Title 8, California Code of Regulations
Chapter 4.5, Division of Workers' Compensation
Subchapter 1

Administrative Director – Administrative Rules

Article 5.3

Official Medical Fee Schedule – Services Rendered after January 1, 2004

Section 9789.10. Physician Services - Definitions.

(a) "Basic value" means the unit value for an anesthesia procedure that is set forth in the Official Medical Fee Schedule 2003.

(b) "CMS" means the Centers for Medicare & Medicaid Services of the United States Department of Health and Human Services.

(c) "Conversion factor" or "CF" means the factor set forth below for the applicable OMFS section:

Evaluation and Management	$8.50
Medicine	$6.15
Surgery	$153.00
Radiology	$12.50
Pathology	$1.50
Anesthesia	$34.50

(d) "CPT®" means the procedure codes set forth in the American Medical Association's Physicians' Current Procedural Terminology (CPT) 1997, copyright 1996, American Medical Association.

(e) "Medicare rate" means the physician fee schedule rate derived from the Resource Based Relative Value Scale and related data, adopted for the Calendar Year 2004, published in the Federal Register on November 7, 2003, Volume 68, No. 216, pages 63262 through 63386 as "Addendum B" which is incorporated by reference. The Medicare rate for each procedure is derived by the Administrative Director utilizing the non-facility rate (or facility rate if no non-facility rate exists), and a weighted average geographic adjustment factor of 1.063.

(f) "Modifying units" means the anesthesia modifiers and qualifying circumstances as set forth in the Official Medical Fee Schedule 2003.

(g) "Official Medical Fee Schedule" or "OMFS" means Article 5.3 of Subchapter 1 of Chapter 4.5 of Title 8, California Code of Regulations (Sections 9789.10 – 9789.110), adopted pursuant to Section 5307.1 of the Labor Code for all medical services, goods,

and treatment provided pursuant to Labor Code Section 4600.

(h) "Official Medical Fee Schedule 2003" or "OMFS 2003" means the Official Medical Fee Schedule incorporated into Section 9791.1 in effect on December 31, 2003, which consists of the OMFS book revised April 1, 1999 and as amended for dates of service on or after July 12, 2002.

(i) "Percentage reduction calculation" means the factor set forth in Table A for each procedure code which will result in a reduction of the OMFS 2003 rate by 5%, or a lesser percent so that the reduction results in a rate that is no lower than the Medicare rate.

(j) "Physician service" means professional medical service that can be provided by a physician, as defined in Section 3209.3 of the Labor Code, and is subject to reimbursement under the Official Medical Fee Schedule. For purposes of the OMFS, "physician service" includes service rendered by a physician or by a non-physician who is acting under the supervision, instruction, referral or prescription of a physician, including but not limited to a physician assistant, nurse practitioner, clinical nurse specialist, and physical therapist.

(k) "RVU" means the relative value unit for a particular procedure that is set forth in the Official Medical Fee Schedule 2003.

(*l*) "Time value" means the unit of time indicating the duration of an anesthesia procedure that is set forth in the Official Medical Fee Schedule 2003.

Authority: Sections 133, 4603.5, 5307.1, and 5307.3, Labor Code.
Reference: Sections 4600, 4603.2, and 5307.1, Labor Code.

Section 9789.11. Physician Services Rendered After January 1, 2004.

(a) Except as specified below, or otherwise provided in this Article, the ground rule materials set forth in each individual section of the OMFS 2003 are applicable to physician services rendered after January 1, 2004.

(1) The OMFS 2003's "General Information and Instructions" section is not applicable. The "General Information and Instructions, Effective for Dates of Service after January 1, 2004," are incorporated by reference and will be made available on the Division of Workers' Compensation Internet site (http://www.dir.ca.gov/DWC/dwc_home_page.htm) or upon request to the Administrative Director at:
Division of Workers' Compensation (Attention: OMFS – Physician Services)
P.O. Box 420603
San Francisco, CA 94142

(b) For physician services rendered after January 1, 2004 the maximum allowable reimbursement amount set forth in the OMFS 2003 for each procedure code is reduced by

five (5) percent, except that those procedures that are reimbursed under OMFS 2003 at a rate between 100% and 105% of the Medicare rate will be reduced between zero and 5% so that the OMFS reimbursement will not fall below the Medicare rate. The reduction rate for each procedure is set forth as the adjustment factor in Table A.

(c) Table A, "OMFS Physician Services Fees for Services Rendered after January 1, 2004," which sets forth each individual procedure code with its corresponding relative value, conversion factor, percentage reduction calculation (between 0 and 5.0%), and maximum reimbursable fee, is incorporated by reference. Table A may be obtained from the Division of Workers' Compensation Internet site (http://www.dir.ca.gov/DWC/dwc_home_page.htm) or upon request to the Administrative Director at:
Division of Workers' Compensation (Attention: OMFS – Physician Services)
P.O. Box 420603
San Francisco, CA 94142

(d) (1) Except for anesthesia services, to determine the maximum allowable reimbursement for a physician service rendered after January 1, 2004 the following formula is utilized: RVU × conversion factor × percentage reduction calculation = maximum reasonable fee before application of ground rules. Applicable ground rules set forth in the OMFS 2003 and the "General Information and Instructions, Effective for Dates of Service after January 1, 2004," are then applied to calculate the maximum reasonable fee.

(2) To determine the maximum allowable reimbursement for anesthesia services (CPT Codes 00100 through 01999) rendered after January 1, 2004, the following formula is utilized: (basic value + modifying units (if any) + time value) × (conversion factor × .95) = maximum reasonable fee.

(e) The following procedures in the Pathology and Laboratory section (both professional and technical component) will be reimbursed under this section: CPT Codes 80500, 80502; 85060 through 85102; 86077 through 86079; 87164; and 88000 through 88399. The following procedure codes in the Pathology and Laboratory section are reimbursed in accordance with subdivision Section 9789.50: CPT Codes 80002 through 80440; 81000 through 85048; 85130 through 86063; 86140 through 87163; 87166 through 87999; and 89050 through 89399. All other pathology and laboratory services will be reimbursed pursuant to Section 9789.50.

Authority: Sections 133, 4603.5, 5307.1, and 5307.3, Labor Code.
Reference: Sections 4600, 4603.2, and 5307.1, Labor Code.

9789.20. General Information for Inpatient Hospital Fee Schedule – Discharge after January 1, 2004.

(a) This Inpatient Hospital Fee Schedule section of the Official Medical Fee Schedule covers charges made by a hospital for inpatient services provided by the hospital.

(b) Charges by a hospital for the professional component of medical services for physician services shall be paid according to Sections 9789.10 through 9789.11.

(c) Sections 9789.20 through 9789.24 shall apply to all bills for inpatient services with a date of discharge after January 1, 2004, except that Sections 9789.20 through 9789.22 will not apply to any bills for medical services with a date of admission on or before December 31, 2003. Bills for services with date of admission on or before December 31, 2003 will be reimbursed in accordance with Section 9792.1.

(d) The Inpatient Hospital Fee schedule shall be adjusted to conform to any relevant changes in the Medicare payment schedule no later than 60 days after the effective date of those changes. Updates will be posted on the Division of Workers' Compensation webpage at http://www.dir.ca.gov/DWC/dwc_home_page.htm. The updates to the Inpatient Hospital Fee schedule will be effective every year on October 1.

(e) Any document incorporated by reference in Sections 9789.20 through 9789.24 is available from the Division of Workers' Compensation Internet site (http://www.dir.ca.gov/DWC/dwc_home_page.htm) or upon request to the Administrative Director at:
Division of Workers' Compensation (Attention: OMFS)
P.O. Box 420603
San Francisco, CA 94142

Authority: Sections 133, 4603.5, 5307.1, and 5307.3, Labor Code.
Reference: Sections 4600, 4603.2, 5307.1, and 5318, Labor Code.

9789.21. Definitions for Inpatient Hospital Fee Schedule.

(a) "Average length of stay" means the geometric mean length of stay for a diagnosis-related group assigned by CMS.

(b) "Capital outlier factor" means fixed loss cost outlier threshold x capital wage index x large urban add-on x (capital cost-to-charge ratio/total cost-to-charge ratio).

(1) The capital wage index, also referred to as the capital geographic factor (GAF), is specified in the Federal Register of October 6, 2003 (correcting the rule published on August 1, 2003) at Vol. 68, page 57736, Table 4A for urban areas, Table 4B on page 57743 for rural areas, and Table 4C on page 57744 for reclassified hospitals, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

(2) The "large urban add-on" is indicated by the post-reclassification urban/rural location published in the Payment Impact File at positions 229-235. As stated in Title 42, Code of Federal Regulations, Section 412.316(b), as it is in effect on November 11, 2003, the "large urban add-on" is an additional 3% of what would otherwise be payable to the health facility.

(3) "Fixed loss cost outlier threshold" means the Medicare fixed loss cost outlier threshold for inpatient admissions. The fixed loss cost outlier threshold for FY 2004 is $31,000 as published in the Federal Register of August 1, 2003 at volume 68, number 148 at page 45477.

(c) "CMS" means the Centers for Medicare & Medicaid Services of the United States Department of Health and Human Services.

(d) "Composite factor" means the factor calculated by the administrative director for a health facility by adding the prospective operating costs and the prospective capital costs for the health facility, excluding the DRG weight and any applicable outlier payment, as determined by the federal Centers for Medicare & Medicaid Services (CMS) for the purpose of determining payment under Medicare.

(1) Prospective capital costs are determined by the following formula:

(A) Capital standard federal payment rate x capital geographic adjustment factor x large urban add-on x [1 + capital disproportionate share adjustment factor + capital indirect medical education adjustment factor]

(B) The "capital standard federal payment rate" is $414.18 as published by CMS in the Federal Register of October 6, 2003 (correcting the publication of August 1, 2003), at Vol. 68, page 57735, Table 1D, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

(C) The "capital geographic adjustment factor" is published in the Payment Impact File at positions 243-252.

(D) The "large urban add-on" is indicated by the post-reclassification urban/rural location published in the Payment Impact File at positions 229-235. As stated in Title 42, Code of Federal Regulations, Section 412.316(b), effective November 11, 2003, the "large urban add-on" is an additional 3% of what would otherwise be payable to the health facility.

(E) The "capital disproportionate share adjustment factor" is published in the Payment Impact File at positions 117-126.

(F) The "capital indirect medical education adjustment factor" (capital IME adjustment) is published in Payment Impact File at positions 202-211.

(2) Prospective operating costs are determined by the following formula:

(A) [(Labor-related national standardized amount x operating wage index) + nonlabor-related national standardized amount] x [1 + operating disproportionate share adjustment factor + operating indirect medical education adjustment]

(B) The "labor-related national standardized amount" is $3,136.39 for large urban areas and $3,086.73 for other areas, as published by the federal Centers for Medicare & Medicaid Services in the Federal Register of October 6, 2003 (correcting the publication of August 1, 2003), at Vol. 68 page 57735, Table 1A, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

(C) The "operating wage index" is published in the Payment Impact File at positions 253-262.

(D) The "nonlabor-related national standardized amount" is $1,274.85 for large urban areas and $1,254.67 for other areas, as published by CMS in the Federal Register of October 6, 2003 (correcting the publication of August 1, 2003), at Vol. 68, page 57735, Table 1A, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

(E) The "operating disproportionate share adjustment factor" is published in the Payment Impact File at positions 127-136.

(F) The "operating indirect medical education adjustment" is published in the Payment Impact File at positions 212-221.

(G) For sole community hospitals, the operating component of the composite rate shall be the higher of the prospective operating costs determined using the formula in (2) or the hospital-specific rate published in the Payment Impact File at positions 137-145.

(3) A table of composite factors for each health facility in California is contained in Section 9789.23. The sole community hospital composite factors that incorporate the operating component specified in subdivision (d)(2)(G) are listed in the column headed "Adjusted Composite Factor (SCH)" set forth in Section 9789.23.

(e) "Costs" means the total billed charges for an admission, excluding non-medical charges such as television and telephone charges and charges for implantable hardware and/or instrumentation reimbursed under subdivision (d) of Section 9789.22, multiplied by the hospital's total cost-to-charge ratio.

(f) "Cost-to-charge ratio" means the sum of the hospital specific operating cost-to-charge ratio and the hospital specific capital cost-to-charge ratio. The operating cost-to-charge

ratio for each hospital is published in the Payment Impact File at positions 161-168. The capital cost-to-charge ratio for each hospital is published in the Payment Impact File at positions 99-106.

(g) “Cost outlier case” means a hospitalization for which the hospital's costs, as defined in subdivision (e) above, exceed the Inpatient Hospital Fee Schedule payment amount by the hospital's outlier factor. If costs exceed the cost outlier threshold, the case is a cost outlier case.

(h) “Cost outlier threshold” means the sum of the Inpatient Hospital Fee Schedule payment amount plus the hospital specific outlier factor.

(i) “Diagnosis Related Group (DRG)” means the inpatient classification scheme used by CMS for hospital inpatient reimbursement. The DRG system classifies patients based on principal diagnosis, surgical procedure, age, presence of comorbidities and complications and other pertinent data.

(j) “DRG weight” means the weighting factor for a diagnosis-related group assigned by CMS for the purpose of determining payment under Medicare. Section 9789.24 lists the DRG weights and geometric mean lengths of stay as assigned by CMS.

(k) “FY” means the CMS fiscal year October 1 through September 30.

(*l*) “Health facility” means any facility as defined in Section 1250 of the Health and Safety Code.

(m) “Inpatient” means a person who has been admitted to a health facility for the purpose of receiving inpatient services. A person is considered an inpatient when he or she is formally admitted as an inpatient with the expectation that he or she will remain at least overnight and occupy a bed, even if it later develops that such person can be discharged or is transferred to another facility and does not actually remain overnight.

(n) “Inpatient Hospital Fee Schedule maximum payment amount” is that amount determined by multiplying the DRG weight x hospital composite factor x 1.20.

(o) “Labor-related portion” is that portion of operating costs attributable to labor costs, as specified in the Federal Register of October 6, 2003 (correcting the publication of August 1, 2003), at Vol. 68, page 57735, Table 1A, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

(p) "Medical services" means those goods and services provided pursuant to Article 2 (commencing with Section 4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code.

(q) "Operating outlier factor" means ((fixed loss cost outlier threshold x ((labor-related portion x wage index) + nonlabor-related portion)) x (operating cost-to-charge ratio/ total cost-to-charge ratio)).

(1) The wage index, also referred to as operating wage index in the Payment Impact File at positions 253–262, is specified as the geographic adjustment factor at Federal Register of October 6, 2003 (correcting rule published on August 1, 2003) at Vol. 68, page 57736, Table 4A for urban areas; Table 4B on page 57743 for rural areas, and Table 4C on page 57744 for reclassified hospitals, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

(2) The nonlabor-related portion is that portion of operating costs attributable to nonlabor costs as defined in the Federal Register of October 6, 2003 (correcting the publication of August 1, 2003), at Vol. 68, page 57735, Table 1A, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

(r) "Outlier factor" means the sum of the capital outlier factor and the operating outlier factor. A table of hospital specific outlier factors for each health facility in California is contained in Section 9789.23.

(s) "Payment Impact File" means the FY 2004 Prospective Payment System Payment Impact File (October 2003 Update) (IMPFILE04) published by the federal Centers for Medicare & Medicaid Services (CMS), which document is hereby incorporated by reference. The description of the file is found at http://cms.hhs.gov/providers/hipps/impact_rcd_lay.pdf . The file is accessible through http://cms.hhs.gov/providers/hipps/ippspufs.asp. A paper copy of the Payment Impact File, with explanatory material, is available from the Administrative Director upon request. An electronic copy is available from the Administrative Director at http://www.dir.ca.gov/DWC/dwc_home_page.htm ..

(t) "Professional Component" means the charges associated with a professional service provided to a patient by a hospital based physician. This component is billed separately from the inpatient charges.

Authority: Sections 133, 4603.5, 5307.1, and 5307.3, Labor Code.
Reference: Sections 4600, 4603.2, 5307.1, and 5318, Labor Code.

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) 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.

(c) 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).

(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 + (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 (d) is excluded from the calculation of costs. Once 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 (d).

(d) 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.

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

(f) 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 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, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

(g) 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(e) or (h), 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, 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 (g)(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 for the first day is half of the payment amount paid under subdivision (a) of this section, plus 50% of the per diem, set forth in subdivision (g)(1) for each subsequent day, up to the full DRG amount.

(h) 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 412.25(f), effective date October 1, 2002, 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 412.25(e), effective date October 1, 2002, 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, except as provided in subdivision (g)(2).

(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.

(i) 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.

Authority: Sections 133, 4603.5, 5307.1, 5307.3, and 5318, Labor Code.
Reference: Sections 4600, 4603.2, 5307.1, and 5318, Labor Code.

Section 9789.23. Hospital Composite Factors and Hospital Specific Outlier Factors.

PROVIDER #	HOSPITAL NAME	COMPOSITE FACTOR	ADJUSTED COMPOSITE FACTOR (SCH)	HOSPITAL SPECIFIC OUTLIER FACTOR
050002	ST. ROSE HOSPITAL	8518.9	**8518.90**	42288.5
050006	ST JOSEPH - EUREKA	4971.8	**4971.85**	30927.4
050007	MILLS PENINSULA MEDICAL CENTER	6385.5	**6385.51**	40970.0
050008	CPMC - DAVIES CAMPUS	6683.5	**6683.50**	40963.7
050009	QUEEN OF THE VALLEY HOSPITAL	6187.8	**6187.79**	38494.1
050013	ST HELENA HOSPITAL	6359.3	**6359.29**	38501.6
050014	SUTTER AMADOR HOSPITAL	4904.3	**4904.34**	30927.6
050015	*NORTHERN INYO HOSPITAL*	4971.8	***7728.5***	30927.4
050016	ARROYO GRANDE COMMUNITY HOSPITAL	5236.3	**5236.34**	34128.7
050017	MERCY GENERAL HOSPITAL	6437.5	**6437.47**	35103.2
050018	PACIFIC ALLIANCE MEDICAL CNTR	9827.0	**9827.02**	35057.5
050022	RIVERSIDE COMMUNITY	6225.8	**6225.81**	34014.9
050024	PARADISE VALLEY HOSPITAL	7744.8	**7744.84**	33596.7
050025	UCSD MEDICAL CENTER	8151.5	**8151.54**	33596.5
050026	GROSSMONT HOSPITAL	5974.1	**5974.07**	33609.2
050028	MAD RIVER COMMUNITY HOSPITAL	4971.8	**4971.85**	30927.4
050029	ST.LUKE MEDICAL CENTER	7747.6	**7747.62**	35124.6
050030	OROVILLE HOSPITAL	5807.8	**5807.78**	31424.0
050036	MEMORIAL HOSPITAL	5299.6	**5299.61**	30927.4
050038	SANTA CLARA VALLEY MEDICAL CENTER	11213.9	**11213.86**	41220.8
050039	ENLOE MEDICAL CENTER	5129.0	**5128.97**	31424.1
050040	LAC OLIVE VIEW/UCLA MEDICAL CENTER	10177.7	**10177.69**	35130.8
050042	ST ELIZABETH COMMUNITY HOSPITAL	5460.3	**5460.3**	33966.9
050043	SUMMIT MEDICAL CENTER	8652.1	**8652.09**	42286.4
050045	EL CENTRO REGIONAL MED. CTR.	6421.1	**6421.08**	30976.2
050046	OJAI VALLEY COMMUNITY HOSPITAL	5113.7	**5113.70**	33332.9
050047	CALIFORNIA PACIFIC MEDICAL CENTER	7708.0	**7707.97**	40965.6
050054	SAN GORGONIO MEMORIAL HOSPITAL	5553.0	**5553.01**	34037.3
050055	ST. LUKES HOSPITAL	9537.4	**9537.43**	40963.5
050056	ANTELOPE VALLEY HOSPITAL	7120.4	**7120.39**	35126.9
050057	KAWEAH DELTA HEALTH CARE DISTRICT	5668.7	**5668.67**	30927.5
050058	GLENDALE MEMORIAL HOSPITAL & HLTH CT	8172.5	**8172.54**	35093.7
050060	COMMUNITY MEDICAL CENTER - FRESNO	7552.6	**7552.60**	31312.2
050061	ST. FRANCIS MEDICAL CENTER	4904.1	**4904.13**	31967.2
050063	QUEEN OF ANGELS - HLLYWD PRES MC	9069.3	**9069.30**	35108.5
050065	WMC SANTA ANA	7216.4	**7216.40**	34368.8
050067	OAK VALLEY DISTRICT HOSPITAL	5433.2	**5433.20**	33807.8

PROVIDER #	HOSPITAL NAME	COMPOSITE FACTOR	ADJUSTED COMPOSITE FACTOR (SCH)	HOSPITAL SPECIFIC OUTLIER FACTOR
050069	ST. JOSEPH HOSPITAL	5728.3	**5728.32**	34317.1
050070	KFH - SOUTH SAN FRANCISCO	6377.6	**6377.58**	40956.9
050071	KFH - SANTA CLARA	7258.6	**7258.65**	42286.0
050072	KFH - WALNUT CREEK	6717.5	**6717.50**	42287.3
050073	KFH - VALLEJO	6548.1	**6548.11**	42255.3
050075	KFH - OAKLAND	7350.6	**7350.63**	42285.8
050076	KFH - SAN FRANCISCO	7437.6	**7437.60**	40959.7
050077	SCRIPPS MERCY HOSPITAL	6732.9	**6732.91**	33582.1
050078	SAN PEDRO PENINSULA HOSPITAL	6365.2	**6365.22**	35108.1
050079	DOCTORS MEDICAL CENTER-SAN PABLO	8292.6	**8292.63**	42285.7
050082	ST. JOHN'S REGIONAL MEDICAL CENTER	5970.6	**5970.58**	33342.5
050084	ST. JOSEPH'S MEDICAL CENTER	5721.0	**5720.99**	31887.7
050088	SAN LUIS OBISPO GEN HOSPITAL	5487.4	**5487.43**	34146.4
050089	COMMUNITY HOSPITAL OF SAN BERNARDINO	8197.0	**8197.04**	34049.2
050090	SONOMA VALLEY HEALTH CARE DIST.	5942.3	**5942.34**	37294.7
050091	COMMUNITY & MISSION HOSP, HUNTINGTON PARK	10067.8	**10067.8**	35124.1
050093	SAINT AGNES MEDICAL CENTER	5186.0	**5185.97**	31312.1
050095	LAURAL GROVE HOSPITAL	6583.0	**6583.0**	42291.3
050096	DOCTOR'S HOSP. OF WEST COVINA	5857.1	**5857.11**	35126.9
050099	SAN ANTONIO COMMUNITY HOSPITAL	5695.9	**5695.85**	34032.4
050100	SHARP MEMORIAL HOSPITAL	5856.0	**5856.01**	33598.9
050101	SUTTER SOLANO MEDICAL CENTER	8442.7	**8442.74**	42213.6
050102	PARKVIEW COMMUNITY HOSPITAL	6752.3	**6752.32**	34028.1
050103	WHITE MEMORIAL MEDICAL CENTER	8892.3	**8892.34**	35112.7
050104	ST. FRANCIS MEDICAL CENTER	8685.2	**8685.22**	35106.3
050107	MARIAN MEDICAL CENTER	5643.0	**5642.98**	31968.0
050108	SUTTER MEDICAL CENTER-SACRAMENTO	6609.3	**6609.27**	35160.5
050110	LOMPOC DISTRICT HOSPITAL	4904.1	**4904.13**	31969.6
050111	TEMPLE COMMUNITY HOSPITAL	8287.1	**8287.13**	35091.8
050112	SANTA MONICA HOSPITAL	6012.2	**6012.23**	35075.7
050113	SAN MATEO COUNTY GENERAL HOSPITAL	7078.2	**7078.17**	40971.3
050114	SHERMAN OAKS HOSP AND HLTH CENTER	5742.3	**5742.28**	35110.5
050115	PALOMAR MEDICAL CENTER	5967.2	**5967.15**	33597.6
050116	NORTHRIDGE HOSPITAL - ROSCO	7117.7	**7117.67**	35110.6
050117	MERCY HOSPITAL & HEALTH SYSTEM	5409.4	**5409.36**	30927.4
050118	DOCTORS HOSPITAL OF MANTECA	5072.0	**5072.01**	31889.2
050121	HANFORD COMM. MEDICAL CENTER	4971.8	**4971.85**	30927.5
050122	DAMERON HOSPITAL	5710.3	**5710.34**	31888.6

PROVIDER #	HOSPITAL NAME	COMPOSITE FACTOR	ADJUSTED COMPOSITE FACTOR (SCH)	HOSPITAL SPECIFIC OUTLIER FACTOR
050124	VERDUGO HILLS HOSPITAL	5464.5	**5464.52**	35135.8
050125	REGIONAL MEDICAL CENTER OF SAN JOSE	8965.9	**8965.85**	41211.2
050126	VALLEY PRESBYTERIAN HOSPITAL	7697.2	**7697.23**	35111.4
050127	WOODLAND MEMORIAL HOSPITAL	5274.6	**5274.64**	30927.5
050128	TRI-CITY MEDICAL CENTER	5621.2	**5621.16**	33615.5
050129	ST. BERNARDINE MEDICAL CENTER	6836.5	**6836.53**	34069.2
050131	NOVATO COMMUNITY HOSPITAL	6377.6	**6377.58**	40976.0
050132	SAN GABRIEL VALLEY MEDICAL CENTER	7938.8	**7938.79**	35110.1
050133	RIDEOUT MEMORIAL HOSPITAL	5278.2	**5278.24**	31430.4
050135	HOLLYWOOD COMM HOSP OF HOLLYWOOD	6932.9	**6932.92**	35124.9
050136	PETALUMA VALLEY HOSPITAL	5996.5	**5996.48**	37308.2
050137	KAISER FOUND. HOSP - PANORAMA	5500.4	**5500.44**	35106.0
050138	KAISER FOUNDATION HOSPITALS - SUNSET	6343.7	**6343.70**	35120.0
050139	KAISER FOUND. HOSPITALS - BELLFLOWER	5527.9	**5527.91**	35078.8
050140	KAISER FOUND. HOSPITALS - FONTANA	5696.4	**5696.37**	34063.7
050144	BROTMAN MEDICAL CENTER	6598.1	**6598.1**	35122.6
050145	COMMUNITY HOSP. MONTEREY PENINSULA	6226.1	**6226.05**	40466.4
050148	*PLUMAS DISTRICT HOSPITAL MCARE RPT*	4971.8	***5834.8***	30927.4
050149	CALIFORNIA HOSPITAL MEDICAL CENTER	9656.8	**9656.76**	35118.3
050150	SIERRA NEVADA MEMORIAL HOSPITAL	5376.0	**5376.00**	35034.4
050152	SAINT FRANCIS MEMORIAL HOSPITAL	7886.2	**7886.23**	40977.8
050153	O'CONNOR HOSPITAL	6831.4	**6831.37**	41215.3
050155	MONROVIA COMMUNITY HOSPITAL	5877.9	**5877.89**	35111.6
050158	ENCINO TARZANA MEDICAL CENTER	5775.4	**5775.41**	35101.5
050159	VENTURA COUNTY MEDICAL CENTER	8580.4	**8580.41**	33340.1
050167	SAN JOAQUIN GENERAL HOSPITAL	8186.1	**8186.10**	31886.9
050168	ST. JUDE MEDICAL CENTER	5671.7	**5671.65**	34349.6
050169	PRESBYTERIAN INTERCOMMUNITY HOSP	6366.5	**6366.48**	35112.0
050172	REDWOOD MEMORIAL HOSPITAL	4971.8	**4971.85**	30927.3
050173	ANAHEIM GENERAL HOSPITAL	7463.7	**7463.7**	34363.9
050174	SANTA ROSA MEMORIAL HOSPITAL	6164.1	**6164.05**	38491.7
050175	WHITTIER HOSPITAL MEDICAL CENTER	6877.6	**6877.59**	35099.1
050177	SANTA PAULA MEMORIAL HOSPITAL	5358.9	**5358.87**	33341.6
050179	EMANUEL MEDICAL CENTER	6011.5	**6011.53**	33806.2
050180	JOHN MUIR MEDICAL CENTER	6596.8	**6596.80**	42290.2
050188	COMM HOSP.& REHAB- LOS GATOS	6426.7	**6426.72**	41224.6
050189	MEE MEMORIAL HOSPITAL	6509.1	***6509.1***	40519.6
050191	ST. MARY MEDICAL CENTER	8141.0	**8140.96**	35094.2

PROVIDER #	HOSPITAL NAME	COMPOSITE FACTOR	ADJUSTED COMPOSITE FACTOR (SCH)	HOSPITAL SPECIFIC OUTLIER FACTOR
050192	SIERRA KINGS DISTRICT HOSPITAL	4971.8	**4971.85**	30927.5
050193	SOUTH COAST MEDICAL CENTER	5352.5	**5352.49**	34376.7
050194	WATSONVILLE COMMUNITY	7831.3	**7831.32**	37468.8
050195	WASHINGTON HOSPITAL DISTRICT	7646.5	**7646.53**	42290.1
050196	CENTRAL VALLEY GEN. HOSPITAL	4971.8	**4971.85**	30927.4
050197	SEQUOIA HEALTH SERVICES	6390.8	**6390.81**	40966.7
050204	LANCASTER COMMUNITY HOSPITAL	5633.7	**5633.69**	35104.8
050205	HUNTINGTON EAST VALLEY HOSPITAL	7563.5	**7563.47**	35097.5
050207	FREMONT MEDICAL CENTER	5566.6	**5566.63**	31431.0
050211	ALAMEDA HOSPITAL	6600.4	**6600.41**	42288.8
050214	GRANADA HILLS HOSPITAL	6941.6	**6941.57**	35079.5
050215	SAN JOSE MEDICAL CENTER	8329.4	**8329.44**	41215.4
050217	FAIRCHILD MEDICAL CENTER	4971.8	***4971.8***	30927.5
050219	COAST PLAZA DOCTORS HOSPITAL	7568.8	**7568.81**	35091.7
050222	SHARP CHULA VISTA MEDICAL CTR	6690.7	**6690.72**	33594.2
050224	HOAG MEMORIAL HOSPITAL PRESBYTERIAN	5354.7	**5354.71**	34346.9
050225	FEATHER RIVER HOSPITAL	5035.8	**5035.81**	31424.1
050226	ANAHEIM MEMORIAL MEDICAL CENTER	5935.2	**5935.24**	34353.2
050228	SAN FRANCISCO GENERAL HOSPITAL	11812.7	**11812.72**	42286.0
050230	GARDEN GROVE MEDICAL CENTER	8953.5	**8953.46**	35124.6
050231	POMONA VALLEY HOSPITAL MED CTR	7612.6	**7612.64**	35098.0
050232	FRENCH HOSPITAL MEDICAL CENTER	5243.3	**5243.26**	34131.4
050234	SHARP CORONADO HOSPITAL	5481.0	**5481.00**	33583.0
050235	PROVIDENCE SAINT JOSEPH MED. CENTER	6067.5	**6067.45**	35102.0
050236	SIMI VALLEY HOSPITAL	5708.7	**5708.67**	35066.5
050238	METHODIST HOSPITAL OF SO. CALIF.	5824.0	**5824.03**	35134.0
050239	GLENDALE ADVENTIST MEDICAL CENTER	7768.1	**7768.14**	35095.7
050240	CENTINELA HOSPITAL MEDICAL CENTER	7397.9	**7397.90**	35130.0
050242	DOMINICAN SANTA CRUZ HOSPITAL	6339.1	**6339.15**	37438.2
050243	DESERT HOSPITAL	6320.0	**6319.96**	34085.7
050245	ARROWHEAD REGIONAL MEDICAL CENTER	8473.5	**8473.47**	34218.7
050248	NATIVIDAD MEDICAL CENTER	10098.0	**10098.05**	40444.3
050251	*LASSEN COMMUNITY HOSPITAL*	5440.4	***5716.4***	32499.5
050253	BELLWOOD GENERAL HOSPITAL	7163.7	**7163.70**	34357.1
050254	MARSHALL HOSPITAL	5688.3	**5688.25**	35159.1
050256	ORTHOPAEDIC HOSPITAL	8240.9	**8240.88**	35090.3
050257	GOOD SAMARITAN HOSPITAL	4971.8	**4971.85**	30927.5
050261	SIERRA VIEW DISTRICT HOSPITAL	5800.2	**5800.17**	30927.7

PROVIDER #	HOSPITAL NAME	COMPOSITE FACTOR	ADJUSTED COMPOSITE FACTOR (SCH)	HOSPITAL SPECIFIC OUTLIER FACTOR
050262	UCLA MEDICAL CENTER	8379.5	**8379.50**	35102.7
050264	SAN LEANDRO HOSPITAL	6873.4	**6873.42**	42290.1
050267	DANIEL FREEMAN MEMORIAL HOSPITAL	7408.0	**7407.98**	35158.5
050270	SMH - CHULA VISTA	7410.6	**7410.61**	33612.4
050272	REDLANDS COMMUNITY HOSPITAL	5557.0	**5557.04**	34041.8
050276	CONTRA COSTA REGIONAL MEDICAL CNTR	10315.3	**10315.25**	42293.1
050277	PACIFIC HOSPITAL OF LONG BEACH	8364.6	**8364.61**	35120.3
050278	PROVIDENCE HOLY CROSS MED. CENTER	6404.2	**6404.19**	35084.6
050279	*HI - DESERT MEDICAL CENTER*	5553.0	***6375.5***	34060.3
050280	MERCY MEDICAL CENTER REDDING	6053.9	**6053.90**	33966.8
050281	ALHAMBRA HOSPITAL	9105.2	**9105.23**	35076.2
050283	VALLEY MEMORIAL HOSPITAL	6595.5	**6595.45**	42292.8
050289	SETON MEDICAL CENTER	7697.3	**7697.28**	40972.3
050290	SAINT JOHN'S HOSPITAL	5471.2	**5471.17**	35094.2
050291	SUTTER MEDICAL CENTER OF SANTA ROSA	8106.4	**8106.36**	37321.0
050292	RIVERSIDE COUNTY REGIONAL MED CENTER	7678.4	**7678.36**	34091.6
050295	MERCY HOSPITAL	5163.8	**5163.81**	30927.5
050296	HAZEL HAWKINS MEM. HOSPITAL	6509.1	**6509.09**	40500.0
050298	BARSTOW COMMUNITY HOSPITAL	5553.0	**5553.01**	34066.2
050299	NORTHRIDGE HOSPITAL MEDICAL CENTER-S	8715.2	**8715.18**	35082.9
050300	ST MARY REGIONAL MEDICAL CENTER	6492.4	**6492.36**	34036.0
050301	UKIAH VALLEY MEDICAL CENTER	4971.8	**4971.85**	30927.3
050305	ALTA BATES MEDICAL CENTER	7641.4	**7641.45**	42290.3
050308	EL CAMINO HOSPITAL	6429.5	**6429.45**	41210.4
050309	SUTTER ROSEVILLE MEDICAL CENTER	5679.8	**5679.83**	35161.2
050312	REDDING MEDICAL CENTER	5361.6	**5361.55**	33974.8
050313	SUTTER TRACY COMMUNITY HOSPITAL	5127.8	**5127.80**	31886.5
050315	KERN MEDICAL CENTER	8250.9	**8250.92**	30927.4
050320	ALAMEDA COUNTY MEDICAL CENTER	11013.0	**11013.01**	42285.6
050324	SCRIPPS MEM HOSPITAL-LA JOLLA	5242.7	**5242.66**	33594.6
050325	TUOLUMNE GENERAL HOSPITAL	5388.5	**5388.46**	33525.1
050327	LOMA LINDA UNIVERSITY MEDICAL CTR.	8219.9	**8219.93**	34044.7
050329	CORONA REGIONAL MEDICAL CENTER	6168.9	**6168.85**	34040.8
050331	HEALSDBURG GENERAL HOSPITAL	5721.9	**5721.93**	37331.2
050333	*SENECA DISTRICT HOSPITAL*	4971.8	***6589.4***	30927.4
050334	SALINAS VALLEY MEMORIAL HOSPITAL	6602.7	**6602.67**	40515.2
050335	SONORA COMMUNITY HOSPITAL	5141.9	**5141.94**	33523.3
050336	LODI MEMORIAL HOSPITAL	5293.1	**5293.14**	31888.0

PROVIDER #	HOSPITAL NAME	COMPOSITE FACTOR	ADJUSTED COMPOSITE FACTOR (SCH)	HOSPITAL SPECIFIC OUTLIER FACTOR
050342	PIONEERS MEM. HOSPITAL	4971.8	**4971.85**	30927.6
050348	UCI MEDICAL CENTER	9380.5	**9380.51**	34348.6
050349	CORCORAN DISTRICT HOSPITAL	4971.8	**4971.85**	30927.4
050350	BEVERLY COMMUNITY HOSPITAL	7447.6	**7447.59**	35084.4
050351	TORRANCE MEMORIAL MEDICAL CENTER	5610.3	**5610.31**	35109.5
050352	*BARTON MEMORIAL HOSP*	5641.6	***6006.4***	35136.7
050353	LITTLE COMPANY OF MARY HOSPITAL	5816.4	**5816.36**	35102.6
050355	*SIERRA VALLEY DISTRICT HOSPITAL*	4744.5	***5414.5***	30927.5
050357	GOLETA VALLEY COTTAGE HOSPITAL	4904.1	**4904.13**	31969.9
050359	TULARE DISTRICT HOSPITAL	5694.5	**5694.49**	30927.5
050360	MARIN GENERAL HOSPITAL	6551.7	**6551.67**	40969.8
050366	*MARK TWAIN ST. JOSEPHS HOPITAL*	4920.8	***6492.5***	30927.4
050367	NORTHBAY MEDICAL CENTER	6923.2	**6923.19**	38487.9
050369	CVMC - QUEEN OF THE VALLEY	7816.5	**7816.48**	35093.3
050373	LAC+USC MEDICAL CENTER	10084.5	**10084.54**	35085.2
050376	HARBOR-UCLA MEDICAL CENTER	10375.1	**10375.13**	35052.7
050378	PACIFICA OF THE VALLEY	8920.7	**8920.71**	35111.8
050379	*MERCY WESTSIDE HOSPITAL*	4971.8	***6174.5***	30927.4
050380	GOOD SAMARITAN HOSPITAL	6427.5	**6427.47**	41214.9
050382	CVMC - INTERCOMMUNITY	6787.4	**6787.42**	35095.1
050385	PALM DRIVE HOSPITAL	5721.9	**5721.93**	37306.4
050390	HEMET VALLEY MEDICAL CENTER	5989.0	**5989.00**	34044.5
050391	SANTA TERESITA HOSPITAL	5726.3	**5726.27**	35093.6
050392	*TRINITY HOSPITAL*	4971.8	***8130.1***	30927.3
050393	DOWNEY REGIONAL MED CTR	6912.4	**6912.38**	35114.4
050394	COMM MEM HOSP OF SAN BUENAVENTURA	5125.4	**5125.39**	33338.7
050396	SANTA BARBARA COTTAGE HOSPITAL	5452.2	**5452.19**	31968.7
050397	*COALINGA REGIONAL MEDICAL CENTER*	5033.7	***9883.8***	31311.2
050407	CHINESE HOSPITAL	6683.5	**6683.50**	40962.5
050410	SANGER GENERAL HOSPITAL	5033.7	**5033.65**	31312.5
050411	KAISER FOUNDATION HOSPITALS -HARBOR	5515.7	**5515.67**	35131.4
050414	MERCY HOSPITAL OF FOLSOM	5469.0	**5468.96**	35138.8
050417	*SUTTER COAST HOSPITAL*	4887.1	***6158.6***	30927.6
050419	*MERCY MEDICAL CENTER MT. SHASTA*	5460.3	***5651.6***	33966.3
050420	ROBERT F. KENNEDY	7871.6	**7871.62**	35113.2
050423	PALO VERDE HOSPITAL	5553.0	***5553.0***	34034.6
050424	SCRIPPS GREEN HOSPITAL	5825.9	**5825.86**	33597.6
050425	KFH - SACRAMENTO	5710.3	**5710.28**	35103.4

PROVIDER #	HOSPITAL NAME	COMPOSITE FACTOR	ADJUSTED COMPOSITE FACTOR (SCH)	HOSPITAL SPECIFIC OUTLIER FACTOR
050426	WEST ANAHEIM MED CTR	6458.9	**6458.87**	34357.5
050430	*MODOC MEDICAL CENTER*	5177.6	***6829.6***	30927.4
050432	GARFIELD MEDICAL CTR.	9814.0	**9813.97**	35047.9
050433	*INDIAN VALLEY HOSPITAL*	4971.8	***6794.2***	30927.4
050434	*COLUSA COMMUNITY HOSPITAL*	5177.6	***7871.2***	30927.4
050435	*FALLBROOK DISTRICT HOSPITAL*	5230.5	***6046.6***	33571.2
050438	HUNTINGTON MEMORIAL HOSPITAL	6334.1	**6334.12**	35112.8
050441	STANFORD HOSPITAL AND CLINICS	9095.3	**9095.27**	41218.3
050444	SUTTER MERCED MEDICAL CENTER	6538.0	**6537.95**	30927.5
050447	VILLA VIEW COMMUNITY HOSPITAL	7980.3	**7980.34**	33593.9
050448	*RIDGECREST REGIONAL HOSPITAL*	4885.9	***5222.6***	30927.5
050454	UC SAN FRANCISCO MEDICAL CENTER	11310.8	**11310.83**	40969.8
050455	SAN JOAQUIN COMMUNITY HOSPITAL	5828.3	**5828.31**	30927.4
050456	GARDENA PHYSICIAN'S HOSP INC	5564.4	**5564.40**	35120.7
050457	ST. MARY MEDICAL CENTER	7777.8	**7777.76**	42291.5
050464	DOCTORS MEDICAL CENTER OF MODESTO	6724.8	**6724.81**	33805.1
050468	MEMORIAL HOSPITAL OF GARDENA	7288.2	**7288.15**	35087.0
050469	*COLORADO RIVER MEDICAL CENTER*	4971.8	***6586.1***	30927.5
050470	SELMA COMMUNITY HOSPITAL	5079.5	**5079.50**	31312.2
050471	GOOD SAMARITAN HOSPITAL	7374.2	**7374.2**	35108.7
050476	*SUTTER LAKESIDE HOSPITAL*	4744.5	***6505.7***	30927.5
050477	MIDWAY HOSPITAL MEDICAL CENTER	6479.3	**6479.27**	35150.2
050478	*SANTA YNEZ VALLEY COTTAGE HOSPITAL*	4904.1	***6596.1***	31968.5
050481	WEST HILLS REG MEDICAL CENTER	5471.6	**5471.63**	35116.8
050485	LONG BEACH MEMORIAL MEDICAL CENTER	6527.0	**6526.99**	35089.7
050488	EDEN MEDICAL CENTER	6866.8	**6866.84**	42287.4
050491	SANTA ANA HOSPITAL MEDICAL CENTER	5604.6	**5604.58**	34414.5
050492	CLOVIS COMMUNITY HOSPITAL	5320.4	**5320.38**	31311.5
050494	*TAHOE FOREST HOSPITAL*	5633.8	***7954.1***	35047.3
050496	MT. DIABLO MEDICAL CENTER	6863.1	**6863.13**	42289.5
050497	DOS PALOS MEMORIAL HOSPITAL	4971.8	**4971.85**	30927.7
050498	SUTTER AUBURN FAITH HOSPITAL	5642.9	**5642.87**	35139.6
050502	ST. VINCENT MEDICAL CENTER	7656.6	**7656.60**	35106.8
050503	SCRIPPS MEM HOSP - ENCINITAS	5244.2	**5244.16**	33592.9
050506	SIERRA VISTA REGINAL MED CTR	5525.5	**5525.55**	34134.1
050510	KFH - SAN RAFAEL	6585.1	**6585.05**	42287.2
050512	KFH - HAYWARD	6656.6	**6656.65**	42285.4
050515	KAISER FOUND. HOSPITALS -SAN DIEGO	5320.4	**5320.42**	33603.1

PROVIDER #	HOSPITAL NAME	COMPOSITE FACTOR	ADJUSTED COMPOSITE FACTOR (SCH)	HOSPITAL SPECIFIC OUTLIER FACTOR
050516	MERCY SAN JUAN HOSPITAL	6431.6	**6431.60**	35148.1
050517	VICTOR VALLEY COMMUNITY HOSP.	7531.4	**7531.44**	34039.1
050523	SUTTER DELTA MEDICAL CENTER	7053.6	**7053.61**	42289.2
050526	HUNTINGTON BEACH MEDICAL CENTER	6481.0	**6480.96**	34384.8
050528	*MEMORIAL HOSPITAL - LOS BANOS*	5177.6	***6750.5***	30927.4
050531	BELLFLOWER MEDICAL CENTER	8184.2	**8184.2**	35075.6
050534	JOHN.F. KENNEDY MEMORIAL HOSP.	7621.8	**7621.77**	34010.7
050535	COASTAL COMMUNITIES HOSPITAL	8350.2	**8350.15**	34382.3
050537	SUTTER DAVIS HOSPITAL	5073.4	**5073.43**	30927.7
050539	*REDBUD COMMUNITY HOSPITAL*	4936.5	***5681.7***	30927.5
050541	KFH - REDWOOD CITY	6870.6	**6870.58**	42286.8
050542	*KERN VALLEY HOSPITAL DISTRICT*	4744.5	***4935.2***	30927.7
050543	COLLEGE HOSPITAL COSTA MESA	8000.9	**8000.88**	34308.9
050545	LANTERMAN DEVELOPMENTAL CENTER	5726.3	**5726.27**	35047.9
050546	PORTERVILLE DEVELOPMENTAL CENTER	4971.8	**4971.85**	30927.3
050547	SONOMA DEVELOPMENTAL CENTER	5996.5	**5996.48**	37316.4
050548	FAIRVIEW DEVELOPMENTAL CENTER	5604.6	**5604.58**	34362.5
050549	LOS ROBLES REGIONAL MEDICAL CENTER	5379.5	**5379.45**	35022.2
050550	CHAPMAN MEDICAL CENTER	5542.3	**5542.3**	34418.9
050551	LOS ALAMITOS MEDICAL CTR.	5606.9	**5606.93**	34349.4
050552	MOTION PICTURE AND TELEVISION FUND	5464.5	**5464.52**	35094.2
050557	MEMORIAL HOSPITAL MODESTO	5703.3	**5703.26**	33796.2
050559	DANIEL FREEMAN MARINA HOSPITAL	5627.4	**5627.38**	35143.0
050561	KAISER FOUND. HOSPITAL - WEST LA	5496.7	**5496.69**	35117.9
050567	MISSION HOSPITAL REGIONAL MED CENTER	5586.9	**5586.89**	34351.8
050568	MADERA COMMUNITY HOSPITAL	6092.0	**6091.99**	31312.5
050569	*MENDOCINO COAST DISTRICT HOSPITAL*	5996.5	***6356.2***	37295.5
050570	FOUNTAIN VALLEY REG MEDICAL CENTER	7631.9	**7631.93**	34378.4
050571	SUBURBAN MEDICAL CENTER	8674.2	**8674.18**	35128.3
050573	EISENHOWER MEMORIAL HOSPITAL	5310.6	**5310.61**	34065.5
050575	TRI-CITY REGIONAL MEDICAL CENTERS	7067.6	**7067.63**	35105.8
050577	SANTA MARTA HOSPITAL	8426.4	**8426.38**	35081.2
050578	MARTIN LUTHER KING, JR./DREW MEDICAL	9820.7	**9820.70**	35118.7
050579	CENTURY CITY HOSP	6323.5	**6323.53**	35055.9
050580	LAPALMA INTERCOMMUNITY HOSPITAL	6943.1	**6943.14**	34361.6
050581	LAKEWOOD REGIONAL MED. CTR.	6479.6	**6479.62**	35101.6
050583	ALVARADO COMMUNITY HOSPITAL	5943.9	**5943.89**	33563.4
050584	KPC GLOBAL MEDICAL	6760.9	**6760.93**	34017.4

PROVIDER #	HOSPITAL NAME	COMPOSITE FACTOR	ADJUSTED COMPOSITE FACTOR (SCH)	HOSPITAL SPECIFIC OUTLIER FACTOR
050585	SAN CLEMENTE HOSPITAL	5604.6	**5604.58**	34357.3
050586	CHINO VALLEY MEDICAL CENTER	6698.2	**6698.22**	34043.2
050588	SAN DIMAS COMMUNITY HOSPITAL	5726.3	**5726.27**	35141.8
050589	PLACENTIA LINDA COMMUNITY HOSPITAL	5492.1	**5492.13**	34316.0
050590	METHODIST HOSPITAL OF SACRAMENTO	7732.8	**7732.82**	35113.9
050591	MONTEREY PARK HOSPITAL	8962.8	**8962.76**	35083.7
050592	BREA COMMUNITY HOSPITAL	5633.2	**5633.22**	34368.7
050594	WESTERN MEDICAL CENTER ANAHEIM	8262.7	**8262.68**	35124.9
050597	FOOTHILL PRESBYTERIAN HOSPITAL	5770.9	**5770.89**	35073.8
050599	UC DAVIS MEDICAL CENTER	9163.9	**9163.93**	35144.7
050601	TARZANA ENCINO REGIONAL MED CTR	6221.5	**6221.53**	35071.5
050603	SADDLEBACK MEMORIAL MEDICAL CENTER	5358.2	**5358.24**	34343.9
050604	KFH - SANTA TERESA	6425.2	**6425.21**	41206.1
050608	DELANO REGIONAL MEDICAL CNT.	7127.2	**7127.25**	30927.7
050609	KAISER FOUNDATION HOSPITALS -ANAHEIM	5892.8	**5892.83**	35110.3
050613	SETON MEDICAL CENTER	6377.6	**6377.6**	40972.1
050615	GREATER EL MONTE COMMUNITY HOSPITAL	9251.5	**9251.45**	35103.9
050616	ST. JOHN'S PLEASANT VALLEY HOSPITAL	5113.7	**5113.70**	33335.5
050618	*BEAR VALLEY COMMUNITY HOSPITAL*	4868.6	***8109.5***	30927.4
050623	HIGH DESERT HOSPITAL	5726.3	**5726.27**	35073.6
050624	HENRY MAYO NEWHALL MEMORIAL HOSPITAL	5609.7	**5609.71**	35166.0
050625	CEDARS-SINAI MEDICAL CENTER	7249.7	**7249.66**	35118.0
050630	INLAND VALLEY REGIONAL MEDICAL CTR	5528.5	**5528.51**	33992.6
050633	TWIN CITIES COMMUNITY HOSPITAL	5385.7	**5385.72**	34144.3
050636	POMERADO HOSPITAL	5230.5	**5230.52**	33593.8
050641	EAST L.A. DOCTOR'S HOSPITAL	8724.3	**8724.30**	35104.7
050643	PHS INDIAN HEALTH SERVICES HOSPITAL	6547.3	**6547.3**	40759.3
050644	LOS ANGELES METROPOLITAN MED CENTER	8741.5	**8741.5**	35137.5
050662	AGNEWS DEVELOPMENTAL CENTER	6723.4	**6723.38**	41197.6
050663	LOS ANGELES COMMUNITY HOSPITAL	8807.5	**8807.46**	35114.3
050667	NELSON M. HOLDERMAN	5905.3	**5905.34**	38402.2
050668	LAGUNA HONDA HOSPITAL	6898.8	**6898.83**	42284.9
050674	KFH SOUTH SACRAMENTO	5830.0	**5830.01**	35089.1
050677	KAISER FOUND. HOSP. - WOODLAND HILLS	5778.8	**5778.82**	35101.6
050678	ORANGE COAST MEMORIAL MEDICAL CENTER	6927.9	**6927.94**	34334.7
050680	VACAVALLEY HOSPITAL	6188.8	**6188.77**	38497.4
050682	KINGSBURG DISTRICT HOSPITAL	5033.7	**5033.65**	31312.7
050684	MENIFEE VALLEY MEDICAL CENTER	5299.2	**5299.22**	34108.0

PROVIDER #	HOSPITAL NAME	COMPOSITE FACTOR	ADJUSTED COMPOSITE FACTOR (SCH)	HOSPITAL SPECIFIC OUTLIER FACTOR
050686	KAISER FOUND. HOSPITALS - RIVERSIDE	5624.2	**5624.18**	34364.4
050688	ST. LOUISE REGIONAL HOSPITAL	6723.4	**6723.38**	41220.2
050689	SAN RAMON REG. MEDICAL CENTER	6587.7	**6587.73**	42287.6
050690	KFH - SANTA ROSA	5726.2	**5726.22**	37326.1
050693	IRVINE MEDICAL CENTER	5362.1	**5362.06**	34539.9
050694	MORENO VALLEY COMMUNITY HOSPITAL	7018.0	**7017.97**	34100.4
050695	ST. DOMINIC'S HOSPITAL	5126.1	**5126.14**	31887.9
050696	USC UNIVERSITY HOSPITAL	7079.8	**7079.84**	35145.2
050697	PATIENTS' HOSPITAL OF REDDING	5330.7	**5330.69**	33973.1
050701	RANCHO SPRINGS MEDICAL CENTER	5553.0	**5553.01**	34035.9
050704	MISSION COMMUNITY HOSPITAL	8515.2	**8515.18**	35082.9
050707	RECOVERY INN OF MENLO PARK	6377.6	**6377.58**	41003.6
050708	FRESNO SURGERY CENTER	4803.4	**4803.43**	31310.3
050709	DESERT VALLEY HOSPITAL	5553.0	**5553.01**	34022.5
050710	KFH - FRESNO	4806.9	**4806.91**	31312.4
050713	LINCOLN HOSPITAL	5726.3	**5726.27**	35067.6
050714	SANTA CRUZ MATERINTY & SURGERY HOSP	5743.7	**5743.70**	37404.8
050717	RANCHO LOS AMIGOS NATL.REHAB.CTR.	7683.4	**7683.35**	35132.3
050718	VALLEY PLAZA DOCTORS HOSPITAL	5553.0	**5553.01**	34012.6
050720	TUSTIN HOSPITAL AND MEDICAL CENTER	5604.6	**5604.58**	34358.5
050722	SHARP MARY BIRCH HOSPITAL FOR WOMEN	5446.1	**5446.07**	33603.4
050723	KAISER FOUND HOSPITAL - BALDWIN	6135.5	**6135.46**	35190.3
050724	BAKERSFIELD HEART HOSPITAL	4971.8	**4971.85**	30927.5
050725	CITY OF ANGELS MEDICAL CENTER	8757.2	**8757.21**	35276.8
050726	STANISLAUS SURGICAL HOSPITAL	5184.6	**5184.61**	33771.9
050727	COMMUNITY HOSPITAL OF LONG BEACH	5475.0	**5475.04**	35108.6
050728	SUTTER WARRACK HOSPITAL	5721.9	**5721.93**	37326.7
050729	DANIEL FREEMAN HOSPITAL	7274.9	**7274.90**	35110.9
050730	DANIEL FREEMAN MARINA HOSPITAL	5689.5	**5689.52**	35127.4

Source

Calculated from FY 2004 Payment Impact File Final Rule

Adjusted Composite Rate reflects Sole Community Hospital adjustment (in italics)

Record Layout at http://cms.hhs.gov/providers/hipps/impact_rcd_lay.pdf

Payment Impact File (impfile04zip) at http://www.cms.gov/providers/hipps/ippspufs.asp

Authority: Sections 133, 4603.5, 5307.1, 5307.3, and 5318, Labor Code.
Reference: Sections 4600, 4603.2, 5307.1, and 5318, Labor Code.

Section 9789.24. Diagnostic Related Groups, Relative Weights, Geometric Mean Length of Stay.

DRGV21	MDC	TYPE	DRG TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS
1	01	SURG	CRANIOTOMY AGE >17 W CC	3.6186	8.0
2	01	SURG	CRANIOTOMY AGE >17 W/O CC	2.0850	4.1
3	01	SURG *	CRANIOTOMY AGE 0-17	1.9753	12.7
4	01	SURG	NO LONGER VALID	0.0000	0.0
5	01	SURG	NO LONGER VALID	0.0000	0.0
6	01	SURG	CARPAL TUNNEL RELEASE	0.8092	2.2
7	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	2.6519	6.6
8	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC	1.5453	1.9
9	01	MED	SPINAL DISORDERS & INJURIES	1.4214	4.7
10	01	MED	NERVOUS SYSTEM NEOPLASMS W CC	1.2448	4.8
11	01	MED	NERVOUS SYSTEM NEOPLASMS W/O CC	0.8571	3.0
12	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS	0.9259	4.5
13	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	0.8176	4.0
14	01	MED	INTRACRANIAL HEMORRHAGE & STROKE W INFARCT	1.2682	4.7
15	01	MED	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT	0.9677	3.9
16	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	1.2618	4.8
17	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	0.6991	2.5
18	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	1.0026	4.2
19	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	0.7041	2.8
20	01	MED	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	2.7394	8.0
21	01	MED	VIRAL MENINGITIS	1.5138	5.0
22	01	MED	HYPERTENSIVE ENCEPHALOPATHY	1.0737	3.9
23	01	MED	NONTRAUMATIC STUPOR & COMA	0.8239	3.2
24	01	MED	SEIZURE & HEADACHE AGE >17 W CC	1.0121	3.7
25	01	MED	SEIZURE & HEADACHE AGE >17 W/O CC	0.6109	2.5
26	01	MED	SEIZURE & HEADACHE AGE 0-17	1.3730	2.2
27	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR	1.3370	3.2
28	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC	1.3386	4.4
29	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC	0.7087	2.7

DRGV21	MDC	TYPE	DRG TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS
30	01	MED *	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0-17	0.3341	2.0
31	01	MED	CONCUSSION AGE >17 W CC	0.9117	3.1
32	01	MED	CONCUSSION AGE >17 W/O CC	0.5684	2.0
33	01	MED *	CONCUSSION AGE 0-17	0.2098	1.6
34	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W CC	0.9931	3.7
35	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	0.6355	2.5
36	02	SURG	RETINAL PROCEDURES	0.6298	1.2
37	02	SURG	ORBITAL PROCEDURES	1.0575	2.5
38	02	SURG	PRIMARY IRIS PROCEDURES	0.4669	1.9
39	02	SURG	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	0.6285	1.5
40	02	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	0.8937	2.7
41	02	SURG *	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	0.3401	1.6
42	02	SURG	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	0.7064	1.9
43	02	MED	HYPHEMA	0.5382	2.4
44	02	MED	ACUTE MAJOR EYE INFECTIONS	0.6597	4.0
45	02	MED	NEUROLOGICAL EYE DISORDERS	0.7250	2.5
46	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W CC	0.7936	3.4
47	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W/O CC	0.5317	2.4
48	02	MED *	OTHER DISORDERS OF THE EYE AGE 0-17	0.2996	2.9
49	03	SURG	MAJOR HEAD & NECK PROCEDURES	1.7277	3.2
50	03	SURG	SIALOADENECTOMY	0.8317	1.5
51	03	SURG	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	0.8410	1.9
52	03	SURG	CLEFT LIP & PALATE REPAIR	0.8018	1.4
53	03	SURG	SINUS & MASTOID PROCEDURES AGE >17	1.2520	2.2
54	03	SURG *	SINUS & MASTOID PROCEDURES AGE 0-17	0.4856	3.2
55	03	SURG	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES	0.9247	2.0
56	03	SURG	RHINOPLASTY	0.9233	1.9
57	03	SURG	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	1.1029	2.4
58	03	SURG *	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	0.2757	1.5
59	03	SURG	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	0.9557	1.9

DRGV21	MDC	TYPE	DRG TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS
60	03	SURG *	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	0.2099	1.5
61	03	SURG	MYRINGOTOMY W TUBE INSERTION AGE >17	1.2334	3.1
62	03	SURG *	MYRINGOTOMY W TUBE INSERTION AGE 0-17	0.2973	1.3
63	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	1.3759	3.0
64	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.3089	4.3
65	03	MED	DYSEQUILIBRIUM	0.5748	2.3
66	03	MED	EPISTAXIS	0.5811	2.4
67	03	MED	EPIGLOTTITIS	0.7780	2.9
68	03	MED	OTITIS MEDIA & URI AGE >17 W CC	0.6531	3.1
69	03	MED	OTITIS MEDIA & URI AGE >17 W/O CC	0.4987	2.5
70	03	MED	OTITIS MEDIA & URI AGE 0-17	0.3188	2.0
71	03	MED	LARYNGOTRACHEITIS	0.7065	2.5
72	03	MED	NASAL TRAUMA & DEFORMITY	0.6954	2.6
73	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	0.8184	3.3
74	03	MED *	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0-17	0.3380	2.1
75	04	SURG	MAJOR CHEST PROCEDURES	3.0437	7.7
76	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.8184	8.4
77	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	1.2378	3.5
78	04	MED	PULMONARY EMBOLISM	1.2731	5.6
79	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	1.5974	6.7
80	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC	0.8400	4.3
81	04	MED *	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17	1.5300	6.1
82	04	MED	RESPIRATORY NEOPLASMS	1.3724	5.1
83	04	MED	MAJOR CHEST TRAUMA W CC	0.9620	4.3
84	04	MED	MAJOR CHEST TRAUMA W/O CC	0.5371	2.6
85	04	MED	PLEURAL EFFUSION W CC	1.1927	4.8
86	04	MED	PLEURAL EFFUSION W/O CC	0.6864	2.8
87	04	MED	PULMONARY EDEMA & RESPIRATORY FAILURE	1.3430	4.8
88	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	0.9031	4.1
89	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	1.0463	4.9
90	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	0.6147	3.4
91	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE 0-17	0.7408	3.1

DRGV21	MDC	TYPE	DRG TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS
92	04	MED	INTERSTITIAL LUNG DISEASE W CC	1.2024	5.0
93	04	MED	INTERSTITIAL LUNG DISEASE W/O CC	0.7176	3.3
94	04	MED	PNEUMOTHORAX W CC	1.1340	4.7
95	04	MED	PNEUMOTHORAX W/O CC	0.6166	3.0
96	04	MED	BRONCHITIS & ASTHMA AGE >17 W CC	0.7464	3.7
97	04	MED	BRONCHITIS & ASTHMA AGE >17 W/O CC	0.5505	2.9
98	04	MED *	BRONCHITIS & ASTHMA AGE 0-17	0.9662	3.7
99	04	MED	RESPIRATORY SIGNS & SYMPTOMS W CC	0.7032	2.4
100	04	MED	RESPIRATORY SIGNS & SYMPTOMS W/O CC	0.5222	1.8
101	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	0.8654	3.3
102	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	0.5437	2.1
103	PRE	SURG	HEART TRANSPLANT	18.6081	26.1
104	05	SURG	CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W CARD CATH	7.9389	12.2
105	05	SURG	CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W/O CARD CATH	5.7156	8.2
106	05	SURG	CORONARY BYPASS W PTCA	7.2936	9.6
107	05	SURG	CORONARY BYPASS W CARDIAC CATH	5.3751	9.2
108	05	SURG	OTHER CARDIOTHORACIC PROCEDURES	5.3656	7.3
109	05	SURG	CORONARY BYPASS W/O PTCA OR CARDIAC CATH	3.9401	6.7
110	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W CC	4.0492	6.2
111	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W/O CC	2.4797	3.2
112	05	SURG	NO LONGER VALID	0.0000	0.0
113	05	SURG	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE	3.0106	10.4
114	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	1.6436	6.3
115	05	SURG	PRM CARD PACEM IMPL W AMI/HR/SHOCK OR AICD LEAD OR GNRTR	3.5465	5.0
116	05	SURG	OTHER PERMANENT CARDIAC PACEMAKER IMPLANT	2.3590	3.1
117	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT	1.3951	2.6
118	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT	1.6089	2.0
119	05	SURG	VEIN LIGATION & STRIPPING	1.3739	3.2

DRGV21	MDC	TYPE	DRG TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS
120	05	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	2.3164	5.6
121	05	MED	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE	1.6169	5.3
122	05	MED	CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE	1.0297	2.9
123	05	MED	CIRCULATORY DISORDERS W AMI, EXPIRED	1.5645	2.9
124	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	1.4367	3.3
125	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	1.0947	2.2
126	05	MED	ACUTE & SUBACUTE ENDOCARDITIS	2.5418	9.2
127	05	MED	HEART FAILURE & SHOCK	1.0265	4.2
128	05	MED	DEEP VEIN THROMBOPHLEBITIS	0.7285	4.6
129	05	MED	CARDIAC ARREST, UNEXPLAINED	1.0229	1.7
130	05	MED	PERIPHERAL VASCULAR DISORDERS W CC	0.9505	4.5
131	05	MED	PERIPHERAL VASCULAR DISORDERS W/O CC	0.5676	3.3
132	05	MED	ATHEROSCLEROSIS W CC	0.6422	2.3
133	05	MED	ATHEROSCLEROSIS W/O CC	0.5559	1.8
134	05	MED	HYPERTENSION	0.5954	2.5
135	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC	0.9282	3.4
136	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC	0.5740	2.2
137	05	MED *	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17	0.8243	3.3
138	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	0.8355	3.1
139	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	0.5160	2.0
140	05	MED	ANGINA PECTORIS	0.5305	2.0
141	05	MED	SYNCOPE & COLLAPSE W CC	0.7473	2.8
142	05	MED	SYNCOPE & COLLAPSE W/O CC	0.5761	2.1
143	05	MED	CHEST PAIN	0.5480	1.7
144	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	1.2260	3.9
145	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	0.5787	2.0
146	06	SURG	RECTAL RESECTION W CC	2.7376	8.8
147	06	SURG	RECTAL RESECTION W/O CC	1.5375	5.6

DRGV21	MDC	TYPE	DRG TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS
148	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	3.4025	10.1
149	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.4590	5.8
150	06	SURG	PERITONEAL ADHESIOLYSIS W CC	2.8711	9.2
151	06	SURG	PERITONEAL ADHESIOLYSIS W/O CC	1.3061	4.4
152	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.9134	6.9
153	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.1310	4.7
154	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC	4.0212	9.9
155	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC	1.3043	3.0
156	06	SURG *	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17	0.8489	6.0
157	06	SURG	ANAL & STOMAL PROCEDURES W CC	1.3152	4.0
158	06	SURG	ANAL & STOMAL PROCEDURES W/O CC	0.6517	2.0
159	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC	1.3744	3.8
160	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC	0.8219	2.2
161	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	1.1676	3.0
162	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	0.6446	1.6
163	06	SURG *	HERNIA PROCEDURES AGE 0-17	0.6965	2.1
164	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	2.3306	7.0
165	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	1.2302	3.9
166	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.4317	3.6
167	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	0.8889	2.0
168	03	SURG	MOUTH PROCEDURES W CC	1.3158	3.3
169	03	SURG	MOUTH PROCEDURES W/O CC	0.7525	1.8
170	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	2.8245	7.5
171	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	1.1912	3.3
172	06	MED	DIGESTIVE MALIGNANCY W CC	1.3670	5.2
173	06	MED	DIGESTIVE MALIGNANCY W/O CC	0.7528	2.8
174	06	MED	G.I. HEMORRHAGE W CC	1.0025	3.9
175	06	MED	G.I. HEMORRHAGE W/O CC	0.5587	2.5

176	06	MED	COMPLICATED PEPTIC ULCER	1.0998	4.1
177	06	MED	UNCOMPLICATED PEPTIC ULCER W CC	0.9259	3.7
178	06	MED	UNCOMPLICATED PEPTIC ULCER W/O CC	0.6940	2.6
179	06	MED	INFLAMMATORY BOWEL DISEASE	1.0885	4.6
180	06	MED	G.I. OBSTRUCTION W CC	0.9642	4.2
181	06	MED	G.I. OBSTRUCTION W/O CC	0.5376	2.8
182	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	0.8223	3.4
183	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC	0.5759	2.3
184	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0-17	0.4813	2.4
185	03	MED	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17	0.8685	3.3
186	03	MED *	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0-17	0.3236	2.9
187	03	MED	DENTAL EXTRACTIONS & RESTORATIONS	0.7778	3.0
188	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	1.1088	4.1
189	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	0.5987	2.4
190	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	0.8104	3.7
191	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W CC	4.2787	9.8
192	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	1.8025	4.7
193	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	3.4211	10.4
194	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC	1.6030	5.7
195	07	SURG	CHOLECYSTECTOMY W C.D.E. W CC	3.0613	8.7
196	07	SURG	CHOLECYSTECTOMY W C.D.E. W/O CC	1.6117	4.8
197	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	2.5547	7.5
198	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC	1.1831	3.8
199	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	2.3953	7.0
200	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY	3.0415	6.7
201	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	3.6841	10.2
202	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS	1.3120	4.8

DRGV21	MDC	TYPE	DRG TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS
203	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	1.3482	5.0
204	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	1.1675	4.4
205	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	1.2095	4.6
206	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC	0.7071	2.9
207	07	MED	DISORDERS OF THE BILIARY TRACT W CC	1.1539	4.0
208	07	MED	DISORDERS OF THE BILIARY TRACT W/O CC	0.6601	2.3
209	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY	2.0327	4.4
210	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC	1.8477	6.1
211	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC	1.2544	4.5
212	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	1.4152	3.2
213	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS	1.8904	6.7
214	08	SURG	NO LONGER VALID	0.0000	0.0
215	08	SURG	NO LONGER VALID	0.0000	0.0
216	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	2.1107	5.0
217	08	SURG	WND DEBRID & SKN GRFT EXCEPT HAND,FOR MUSCSKELET & CONN TISS DIS	3.0020	9.0
218	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W CC	1.5750	4.3
219	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W/O CC	1.0258	2.7
220	08	SURG *	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE 0-17	0.5881	5.3
221	08	SURG	NO LONGER VALID	0.0000	0.0
222	08	SURG	NO LONGER VALID	0.0000	0.0
223	08	SURG	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC	1.0573	2.2
224	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC, W/O CC	0.7898	1.6
225	08	SURG	FOOT PROCEDURES	1.1704	3.6
226	08	SURG	SOFT TISSUE PROCEDURES W CC	1.5529	4.5

DRGV21	MDC	TYPE	DRG TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS
227	08	SURG	SOFT TISSUE PROCEDURES W/O CC	0.8190	2.1
228	08	SURG	MAJOR THUMB OR JOINT PROC,OR OTH HAND OR WRIST PROC W CC	1.1639	2.7
229	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	0.7064	1.8
230	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR	1.3147	3.6
231	08	SURG	NO LONGER VALID	0.0000	0.0
232	08	SURG	ARTHROSCOPY	0.9674	1.8
233	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	2.0024	5.0
234	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC	1.1977	2.2
235	08	MED	FRACTURES OF FEMUR	0.7580	3.8
236	08	MED	FRACTURES OF HIP & PELVIS	0.7358	3.9
237	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	0.5983	2.9
238	08	MED	OSTEOMYELITIS	1.3564	6.5
239	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY	1.0614	5.1
240	08	MED	CONNECTIVE TISSUE DISORDERS W CC	1.3153	4.9
241	08	MED	CONNECTIVE TISSUE DISORDERS W/O CC	0.6358	3.0
242	08	MED	SEPTIC ARTHRITIS	1.1695	5.3
243	08	MED	MEDICAL BACK PROBLEMS	0.7525	3.7
244	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	0.7155	3.7
245	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	0.4786	2.6
246	08	MED	NON-SPECIFIC ARTHROPATHIES	0.6063	3.0
247	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE	0.5724	2.6
248	08	MED	TENDONITIS, MYOSITIS & BURSITIS	0.8585	3.8
249	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	0.6744	2.5
250	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC	0.7091	3.2
251	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC	0.4578	2.3
252	08	MED *	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0-17	0.2553	1.8
253	08	MED	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W CC	0.7581	3.7

DRGV21	MDC	TYPE	DRG TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS
254	08	MED	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W/O CC	0.4464	2.6
255	08	MED *	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE 0-17	0.2974	2.9
256	08	MED	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	0.8190	3.8
257	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W CC	0.8913	2.1
258	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.7018	1.6
259	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	0.9420	1.8
260	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.6854	1.2
261	09	SURG	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION	0.8944	1.6
262	09	SURG	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	0.9533	2.9
263	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	2.0556	8.3
264	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC	1.0605	5.0
265	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC	1.5984	4.2
266	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC	0.8791	2.3
267	09	SURG	PERIANAL & PILONIDAL PROCEDURES	0.9574	2.9
268	09	SURG	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES	1.1513	2.4
269	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.7747	6.0
270	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	0.8129	2.5
271	09	MED	SKIN ULCERS	1.0280	5.6
272	09	MED	MAJOR SKIN DISORDERS W CC	1.0185	4.6
273	09	MED	MAJOR SKIN DISORDERS W/O CC	0.6192	3.0
274	09	MED	MALIGNANT BREAST DISORDERS W CC	1.1574	4.7
275	09	MED	MALIGNANT BREAST DISORDERS W/O CC	0.5729	2.4
276	09	MED	NON-MALIGANT BREAST DISORDERS	0.6471	3.5
277	09	MED	CELLULITIS AGE >17 W CC	0.8805	4.7
278	09	MED	CELLULITIS AGE >17 W/O CC	0.5432	3.5
279	09	MED	CELLULITIS AGE 0-17	0.7779	4.0
280	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC	0.7109	3.2
281	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC	0.4866	2.3

DRGV21	MDC	TYPE	DRG TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS
282	09	MED *	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17	0.2586	2.2
283	09	MED	MINOR SKIN DISORDERS W CC	0.7322	3.5
284	09	MED	MINOR SKIN DISORDERS W/O CC	0.4215	2.3
285	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DISORDERS	2.0825	7.9
286	10	SURG	ADRENAL & PITUITARY PROCEDURES	2.0342	4.4
287	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS	1.8899	7.7
288	10	SURG	O.R. PROCEDURES FOR OBESITY	2.1498	3.9
289	10	SURG	PARATHYROID PROCEDURES	0.9441	1.8
290	10	SURG	THYROID PROCEDURES	0.8938	1.7
291	10	SURG	THYROGLOSSAL PROCEDURES	0.6468	1.4
292	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	2.7336	7.3
293	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	1.3896	3.2
294	10	MED	DIABETES AGE >35	0.7800	3.5
295	10	MED	DIABETES AGE 0-35	0.7975	3.0
296	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	0.8639	4.0
297	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	0.5085	2.7
298	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0-17	0.4537	2.4
299	10	MED	INBORN ERRORS OF METABOLISM	0.9466	3.8
300	10	MED	ENDOCRINE DISORDERS W CC	1.1001	4.7
301	10	MED	ENDOCRINE DISORDERS W/O CC	0.6158	2.8
302	11	SURG	KIDNEY TRANSPLANT	3.2343	7.2
303	11	SURG	KIDNEY,URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM	2.3659	6.4
304	11	SURG	KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC	2.3856	6.2
305	11	SURG	KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC	1.1854	2.8
306	11	SURG	PROSTATECTOMY W CC	1.2257	3.5
307	11	SURG	PROSTATECTOMY W/O CC	0.6145	1.7
308	11	SURG	MINOR BLADDER PROCEDURES W CC	1.5993	4.0
309	11	SURG	MINOR BLADDER PROCEDURES W/O CC	0.8991	1.7

DRGV21	MDC	TYPE	DRG TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS
310	11	SURG	TRANSURETHRAL PROCEDURES W CC	1.1502	2.9
311	11	SURG	TRANSURETHRAL PROCEDURES W/O CC	0.6258	1.5
312	11	SURG	URETHRAL PROCEDURES, AGE >17 W CC	1.0841	3.0
313	11	SURG	URETHRAL PROCEDURES, AGE >17 W/O CC	0.6814	1.7
314	11	SURG *	URETHRAL PROCEDURES, AGE 0-17	0.4984	2.3
315	11	SURG	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	2.0796	3.7
316	11	MED	RENAL FAILURE	1.2987	4.9
317	11	MED	ADMIT FOR RENAL DIALYSIS	0.8503	2.4
318	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W CC	1.1871	4.4
319	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W/O CC	0.6771	2.2
320	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	0.8853	4.3
321	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	0.5685	3.1
322	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE 0-17	0.4625	2.8
323	11	MED	URINARY STONES W CC, &/OR ESW LITHOTRIPSY	0.8088	2.4
324	11	MED	URINARY STONES W/O CC	0.4797	1.6
325	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC	0.6553	2.9
326	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	0.4206	2.1
327	11	MED *	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17	0.3727	3.1
328	11	MED	URETHRAL STRICTURE AGE >17 W CC	0.7613	2.7
329	11	MED	URETHRAL STRICTURE AGE >17 W/O CC	0.5296	1.7
330	11	MED *	URETHRAL STRICTURE AGE 0-17	0.3210	1.6
331	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	1.0618	4.2
332	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC	0.5982	2.4
333	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17	0.9483	3.7
334	12	SURG	MAJOR MALE PELVIC PROCEDURES W CC	1.4810	3.9
335	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O CC	1.0835	2.8
336	12	SURG	TRANSURETHRAL PROSTATECTOMY W CC	0.8595	2.6
337	12	SURG	TRANSURETHRAL PROSTATECTOMY W/O CC	0.5869	1.8
338	12	SURG	TESTES PROCEDURES, FOR MALIGNANCY	1.2316	3.5
339	12	SURG	TESTES PROCEDURES, NON-MALIGNANCY AGE >17	1.1345	2.9
340	12	SURG *	TESTES PROCEDURES, NON-MALIGNANCY AGE 0-17	0.2853	2.4
341	12	SURG	PENIS PROCEDURES	1.2739	1.9

DRGV21	MDC	TYPE	DRG TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS
342	12	SURG	CIRCUMCISION AGE >17	0.7800	2.4
343	12	SURG *	CIRCUMCISION AGE 0-17	0.1551	1.7
344	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY	1.3306	1.6
345	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY	1.1671	3.0
346	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	1.0213	4.5
347	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	0.5417	2.2
348	12	MED	BENIGN PROSTATIC HYPERTROPHY W CC	0.7472	3.3
349	12	MED	BENIGN PROSTATIC HYPERTROPHY W/O CC	0.4608	2.0
350	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	0.7370	3.6
351	12	MED *	STERILIZATION, MALE	0.2379	1.3
352	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	0.7097	2.9
353	13	SURG	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY	1.8390	4.9
354	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	1.4808	4.7
355	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	0.8912	3.0
356	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	0.7556	1.8
357	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY	2.2737	6.7
358	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	1.1807	3.4
359	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	0.8099	2.3
360	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES	0.8661	2.2
361	13	SURG	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	1.0793	2.2
362	13	SURG *	ENDOSCOPIC TUBAL INTERRUPTION	0.3041	1.4
363	13	SURG	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	0.9374	2.6
364	13	SURG	D&C, CONIZATION EXCEPT FOR MALIGNANCY	0.9098	2.9
365	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	2.1284	5.3
366	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	1.2826	4.8
367	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	0.5588	2.3
368	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	1.1657	5.1

DRGV21	MDC	TYPE	DRG TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS
369	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	0.6065	2.4
370	14	SURG	CESAREAN SECTION W CC	1.0119	4.2
371	14	SURG	CESAREAN SECTION W/O CC	0.6317	3.2
372	14	MED	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	0.5520	2.7
373	14	MED	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	0.3856	2.0
374	14	SURG	VAGINAL DELIVERY W STERILIZATION &/OR D&C	0.7402	2.5
375	14	SURG *	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	0.5806	4.4
376	14	MED	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	0.5693	2.5
377	14	SURG	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	1.0321	3.1
378	14	MED	ECTOPIC PREGNANCY	0.7950	2.0
379	14	MED	THREATENED ABORTION	0.3626	2.0
380	14	MED	ABORTION W/O D&C	0.4323	1.6
381	14	SURG	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	0.5257	1.5
382	14	MED	FALSE LABOR	0.2190	1.3
383	14	MED	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	0.5123	2.7
384	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	0.3485	1.9
385	15	MED *	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	1.3855	1.8
386	15	MED *	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	4.5687	17.9
387	15	MED *	PREMATURITY W MAJOR PROBLEMS	3.1203	13.3
388	15	MED *	PREMATURITY W/O MAJOR PROBLEMS	1.8827	8.6
389	15	MED *	FULL TERM NEONATE W MAJOR PROBLEMS	3.2052	4.7
390	15	MED *	NEONATE W OTHER SIGNIFICANT PROBLEMS	1.1344	3.4
391	15	MED *	NORMAL NEWBORN	0.1536	3.1
392	16	SURG	SPLENECTOMY AGE >17	3.3164	7.1
393	16	SURG *	SPLENECTOMY AGE 0-17	1.3571	9.1
394	16	SURG	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS	1.9338	4.7
395	16	MED	RED BLOOD CELL DISORDERS AGE >17	0.8307	3.2
396	16	MED	RED BLOOD CELL DISORDERS AGE 0-17	0.6986	2.9

DRGV21	MDC	TYPE	DRG TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS
397	16	MED	COAGULATION DISORDERS	1.2648	3.7
398	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	1.2360	4.5
399	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	0.6651	2.7
400	17	SURG	NO LONGER VALID	0.0000	0.0
401	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	2.8946	8.1
402	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC	1.1430	2.7
403	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	1.8197	5.8
404	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	0.8658	3.0
405	17	MED *	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0-17	1.9241	4.9
406	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC	2.7055	6.9
407	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC	1.2410	3.2
408	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC	2.1984	4.8
409	17	MED	RADIOTHERAPY	1.2439	4.6
410	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	1.0833	3.2
411	17	MED *	HISTORY OF MALIGNANCY W/O ENDOSCOPY	0.3948	4.7
412	17	MED	HISTORY OF MALIGNANCY W ENDOSCOPY	0.5679	2.5
413	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	1.3224	5.2
414	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	0.7370	3.2
415	18	SURG	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	3.6276	10.4
416	18	MED	SEPTICEMIA AGE >17	1.5918	5.6
417	18	MED	SEPTICEMIA AGE 0-17	0.9612	4.4
418	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	1.0672	4.8
419	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W CC	0.8476	3.6
420	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	0.6107	2.8
421	18	MED	VIRAL ILLNESS AGE >17	0.7464	3.1
422	18	MED	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17	0.7248	2.5
423	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	1.8155	5.9
424	19	SURG	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	2.4074	8.0

DRGV21	MDC	TYPE	DRG TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS
425	19	MED	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	0.6781	2.8
426	19	MED	DEPRESSIVE NEUROSES	0.5087	3.2
427	19	MED	NEUROSES EXCEPT DEPRESSIVE	0.5012	3.1
428	19	MED	DISORDERS OF PERSONALITY & IMPULSE CONTROL	0.7291	4.5
429	19	MED	ORGANIC DISTURBANCES & MENTAL RETARDATION	0.8291	4.5
430	19	MED	PSYCHOSES	0.6801	5.6
431	19	MED	CHILDHOOD MENTAL DISORDERS	0.6620	4.4
432	19	MED	OTHER MENTAL DISORDER DIAGNOSES	0.6513	2.9
433	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	0.2904	2.2
434	20	MED	NO LONGER VALID	0.0000	0.0
435	20	MED	NO LONGER VALID	0.0000	0.0
436	20	MED	NO LONGER VALID	0.0000	0.0
437	20	MED	NO LONGER VALID	0.0000	0.0
438	20		NO LONGER VALID	0.0000	0.0
439	21	SURG	SKIN GRAFTS FOR INJURIES	1.7547	5.2
440	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES	1.8878	5.8
441	21	SURG	HAND PROCEDURES FOR INJURIES	0.9662	2.1
442	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W CC	2.4200	5.6
443	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W/O CC	0.9787	2.5
444	21	MED	TRAUMATIC INJURY AGE >17 W CC	0.7475	3.2
445	21	MED	TRAUMATIC INJURY AGE >17 W/O CC	0.5015	2.3
446	21	MED *	TRAUMATIC INJURY AGE 0-17	0.2983	2.4
447	21	MED	ALLERGIC REACTIONS AGE >17	0.5238	1.9
448	21	MED *	ALLERGIC REACTIONS AGE 0-17	0.0981	2.9
449	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC	0.8352	2.6
450	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	0.4246	1.6
451	21	MED *	POISONING & TOXIC EFFECTS OF DRUGS AGE 0-17	0.2648	2.1
452	21	MED	COMPLICATIONS OF TREATMENT W CC	1.0455	3.5
453	21	MED	COMPLICATIONS OF TREATMENT W/O CC	0.5113	2.1
454	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC	0.8153	3.0
455	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC	0.4773	1.8
456	22		NO LONGER VALID	0.0000	0.0

DRGV21	MDC	TYPE	DRG TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS
457	22	MED	NO LONGER VALID	0.0000	0.0
458	22	SURG	NO LONGER VALID	0.0000	0.0
459	22	SURG	NO LONGER VALID	0.0000	0.0
460	22	MED	NO LONGER VALID	0.0000	0.0
461	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES	1.1692	2.2
462	23	MED	REHABILITATION	0.9747	9.0
463	23	MED	SIGNS & SYMPTOMS W CC	0.6856	3.1
464	23	MED	SIGNS & SYMPTOMS W/O CC	0.4982	2.4
465	23	MED	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.8881	2.0
466	23	MED	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.8088	2.2
467	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	0.5274	1.9
468			EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	3.8454	9.4
469		**	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	0.0000	0.0
470		**	UNGROUPABLE	0.0000	0.0
471	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY	3.0576	4.7
472	22	SURG	NO LONGER VALID	0.0000	0.0
473	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	3.4885	7.4
474	04	SURG	NO LONGER VALID	0.0000	0.0
475	04	MED	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	3.6000	8.0
476		SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	2.2477	8.0
477		SURG	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	1.8873	5.4
478	05	SURG	OTHER VASCULAR PROCEDURES W CC	2.3743	4.9
479	05	SURG	OTHER VASCULAR PROCEDURES W/O CC	1.4300	2.4
480	PRE	SURG	LIVER TRANSPLANT	9.7823	14.0
481	PRE	SURG	BONE MARROW TRANSPLANT	6.1074	19.2
482	PRE	SURG	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES	3.4803	9.6

DRGV21	MDC	TYPE	DRG TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS
483	PRE	SURG	TRAC W MECH VENT 96+HRS OR PDX EXCEPT FACE,MOUTH & NECK DX OSES	16.7762	34.2
484	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	5.4179	9.7
485	24	SURG	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TRA	3.2121	7.9
486	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	4.8793	8.7
487	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA	2.0057	5.3
488	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE	4.8118	11.7
489	25	MED	HIV W MAJOR RELATED CONDITION	1.8603	6.0
490	25	MED	HIV W OR W/O OTHER RELATED CONDITION	1.0512	3.9
491	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY	1.7139	2.8
492	17	MED	CHEMOTHERAPY W ACUTE LEUKEMIA OR W USE OF HI DOSE CHEMOAGENT	3.8371	9.3
493	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.8302	4.4
494	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	1.0034	2.0
495	PRE	SURG	LUNG TRANSPLANT	8.5551	13.4
496	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	5.6839	6.8
497	08	SURG	SPINAL FUSION EXCEPT CERVICAL W CC	3.4056	5.2
498	08	SURG	SPINAL FUSION EXCEPT CERVICAL W/O CC	2.5319	3.6
499	08	SURG	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC	1.4244	3.3
500	08	SURG	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC	0.9369	2.0
501	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W CC	2.6393	8.3
502	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W/O CC	1.4192	5.1
503	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION	1.2233	3.0
504	22	SURG	EXTENSIVE 3RD DEGREE BURNS W SKIN GRAFT	11.6215	20.3
505	22	MED	EXTENSIVE 3RD DEGREE BURNS W/O SKIN GRAFT	2.0006	2.3
506	22	SURG	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA	4.1070	12.1
507	22	SURG	FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA	1.8154	6.5
508	22	MED	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA	1.3775	5.6

DRGV21	MDC	TYPE	DRG TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS
509	22	MED	FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA	0.6426	3.1
510	22	MED	NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA	1.1812	4.6
511	22	MED	NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA	0.6753	3.2
512	PRE	SURG	SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	5.3405	11.1
513	PRE	SURG	PANCREAS TRANSPLANT	6.1594	8.7
514	05	SURG	NO LONGER VALID	0.0000	0.0
515	05	SURG	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH	5.3366	3.0
516	05	SURG	PERCUTANEOUS CARDIOVASC PROC W AMI	2.6911	3.8
517	05	SURG	PERC CARDIO PROC W NON-DRUG ELUTING STENT W/O AMI	2.1598	1.8
518	05	SURG	PERC CARDIO PROC W/O CORONARY ARTERY STENT OR AMI	1.7494	2.3
519	08	SURG	CERVICAL SPINAL FUSION W CC	2.4266	3.2
520	08	SURG	CERVICAL SPINAL FUSION W/O CC	1.5780	1.7
521	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	0.7115	4.3
522	20	MED	ALC/DRUG ABUSE OR DEPEND W REHABILITATION THERAPY W/O CC	0.5226	7.7
523	20	MED	ALC/DRUG ABUSE OR DEPEND W/O REHABILITATION THERAPY W/O CC	0.3956	3.3
524	01	MED	TRANSIENT ISCHEMIA	0.7320	2.7
525	05	SURG	HEART ASSIST SYSTEM IMPLANT	14.1896	10.2
526	05	SURG	PERCUTNEOUS CARDIOVASULAR PROC W DRUG ELUTING STENT W AMI	2.9891	3.6
527	05	SURG	PERCUTNEOUS CARDIOVASULAR PROC W DRUG ELUTING STENT W/O AMI	2.4483	1.8
528	01	SURG	INTRACRANIAL VASCULAR PROC W PDX HEMORRHAGE	7.2205	14.2
529	01	SURG	VENTRICULAR SHUNT PROCEDURES W CC	2.2529	5.3
530	01	SURG	VENTRICULAR SHUNT PROCEDURES W/O CC	1.2017	2.8
531	01	SURG	SPINAL PROCEDURES W CC	3.0552	6.8
532	01	SURG	SPINAL PROCEDURES W/O CC	1.4482	2.9
533	01	SURG	EXTRACRANIAL PROCEDURES W CC	1.6678	2.7
534	01	SURG	EXTRACRANIAL PROCEDURES W/O CC	1.0748	1.6
535	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK	8.1560	8.1
536	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK	6.2775	3.9

DRGV21	MDC	TYPE	DRG TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS
537	08	SURG	LOCAL EXCIS & REMOV OF INT FIX DEV EXCEPT HIP & FEMUR W CC	1.8185	4.7
538	08	SURG	LOCAL EXCIS & REMOV OF INT FIX DEV EXCEPT HIP & FEMUR W/O CC	0.9919	2.1
539	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR OR PROCEDURE W CC	3.3846	7.4
540	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR OR PROCEDURE W/O CC	1.2891	2.9

Section 9789.30. Hospital Outpatient Departments and Ambulatory Surgical Centers - Definitions.

(a) "Adjusted Conversion Factor" means the CMS' conversion factor for 2003 of 52.151 x the market basket inflation factor of 1.034 x (0.4 + (0.6 x wage index)).

(b) "Ambulatory Payment Classifications (APC)" means the Centers for Medicare & Medicaid Services' (CMS) list of ambulatory payment classifications of hospital outpatient services.

(c) "Ambulatory Surgical Center (ASC)" means any surgical clinic as defined in the California Health and Safety Code Section 1204, subdivision (b)(1), any ambulatory surgical center that is certified to participate in the Medicare program under Title XVIII (42 U.S.C. SEC. 1395 et seq.) of the federal Social Security Act, or any surgical clinic accredited by an accrediting agency as approved by the Licensing Division of the Medical Board of California pursuant to Health and Safety Code Sections 1248.15 and 1248.4.

(d) "Annual Utilization Report of Specialty Clinics" means the Annual Utilization Report of Clinics which is filed by February 15 of each year with the Office of Statewide Health Planning and Development by the ASCs as required by Section 127285 and Section 1216 of the Health and Safety Code.

(e) "APC Payment Rate" means CMS' hospital outpatient prospective payment system rate for Calendar Year 2004 as set forth in the Federal Register on November 7, 2003, Volume 68, No. 216, Addendum B, pages 63488 through 63655.

(f) "APC Relative Weight" means CMS' APC relative weight as set forth in CMS' hospital outpatient prospective payment system for the Calendar Year 2004 as set forth in the Federal Register on November 7, 2003, Volume 68, No. 216, Addendum B, pages 63488 through 63655.

(g) "CMS" means the Centers for Medicare & Medicaid Services of the United States Department of Health and Human Services.

(h) "Cost to Charge Ratio for ASC" means the ratio of the facility's total operating costs to total gross charges during the preceding calendar year.

(i) "Cost to Charge Ratio for Hospital Outpatient Department" means the hospital cost-to-charge used by the Medicare fiscal intermediary to determine high cost outlier payments.

(j) "HCPCS" means CMS' Healthcare Common Procedure Coding System, which describes products, supplies, procedures and health professional services and includes, the American Medical Associations (AMA's) Physician "*Current Procedural Terminology*", Fourth Edition (CPT-4) codes, alphanumeric codes, and related modifiers.

(k) "HCPCS Level I Codes" are the AMA's CPT-4 codes and modifiers for professional services and procedures.

(l) "HCPCS Level II Codes" are national alphanumeric codes and modifiers maintained by CMS for health care products and supplies, as well as some codes for professional services not included in the AMA's CPT-4.

(m) "Health facility" means any facility as defined in Section 1250 of the Health and Safety Code.

(n) "Hospital Outpatient Department" means any hospital outpatient department of a health facility as defined in the California Health and Safety Code Section 1250 and any hospital outpatient department that is certified to participate in the Medicare program under Title XVIII (42 U.S.C. SEC. 1395 et seq.) of the federal Social Security Act.

(o) "Hospital Outpatient Department Services" means services furnished by any health facility as defined in the California Health and Safety Code Section 1250 and any hospital that is certified to participate in the Medicare program under Title XVIII (42 U.S.C. SEC. 1395 et seq.) of the federal Social Security Act to a patient who has not been admitted as an inpatient but who is registered as an outpatient in the records of the hospital.

(p) "Market Basket Inflation Factor" means 3.4%, the market basket percentage increase determined by CMS for FY 2004, as set forth in the Federal Register on August 1, 2003, Volume 68, at page 45346.

(q) "Outpatient Prospective Payment System (OPPS)" means Medicare's payment system for outpatient services at hospitals. These outpatient services are classified according to a list of ambulatory payment classifications (APCs).

(r) "Total Gross Charges" means the facility's total usual and customary charges to patients and third-party payers before reductions for contractual allowances, bad debts, courtesy allowances and charity care.

(s) "Total Operating Costs" means the direct cost 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.

(t) "Wage Index" means CMS' wage index for urban, rural and hospitals that are reclassified as described in CMS' 2004 Hospital Outpatient Prospective Payment System (HOPPS), adopted for the Calendar Year 2004, published in the Federal Register on November 7, 2003, Volume 68, No. 216, Addenda H through J, pages 63682 through 63690.

(u) "Workers' Compensation Multiplier" means the 120% Medicare multiplier

required by Labor Code Section 5307.1, or the 122% multiplier that includes an extra 2% reimbursement for high cost outlier cases.

Authority: Sections 133, 4603.5, 5307.1, and 5307.3, Labor Code.
Reference: Sections 4600, 4603.2, and 5307.1, Labor Code.

Section 9789.31. Hospital Outpatient Departments and Ambulatory Surgical Centers – Adoption of Standards.

(a) The Administrative Director incorporates by reference, the Centers for Medicare and Medicaid Services' (CMS) 2004 Hospital Outpatient Prospective Payment System (HOPPS), adopted for the Calendar Year 2004, published in the Federal Register on November 7, 2003, Volume 68, No. 216, Addenda A through J, pages 63478 through 63690 as follows:

(1) Addendum A "List of Ambulatory Payment Classifications (APCs) with Status Indicators, Relative Weights, Payment Rates, and Copayment Amounts Calendar Year 2004."

(2) Addendum B "Payment Status by HCPCS Code and Related Information Calendar Year 2004."

(3) Addendum D1 "Payment Status Indicators for Hospital Outpatient Prospective Payment System."

(4) Addendum D2 "Code Conditions."

(5) Addendum E "CPT Codes Which Would Be Paid Only As Inpatient Procedures."

(6) Addendum H "Wage Index For Urban Areas"

(7) Addendum I "Wage Index For Rural Areas"

(8) Addendum J "Wage Index For Hospitals That Are Reclassified."

(b) The Administrative Director incorporates by reference the American Medical Associations' Physician "*Current Procedural Terminology*," 2004 Edition.

(c) The Administrative Director incorporates by reference CMS' 2004 Alphanumeric *"Healthcare Common Procedure Coding System* (HCPCS)."

Authority: Sections 133, 4603.5, 5307.1, and 5307.3, Labor Code.
Reference: Sections 4600, 4603.2, and 5307.1, Labor Code.

Section 9789.32. Outpatient Hospital Department and Ambulatory Surgical Center Fee Schedule – Applicability.

(a) Sections 9789.30 through 9789.36 shall be applicable to the maximum allowable fees for emergency room visits and surgical procedures rendered after January 1, 2004. For purposes of this section, emergency room visits shall be defined by CPT codes 99281-99285 and surgical procedures shall be defined by CPT codes 10040-69990. A facility fee is payable only for the specified emergency room and surgical codes and for supplies, drugs, devices, blood products and biologicals that are an integral part of the emergency room visit or surgical procedure. A supply, drug, device, blood product and biological is considered an integral part of an emergency room visit or surgical procedure if:

(1) the item has a status code N and is packaged into the APC payment for the emergency room visit or surgical procedure (in which case no additional fee is allowable) or,

(2) the item is assigned to the same APC as the emergency room visit or surgical procedure and has a status indicator H or,

(3) the item is furnished in conjunction with an emergency room visit or surgical procedure and has been assigned Status Code G, H or K.

(b) Sections 9789.30 through 9789.36 apply to any hospital outpatient department as defined in Section 9789.30(n) and any hospital outpatient department that is certified to participate in the Medicare program under Title XVIII (42 U.S.C. SEC. 1395 et seq.) of the federal Social Security Act and any ASC as defined in the California Health and Safety Code Section 1204, subdivision (b)(1), any ambulatory surgical center that is certified to participate in the Medicare program under Title XVIII (42 U.S.C. SEC. 1395 et seq.) of the federal Social Security Act, and any surgical clinic accredited by an accrediting agency as approved by the Licensing Division of the Medical Board of California pursuant to Health and Safety Code Sections 1248.15 and 1248.4, performing procedures and services on an outpatient basis.

(c) The maximum allowable fees for services and supplies furnished by hospitals and ambulatory surgical centers that do not meet the requirements in (a) for a facility fee payment will be determined as follows:

(1) The maximum allowable fees for the technical component of the diagnostic services shall be determined according to Section 9789.10 and Section 9789.11.

(2) The maximum allowable fees for the professional component of medical services that are not included in the APC payment rate for emergency room visits and surgical procedures, and which are performed by physicians and other licensed health care providers shall be paid according to Section 9789.10 and Section 9789.11.

(3) The maximum allowable fees for organ acquisition costs and corneal tissue acquisition costs shall be based on the documented paid cost of procuring the organ or tissue.

(4) The maximum allowable fee for drugs shall be 100% of the fee prescribed by Medi-Cal pursuant to Labor Code Section 5307.1 subdivision (a), or, where applicable, Section 9789.40.

(5) The maximum allowable fee for clinical diagnostic tests shall be determined according to Section 9789.50.

(6) The maximum allowable fee for durable medical equipment, prosthetics and orthotics shall be determined according to Section 9789.60.

(7) The maximum allowable fee for ambulance service shall be determined according to Section 9789.70.

(d) Only hospitals may charge or collect a facility fee for emergency room visits. Only hospital outpatient departments and ambulatory surgical centers as defined in Section 9789.30(n) and Section 9789.30(c) may charge or collect a facility fee for surgical services provided on an outpatient basis.

(e) Hospital outpatient departments and ambulatory surgical centers shall not be reimbursed for procedures on the inpatient only list, Section 9789.31(a)(5), Addendum E, except that pre-authorized services rendered are payable at the pre-negotiated fee arrangement. The pre-authorization must be provided by an authorized agent of the claims administrator to the provider. The fee agreement and pre-authorization must be memorialized in writing prior to performing the medical services.

(f) Critical access hospitals and hospitals that are excluded from acute PPS are exempt from this fee schedule.

Authority: Sections 133, 4603.5, 5307.1, and 5307.3, Labor Code.
Reference: Sections 4600, 4603.2, and 5307.1, Labor Code.

Section 9789.33. Hospital Outpatient Departments and Ambulatory Surgical Facilities Fee Schedule – Determination of Maximum Reasonable Fee.

(a) For Services rendered after January 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) Procedure codes with status code indicators “S”, “T” or “V”:

(APC relative weight x $52.151) x (.40 + .60 x applicable wage index) x inflation factor of 1.034 x 1.22

(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 relative weight x adjusted conversion factor x 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. The maximum payment rate for the listed hospitals can be determined as follows:

APC relative weight x adjusted conversion factor x 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%.

(4) Procedure codes for drugs and biologicals with status code indicator “K”:
APC payment rate 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) Procedure codes with status code indicators “S”, “T” or “V”:

(APC relative weight x $52.151) x (.40 + .60 x applicable wage index) x inflation factor of 1.034 x 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%

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

APC payment rate x 1.20

(2) Additional payment for high cost outlier case:

[(Facility charges x cost-to-charge ratio) – (standard payment x 2.6)] x .50

(3) In determining the additional payment, the facility’s charges and standard 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. The form must be filed 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 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 Administrative Director at: Division of Workers' Compensation (Attention: OMFS-Outpatient) P.O. Box 420603, San Francisco, CA 94142.

(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 Administrative Director at: Division of Workers' Compensation (Attention: OMFS-Outpatient), P.O. Box 420603, San Francisco, CA 94142

(d) The OPPS 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.

(e) The OPPS 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.

(f) The payment determined under subdivisions (a) and (b) include reimbursement for all of the included cost items specified in 42 CFR § 419.2(b), which is incorporated by

reference, as contained in Section 9789.38 Appendix X. In addition, all of the cost items specified in 42 C.F.R. § 419.2(c)1-6 are included in the maximum allowable payment rate and are incorporated by reference as contained in Section 9789.38 Appendix X.

(g) The maximum allowable fees shall be determined without regard to the provisions in 42 C.F.R. § 419.70 as contained in Section 9789.38 Appendix X.

Authority: Sections 133, 4603.5, 5307.1, and 5307.3, Labor Code.
Reference: Sections 4600, 4603.2, and 5307.1, Labor Code.

Section 9789.34. Table A.
(See Addenda H and I set forth in Section 9789.31)

MSA Code	Urban/Rural Area	Constituent Counties	Wage Index	Adjusted Conversion Factor (Before CA WC Adjustment Factor)*
680	Bakersfield, CA	Kern	0.9967	53.82
1620	Chico-Paradise, CA	Butte	1.0193	54.55
2840	Fresno, CA	Fresno Madera	1.0142	54.38
4480	Los Angeles-Long Beach, CA	Los Angeles	1.1832	59.85
4940	Merced, CA	Merced	0.9967	53.82
5170	Modesto, CA	Stanislaus	1.1275	58.05
5775	Oakland, CA	Alameda Contra Costa	1.5119	70.49
5945	Orange County, CA	Orange	1.1492	58.75
6690	Redding, CA	Shasta	1.1352	58.30
6780	Riverside-San Bernardino, CA	Riverside San Bernardino	1.1348	58.29
6920	Sacramento, CA	El Dorado Placer Sacramento	1.1845	59.89
7120	Salinas, CA	Monterey	1.4339	67.96
7320	San Diego, CA	San Diego	1.1147	57.64
7360	San Francisco, CA	Marin San Francisco San Mateo	1.4514	68.53
7400	San Jose, CA	Santa Clara	1.4626	68.89
7460	San Luis Obispo-Atascadero-Paso Robles, CA	San Luis Obispo	1.1429	58.55
7480	Santa Barbara-Santa Maria-Lompoc, CA	Santa Barbara	1.0441	55.35
7485	Santa Cruz-Watsonville, CA	Santa Cruz	1.2942	63.44
7500	Santa Rosa, CA	Sonoma	1.2877	63.23

8120	Stockton-Lodi, CA	San Joaquin	1.0404	55.23
8720	Vallejo-Fairfield-Napa, CA	Napa Solano	1.3425	65.01
8735	Ventura, CA	Ventura	1.1064	57.37
8780	Visalia-Tulare-Porterville, CA	Tulare	0.9967	53.82
9270	Yolo, CA	Yolo	0.9967	53.82
9340	Yuba City, CA	Sutter Yuba	1.0196	54.56
Non-MSA Areas of State			0.9967	53.82

***** $52.151 x (.40 + .60 x applicable wage index) x inflation factor of 1.034***

Section 9789.35. Table B.
(See Addenda H, I and J set forth in Section 9789.31)

PROVIDER #	NAME	WIGRN - MSA WAGE INDEX	Adjusted Conversion Factor (before CA WC Adjustment Factor)
050002	ST. ROSE HOSPITAL	1.5119	70.49
050006	ST JOSEPH - EUREKA	0.9967	53.82
050007	MILLS PENINSULA MEDICAL CENTER	1.4514	68.53
050008	CPMC - DAVIES CAMPUS	1.4514	68.53
050009	QUEEN OF THE VALLEY HOSPITAL	1.3425	65.01
050013	ST HELENA HOSPITAL	1.3425	65.01
050014	SUTTER AMADOR HOSPITAL	0.9967	53.82
050015	NORTHERN INYO HOSPITAL	0.9967	53.82
050016	ARROYO GRANDE COMMUNITY HOSPITAL	1.1429	58.55
050017	MERCY GENERAL HOSPITAL	1.1845	59.89
050018	PACIFIC ALLIANCE MEDICAL CNTR	1.1832	59.85
050022	RIVERSIDE COMMUNITY	1.1348	58.29
050024	PARADISE VALLEY HOSPITAL	1.1147	57.64
050025	UCSD MEDICAL CENTER	1.1147	57.64
050026	GROSSMONT HOSPITAL	1.1147	57.64
050028	MAD RIVER COMMUNITY HOSPITAL	0.9967	53.82
050029	ST.LUKE MEDICAL CENTER	1.1832	59.85
050030	OROVILLE HOSPITAL	1.0193	54.55
050036	MEMORIAL HOSPITAL	0.9967	53.82
050038	SANTA CLARA VALLEY MEDICAL CENTER	1.4626	68.89
050039	ENLOE MEDICAL CENTER	1.0193	54.55
050040	LAC OLIVE VIEW/UCLA MEDICAL CENTER	1.1832	59.85
050042	ST ELIZABETH COMMUNITY HOSPITAL	1.1352	58.30
050043	SUMMIT MEDICAL CENTER	1.5119	70.49
050045	EL CENTRO REGIONAL MED. CTR.	0.9967	53.82

050046	**OJAI VALLEY COMMUNITY HOSPITAL**	1.1064	57.37
050047	**CALIFORNIA PACIFIC MEDICAL CENTER**	1.4514	68.53
050054	**SAN GORGONIO MEMORIAL HOSPITAL**	1.1348	58.29
050055	**ST. LUKES HOSPITAL**	1.4514	68.53
050056	**ANTELOPE VALLEY HOSPITAL**	1.1832	59.85
050057	**KAWEAH DELTA HEALTH CARE DISTRICT**	0.9967	53.82
050058	**GLENDALE MEMORIAL HOSPITAL & HLTH CT**	1.1832	59.85
050060	**COMMUNITY MEDICAL CENTER - FRESNO**	1.0142	54.38
050061	**ST. FRANCIS MEDICAL CENTER**	1.0441	55.35
050063	**QUEEN OF ANGELS - HLLYWD PRES MC**	1.1832	59.85
050065	**WMC SANTA ANA**	1.1492	58.75
050067	**OAK VALLEY DISTRICT HOSPITAL**	1.1275	58.05
050069	**ST. JOSEPH HOSPITAL**	1.1492	58.75
050070	**KFH - SOUTH SAN FRANCISCO**	1.4514	68.53
050071	**KFH - SANTA CLARA**	1.5119	70.49
050072	**KFH - WALNUT CREEK**	1.5119	70.49
050073	**KFH - VALLEJO**	1.5119	70.49
050075	**KFH - OAKLAND**	1.5119	70.49
050076	**KFH - SAN FRANCISCO**	1.4514	68.53
050077	**SCRIPPS MERCY HOSPITAL**	1.1147	57.64
050078	**SAN PEDRO PENINSULA HOSPITAL**	1.1832	59.85
050079	**DOCTORS MEDICAL CENTER-SAN PABLO**	1.5119	70.49
050082	**ST. JOHN'S REGIONAL MEDICAL CENTER**	1.1064	57.37
050084	**ST. JOSEPH'S MEDICAL CENTER**	1.0404	55.23
050088	**SAN LUIS OBISPO GEN HOSPITAL**	1.1429	58.55
050089	**COMMUNITY HOSPITAL OF SAN BERNARDINO**	1.1348	58.29
050090	**SONOMA VALLEY HEALTH CARE DIST.**	1.2877	63.23
050091	**HUNTINGTON PARK**	1.1832	59.85
050093	**SAINT AGNES MEDICAL CENTER**	1.0142	54.38
050095	**LAURAL GROVE HOSPITAL**	1.5119	70.49
050096	**DOCTOR'S HOSP. OF WEST COVINA**	1.1832	59.85
050099	**SAN ANTONIO COMMUNITY HOSPITAL**	1.1348	58.29
050100	**SHARP MEMORIAL HOSPITAL**	1.1147	57.64
050101	**SUTTER SOLANO MEDICAL CENTER**	1.5119	70.49
050102	**PARKVIEW COMMUNITY HOSPITAL**	1.1348	58.29
050103	**WHITE MEMORIAL MEDICAL CENTER**	1.1832	59.85
050104	**ST. FRANCIS MEDICAL CENTER**	1.1832	59.85
050107	**MARIAN MEDICAL CENTER**	1.0441	55.35
050108	**SUTTER MEDICAL CENTER-SACRAMENTO**	1.1845	59.89
050110	**LOMPOC DISTRICT HOSPITAL**	1.0441	55.35
050111	**TEMPLE COMMUNITY HOSPITAL**	1.1832	59.85
050112	**SANTA MONICA HOSPITAL**	1.1832	59.85
050113	**SAN MATEO COUNTY GENERAL HOSPITAL**	1.4514	68.53
050114	**SHERMAN OAKS HOSP AND HLTH CENTER**	1.1832	59.85
050115	**PALOMAR MEDICAL CENTER**	1.1147	57.64
050116	**NORTHRIDGE HOSPITAL - ROSCO**	1.1832	59.85
050117	**MERCY HOSPITAL & HEALTH SYSTEM**	0.9967	53.82
050118	**DOCTORS HOSPITAL OF MANTECA**	1.0404	55.23
050121	**HANFORD COMM. MEDICAL CENTER**	0.9967	53.82
050122	**DAMERON HOSPITAL**	1.0404	55.23

050124	**VERDUGO HILLS HOSPITAL**	1.1832	59.85
050125	**REGIONAL MEDICAL CENTER OF SAN JOSE**	1.4626	68.89
050126	**VALLEY PRESBYTERIAN HOSPITAL**	1.1832	59.85
050127	**WOODLAND MEMORIAL HOSPITAL**	0.9967	53.82
050128	**TRI-CITY MEDICAL CENTER**	1.1147	57.64
050129	**ST. BERNARDINE MEDICAL CENTER**	1.1348	58.29
050131	**NOVATO COMMUNITY HOSPITAL**	1.4514	68.53
050132	**SAN GABRIEL VALLEY MEDICAL CENTER**	1.1832	59.85
050133	**RIDEOUT MEMORIAL HOSPITAL**	1.0196	54.56
050135	**HOLLYWOOD COMM HOSP OF HOLLYWOOD**	1.1832	59.85
050136	**PETALUMA VALLEY HOSPITAL**	1.2877	63.23
050137	**KAISER FOUND. HOSP - PANORAMA**	1.1832	59.85
050138	**KAISER FOUNDATION HOSPITALS - SUNSET**	1.1832	59.85
050139	**KAISER FOUND. HOSPITALS - BELLFLOWER**	1.1832	59.85
050140	**KAISER FOUND. HOSPITALS - FONTANA**	1.1348	58.29
050144	**BROTMAN MEDICAL CENTER**	1.1832	59.85
050145	**COMMUNITY HOSP. MONTEREY PENINSULA**	1.4339	67.96
050148	**PLUMAS DISTRICT HOSPITAL MCARE RPT**	0.9967	53.82
050149	**CALIFORNIA HOSPITAL MEDICAL CENTER**	1.1832	59.85
050150	**SIERRA NEVADA MEMORIAL HOSPITAL**	1.1845	59.89
050152	**SAINT FRANCIS MEMORIAL HOSPITAL**	1.4514	68.53
050153	**O'CONNOR HOSPITAL**	1.4626	68.89
050155	**MONROVIA COMMUNITY HOSPITAL**	1.1832	59.85
050158	**ENCINO TARZANA MEDICAL CENTER**	1.1832	59.85
050159	**VENTURA COUNTY MEDICAL CENTER**	1.1064	57.37
050167	**SAN JOAQUIN GENERAL HOSPITAL**	1.0404	55.23
050168	**ST. JUDE MEDICAL CENTER**	1.1492	58.75
050169	**PRESBYTERIAN INTERCOMMUNITY HOSP**	1.1832	59.85
050172	**REDWOOD MEMORIAL HOSPITAL**	0.9967	53.82
050173	**ANAHEIM GENERAL HOSPITAL**	1.1492	58.75
050174	**SANTA ROSA MEMORIAL HOSPITAL**	1.3425	65.01
050175	**WHITTIER HOSPITAL MEDICAL CENTER**	1.1832	59.85
050177	**SANTA PAULA MEMORIAL HOSPITAL**	1.1064	57.37
050179	**EMANUEL MEDICAL CENTER**	1.1275	58.05
050180	**JOHN MUIR MEDICAL CENTER**	1.5119	70.49
050188	**COMM HOSP.& REHAB- LOS GATOS**	1.4626	68.89
050189	**MEE MEMORIAL HOSPITAL**	1.4339	67.96
050191	**ST. MARY MEDICAL CENTER**	1.1832	59.85
050192	**SIERRA KINGS DISTRICT HOSPITAL**	0.9967	53.82
050193	**SOUTH COAST MEDICAL CENTER**	1.1492	58.75
050194	**WATSONVILLE COMMUNITY**	1.2942	63.44
050195	**WASHINGTON HOSPITAL DISTRICT**	1.5119	70.49
050196	**CENTRAL VALLEY GEN. HOSPITAL**	0.9967	53.82
050197	**SEQUOIA HEALTH SERVICES**	1.4514	68.53
050204	**LANCASTER COMMUNITY HOSPITAL**	1.1832	59.85
050205	**HUNTINGTON EAST VALLEY HOSPITAL**	1.1832	59.85
050207	**FREMONT MEDICAL CENTER**	1.0196	54.56
050211	**ALAMEDA HOSPITAL**	1.5119	70.49
050214	**GRANADA HILLS HOSPITAL**	1.1832	59.85
050215	**SAN JOSE MEDICAL CENTER**	1.4626	68.89

050217	**FAIRCHILD MEDICAL CENTER**	0.9967	53.82
050219	**COAST PLAZA DOCTORS HOSPITAL**	1.1832	59.85
050222	**SHARP CHULA VISTA MEDICAL CTR**	1.1147	57.64
050224	**HOAG MEMORIAL HOSPITAL PRESBYTERIAN**	1.1492	58.75
050225	**FEATHER RIVER HOSPITAL**	1.0193	54.55
050226	**ANAHEIM MEMORIAL MEDICAL CENTER**	1.1492	58.75
050228	**SAN FRANCISCO GENERAL HOSPITAL**	1.5119	70.49
050230	**GARDEN GROVE MEDICAL CENTER**	1.1832	59.85
050231	**POMONA VALLEY HOSPITAL MED CTR**	1.1832	59.85
050232	**FRENCH HOSPITAL MEDICAL CENTER**	1.1429	58.55
050234	**SHARP CORONADO HOSPITAL**	1.1147	57.64
050235	**PROVIDENCE SAINT JOSEPH MED. CENTER**	1.1832	59.85
050236	**SIMI VALLEY HOSPITAL**	1.1832	59.85
050238	**METHODIST HOSPITAL OF SO. CALIF.**	1.1832	59.85
050239	**GLENDALE ADVENTIST MEDICAL CENTER**	1.1832	59.85
050240	**CENTINELA HOSPITAL MEDICAL CENTER**	1.1832	59.85
050242	**DOMINICAN SANTA CRUZ HOSPITAL**	1.2942	63.44
050243	**DESERT HOSPITAL**	1.1348	58.29
050245	**ARROWHEAD REGIONAL MEDICAL CENTER**	1.1348	58.29
050248	**NATIVIDAD MEDICAL CENTER**	1.4339	67.96
050251	**LASSEN COMMUNITY HOSPITAL**	1.0682	56.13
050253	**BELLWOOD GENERAL HOSPITAL**	1.1492	58.75
050254	**MARSHALL HOSPITAL**	1.1845	59.89
050256	**ORTHOPAEDIC HOSPITAL**	1.1832	59.85
050257	**GOOD SAMARITAN HOSPITAL**	0.9967	53.82
050261	**SIERRA VIEW DISTRICT HOSPITAL**	0.9967	53.82
050262	**UCLA MEDICAL CENTER**	1.1832	59.85
050264	**SAN LEANDRO HOSPITAL**	1.5119	70.49
050267	**DANIEL FREEMAN MEMORIAL HOSPITAL**	1.1832	59.85
050270	**SMH - CHULA VISTA**	1.1147	57.64
050272	**REDLANDS COMMUNITY HOSPITAL**	1.1348	58.29
050276	**CONTRA COSTA REGIONAL MEDICAL CNTR**	1.5119	70.49
050277	**PACIFIC HOSPITAL OF LONG BEACH**	1.1832	59.85
050278	**PROVIDENCE HOLY CROSS MED. CENTER**	1.1832	59.85
050279	**HI - DESERT MEDICAL CENTER**	1.1348	58.29
050280	**MERCY MEDICAL CENTER REDDING**	1.1352	58.30
050281	**ALHAMBRA HOSPITAL**	1.1832	59.85
050283	**VALLEY MEMORIAL HOSPITAL**	1.5119	70.49
050289	**SETON MEDICAL CENTER**	1.4514	68.53
050290	**SAINT JOHN'S HOSPITAL**	1.1832	59.85
050291	**SUTTER MEDICAL CENTER OF SANTA ROSA**	1.2877	63.23
050292	**RIVERSIDE COUNTY REGIONAL MED CENTER**	1.1348	58.29
050295	**MERCY HOSPITAL**	0.9967	53.82
050296	**HAZEL HAWKINS MEM. HOSPITAL**	1.4339	67.96
050298	**BARSTOW COMMUNITY HOSPITAL**	1.1348	58.29
050299	**NORTHRIDGE HOSPITAL MEDICAL CENTER-S**	1.1832	59.85
050300	**ST MARY REGIONAL MEDICAL CENTER**	1.1348	58.29
050301	**UKIAH VALLEY MEDICAL CENTER**	0.9967	53.82
050305	**ALTA BATES MEDICAL CENTER**	1.5119	70.49
050308	**EL CAMINO HOSPITAL**	1.4626	68.89

050309	**SUTTER ROSEVILLE MEDICAL CENTER**	1.1845	59.89
050312	**REDDING MEDICAL CENTER**	1.1352	58.30
050313	**SUTTER TRACY COMMUNITY HOSPITAL**	1.0404	55.23
050315	**KERN MEDICAL CENTER**	0.9967	53.82
050320	**ALAMEDA COUNTY MEDICAL CENTER**	1.5119	70.49
050324	**SCRIPPS MEM HOSPITAL-LA JOLLA**	1.1147	57.64
050325	**TUOLUMNE GENERAL HOSPITAL**	1.1148	57.64
050327	**LOMA LINDA UNIVERSITY MEDICAL CTR.**	1.1348	58.29
050329	**CORONA REGIONAL MEDICAL CENTER**	1.1348	58.29
050331	**HEALSDBURG GENERAL HOSPITAL**	1.2877	63.23
050333	**SENECA DISTRICT HOSPITAL**	0.9967	53.82
050334	**SALINAS VALLEY MEMORIAL HOSPITAL**	1.4339	67.96
050335	**SONORA COMMUNITY HOSPITAL**	1.1148	57.64
050336	**LODI MEMORIAL HOSPITAL**	1.0404	55.23
050342	**PIONEERS MEM. HOSPITAL**	0.9967	53.82
050348	**UCI MEDICAL CENTER**	1.1492	58.75
050349	**CORCORAN DISTRICT HOSPITAL**	0.9967	53.82
050350	**BEVERLY COMMUNITY HOSPITAL**	1.1832	59.85
050351	**TORRANCE MEMORIAL MEDICAL CENTER**	1.1832	59.85
050352	**BARTON MEMORIAL HOSP**	1.1845	59.89
050353	**LITTLE COMPANY OF MARY HOSPITAL**	1.1832	59.85
050355	**SIERRA VALLEY DISTRICT HOSPITAL**	0.9967	53.82
050357	**GOLETA VALLEY COTTAGE HOSPITAL**	1.0441	55.35
050359	**TULARE DISTRICT HOSPITAL**	0.9967	53.82
050360	**MARIN GENERAL HOSPITAL**	1.4514	68.53
050366	**MARK TWAIN ST. JOSEPHS HOPITAL**	0.9967	53.82
050367	**NORTHBAY MEDICAL CENTER**	1.3425	65.01
050369	**CVMC - QUEEN OF THE VALLEY**	1.1832	59.85
050373	**LAC+USC MEDICAL CENTER**	1.1832	59.85
050376	**HARBOR-UCLA MEDICAL CENTER**	1.1832	59.85
050378	**PACIFICA OF THE VALLEY**	1.1832	59.85
050379	**MERCY WESTSIDE HOSPITAL**	0.9967	53.82
050380	**GOOD SAMARITAN HOSPITAL**	1.4626	68.89
050382	**CVMC - INTERCOMMUNITY**	1.1832	59.85
050385	**PALM DRIVE HOSPITAL**	1.2877	63.23
050390	**HEMET VALLEY MEDICAL CENTER**	1.1348	58.29
050391	**SANTA TERESITA HOSPITAL**	1.1832	59.85
050392	**TRINITY HOSPITAL**	0.9967	53.82
050393	**DOWNEY REGIONAL MED CTR**	1.1832	59.85
050394	**COMM MEM HOSP OF SAN BUENAVENTURA**	1.1064	57.37
050396	**SANTA BARBARA COTTAGE HOSPITAL**	1.0441	55.35
050397	**COALINGA REGIONAL MEDICAL CENTER**	1.0142	54.38
050407	**CHINESE HOSPITAL**	1.4514	68.53
050410	**SANGER GENERAL HOSPITAL**	1.0142	54.38
050411	**KAISER FOUNDATION HOSPITALS -HARBOR**	1.1832	59.85
050414	**MERCY HOSPITAL OF FOLSOM**	1.1845	59.89
050417	**SUTTER COAST HOSPITAL**	0.9967	53.82
050419	**MERCY MEDICAL CENTER MT. SHASTA**	1.1352	58.30
050420	**ROBERT F. KENNEDY**	1.1832	59.85
050423	**PALO VERDE HOSPITAL**	1.1348	58.29

050424	**SCRIPPS GREEN HOSPITAL**	1.1147	57.64
050425	**KFH - SACRAMENTO**	1.1845	59.89
050426	**WEST ANAHEIM MED CTR**	1.1492	58.75
050430	**MODOC MEDICAL CENTER**	0.9967	53.82
050432	**GARFIELD MEDICAL CTR.**	1.1832	59.85
050433	**INDIAN VALLEY HOSPITAL**	0.9967	53.82
050434	**COLUSA COMMUNITY HOSPITAL**	0.9967	53.82
050435	**FALLBROOK DISTRICT HOSPITAL**	1.1147	57.64
050438	**HUNTINGTON MEMORIAL HOSPITAL**	1.1832	59.85
050441	**STANFORD HOSPITAL AND CLINICS**	1.4626	68.89
050444	**SUTTER MERCED MEDICAL CENTER**	0.9967	53.82
050447	**VILLA VIEW COMMUNITY HOSPITAL**	1.1147	57.64
050448	**RIDGECREST REGIONAL HOSPITAL**	0.9967	53.82
050454	**UC SAN FRANCISCO MEDICAL CENTER**	1.4514	68.53
050455	**SAN JOAQUIN COMMUNITY HOSPITAL**	0.9967	53.82
050456	**GARDENA PHYSICIAN'S HOSP INC**	1.1832	59.85
050457	**ST. MARY MEDICAL CENTER**	1.5119	70.49
050464	**DOCTORS MEDICAL CENTER OF MODESTO**	1.1275	58.05
050468	**MEMORIAL HOSPITAL OF GARDENA**	1.1832	59.85
050469	**COLORADO RIVER MEDICAL CENTER**	0.9967	53.82
050470	**SELMA COMMUNITY HOSPITAL**	1.0142	54.38
050471	**GOOD SAMARITAN HOSPITAL**	1.1832	59.85
050476	**SUTTER LAKESIDE HOSPITAL**	0.9967	53.82
050477	**MIDWAY HOSPITAL MEDICAL CENTER**	1.1832	59.85
050478	**SANTA YNEZ VALLEY COTTAGE HOSPITAL**	1.0441	55.35
050481	**WEST HILLS REG MEDICAL CENTER**	1.1832	59.85
050485	**LONG BEACH MEMORIAL MEDICAL CENTER**	1.1832	59.85
050488	**EDEN MEDICAL CENTER**	1.5119	70.49
050491	**SANTA ANA HOSPITAL MEDICAL CENTER**	1.1492	58.75
050492	**CLOVIS COMMUNITY HOSPITAL**	1.0142	54.38
050494	**TAHOE FOREST HOSPITAL**	1.1845	59.89
050496	**MT. DIABLO MEDICAL CENTER**	1.5119	70.49
050497	**DOS PALOS MEMORIAL HOSPITAL**	0.9967	53.82
050498	**SUTTER AUBURN FAITH HOSPITAL**	1.1845	59.89
050502	**ST. VINCENT MEDICAL CENTER**	1.1832	59.85
050503	**SCRIPPS MEM HOSP - ENCINITAS**	1.1147	57.64
050506	**SIERRA VISTA REGINAL MED CTR**	1.1429	58.55
050510	**KFH - SAN RAFAEL**	1.5119	70.49
050512	**KFH - HAYWARD**	1.5119	70.49
050515	**KAISER FOUND. HOSPITALS -SAN DIEGO**	1.1147	57.64
050516	**MERCY SAN JUAN HOSPITAL**	1.1845	59.89
050517	**VICTOR VALLEY COMMUNITY HOSP.**	1.1348	58.29
050523	**SUTTER DELTA MEDICAL CENTER**	1.5119	70.49
050526	**HUNTINGTON BEACH MEDICAL CENTER**	1.1492	58.75
050528	**MEMORIAL HOSPITAL - LOS BANOS**	0.9967	53.82
050531	**BELLFLOWER MEDICAL CENTER**	1.1832	59.85
050534	**JOHN.F. KENNEDY MEMORIAL HOSP.**	1.1348	58.29
050535	**COASTAL COMMUNITIES HOSPITAL**	1.1492	58.75
050537	**SUTTER DAVIS HOSPITAL**	0.9967	53.82
050539	**REDBUD COMMUNITY HOSPITAL**	0.9967	53.82

050541	**KFH - REDWOOD CITY**	1.5119	70.49
050542	**KERN VALLEY HOSPITAL DISTRICT**	0.9967	53.82
050543	**COLLEGE HOSPITAL COSTA MESA**	1.1492	58.75
050545	**LANTERMAN DEVELOPMENTAL CENTER**	1.1832	59.85
050546	**PORTERVILLE DEVELOPMENTAL CENTER**	0.9967	53.82
050547	**SONOMA DEVELOPMENTAL CENTER**	1.2877	63.23
050548	**FAIRVIEW DEVELOPMENTAL CENTER**	1.1492	58.75
050549	**LOS ROBLES REGIONAL MEDICAL CENTER**	1.1832	59.85
050550	**CHAPMAN MEDICAL CENTER**	1.1492	58.75
050551	**LOS ALAMITOS MEDICAL CTR.**	1.1492	58.75
050552	**MOTION PICTURE AND TELEVISION FUND**	1.1832	59.85
050557	**MEMORIAL HOSPITAL MODESTO**	1.1275	58.05
050559	**DANIEL FREEMAN MARINA HOSPITAL**	1.1832	59.85
050561	**KAISER FOUND. HOSPITAL - WEST LA**	1.1832	59.85
050567	**MISSION HOSPITAL REGIONAL MED CENTER**	1.1492	58.75
050568	**MADERA COMMUNITY HOSPITAL**	1.0142	54.38
050569	**MENDOCINO COAST DISTRICT HOSPITAL**	1.2877	63.23
050570	**FOUNTAIN VALLEY REG MEDICAL CENTER**	1.1492	58.75
050571	**SUBURBAN MEDICAL CENTER**	1.1832	59.85
050573	**EISENHOWER MEMORIAL HOSPITAL**	1.1348	58.29
050575	**TRI-CITY REGIONAL MEDICAL CENTERS**	1.1832	59.85
050577	**SANTA MARTA HOSPITAL**	1.1832	59.85
050578	**MARTIN LUTHER KING, JR./DREW MEDICAL**	1.1832	59.85
050579	**CENTURY CITY HOSP**	1.1832	59.85
050580	**LAPALMA INTERCOMMUNITY HOSPITAL**	1.1492	58.75
050581	**LAKEWOOD REGIONAL MED. CTR.**	1.1832	59.85
050583	**ALVARADO COMMUNITY HOSPITAL**	1.1147	57.64
050584	**KPC GLOBAL MEDICAL**	1.1348	58.29
050585	**SAN CLEMENTE HOSPITAL**	1.1492	58.75
050586	**CHINO VALLEY MEDICAL CENTER**	1.1348	58.29
050588	**SAN DIMAS COMMUNITY HOSPITAL**	1.1832	59.85
050589	**PLACENTIA LINDA COMMUNITY HOSPITAL**	1.1492	58.75
050590	**METHODIST HOSPITAL OF SACRAMENTO**	1.1845	59.89
050591	**MONTEREY PARK HOSPITAL**	1.1832	59.85
050592	**BREA COMMUNITY HOSPITAL**	1.1492	58.75
050594	**WESTERN MEDICAL CENTER ANAHEIM**	1.1832	59.85
050597	**FOOTHILL PRESBYTERIAN HOSPITAL**	1.1832	59.85
050599	**UC DAVIS MEDICAL CENTER**	1.1845	59.89
050601	**TARZANA ENCINO REGIONAL MED CTR**	1.1832	59.85
050603	**SADDLEBACK MEMORIAL MEDICAL CENTER**	1.1492	58.75
050604	**KFH - SANTA TERESA**	1.4626	68.89
050608	**DELANO REGIONAL MEDICAL CNT.**	0.9967	53.82
050609	**KAISER FOUNDATION HOSPITALS -ANAHEIM**	1.1832	59.85
050613	**SETON MEDICAL CENTER**	1.4514	68.53
050615	**GREATER EL MONTE COMMUNITY HOSPITAL**	1.1832	59.85
050616	**ST. JOHN'S PLEASANT VALLEY HOSPITAL**	1.1064	57.37
050618	**BEAR VALLEY COMMUNITY HOSPITAL**	0.9967	53.82
050623	**HIGH DESERT HOSPITAL**	1.1832	59.85
050624	**HENRY MAYO NEWHALL MEMORIAL HOSPITAL**	1.1832	59.85
050625	**CEDARS-SINAI MEDICAL CENTER**	1.1832	59.85

050630	**INLAND VALLEY REGIONAL MEDICAL CTR**	1.1348	58.29
050633	**TWIN CITIES COMMUNITY HOSPITAL**	1.1429	58.55
050636	**POMERADO HOSPITAL**	1.1147	57.64
050641	**EAST L.A. DOCTOR'S HOSPITAL**	1.1832	59.85
050643	**PHS INDIAN HEALTH SERVICES HOSPITAL**	1.4448	68.32
050644	**LOS ANGELES METROPOLITAN MEDICAL CENTER**	1.1832	59.85
050662	**AGNEWS DEVELOPMENTAL CENTER**	1.4626	68.89
050663	**LOS ANGELES COMMUNITY HOSPITAL**	1.1832	59.85
050667	**NELSON M. HOLDERMAN**	1.3425	65.01
050668	**LAGUNA HONDA HOSPITAL**	1.5119	70.49
050674	**KFH SOUTH SACRAMENTO**	1.1845	59.89
050677	**KAISER FOUND. HOSP. - WOODLAND HILLS**	1.1832	59.85
050678	**ORANGE COAST MEMORIAL MEDICAL CENTER**	1.1492	58.75
050680	**VACAVALLEY HOSPITAL**	1.3425	65.01
050682	**KINGSBURG DISTRICT HOSPITAL**	1.0142	54.38
050684	**MENIFEE VALLEY MEDICAL CENTER**	1.1348	58.29
050686	**KAISER FOUND. HOSPITALS - RIVERSIDE**	1.1492	58.75
050688	**ST. LOUISE REGIONAL HOSPITAL**	1.4626	68.89
050689	**SAN RAMON REG. MEDICAL CENTER**	1.5119	70.49
050690	**KFH - SANTA ROSA**	1.2877	63.23
050693	**IRVINE MEDICAL CENTER**	1.1492	58.75
050694	**MORENO VALLEY COMMUNITY HOSPITAL**	1.1348	58.29
050695	**ST. DOMINIC'S HOSPITAL**	1.0404	55.23
050696	**USC UNIVERSITY HOSPITAL**	1.1832	59.85
050697	**PATIENTS' HOSPITAL OF REDDING**	1.1352	58.30
050701	**RANCHO SPRINGS MEDICAL CENTER**	1.1348	58.29
050704	**MISSION COMMUNITY HOSPITAL**	1.1832	59.85
050707	**RECOVERY INN OF MENLO PARK**	1.4514	68.53
050708	**FRESNO SURGERY CENTER**	1.0142	54.38
050709	**DESERT VALLEY HOSPITAL**	1.1348	58.29
050710	**KFH - FRESNO**	1.0142	54.38
050713	**LINCOLN HOSPITAL**	1.1832	59.85
050714	**SANTA CRUZ MATERINTY & SURGERY HOSP**	1.2942	63.44
050717	**RANCHO LOS AMIGOS NATL.REHAB.CTR.**	1.1832	59.85
050718	**VALLEY PLAZA DOCTORS HOSPITAL**	1.1348	58.29
050720	**TUSTIN HOSPITAL AND MEDICAL CENTER**	1.1492	58.75
050722	**SHARP MARY BIRCH HOSPITAL FOR WOMEN**	1.1147	57.64
050723	**KAISER FOUND HOSPITAL - BALDWIN**	1.1832	59.85
050724	**BAKERSFIELD HEART HOSPITAL**	0.9967	53.82
050725	**CITY OF ANGELS MEDICAL CENTER**	1.1832	59.85
050726	**STANISLAUS SURGICAL HOSPITAL**	1.1275	58.05
050727	**COMMUNTIY HOSPITAL OF LONG BEACH**	1.1832	59.85
050728	**SUTTER WARRACK HOSPITAL**	1.2877	63.23
050729	**DANIEL FREEMAN HOSPITAL**	1.1832	59.85
050730	**DANIEL FREEMAN MARIAN HOSPITAL**	1.1832	59.85

***** $52.151 x (.40 + .60 x applicable wage index) x inflation factor of 1.034***

Authority: Sections 133, 4603.5, 5307.1, and 5307.3, Labor Code.

Reference: Sections 4600, 4603.2, and 5307.1, Labor Code.

Section 9789.36. Update of Rules to Reflect Changes in the Medicare Payment System.

Sections 9789.30 through 9789.38 shall be adjusted to conform to any relevant changes in the Medicare payment system as required by law. The Administrative Director shall determine the effective date of the change and issue an order informing the public of the change and the effective date. Such order shall be posted on the Division's Internet Website: http://www.dir.ca.gov/DWC/dwc_home_page.htm.

Authority: Sections 133, 4603.5, 5307.1, and 5307.3, Labor Code.
Reference: Sections 4600, 4603.2, and 5307.1, Labor Code.

Section 9789.37. DWC Form 15 Election for High Cost Outlier.

[Set forth on next page]

Authority: Sections 133, 4603.5, 5307.1, and 5307.3, Labor Code.
Reference: Sections 4600, 4603.2, and 5307.1, Labor Code.

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

ELECTION FOR HIGH COST OUTLIER

Labor Code § 5307.1; Title 8, California Code of Regulations § 9789.37
For the 12 month period commencing on April 1, 20____.

This Election is filed with the Administrative Director pursuant to Labor Code Section 5307.1, and Title 8, California Code of Regulations Section 9789.33. A provider who elects to participate in the alternative payment methodology for high cost outlier cases under Section 9789.33, subdivision (b) in lieu of the maximum allowable fees set forth under Section 9789.33 subdivision (a), shall file this form by March 1 of each year providing the requested information to the Administrative Director. The maximum allowable fees applicable to a facility that does not file a timely election satisfying the requirements set forth in Section 9789.33, subdivision (b), shall be determined under subdivision (a).

1. PROVIDER'S NAME: ____
2. OSHPD FACILITY NUMBER: ____
3. MEDICARE PROVIDER NUMBER: ____
4. CONTACT PERSON AND PHONE NUMBER: ____

Hospital Outpatient Department Cost-to-Charge Ratio

Pursuant to Section 9789.33(c)(4), the cost-to-charge ratio applicable to a hospital outpatient department 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 CFR 419.43(d). List below the cost-to-charge ratio being used by the intermediary for services furnished on February 15 of the year this election is filed:
5. Cost-to-charge ratio ____

______________________________ ______________________________
Signature and Title Date

Ambulatory Surgical Center (ASC) Cost-to-Charge Ratio

Pursuant to Section 9789.33(c)(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 gross charges is defined as the facility's total usual and customary charges to patients and third-party payers before reductions for contractual allowances, bad debts, courtesy allowances and charity care.

6. Provide:
   (a) The facility's total operating costs during the preceding calendar year__________________________
   (b) The facility's total gross charges during the preceding calendar year __________________________
   (c) Provide county where facility is located______________________________

7. Attach completed Annual Utilization Report of Specialty Clinics (OSHPD) which is incorporated by reference, and may be obtained at OSHPD's website at http://www.oshpd.ca.gov/HID/HID/clinic/util/index.htm#Forms or is available upon request to the Administrative Director at: Division of Workers' Compensation (Attention: OMFS-Outpatient), P.O. Box 420603, San Francisco, CA 94142.

Upon request from the Administrative Director, an independent audit may be conducted at the expense of the ASC.

8. We, the undersigned, declare under penalty of perjury under the laws of the State of California that the foregoing, and attachment(s), are true and correct.

______________________________ ______________________________
Signature, Chief Executive Officer Date

______________________________ ______________________________
Signature, Certified Public Accountant Date

DWC Form 15 (1/1/04)

Section 9789.38. Appendix X.

The federal regulations as incorporated by reference and/or referred to in Sections 9789.30 through 9789.36 are set forth below in numerical order.

42 C.F.R. § 419.2

Basis of payment.

(a) Unit of payment. Under the hospital outpatient prospective payment system, predetermined amounts are paid for designated services furnished to Medicare beneficiaries. These services are identified by codes established under the Centers for Medicare & Medicaid Services Common Procedure Coding System (HCPCS). The prospective payment rate for each service or procedure for which payment is allowed under the hospital outpatient prospective payment system is determined according to the methodology described in subpart C of this part. The manner in which the Medicare payment amount and the beneficiary copayment amount for each service or procedure are determined is described in subpart D of this part.

(b) Determination of hospital outpatient prospective payment rates: Included costs. The prospective payment system establishes a national payment rate, standardized for geographic wage differences, that includes operating and capital-related costs that are directly related and integral to performing a procedure or furnishing a service on an outpatient basis. In general, these costs include, but are not limited to

(1) Use of an operating suite, procedure room, or treatment room;

(2) Use of recovery room;

(3) Use of an observation bed;

(4) Anesthesia, certain drugs, biologicals, and other pharmaceuticals; medical and surgical supplies and equipment; surgical dressings; and devices used for external reduction of fractures and dislocations;

(5) Supplies and equipment for administering and monitoring anesthesia or sedation;

(6) Intraocular lenses (IOLs);

(7) Incidental services such a venipuncture;

(8) Capital-related costs;

(9) Implantable items used in connection with diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests;

(10) Durable medical equipment that is implantable;

(11) Implantable prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care), including replacement of these devices; and;

(12) Costs incurred to procure donor tissue other than corneal tissue.

(c) Determination of hospital outpatient prospective payment rates: Excluded costs. The following costs are excluded from the hospital outpatient prospective payment system.

(1) The costs of direct graduate medical education activities as described in §413.86 of this chapter.

(2) The costs of nursing and allied health programs as described in §413.86 of this chapter.

(3) The costs associated with interns and residents not in approved teaching programs as described in §415.202 of this chapter.

(4) The costs of teaching physicians attributable to Part B services for hospitals that elect cost-based reimbursement for teaching physicians under §415.160.

(5) The reasonable costs of anesthesia services furnished to hospital outpatients by qualified nonphysician anesthetists (certified registered nurse anesthetists and anesthesiologists' assistants) employed by the hospital or obtained under arrangements, for hospitals that meet the requirements under §412.113(c) of this chapter.

(6) Bad debts for uncollectible deductibles and coinsurances as described in §413.80(b) of this chapter.

(7) Organ acquisition costs paid under Part B.

(8) Corneal tissue acquisition costs.

42 C.F.R. § 419.32

Calculation of prospective payment rates for hospital outpatient services.

(a) Conversion factor for 1999. CMS calculates a conversion factor in such a manner that payment for hospital outpatient services furnished in 1999 would have equaled the base expenditure target calculated in § 419.30, taking into account APC group weights and estimated service frequencies and reduced by the amounts that would be payable in 1999 as outlier payments under § 419.43(d) and transitional pass-through payments under § 419.43(e).

(b) Conversion factor for calendar year 2000 and subsequent years. (1) Subject to paragraph (b)(2) of this section, the conversion factor for a calendar year is equal to the conversion factor calculated for the previous year adjusted as follows:

(i) For calendar year 2000, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act reduced by one percentage point.
(ii) For calendar year 2001 –

(A) For services furnished on or after January 1, 2001 and before April 1, 2001, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act reduced by one percentage point; and

(B) For services furnished on or after April 1, 2001 and before January 1, 2002, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act, and increased by a transitional percentage allowance equal to 0.32 percent.

(iii) For the portion of calendar year 2002 that is affected by these rules, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act reduced by one percentage point, without taking into account the transitional percentage allowance referenced in § 419.32(b)(ii)(B).

(iv) For calendar year 2003 and subsequent years, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act.

(2) Beginning in calendar year 2000, CMS may substitute for the hospital inpatient market basket percentage in paragraph (b) of this section a market basket percentage increase that is determined and applied to hospital outpatient services in the same manner that the hospital inpatient market basket percentage increase is determined and applied to inpatient hospital services.

(c) Payment rates. The payment rate for services and procedures for which payment is made under the hospital outpatient prospective payment system is the product of the conversion factor calculated under paragraph (a) or paragraph (b) of this section and the relative weight determined under § 419.31(b).

(d) Budget neutrality. CMS adjusts the conversion factor as needed to ensure that updates and adjustments under § 419.50(a) are budget neutral.

42 C.F.R. § 419.43

Adjustments to national program payment and beneficiary copayment amounts.

(a) General rule. CMS determines national prospective payment rates for hospital outpatient department services and determines a wage adjustment factor to adjust the

portion of the APC payment and national beneficiary copayment amount attributable to labor-related costs for relative differences in labor and labor-related costs across geographic regions in a budget neutral manner.

(b) Labor-related portion of payment and copayment rates for hospital outpatient services. CMS determines the portion of hospital outpatient costs attributable to labor and labor-related costs (known as the "labor-related portion" of hospital outpatient costs) in accordance with § 419.31(c)(1).

(c) Wage index factor. CMS uses the hospital inpatient prospective payment system wage index established in accordance with part 412 of this chapter to make the adjustment referred to in paragraph (a) of this section.

(d) Outlier adjustment -- (1) General rule. Subject to paragraph (d)(4) of this section, CMS provides for an additional payment for each hospital outpatient service (or group of services) for which a hospital's charges, adjusted to cost, exceed the following:
(i) A fixed multiple of the sum of –

(A) The applicable Medicare hospital outpatient payment amount determined under § 419.32(c), as adjusted under § 419.43 (other than for adjustments under this paragraph (d) or paragraph (e) of this section); and

(B) Any transitional pass-through payment under paragraph (e) of this section.

(ii) At the option of CMS, a fixed dollar amount.

(2) Amount of adjustment. The amount of the additional payment under paragraph (d)(1) of this section is determined by CMS and approximates the marginal cost of care beyond the applicable cutoff point under paragraph (d)(1) of this section.

(3) Limit on aggregate outlier adjustments -- (i) In general. The total of the additional payments made under this paragraph (d) for covered hospital outpatient department services furnished in a year (as estimated by CMS before the beginning of the year) may not exceed the applicable percentage specified in paragraph (d)(3)(ii) of this section of the total program payments (sum of both the Medicare and beneficiary payments to the hospital) estimated to be made under this part for all hospital outpatient services furnished in that year. If this paragraph is first applied to less than a full year, the limit applies only to the portion of the year.

(ii) Applicable percentage. For purposes of paragraph (d)(3)(i) of this section, the term "applicable percentage" means a percentage specified by CMS up to (but not to exceed) –

(A) For a year (or portion of a year) before 2004, 2.5 percent; and

(B) For 2004 and thereafter, 3.0 percent.

(4) Transitional authority. In applying paragraph (d)(1) of this section for hospital outpatient services furnished before January 1, 2002, CMS may –

(i) Apply paragraph (d)(1) of this section to a bill for these services related to an outpatient encounter (rather than for a specific service or group of services) using hospital outpatient payment amounts and transitional pass-through payments covered under the bill; and

(ii) Use an appropriate cost-to-charge ratio for the hospital or CMHC (as determined by CMS), rather than for specific departments within the hospital.

(e) Budget neutrality. CMS establishes payment under paragraph (d) of this section in a budget-neutral manner.

42 C.F.R. § 419.44

(a) Multiple surgical procedures. When more than one surgical procedure for which payment is made under the hospital outpatient prospective payment system is performed during a single surgical encounter, the Medicare program payment amount and the beneficiary copayment amount are based on – -

(1) The full amounts for the procedure with the highest APC payment rate; and

(2) One-half of the full program and the beneficiary payment amounts for all other covered procedures.

(b) Terminated procedures. When a surgical procedure is terminated prior to completion due to extenuating circumstances or circumstances that threaten the well-being of the patient, the Medicare program payment amount and the beneficiary copayment amount are based on – -

(1) The full amounts if the procedure is discontinued after the induction of anesthesia or after the procedure is started; or

(2) One-half of the full program and the beneficiary coinsurance amounts if the procedure is discontinued after the patient is prepared for surgery and taken to the room where the procedure is to be performed but before anesthesia is induced.]

42 C.F.R. § 419.62

Transitional pass-through payments: General rules.

(a) General. CMS provides for additional payments under §§ 419.64 and 419.66 for certain innovative medical devices, drugs, and biologicals.

(b) Budget neutrality. CMS establishes the additional payments under §§ 419.64 and 419.66 in a budget neutral manner.

(c) Uniform prospective reduction of pass-through payments. (1) If CMS estimates before the beginning of a calendar year that the total amount of pass-through payments under §§ 419.64 and 419.66 for the year would exceed the applicable percentage (as described in paragraph (c)(2) of this section) of the total amount of Medicare payments under the outpatient prospective payment system. CMS will reduce, pro rata, the amount of each of the additional payments under §§ 419.64 and 419.66 for that year to ensure that the applicable percentage is not exceeded.

(2) The applicable percentages are as follows:

(i) For a year before CY 2004, the applicable percentage is 2.5 percent.

(ii) For 2004 and subsequent years, the applicable percentage is a percentage specified by CMS up to (but not to exceed) 2.0 percent.

(d) CY 2002 incorporated amount. For the portion of CY 2002 affected by these rules, CMS incorporated 75 percent of the estimated pass-through costs (before the incorporation and any pro rata reduction) for devices into the procedure APCs associated with these devices.

42 C.F.R. § 419.64

Transitional pass-through payments: drugs and biologicals.

(a) Eligibility for pass-through payment. CMS makes a transitional pass-through payment for the following drugs and biologicals that are furnished as part of an outpatient hospital service:

(1) Orphan drugs. A drug or biological that is used for a rare disease or condition and has been designated as an orphan drug under section 526 of the Federal Food, Drug and Cosmetic Act if payment for the drug or biological as an outpatient hospital service was being made on August 1, 2000.

(2) Cancer therapy drugs and biologicals. A drug or biological that is used in cancer therapy, including, but not limited to, a chemotherapeutic agent, an antiemetic, a hematopoietic growth factor, a colony stimulating factor, a biological response modifier, and a bisphosphonate if payment for the drug or biological as an outpatient hospital service was being made on August 1, 2000.

(3) Radiopharmaceutical drugs and biological products. A radiopharmaceutical drug or biological product used in diagnostic, monitoring, and therapeutic nuclear medicine services if payment for the drug or biological as an outpatient hospital service was being made on August 1, 2000.

(4) Other drugs and biologicals. A drug or biological that meets the following conditions:

(i) It was first payable as an outpatient hospital service after December 31, 1996.

(ii) CMS has determined the cost of the drug or biological is not insignificant in relation to the amount payable for the applicable APC (as calculated under § 419.32(c)) as defined in paragraph (b) of this section.

(b) Cost. CMS determines the cost of a drug or biological to be not insignificant if it meets the following requirements:
(1) Services furnished before January 1, 2003. The expected reasonable cost of a drug or biological must exceed 10 percent of the applicable APC payment amount for the service related to the drug or biological.

(2) Services furnished after December 31, 2002. CMS considers the average cost of a new drug or biological to be not insignificant if it meets the following conditions:

(i) The estimated average reasonable cost of the drug or biological in the category exceeds 10 percent of the applicable APC payment amount for the service related to the drug or biological.

(ii) The estimated average reasonable cost of the drug or biological exceeds the cost of the drug or biological portion of the APC payment amount for the related service by at least 25 percent.

(iii) The difference between the estimated reasonable cost of the drug or biological and the estimated portion of the APC payment amount for the drug or biological exceeds 10 percent of the APC payment amount for the related service.

(c) Limited period of payment. CMS limits the eligibility for a pass-through payment under this section to a period of at least 2 years, but not more than 3 years, that begins as follows:

(1) For a drug or biological described in paragraphs (a)(1) through (a)(3) of this section -- August 1, 2000.

(2) For a drug or biological described in paragraph (a)(4) of this section-the date that CMS makes its first pass-through payment for the drug or biological.

(d) Amount of pass-through payment. Subject to any reduction determined under § 419.62(b), the pass-through payment for a drug or biological is 95 percent of the average wholesale price of the drug or biological minus the portion of the APC payment amount CMS determines is associated with the drug or biological.

42 C.F.R. § 419.66

Transitional pass-through payments: medical devices.

(a) General rule. CMS makes a pass-through payment for a medical device that meets the requirements in paragraph (b) of this section and that is described by a category of devices established by CMS under the criteria in paragraph (c) of this section.

(b) Eligibility. A medical device must meet the following requirements:

(1) If required by the FDA, the device must have received FDA approval or clearance (except for a device that has received an FDA investigational device exemption (IDE) and has been classified as a Category B device by the FDA in accordance with §§ 405.203 through 405.207 and 405.211 through 405.215 of this chapter) or another appropriate FDA exemption.

(2) The device is determined to be reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body part (as required by section 1862(a)(1)(A) of the Act).

(3) The device is an integral and subordinate part of the service furnished, is used for one patient only, comes in contact with human tissue, and is surgically implanted or inserted whether or not it remains with the patient when the patient is released from the hospital.

(4) The device is not any of the following:

(i) Equipment, an instrument, apparatus, implement, or item of this type for which depreciation and financing expenses are recovered as depreciable assets as defined in Chapter 1 of the Medicare Provider Reimbursement Manual (CMS Pub. 15-1).

(ii) A material or supply furnished incident to a service (for example, a suture, customized surgical kit, or clip, other than radiological site marker).

(iii) A material that may be used to replace human skin (for example, a biological or synthetic material).

(c) Criteria for establishing device categories. CMS uses the following criteria to establish a category of devices under this section:

(1) CMS determines that a device to be included in the category is not described by any of the existing categories or by any category previously in effect, and was not being paid for as an outpatient service as of December 31, 1996.

(2) CMS determines that a device to be included in the category has demonstrated that it will substantially improve the diagnosis or treatment of an illness or injury or improve the

functioning of a malformed body part compared to the benefits of a device or devices in a previously established category or other available treatment.

(3) Except for medical devices identified in paragraph (e) of this section, CMS determines the cost of the device is not insignificant as described in paragraph (d) of this section.

(d) Cost criteria. CMS considers the average cost of a category of devices to be not insignificant if it meets the following conditions:

(1) The estimated average reasonable cost of devices in the category exceeds 25 percent of the applicable APC payment amount for the service related to the category of devices.

(2) The estimated average reasonable cost of the devices in the category exceeds the cost of the device-related portion of the APC payment amount for the related service by at least 25 percent.

(3) The difference between the estimated average reasonable cost of the devices in the category and the portion of the APC payment amount for the device exceeds 10 percent of the APC payment amount for the related service.

(e) Devices exempt from cost criteria. The following medical devices are not subject to the cost requirements described in paragraph (d) of this section, if payment for the device was being made as an outpatient service on August 1, 2000:

(1) A device of brachytherapy.

(2) A device of temperature-monitored cryoablation.

(f) Identifying a category for a device. A device is described by a category, if it meets the following conditions:

(1) Matches the long descriptor of the category code established by CMS.

(2) Conforms to guidance issued by CMS relating to the definition of terms and other information in conjunction with the category descriptors and codes.

(g) Limited period of payment for devices. CMS limits the eligibility for a pass-through payment established under this section to a period of at least 2 years, but not more than 3 years beginning on the date that CMS establishes a category of devices.

(h) Amount of pass-through payment. Subject to any reduction determined under § 419.62(b), the pass-through payment for a device is the hospital's charge for the device, adjusted to the actual cost for the device, minus the amount included in the APC payment amount for the device.

42 C.F.R. § 419.70

Transitional adjustment to limit decline in payment.

(a) Before 2002. Except as provided in paragraph (d) of this section, for covered hospital outpatient services furnished before January 1, 2002, for which the prospective payment system amount (as defined in paragraph (e) of this section) is –

(1) At least 90 percent, but less than 100 percent, of the pre-BBA amount (as defined in paragraph (f) of this section), the amount of payment under this part is increased by 80 percent of the amount of this difference;

(2) At least 80 percent, but less than 90 percent, of the pre-BBA amount, the amount of payment under this part is increased by the amount by which the product of 0.71 and the pre-BBA amount exceeds the product of 0.70 and the prospective payment system amount;

(3) At least 70 percent, but less than 80 percent, of the pre-BBA amount, the amount of payment under this part is increased by the amount by which the product of 0.63 and the pre-BBA amount, exceeds the product of 0.60 and the PPS amount; or

(4) Less than 70 percent of the pre-BBA amount, the amount of payment under this part shall be increased by 21 percent of the pre-BBA amount.

(b) For 2002. Except as provided in paragraph (d) of this section, for covered hospital outpatient services furnished during 2002, for which the prospective payment system amount is –

(1) At least 90 percent, but less than 100 percent, of the pre-BBA amount, the amount of payment under this part is increased by 70 percent of the amount of this difference;

(2) At least 80 percent, but less than 90 percent, of the pre-BBA amount, the amount of payment under this part is increased by the amount by which the product of 0.61 and the pre-BBA amount exceeds the product of 0.60 and the prospective payment system amount; or

(3) Less than 80 percent of the pre-BBA amount, the amount of payment under this part is increased by 13 percent of the pre-BBA amount.

(c) For 2003. Except as provided in paragraph (d) of this section, for covered hospital outpatient services furnished during 2003, for which the prospective payment system amount is –

(1) At least 90 percent, but less than 100 percent, of the pre-BBA amount, the amount of payment under this part is increased by 60 percent of the amount of this difference; or

(2) Less than 90 percent of the pre-BBA amount, the amount of payment under this part is increased by 6 percent of the pre-BBA amount.

(d) Hold harmless provisions -- (1) Temporary treatment for small rural hospitals. For covered hospital outpatient services furnished in a calendar year before January 1, 2004 for which the prospective payment system amount is less than the pre-BBA amount, the amount of payment under this part is increased by the amount of that difference if the hospital –

(i) Is located in a rural area as defined in § 412.63(b) of this chapter or is treated as being located in a rural area under section 1886(d)(8)(E) of the Act; and

(ii) Has 100 or fewer beds as defined in § 412.105(b) of this chapter.

(2) Permanent treatment for cancer hospitals and children's hospitals. In the case of a hospital described in § 412.23(d) or § 412.23(f) of this chapter for which the prospective payment system amount is less than the pre-BBA amount for covered hospital outpatient services, the amount of payment under this part is increased by the amount of this difference.

(e) Prospective payment system amount defined. In this paragraph, the term "prospective payment system amount" means, with respect to covered hospital outpatient services, the amount payable under this part for these services (determined without regard to this paragraph or any reduction in coinsurance elected under § 419.42), including amounts payable as copayment under § 419.41, coinsurance under section 1866(a)(2)(A)(ii) of the Act, and the deductible under section 1833(b) of the Act.

(f) Pre-BBA amount defined -- (1) General rule. In this paragraph, the "pre-BBA amount" means, with respect to covered hospital outpatient services furnished by a hospital or a community mental health center (CMHC) in a year, an amount equal to the product of the reasonable cost of the provider for these services for the portions of the provider's cost reporting period (or periods) occurring in the year and the base provider outpatient payment-to-cost ratio for the provider (as defined in paragraph (f)(2) of this section).

(2) Base payment-to-cost-ratio defined. For purposes of this paragraph, CMS shall determine these ratios as if the amendments to sections 1833(i)(3)(B)(i)(II) and 1833(n)(1)(B)(i) of the Act made by section 4521 of the BBA, to require that the full amount beneficiaries paid as coinsurance under section 1862(a)(2)(A) of the Act are taken into account in determining Medicare Part B Trust Fund payment to the hospital, were in effect in 1996. The "base payment-to-cost ratio" for a hospital or CMHC means the ratio of –

(i) The provider's payment under this part for covered outpatient services furnished during the cost reporting period ending in 1996, including any payment for these services through cost-sharing described in paragraph (e) of this section; and
(ii) The reasonable cost of these services for this period.

(g) Interim payments. CMS makes payments under this paragraph to hospitals and CMHCs on an interim basis, subject to retrospective adjustments based on settled cost reports.

(h) No effect on coinsurance. No payment made under this section affects the unadjusted coinsurance amount or the coinsurance amount described in § 419.41.

(i) Application without regard to budget neutrality. The additional payments made under this paragraph –

(1) Are not considered an adjustment under § 419.43(f); and

(2) Are not implemented in a budget neutral manner.

Authority: Sections 133, 4603.5, 5307.1, and 5307.3, Labor Code.
Reference: Sections 4600, 4603.2, and 5307.1, Labor Code.

Section 9789.40. Pharmacy.

The maximum reasonable fee for pharmacy services rendered after January 1, 2004 is100% of the fee prescribed in the relevant Medi-Cal payment system. Medi-Cal rates will be made available on the Division of Workers' Compensation's Internet Website (http://www.dir.ca.gov/DWC/dwc_home_page.htm) or upon request to the Administrative Director at:

Division of Workers' Compensation (Attention: OMFS - Pharmacy)
P.O. Box 420603
San Francisco, CA 94142.

Authority: Sections 133, 4603.5, 5307.1, and 5307.3, Labor Code.
Reference: Sections 4600, 4603.2, and 5307.1, Labor Code.

Section 9789.50 Pathology and Laboratory

(a) Effective for services after January 1, 2004, the maximum reasonable fees for pathology and laboratory services shall not exceed one hundred twenty (120) percent of the rate for the same procedure code in the CMS' Clinical Diagnostic Laboratory Fee Schedule, as established by Sections 1833 and 1834 of the Social Security Act (42 U.S.C. §§ 1395*l* and 1395m) and applicable to California. The Clinical Diagnostic Laboratory Fee Schedule, which can be found on the CMS Internet Website (http://www.cms.hhs.gov/paymentsystems) is incorporated by reference and will be made available on the Division of Workers' Compensation's Internet Website (http://www.dir.ca.gov/DWC/dwc_home_page.htm) or upon request to the Administrative Director at:
Division of Workers' Compensation (Attention: OMFS)
P.O. Box 420603
San Francisco, CA 94142.

(b) The following procedures in the Special Services and Reports section of the OMFS 2003 will not be valid for services rendered after January 1, 2004: CPT Codes 99000, 99001, 99017, 99019, 99020, 99021, 99026, and 99027.

Authority: Sections 133, 4603.5, 5307.1, and 5307.3, Labor Code.
Reference: Sections 4600, 4603.2, and 5307.1, Labor Code.

Section 9789.60. Durable Medical Equipment, Prosthetics, Orthotics, Supplies.

(a) For services, equipment, or goods provided after January 1, 2004, the maximum reasonable reimbursement for durable medical equipment, supplies and materials, orthotics, prosthetics, and miscellaneous supplies and services shall not exceed one hundred twenty (120) percent of the rate set forth in the CMS' Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS) Fee Schedule, as established by Section 1834 of the Social Security Act (42 U.S.C. § 1395m) and applicable to California. The DMEPOS Fee Schedule, which can be found on the CMS Internet Website (http://www.cms.hhs.gov/paymentsystems) is incorporated by reference and will be made available on the Division of Workers' Compensation's Internet Website (http://www.dir.ca.gov/DWC/dwc_home_page.htm) or upon request to the Administrative Director at:
Division of Workers' Compensation (Attention: OMFS)
P.O. Box 420603
San Francisco, CA 94142.

(b) The following procedures in the Special Services and Reports section of the OMFS 2003 will not be valid for services rendered after January 1, 2004: CPT Codes 99002 and 99070.

Authority: Sections 133, 4603.5, 5307.1, and 5307.3, Labor Code.
Reference: Sections 4600, 4603.2, and 5307.1, Labor Code.

Section 9789.70. Ambulance Services.

The maximum reasonable fee for ambulance services rendered after January 1, 2004 shall not exceed 120% of the applicable fee for the Calendar Year 2006 set forth in CMS's Ambulance Fee Schedule, which is established pursuant to Section 1834 of the Social Security Act (42 U.S.C. § 1395m) and applicable to California. The Ambulance Fee Schedule, which can be found at the CMS Internet Website (http://cms.hhs.gov/paymentsystems) is incorporated by reference and will be made available on the Division of Workers' Compensation's Internet Website (http://www.dir.ca.gov/DWC/dwc_home_page.htm) or upon request to the Administrative Director at:

Division of Workers' Compensation (Attention: OMFS)
P.O. Box 420603
San Francisco, CA 94142.

Authority: Sections 133, 4603.5, 5307.1, and 5307.3, Labor Code.
Reference: Sections 4600, 4603.2, and 5307.1, Labor Code.

Section 9789.80 Skilled Nursing Facility [Reserved]

Section 9789.90 Home Health Care [Reserved]

Section 9789.100 Outpatient Renal Dialysis [Reserved]

Section 9789.110 Update of Rules to Reflect Changes in the Medicare Payment System

The OMFS shall be adjusted to conform to any relevant changes in the Medicare and Medi-Cal Medicare payment systems as required by law. The Administrative Director shall determine the effective date of the change and issue an order informing the public of the change and the effective date. Such order shall be posted on the Division's Internet Website: http://www.dir.ca.gov/DWC/dwc_home_page.htm.

Authority: Sections 133, 4603.5, 5307.1, and 5307.3, Labor Code.
Reference: Sections 4600, 4603.2, and 5307.1, Labor Code.