register of August 12, 2005 (CMS-1500-F; 70 FR 47278), beginning on page 47617; and the correction notice published on September 30, 2005 in the Federal Register (CMS-1500-CN; Vol. 70, FR 57161), beginning on page 57163, which documents are hereby incorporated by reference and will be made available upon request to the Administrative Director: 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, as specified in the Federal Register of October 11, 2006, (CMS-1488-N; Vol. 71, FR 59886), beginning on page 60013, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director: 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, as specified in the Federal Register of October 11, 2006 (CMS-1488-N; Vol. 71, FR 59886), beginning on page 60013; and Correction of Notice published on January 5, 2007 (CMS-1488-CN2;Vol. 72, No. 3, FR 569), beginning on page 573, which documents are hereby incorporated by reference and will be made available upon request to the Administrative Director: 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 Medicare-Severity 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 27, 2007, (CMS-1533-FC, Vol. 72, FR 47130), beginning on page 47539; and correction published in the Federal Register on October 10, 2007, (CMS-1533-CN2; Vol. 72, FR 57634) on page 57727, which documents are hereby 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.

For discharges on or after December 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 Medicare-Severity DRGs designated with a "yes" in the "FY09 Final Rule Special Pay DRG" column in Table 5 of the addendum to the final rule published in the Federal Register on August 19, 2008, (CMS-1390-F; Vol. 73 FR 48434), beginning on page 48899, 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.

For discharges on or after December 1, 2009: 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 Medicare-Severity DRGs designated with a "yes" in the "FY2010 Final Rule Special Pay DRG" column in Table 5 of the addendum to the final rule published in the Federal Register on August 27, 2009, (CMS-1406-F; Vol. 74 FR 43754), beginning on page 44126, 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.

(j) The following are exempt from the maximum reimbursement formula set forth in subdivision (a) and are paid on a reasonable cost basis.

(1) Critical access hospitals;

(2) Children's hospitals that are engaged in furnishing services to inpatients who are predominantly individuals under the age of 18.

(3) Cancer hospitals as defined by *Title 42, Code of Federal Regulations, Section 412.23(f),* effective date October 1, 2002 and as revised as of October 1, 2003, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

(4) Veterans Administration hospitals.

(5) Long term care hospitals as defined by *Title 42, Code of Federal Regulations, Section 412.23(e),* effective date October 1, 2002 and as revised as of October 1, 2003, which document is

hereby incorporated by reference and will be made available upon request to the Administrative Director.

As of December 1, 2009, long term care hospitals as defined by *Title 42, Code of Federal Regulations, Section 412.23(e)*, effective date October 1, 2002 and revised October 1, 2003 and amended as of October 1, 2009, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

(6) Rehabilitation hospital or distinct part rehabilitation units of an acute care hospital or a psychiatric hospital or distinct part psychiatric unit of an acute care hospital.

(7) The cost of durable medical equipment provided for use at home is exempt from this Inpatient Hospital Fee Schedule. The cost of durable medical equipment shall be paid pursuant to Section 9789.60.

(8) Out of state hospitals.

(k) A health facility that is not listed on the Medicare Cost Report should notify the Administrative Director and provide in writing the following information: OSHPD Licensure number, Medicare provider number, physical location, number of beds, and, if applicable, average FTE residents in approved training programs. If a hospital has been in operation for more than one year, information should also be provided on the percentage of inpatient days attributable to Medicaid patients.

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