

8 CCR 9789.33 (As of September 15, 2011)
*(The underlined text reflects amendments made in accordance with the administrative
director Orders effective September 15, 2011.)*

(a) For Services rendered on or after July 1, 2004, the maximum allowable payment for outpatient facility fees for hospital emergency room services or for surgical services performed at a hospital outpatient department or at an ambulatory surgical center shall be determined based on the following. The 1.22 factor shall be used in lieu of an additional payment for high cost outlier cases.

(1) CTP codes 99281-99285 and CPT codes 10040-69990 with status code indicators "S", "T", "X" or "V":

For services rendered on or after March 1, 2008, use: CPT codes 99281-99285 and CPT codes 10040-69990 with status code indicators "S", "T", "X", "V", or "Q". Status code indicator "Q" must qualify for separate payment.

For services rendered on or after March 1, 2009, use: CPT codes 99281-99285 and CPT codes 10040-69990 with status code indicators "S", "T", "X", "V", "Q1", "Q2", or "Q3". Status code indicators "Q1", "Q2", and "Q3" must qualify for separate payment.

$(APC \text{ relative weight} \times \$ 52.151) \times (.40 + .60 \times \text{applicable wage index}) \times \text{inflation factor of } 1.034 \times 1.22$

For services rendered on or after July 15, 2005, use: $(APC \text{ relative weight} \times \text{unadjusted conversion factor}) \times (.40 + .60 \times \text{applicable wage index}) \times 1.22$.

For services rendered on or after July 15, 2005, the unadjusted conversion factor is \$55.703 (2004 unadjusted conversion factor of \$53.924 x estimated inflation factor of 1.033).

For services rendered on or after February 15, 2006, the unadjusted conversion factor is \$57.764 (2005 unadjusted conversion factor of \$55.703 x estimated inflation factor of 1.037).

For services rendered on or after March 1, 2007, the unadjusted conversion factor is \$59.728 (2006 unadjusted conversion factor of \$57.764 x estimated inflation factor of 1.034).

For services rendered on or after March 1, 2008, the unadjusted conversion factor is \$61.699 (2007 unadjusted conversion factor of \$59.728 x estimated inflation factor of 1.033).

For services rendered on or after March 1, 2009, the unadjusted conversion factor is \$63.920 (2008 unadjusted conversion factor of \$61.699 x estimated inflation factor of 1.036).

For services rendered on or after April 15, 2010, the unadjusted conversion factor is \$65.262 (2009 unadjusted conversion factor of \$63.920 x estimated inflation factor of 1.021).

For services rendered on or after September 15, 2011, the unadjusted conversion factor is \$66.959 (2010 unadjusted conversion factor of \$65.262 x estimated inflation factor of 1.026).

(A) Table A in Section 9789.34 contains an "adjusted conversion factor" which incorporates the standard conversion factor, wage index and inflation factor. The maximum payment rate for ASCs and non-listed hospitals can be determined as follows:

$APC \text{ relative weight} \times \text{adjusted conversion factor} \times 1.22$

(B) Table B in Section 9789.35 contains an "adjusted conversion factor" which incorporates the standard conversion factor, wage index and inflation factor.

For services rendered on or after February 15, 2006, table B in Section 9789.35 contains an "adjusted conversion factor" which incorporates the standard conversion factor, wage index, rural SCH adjustment factor, and inflation factor, as described in CMS' 2006 Hospital Outpatient Prospective Payment System final rule of November 10, 2005, published in the Federal Register (CMS-1501-FC, 70 FR 68516), at page 68556.

The maximum payment rate for the listed hospitals can be determined as follows:

$APC \text{ relative weight} \times \text{adjusted conversion factor} \times 1.22$

(2) Procedure codes for drugs and biologicals with status code indicator "G":

APC payment rate x 1.22

(3) Procedure codes for devices with status code indicator "H":

Documented paid costs, net of discounts and rebates, plus 10% not to exceed \$ 250.00, plus any sales tax and/or shipping and handling charges actually paid.

(4) Procedure codes for drugs and biologicals with status code indicator "K":

APC payment rate x 1.22

(5) For services rendered on or after March 1, 2009: Procedure codes for blood and blood products with status code indicator "R":

APC payment x 1.22

(6) For services rendered on or after March 1, 2009: Procedure codes for brachytherapy services with status code indicator "U":

Documented paid costs, net of discounts and rebates, plus 10% not to exceed \$250.00, plus any sales tax and/or shipping and handling charges actually paid.

For services rendered on or after April 15, 2010: Procedure codes for brachytherapy services with status code indicator "U":

APC payment x 1.22

(b) Alternative payment methodology. In lieu of the maximum allowable fees set forth under (a), the maximum allowable fees for a facility meeting the requirements in subdivisions (c)(1) through (c)(5) will be determined as follows:

(1) Standard payment:

(A) CTP codes 99281-99285 and CPT codes 10040-69990 with status code indicators "S", "T", "X" or "V":

For services rendered on or after March 1, 2008, use: CPT codes 99281-99285 and CPT codes 10040-69990 with status code indicators "S", "T", "X", "V", or "Q". Status code indicator "Q" must qualify for separate payment.

For services rendered on or after March 1, 2009, use: CPT codes 99281-99285 and CPT codes 10040-69990 with status code indicators "S", "T", "X", "V", "Q1", "Q2", or "Q3". Status code indicators "Q1", "Q2", and "Q3" must qualify for separate payment.

$(APC \text{ relative weight} \times \$ 52.151) \times (.40 + .60 \times \text{applicable wage index}) \times \text{inflation factor of } 1.034 \times 1.20$

For services rendered on or after July 15, 2005, use: $(APC \text{ relative weight} \times \text{unadjusted conversion factor}) \times (.40 + .60 \times \text{applicable wage index}) \times 1.20$

For services rendered on or after February 15, 2006, by rural SCH hospitals, use: $(APC \text{ relative weight} \times \text{unadjusted conversion factor} \times 1.071) \times (.40 + .60 \times \text{applicable wage index}) \times 1.20$.

(B) Procedure codes for drugs and biologicals with status code indicator "G":

APC payment rate x 1.20

(C) Procedure codes for devices with status code indicator "H":

Documented paid costs, net of discounts and rebates, plus 10% not to exceed \$ 250.00, plus any sales tax and/or shipping and handling charges actually paid.

(D) Procedure codes for drugs and biologicals with status code indicator "K"

APC payment rate x 1.20

(E) For services rendered on or after March 1, 2009: Procedure codes for blood and blood products with status code indicator "R":

APC payment x 1.20

(F) For services rendered on or after March 1, 2009: Procedure codes for brachytherapy services with status code indicator "U":

Documented paid costs, net of discounts and rebates, plus 10% not to exceed \$250.00, plus any sales tax and/or shipping and handling charges actually paid.

For services rendered on or after April 15, 2010: Procedure codes for brachytherapy services with status code indicator "U":

APC payment x 1.20

(2) Additional payment for high cost outlier case:

$[(\text{Facility charges} \times \text{cost-to-charge ratio}) - (\text{standard payment} \times 2.6)] \times .50$

For services rendered on or after July 15, 2005, if $(\text{Facility charges} \times \text{cost-to-charge ratio}) > (\text{standard payment} + \text{outlier threshold})$, additional payment = $[(\text{Facility charges} \times \text{cost-to-charge ratio}) - (\text{standard payment} \times 1.75)] \times .50$

For services rendered on or after July 15, 2005, the outlier factor is \$1,175 as described in CMS' 2005 Hospital Outpatient Prospective Payment System final rule of November 15, 2004, published in the Federal Register (CMS-1427-FC, 69 FR 65682), at page 65846.

For services rendered on or after February 15, 2006, the outlier factor is \$1,250 as described in CMS' 2006 Hospital Outpatient Prospective Payment System final rule of November 10, 2005, published in the Federal Register (CMS-1501-FC, 70 FR 68516), at page 68565.

For services rendered on or after March 1, 2007, the outlier factor is \$1,825 as described in CMS' 2007 Hospital Outpatient Prospective Payment System final rule of November 24, 2006, published in the Federal Register (CMS-1506-FC, 71 FR 67960), at page 68012.

For services rendered on or after March 1, 2008, the outlier factor is \$1,575 as described in CMS' 2008 Hospital Outpatient Prospective Payment System final rule of November 27, 2007, published in the Federal Register (CMS-1392-FC, 72 FR 66580), at page 66686.

For services rendered on or after March 1, 2009, the outlier factor is \$1,800 as described in CMS' 2009 Hospital Outpatient Prospective Payment System final rule of November 18, 2008, published in the Federal Register (CMS-1404-FC, 73 FR 68502), at page 68594.

For services rendered on or after April 15, 2010, the outlier factor is \$2,175 as described in CMS' 2010 Hospital Outpatient Prospective Payment System final rule of November 20, 2009, published in the Federal Register (CMS-1414-FC, 74 FR 60316), at page 60428.

For services rendered on or after September 15, 2011, the outlier factor is \$2,025.00 as described in CMS' 2011 Hospital Outpatient Prospective Payment System final rule of November 24, 2010, published in the Federal Register (CMS-1504-FC, 75 FR 71800), at page 71889.

(3) In determining the additional payment, the facility's charges and payment for devices with status code indicator "H" shall be excluded from the computation.

For services rendered on or after March 1, 2009: In determining the additional payment, the facility's charges and payment for devices with status code indicator "H" and for brachytherapy services with status code indicator "U" shall be excluded from the computation.

For services rendered on or after April 15, 2010: In determining the additional payment, the facility's charges and payment for devices with status code indicator "H" shall be excluded from the computation.

(c) The following requirements shall be met for election of the alternative payment methodology:

(1) A facility seeking to be paid for high cost outlier cases under subdivision 9789.33(b) must file a written election using DWC Form 15 "Election for High Cost Outlier," contained in Section 9789.37 with the Division of Workers' Compensation, Medical Unit (Attention: OMFS-Outpatient). P.O. Box 420603, San Francisco, CA 94142-0603. The

form must be post-marked by March 1 of each year and shall be effective for one year commencing with services furnished on or after April 1 of the year in which the election is made.

(2) The maximum allowable fees applicable to a facility that does not file a timely election satisfying the requirements set forth in this subdivision and Section 9789.37 shall be determined under subdivision (a).

(3) The maximum allowable fees applicable to a hospital that does not participate under the Medicare program shall be determined under subdivision (a).

(4) The cost-to-charge ratio applicable to a hospital participating in the Medicare program shall be the hospital's cost-to-charge ratio used by the Medicare fiscal intermediary to determine high cost outlier payments under *42 C.F.R. § 419.43(d)*, which is incorporated by reference, as contained in Section 9789.38 Appendix X. The cost-to-charge ratio being used by the intermediary for services furnished on February 15 of the year the election is filed shall be included on the hospital's election form.

(5) The cost-to-charge ratio applicable to an ambulatory surgery center shall be the ratio of the facility's total operating costs to total gross charges during the preceding calendar year. Total Operating Costs are the direct costs incurred in providing care to patients. Included in operating cost are: salaries and wages, rent or mortgage, employee benefits, supplies, equipment purchase and maintenance, professional fees, advertising, overhead, etc. It does not include start up costs. Total gross charges are defined as the facility's total usual and customary charges to all patients and third-party payers before reductions for contractual allowances, bad debts, courtesy allowances and charity care. The facility's election form, as contained in Section 9789.37 shall include a completed Annual Utilization Report of Specialty Clinics filed with Office of Statewide Health Planning and Development (OSHPD) for the preceding calendar year, which is incorporated by reference. The facility's election form shall further include the facility's total operating costs during the preceding calendar year, the facility's total gross charges during the preceding calendar year, and a certification under penalty of perjury signed by the Chief Executive Officer and a Certified Public Accountant, as to the accuracy of the information. Upon request from the Administrative Director, an independent audit may be conducted at the expense of the ASC. (Note: While ASCs may not typically file Annual Utilization Report of Specialty Clinics with OSHPD, any ASC applying for the alternative payment methodology must file the equivalent, subject to the Division of Workers' Compensation's audit.) A copy of the Annual Utilization Report of Specialty Clinics may be obtained at OSHPD's website at <http://www.oshpd.ca.gov/HID/HID/clinic/util/index.htm#Forms> or upon request to the Division of Workers' Compensation, Medical Unit (Attention: OMFS-Outpatient), P.O. Box 420603, San Francisco, CA 94142-0603.

(6) Before April 1 of each year the AD shall post a list of those facilities that have elected to be paid under this paragraph and the facility-specific cost-to-charge ratio that shall be used to determine additional fees allowable for high cost outlier cases. The list shall be posted on the Division of Workers' Compensation website: <http://www.dir.ca.gov/DWC/dwc.home.page.htm> or is available upon request to the Division of Workers' Compensation, Medical Unit (Attention: OMFS-Outpatient), P.O. Box 420603, San Francisco, CA 94142-0603.

(d) Any ambulatory surgical center that believes its cost-to-charge ratio in connection with its election to participate in the alternative payment methodology for high cost outlier cases under Section 9789.33(b) was erroneously determined because of error in tabulating data may request the Administrative Director for a re-determination of its cost-to-charge ratio. 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 cost-to-charge ratio or reaffirm the published cost-to-charge ratio.

(e) The OPSS rules in *42 C.F.R. § 419.44* regarding reimbursement for multiple procedures are incorporated by reference as contained in Section 9789.38 Appendix X.

(f) The OPSS rules in *42 C.F.R. §§ 419.62, 419.64, and 419.66* regarding transitional pass-through payments for innovative medical devices, drugs and biologicals shall be incorporated by reference, as contained in Section 9789.38 Appendix X, except that payment for these items shall be in accordance with subdivisions (a) or (b) as applicable.

(g) The payment determined under subdivisions (a) and (b) include reimbursement for all of the included cost items specified in *42 CFR §419.2(b)(1)-(12)*, which is incorporated by reference, as contained in Section 9789.38 Appendix X.

(h) The maximum allowable fee shall be determined without regard to the cost items specified in *42 C.F.R. § 419.2(c)(1), (2), (3), (4), and (6)*, as contained in Section 9789.38 Appendix X. Cost item set forth at *42 C.F.R. §*

419.2(c)(5), as contained in Section 9789.38 Appendix X, is payable pursuant to Section 9789.32(c)(1). Cost items set forth at *42 C.F.R. § 419.2(c)(7)* and (8), as contained in Section 9789.38 Appendix X, are payable pursuant to Section 9789.32(c)(2).

- (i) The maximum allowable fees shall be determined without regard to the provisions in *42 C.F.R. § 419.70*.