

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—Inpatient Hospital Fee Schedule
Discharge on or after January 1, 2004

§9789.20. General Information for Inpatient Hospital Fee Schedule—Discharge On or After July 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 9789.245 shall apply to all bills for inpatient services with a date of discharge on or after July 1, 2004. Services for discharges after January 1, 2004, but before July 1, 2004 are governed by the "emergency" regulations that were effective on January 2, 2004. 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, including mid-year changes no later than 60 days after the effective date of those changes. Updates shall be posted on the Division of Workers' Compensation webpage at <http://www.dir.ca.gov/DWC/dwc.home.page.htm>. The annual updates to the Inpatient Hospital Fee schedule shall be effective every year on ~~October~~ December 1.

(e) Any document incorporated by reference in Sections 9789.20 through 9789.245 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 for discharges occurring on or after January 1, 2004 and before January 1, 2008, the 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).

For discharges on or after January 1, 2008, "Capital outlier factor" means fixed loss cost outlier threshold x capital wage index x (capital cost-to-charge ratio/total cost-to-charge ratio) as modified by Title 42, Code of Federal Regulations, Section 412.316(b), as it is in effect on November 11, 2003, amended October 1, 2004, amended October 1, 2006, and amended as of October 1, 2007, which document is hereby incorporated by reference and will be made available upon request of to the Administrative Director.

(1) The capital wage index, also referred to as the capital geographic factor (GAF), is specified in the Federal Register notices announcing revisions in the Medicare payment rates. See Section 9789.25(b) for the Federal Register reference that contains the capital wage index value for a given discharge. 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.

~~For discharges on or after November 29, 2004, the capital wage index, also referred to as the capital geographic factor (GAF), is specified in the Federal Register of December 30, 2004 at Vol. 69 FR 78526 (CMS 1428 F2)(correcting the final rule published on August 11, 2004 (CMS 1428 F; 69 FR 48916) and correcting the correction to the final rule published on October 7, 2004 (CMS 1428 CN2; 69 FR 60242)), Table 4A₁ beginning on page 78619 for urban areas by MSA, Table 4A₂ beginning on page 78637 for urban areas by CBSA; Table 4B₁ beginning on page 78660 for rural areas by MSA and Table 4B₂ beginning on page 78661 for rural areas by CBSA; and Table 4C₁ beginning on page 78662 for reclassified hospitals by MSA and Table 4C₂ beginning on page 78665 for reclassified hospitals by CBSA, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.~~

~~———— For discharges on or after December 1, 2005, the capital wage index, also referred to as the capital geographic factor (GAF), is specified in the Federal Register of September 30, 2005 at Vol. 70 FR 57161 (CMS 1500 CN) (correcting the final rule published on August 12, 2005 at Vol. 70 FR 47278 (CMS 1500 F)), on page 57163 for Table 4A for certain urban areas by CBSA, Table 4B for certain rural areas by CBSA, and Table 4C for certain reclassified hospitals by CBSA; and as specified in the final rule published on August 12, 2005 (CMS 1500 F; 70 FR 47278), Table 4A beginning on page 47580 for urban areas by CBSA; Table 4B beginning on page 47603 for rural areas by CBSA; and Table 4C beginning on page 47604 for reclassified hospitals by CBSA, which documents are hereby incorporated by reference and will be made available upon request to the Administrative Director.~~

~~———— The capital wage index, also referred to as the capital geographic factor (GAF), is specified in the Federal Register of October 11, 2006 at Vol. 71 FR 59886 (CMS 1488 N) (additional notice to the final rule published on August 18, 2006 (CMS 1488 F; 71 FR 47870)), Table 4A-1 beginning on page 59975 for urban areas by CBSA for discharges effective December 1, 2006 through March 31, 2007, Table 4A-2 beginning on page 59998 for certain urban areas by CBSA for discharges effective April 1, 2007; Table 4B-1 beginning on page 59998 for rural areas by CBSA for discharges effective December 1, 2006 through March 31, 2007, Table 4B-2 beginning on page 59999 for certain rural areas by CBSA for discharges effective April 1, 2007; and Table 4C-1 beginning on page 59999 for reclassified hospitals by CBSA for discharges effective December 1, 2006 through March 31, 2007, and Table 4C-2 beginning on page 60003 for certain reclassified hospitals by CBSA for discharges effective~~

April 1, 2007, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.—

——— For discharges on or after January 1, 2008, the capital wage index, also referred to as the capital geographic factor (GAF), is specified in the Federal Register of October 10, 2007 at Vol. 72 FR 57634 (CMS 1533 CN2) (correcting the final rule published on August 22, 2007 (CMS 1533 FC; 72 FR 47130)), Table 4A beginning on page 57698 for urban areas by CBSA; Table 4B beginning on page 57721 for rural areas by CBSA; and Table 4C beginning on page 57722 for reclassified hospitals by CBSA, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

——— For discharges on or after December 1, 2008, the capital wage index, also referred to as the capital geographic factor (GAF), is specified in the Federal Register of October 3, 2008 at Vol. 73 FR 57888 (CMS 1390 N) (notice to the final rule published on August 19, 2008 (CMS 1390 F; 73 FR 48434)), Table 4A beginning on page 57956 for urban areas by CBSA and by state; Table 4B beginning on page 57961 for rural areas by CBSA and by state; and Table 4C beginning on page 57962 for reclassified hospitals by CBSA and by state, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

——— For discharges on or after December 1, 2009, the capital wage index, also referred to as the capital geographic factor (GAF), is specified in the Federal Register of October 7, 2009 at Vol. 74 FR 51496 (CMS 1406 CN) (correcting the final rule published on August 27, 2009 at Vol. 74 FR 43754 (CMS 1406 F)), Table 4A beginning on page 51505 for certain urban areas by CBSA and by state, Table 4B on page 51506 for certain rural areas by CBSA and by state, and Table 4C on page 51506 for certain reclassified hospitals by CBSA and state; and as specified in the Federal Register of August 27, 2009 at Vol. 74 FR 43754 (CMS 1406 F), Table 4A beginning on page 44085 for urban areas by CBSA and by state; Table 4B beginning on page 44091 for rural areas by CBSA and by state; and Table 4C beginning on page 44091 for reclassified hospitals by CBSA and by state, which documents are hereby incorporated by reference and will be made available upon request to the Administrative Director.

(2) For discharges occurring on or before January 1, 2008, the "large urban add-on" is an additional 3% of what would otherwise be payable to the hospital, and the large urban add-on is eliminated for discharges occurring on or after January 1, 2008, pursuant to Title 42, Code of Federal Regulations, Section 412.316(b). See Section 9789.25(a) for the Federal Regulation reference to the large urban add-on. 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.

For discharges on or after November 29, 2004, the "large urban add-on" is indicated by the standardized payment amount location published in the FY2005 Final Rule Impact File. As stated in *Title 42, Code of Federal Regulations, Section 412.316(b)*, as it is in effect on November 11, 2003 and amended as of October 1, 2004, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director, the "large urban add-on" is an additional 3% of what would otherwise be payable to the health facility.

For discharges on or after December 1, 2005, the "large urban add-on" is indicated by the URSPA—urban or rural designation for the standardized payment amount location published in the

Impact File for IPPS FY 2006 Final Rule. As stated in *Title 42, Code of Federal Regulations, Section 412.316(b)*, as it is in effect on November 11, 2003 and amended as of October 1, 2004, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director, the "large urban add-on" is an additional 3% of what would otherwise be payable to the health facility.

For discharges on or after December 1, 2006, the "large urban add-on" is indicated by the URSPA—urban or rural designation for the standardized payment amount location published in the Impact file for FY2007 Final Rule (October 2006). As stated in *Title 42, Code of Federal Regulations, Section 412.316(b)*, as it is in effect on November 11, 2003, amended October 1, 2004, and amended as of October 1, 2006, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director, the "large urban add-on" is an additional 3% of what would otherwise be payable to the health facility.

For discharges on or after January 1, 2008, the "large urban add-on" adjustment was eliminated as stated in *Title 42, Code of Federal Regulations, Section 412.316(b)*, as it is in effect on November 11, 2003, amended October 1, 2004, amended October 1, 2006, and amended as of October 1, 2007, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

(3) "Fixed loss cost outlier threshold" means the Medicare fixed loss cost outlier threshold for inpatient admissions. The threshold is specified in the Federal Register notices announcing revisions in the Medicare payment rates. See Section 9789.25(b) for the Federal Register reference that defines the fixed loss cost outlier threshold by date of discharge. 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.

~~The fixed loss cost outlier threshold for FY 2005 is \$ 25,800 as published in the Federal Register of August 11, 2004 at volume 69, number 154 at page 49278, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.~~

~~———— The fixed loss cost outlier threshold for FY 2006 is \$ 23,600 as published in the Federal Register of August 12, 2005 at volume 70, number 155 at page 47494, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.~~

~~———— The fixed loss cost outlier threshold for FY 2007 is \$ 24,485 as published in the Federal Register of October 11, 2006 at volume 71, number 196 at page 59890, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.~~

~~———— The fixed loss cost outlier threshold for FY 2008 is \$ 22,185 as published in the Federal Register of November 27, 2007 at volume 72, number 227 at page 66887, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.~~

~~———— The fixed loss cost outlier threshold for FY 2009 is \$ 20,045 as published in the Federal Register of October 3, 2008 at volume 73, number 193 at page 57891, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.~~

~~———— The fixed loss cost outlier threshold for FY 2010 is \$ 23,140 as published in the Federal Register of August 27, 2009 at volume 74, number 165 at page 44011, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.~~

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

(d) "Complex spinal surgery" is defined by the DRG to which a patient is assigned and is used to determine whether any additional payment is allowed for spinal hardware used during the spinal surgery. See Section 9789.25(b) for the DRGs that define complex spinal surgery by date of discharge.

~~(d e) "Composite factor" means the standard OMFS rate factor calculated by the administrative director for a health facility hospital by adding the hospital-adjusted rates for prospective operating costs and for the prospective capital costs, for the health facility, excluding It excludes the DRG weight and any applicable payments for outlier cases, spinal hardware used in complex spinal surgery, and new technology. payment, as determined by the federal Centers for Medicare & Medicaid Services (CMS) for the purpose of determining payment under Medicare.~~

(1) The hospital-adjusted rate for Pprospective capital costs are is determined by the following formula:

(A) For discharges on or after January 1, 2004 and before January 1, 2008, the hospital-adjusted rate for prospective capital costs is determined by the following formula: 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].

For discharges on or after January 1, 2008, the hospital-adjusted rate for prospective capital costs are is determined by the following formula as modified by Title 42, Code of Federal Regulations, Section 412.316(b), as it is in effect on November 11, 2003, amended October 1, 2004, amended October 1, 2006, and amended as of October 1, 2007, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director: Capital standard federal payment rate x capital geographic adjustment factor x [1 + capital disproportionate share adjustment factor + capital indirect medical education adjustment factor].

(B) The "capital market basket" means the Medicare capital input price index (CIPI). To determine the capital standard federal payment rate, the capital market basket is applied to the preceding capital standard federal payment rate. The capital market basket is specified in the Federal Register notices announcing revisions in the Medicare payment rates. See Section 9789.25(b) for the percentage change in the capital market basket that was applied to the preceding capital standard federal payment rate to establish the applicable capital payment rate for a discharge date.

~~(B C) The "capital standard federal payment rate" is \$ 414.18 for discharges occurring on or after January 1, 2004 and before November 29, 2004. For each update in the composite factor, the capital standard federal payment rate for the preceding period is adjusted by the rate of change in the capital market basket. See Section 9789.25(b) for the capital standard federal payment rate for discharges occurring on or after November 29, 2004 by date of discharge. 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.~~

For discharges on or after November 29, 2004, the OMFS "capital standard payment rate" is \$416.73 (\$413.83 x 1.007). The estimated increase in the capital market basket is 0.7%, as published

by CMS in the Federal Register of August 11, 2004 (CMS-1428-F, 69 FR 48916) at page 49285, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

——— For discharges on or after December 1, 2005, the OMFS "capital standard payment rate" is \$420.06 ($\416.73×1.008). The estimated increase in the capital market basket is 0.8%, as published by CMS in the Federal Register of August 12, 2005 (CMS-1500-F, 70 FR 47278) at page 47500, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

——— For discharges on or after December 1, 2006, the OMFS "capital standard payment rate" is \$424.68 ($\420.06×1.0110). The estimated increase in the capital market basket is 1.10%, as published by CMS in the Federal Register of August 18, 2006 (CMS-1488-F, 71 FR 47870) at page 48163, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

——— For discharges on or after January 1, 2008, the OMFS "capital standard payment rate" is \$430.20 ($\424.68×1.013). The estimated increase in the capital market basket is 1.3%, as published by CMS in the Federal Register of August 22, 2007 (CMS-1533-FC, 72 FR 47130) at page 47426, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

——— For discharges on or after December 1, 2008, the OMFS "capital standard payment rate" is \$436.22 ($\430.20×1.014). The estimated increase in the capital market basket is 1.4%, as published by CMS in the Federal Register of August 19, 2008 (CMS-1390-F, 73 FR 48434) at page 48776, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

——— For discharges on or after December 1, 2009, the OMFS "capital standard payment rate" is \$441.46 ($\436.22×1.012). The estimated increase in the capital market basket is 1.2%, as published by CMS in the Federal Register of October 7, 2009 (CMS-1406-CN, 74 FR 51496) (correcting final rule of August 27, 2009 (CMS-1406-F, 74 FR 43754)) at 51498, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

(C D) The "capital geographic adjustment factor" is the post-reclassification geographic adjustment factor that is published in the Payment Impact File for each Medicare payment update. See Section 9789.25(c) for the variable name on the Payment Impact File by date of discharge. published in the Payment Impact File at positions 243-252.

For discharges on or after November 29, 2004, the "capital geographic adjustment factor" is indicated by the POST RECLASS GAF (post reclass geographic adjustment factor for capital) location published in the FY2005 Final Rule Impact File.

For discharges on or after December 1, 2005, the "capital geographic adjustment factor" is indicated by the WICGRN (post reclass GAF for capital) location published in the Impact File for IPPS FY 2006 Final Rule.

For discharges on or after December 1, 2006, the "capital geographic adjustment factor" is indicated by the Post Reclass GAF_a (post reclass geographic adjustment factor (GAF) for capital first

half FY 2007) and Post Reclass GAF_b (post reclass geographic adjustment factor (GAF) for capital second half FY 2007) locations published in the Impact file FY2007 Final Rule (October 2006).

For discharges on or after January 1, 2008, the "capital geographic adjustment factor" is indicated by the Post Reclass GAF (post reclass geographic adjustment factor (GAF) for capital FY 2008) location published in the Impact file for IPPS FY 2008 Final Rule—November 2007 FY 2008 Final Notice Data.

For discharges on or after December 1, 2008, the "capital geographic adjustment factor" is indicated by the Post Reclass GAF (post reclass geographic adjustment factor (GAF) for capital FY 2009) location published in the Impact file for FY 2009 Final Rule (September 2008).

For discharges on or after December 1, 2009, the "capital geographic adjustment factor" is indicated by the Post Reclass GAF (post reclass geographic adjustment factor (GAF) for capital FY 2010) location published in the Impact file for FY 2010; Correction Notice.

~~(D E)~~ For discharges occurring on or before to January 1, 2008, ~~the~~ "large urban add-on" is an additional 3% of what would otherwise be payable to the hospital, and the large urban add-on is eliminated for discharges occurring on or after January 1, 2008. 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.

For discharges on or after November 29, 2004, the "large urban add-on" is indicated by the standardized payment amount location published in the FY2005 Final Rule Impact File. As stated in *Title 42, Code of Federal Regulations, Section 412.316(b)*, as it is in effect on November 11, 2003 and amended as of October 1, 2004, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director, the "large urban add-on" is an additional 3% of what would otherwise be payable to the health facility.

For discharges on or after December 1, 2005, the "large urban add-on" is indicated by the URSPA—urban or rural designation for the standardized payment amount location published in the Impact File for IPPS FY 2006 Final Rule. As stated in *Title 42, Code of Federal Regulations, Section 412.316(b)*, as it is in effect on November 11, 2003 and amended as of October 1, 2004, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director, the "large urban add-on" is an additional 3% of what would otherwise be payable to the health facility.

For discharges on or after December 1, 2006, the "large urban add-on" is indicated by the URSPA—urban or rural designation for the standardized payment amount location published in the Impact file for FY2007 Final Rule (October 2006). As stated in *Title 42, Code of Federal Regulations, Section 412.316(b)*, as it is in effect on November 11, 2003, amended October 1, 2004, and amended as of October 1, 2006, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director, the "large urban add-on" is an additional 3% of what would otherwise be payable to the health facility.

For discharges on or after January 1, 2008, the "large urban add-on" adjustment was eliminated as stated in *Title 42, Code of Federal Regulations, Section 412.316(b)*, as it is in effect on November 11, 2003, amended October 1, 2004, amended October 1, 2006, and amended as of October 1, 2007, which

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

(~~E~~ F) The "capital disproportionate share adjustment factor" is published in the Payment Impact File for each Medicare payment update. See Section 9789.25(c) for the variable name on the Payment Impact File by date of discharge, at positions 117-126.

~~For discharges on or after November 29, 2004, the "capital disproportionate share adjustment factor" is indicated by the CAPITAL DSH ADJ. (capital disproportionate share (DSH) adjustment) location published in the FY2005 Final Rule Impact File.~~

~~For discharges on or after December 1, 2005, the "capital disproportionate share adjustment factor" is indicated by the DSHCPG (capital disproportionate share (DSH) adjustment) location published in the Impact File for IPPS FY 2006 Final Rule.~~

~~For discharges on or after December 1, 2006, the "capital disproportionate share adjustment factor" is indicated by the DSHCPG (capital disproportionate share (DSH) adjustment) location published in the Impact file FY2007 Final Rule (October 2006).~~

~~For discharges on or after January 1, 2008, the "capital disproportionate share adjustment factor" is indicated by the DSHCPG (capital disproportionate share (DSH) adjustment) location published in the Impact file for IPPS FY 2008 Final Rule—November 2007 FY 2008 Final Notice Data.~~

~~For discharges on or after December 1, 2008, the "capital disproportionate share adjustment factor" is indicated by the DSHCPG (capital disproportionate share (DSH) adjustment) location published in the Impact file for FY 2009 Final Rule (September 2008).~~

~~For discharges on or after December 1, 2009, the "capital disproportionate share adjustment factor" is indicated by the DSHCPG (capital disproportionate share (DSH) adjustment) location published in the Impact file for FY 2010; Correction Notice.~~

(~~F~~ G) The "capital indirect medical education adjustment factor" (capital IME adjustment) is published in Payment Impact File for each Medicare payment update. See Section 9789.25(c) for the variable name on the Payment Impact File by date of discharge, at positions 202-211.

~~For discharges on or after November 29, 2004, the "capital indirect medical education adjustment factor" is indicated by the IME ADJUSTMENT—CAPITAL (IME adjustment factor for capital PPS) location published in the FY2005 Final Rule Impact File.~~

~~For discharges on or after December 1, 2005, the "capital indirect medical education adjustment factor" is indicated by the TCHCP (IME adjustment factor for capital PPS) location published in the Impact File for IPPS FY 2006 Final Rule.~~

~~For discharges on or after December 1, 2006, the "capital indirect medical education adjustment factor" is indicated by the TCHCP (IME adjustment factor for capital PPS) location published in the Impact file FY2007 Final Rule (October 2006).~~

~~For discharges on or after January 1, 2008, the "capital indirect medical education adjustment factor" is indicated by the TCHCP (IME adjustment factor for capital PPS) location published in the Impact file for IPPS FY 2008 Final Rule—November 2007 FY 2008 Final Notice Data.~~

For discharges on or after December 1, 2008, the "capital indirect medical education adjustment factor" is indicated by the TCHCP (IME adjustment factor for capital PPS) location published in the Impact file for FY 2009 Final Rule (September 2008).

For discharges on or after December 1, 2009, the "capital indirect medical education adjustment factor" is indicated by the TCHCP (IME adjustment factor for capital PPS) location published in the Impact file for FY 2010; Correction Notice.

(2) The hospital-adjusted rate for P prospective operating costs are is 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].

For discharges on or after November 29, 2004, the hospital-adjusted rate for prospective operating costs is determined by the following formula as modified by Section 403 of Public Law 108-173 amended sSections 1886(d)(3)(E) of the Social Security Act, and as stated in Title 42, Code of Regulations, Section 412.64(h)(3), as it is in effect on October 1, 2004, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director and in conformance with California Labor Code Section 5307.1(g)(1)(A)(i):

1. The wage-adjusted standard rate is determined as follows:

If operating wage index >1.0, wage-adjusted rate = ~~OMFS~~ labor-related national standard operating rate x (labor-related share x operating wage index + nonlabor-related share).

If operating wage index <=1.0, wage-adjusted rate = ~~OMFS~~ labor-related national standard operating rate x (.62 x operating wage index + .38).

2. The wage-adjusted operating rate is further adjusted for any additional payments for teaching and serving a disproportionate share of low-income patients.

OMFS Adjusted operating rate = wage-adjusted standard rate x (1 + operating disproportionate share adjustment factor + operating indirect medical education adjustment).

(B) The "labor-related national standardized amount" is \$ 3,136.39 for discharges occurring on or after January 1, 2004 and before November 29, 2004. For each update in the composite factor, the labor-related national standardized amount for the preceding period is adjusted by the rate of change in the operating market basket. See Section 9789.25(b) for the labor-related national standard operating rate for discharges occurring on or after November 29, 2004 by date of discharge., 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 and as modified by Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, §401, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

For discharges on or after November 29, 2004, the ~~OMFS standard operating rate is \$4,569.83 (\$4,423.84 x 1.033). The estimated operating market basket is 3.3%, as published by CMS in the Federal Register of August 11, 2004 (CMS-1428-F, 69 FR 48916) at page 49274, which document is~~

hereby incorporated by reference and will be made available upon request to the Administrative Director. For wage indexes greater than 1.0, the labor-related portion is 71.066 percent of the standard operating rate, as published by CMS in the Federal Register of August 11, 2004 (CMS 1428 F, 69 FR 48916) at page 49070, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director. For wage indexes less than or equal to 1.0, the labor-related portion is 62 percent of the standard operating rate, as stated in *Title 42, Code of Regulations, Section 412.64(h)(3)*, as it is in effect on October 1, 2004, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

——— For discharges on or after December 1, 2005, the OMFS standard operating rate is \$ 4,738.91 ($\$4,569.83 \times 1.037$). The estimated operating market basket is 3.7%, as published by CMS in the Federal Register of August 12, 2005 (CMS 1500 F, 70 FR 47278) at page 47492, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director. For wage indexes greater than 1.0, the labor-related portion is 69.731 percent of the standard operating rate, as published by CMS in the Federal Register of August 12, 2005 (CMS 1500 F, 70 FR 47278) at page 47393, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director. For wage indexes less than or equal to 1.0, the labor-related portion is 62 percent of the standard operating rate, as stated in *Title 42, Code of Regulations, Section 412.64(h)(3)*, as it is in effect on October 1, 2004, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

For discharges on or after December 1, 2006, the OMFS standard operating rate is \$ 4,900.03 ($\$4,738.91 \times 1.034$). The estimated operating market basket is 3.4%, as published by CMS in the Federal Register of August 18, 2006 (CMS 1488 F, 71 FR 47870) at page 48146, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director. For wage indexes greater than 1.0, the labor-related portion is 69.731 percent of the standard operating rate, as published by CMS in the Federal Register of August 18, 2006 (CMS 1488 F, 71 FR 47870) at page 48029, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director. For wage indexes less than or equal to 1.0, the labor-related portion is 62 percent of the standard operating rate, as stated in *Title 42, Code of Regulations, Section 412.64(h)(3)*, as it is in effect on October 1, 2004, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

——— For discharges on or after January 1, 2008, the OMFS standard operating rate is \$ 5,061.73 ($\$4,900.03 \times 1.033$). The estimated operating market basket is 3.3%, as published by CMS in the Federal Register of August 22, 2007 (CMS 1533 FC, 72 FR 47130) at page 47415, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director. For wage indexes greater than 1.0, the labor-related portion is 69.731 percent of the standard operating rate, as published by CMS in the Federal Register of August 22, 2007 (CMS 1533 FC, 72 FR 47130) at page 47344, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director. For wage indexes less than or equal to 1.0, the labor-related portion is 62 percent of the standard operating rate, as stated in *Title 42, Code of Regulations, Section 412.64(h)(3)*, as it is in effect on October 1, 2004, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

——— For discharges on or after December 1, 2008, the OMFS standard operating rate is \$ 5,243.95 ($\$5,061.73 \times 1.036$). The estimated operating market basket is 3.6%, as published by CMS in

~~the Federal Register of August 19, 2008 (CMS-1390-F, 73 FR 48434) at page 48759, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director. For wage indexes greater than 1.0, the labor related portion is 69.731 percent of the standard operating rate, as published by CMS in the Federal Register of August 19, 2008 (CMS-1390-F, 73 FR 48434) at page 48592, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director. For wage indexes less than or equal to 1.0, the labor-related portion is 62 percent of the standard operating rate, as stated in *Title 42, Code of Regulations, Section 412.64(h)(3)*, as it is in effect on October 1, 2004, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.~~

~~————— For discharges on or after December 1, 2009, the OMFS standard operating rate is \$ 5,354.08 (\$5,243.95 x 1.021). The estimated operating market basket is 2.1%, as published by CMS in the Federal Register of August 27, 2009 (CMS-1406-F, 74 FR 43754) at page 44002, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director. For wage indexes greater than 1.0, the labor related portion is 68.802 percent of the standard operating rate, as published by CMS in the Federal Register of August 27, 2009 (CMS-1406-F, 74 FR 43754) at page 43856, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director. For wage indexes less than or equal to 1.0, the labor-related portion is 62 percent of the standard operating rate, as stated in *Title 42, Code of Regulations, Section 412.64(h)(3)*, as it is in effect on October 1, 2004, 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 for each Medicare payment update. See Section 9789.25(c) for the variable name on the Payment Impact File by date of discharge at positions 253-262.

~~For discharges on or after November 29, 2004, the "operating wage index" is indicated by the final wage index location published in the FY2005 Final Rule Impact File.~~

~~For discharges on or after December 1, 2005, the "operating wage index" is indicated by the post reclass wage index location published in the Impact File for IPPS FY 2006 Final Rule.~~

~~For discharges on or after December 1, 2006, the "operating wage index" is indicated by the post reclass wage index_a and post reclass wage index_b locations published in the Impact file FY2007 Final Rule (October 2006).~~

~~For discharges on or after January 1, 2008, the "operating wage index" is indicated by the post reclass wage index location published in the Impact file for IPPS FY 2008 Final Rule—November 2007 FY 2008 Final Notice Data.~~

~~For discharges on or after December 1, 2008, the "operating wage index" is indicated by the post reclass wage index location published in the Impact file for FY 2009 Final Rule (September 2008).~~

~~For discharges on or after December 1, 2009, the "operating wage index" is indicated by the post reclass wage index location published in the Impact file for FY 2010; Correction Notice.~~

(D) The "nonlabor-related national standardized amount" is \$ 1,274.85, 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 and as modified by Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, §401, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

For discharges on or after November 29, 2004, the nonlabor-related portion is that portion of operating costs attributable to nonlabor costs, and is determined by the following formula as modified by Section 403 of Public Law 108-173 amended sections 1886(d)(3)(E) of the Social Security Act, and as stated in Title 42, Code of Regulations, Section 412.64(h), as it is in effect on October 1, 2004, which documents are hereby incorporated by reference and will be made available upon request to the Administrative Director:

100% - labor-related portion_(%).

(E) The "operating disproportionate share adjustment factor" is published in the Payment Impact File for each Medicare payment update, and as modified by Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, §402, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director. See Section 9789.25(c) for the variable name on the Payment Impact File by date of discharge. at positions 127-136 and as modified by Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, §402, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

~~For discharges on or after November 29, 2004, the "operating disproportionate share adjustment factor" is indicated by the OPERATING-DSH-ADJ. (operating disproportionate share (DSH) adjustment) location published in the FY2005 Final Rule Impact File.~~

~~For discharges on or after December 1, 2005, the "operating disproportionate share adjustment factor" is indicated by the DSHOPG (operating disproportionate share (DSH) adjustment) location published in the Impact File for IPPS FY 2006 Final Rule.~~

~~For discharges on or after December 1, 2006, the "operating disproportionate share adjustment factor" is indicated by the DSHOPG (operating disproportionate share (DSH) adjustment) location published in the Impact file FY2007 Final Rule (October 2006).~~

~~For discharges on or after January 1, 2008, the "operating disproportionate share adjustment factor" is indicated by the DSHOPG (operating disproportionate share (DSH) adjustment) location published in the Impact file for IPPS FY 2008 Final Rule—November 2007 FY 2008 Final Notice Data.~~

~~For discharges on or after December 1, 2008, the "operating disproportionate share adjustment factor" is indicated by the DSHOPG (operating disproportionate share hospital (DSH) adjustment) location published in the Impact file for FY 2009 Final Rule (September 2008).~~

~~For discharges on or after December 1, 2009, the "operating disproportionate share adjustment factor" is indicated by the DSHOPG (operating disproportionate share hospital (DSH) adjustment) location published in the Impact file for FY 2010; Correction Notice.~~

(F) The "operating indirect medical education adjustment" is published in the Payment Impact File for each Medicare payment update, and as modified by Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, §502, which document is hereby incorporated by

~~reference and will be made available upon request to the Administrative Director. See Section 9789.25(c) for the variable name on the Payment Impact File by date of discharge, at positions 212-221 and as modified by Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, §502, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.~~

~~For discharges on or after November 29, 2004, the "operating indirect medical education adjustment" is indicated by the IME ADJUSTMENT – OPERATING (IME adjustment factor for operating PPS) location published in the FY2005 Final Rule Impact File.~~

~~For discharges on or after December 1, 2005, the "operating indirect medical education adjustment" is indicated by the TCHOP (IME adjustment factor for operating PPS) location published in the Impact File for IPPS FY 2006 Final Rule.~~

~~For discharges on or after December 1, 2006, the "operating indirect medical education adjustment" is indicated by the TCHOP (IME adjustment factor for operating PPS) location published in the Impact file FY2007 Final Rule (October 2006).~~

~~For discharges on or after January 1, 2008, the "operating indirect medical education adjustment" is indicated by the TCHOP (IME adjustment factor for operating PPS) location published in the Impact file for IPPS FY 2008 Final Rule – November 2007 FY 2008 Final Notice Data.~~

~~For discharges on or after December 1, 2008, the "operating indirect medical education adjustment" is indicated by the TCHOP (IME adjustment factor for operating PPS) location published in the Impact file for FY 2009 Final Rule (September 2008).~~

~~For discharges on or after December 1, 2009, the "operating indirect medical education adjustment" is indicated by the TCHOP (IME adjustment factor for operating PPS) location published in the Impact file for FY 2010; Correction Notice.~~

(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 Section 9789.21(e)(2) or the hospital-specific rate published in the Payment Impact File for each Medicare payment update. See Section 9789.25(c) for the variable name on the Payment Impact File by date of discharge, at positions 137-145.

~~For discharges on or after November 29, 2004, the hospital specific rate is indicated by the sole community hospital cost/case 1982/1987 and sole community hospital cost/case 1996 locations published in the FY2005 Final Rule Impact File.~~

~~For discharges on or after December 1, 2005, the hospital specific rate is indicated by the OLDHSPPS (82/87 hospital specific rate updated to FY2006) and HSP96 (1996 hospital specific rate updated to FY2006) locations published in the Impact File for IPPS FY 2006 Final Rule.~~

~~For discharges on or after December 1, 2006, the hospital specific rate is indicated by the HSP Rate (82/87/96 hospital specific rate updated to FY2007 for SCH providers) location published in the Impact file FY2007 Final Rule (October 2006).~~

~~For discharges on or after January 1, 2008, the hospital specific rate is indicated by the HSP Rate (82/87/96 hospital specific rate updated to FY2008 for SCH providers) location published in the Impact file for IPPS FY 2008 Final Rule – November 2007 FY 2008 Final Notice Data.~~

For discharges on or after December 1, 2008, the hospital-specific rate is indicated by the HSP Rate (82/87/96 hospital-specific payment (HSP) rate updated to FY2009 for SCH providers) location published in the Impact file for FY 2009 Final Rule (September 2008).

For discharges on or after December 1, 2009, the hospital-specific rate is indicated by the FY10 HSP Rate (82/87/96/06 hospital-specific payment (HSP) rate updated to FY2010 for SCH providers) location published in the Impact file for FY 2010; Correction Notice.

(3) A table of composite factors for each health facility hospital in California is contained in Section 9789.23. The sole community hospital composite factors that incorporate the operating component specified in subdivision Section 9789.21 (d e)(2)(G) are listed in italics in the column headed "Composite" 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, charges for Durable Medical Equipment for in-home use, charges for implantable medical devices, hardware, and/or instrumentation reimbursed under subdivision (f) 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 and capital cost-to-charge ratio for each hospital is are published in the Payment Impact File for each Medicare payment update. See Section 9789.25(c) for the variable names on the Payment Impact File by date of discharge. at positions 99-106.

For discharges on or after November 29, 2004, the operating cost-to-charge ratio for each hospital is indicated by the OPCCR (from provider specific file; ratio of Medicare operating costs to Medicare covered charges) location published in the FY2005 Final Rule Impact File. The capital cost-to-charge ratio for each hospital is indicated by the CPCCR (from provider specific file; ratio of Medicare capital costs to Medicare covered charges) location published in the FY2005 Final Rule Impact File.

For discharges on or after December 1, 2005, the operating cost-to-charge ratio for each hospital is indicated by the OPCCR (from provider specific file; ratio of Medicare operating costs to Medicare covered charges) location published in the Impact File for IPPS FY 2006 Final Rule. The capital cost-to-charge ratio for each hospital is indicated by the CPCCR (from provider specific file; ratio of Medicare capital costs to Medicare covered charges) location published in the Impact File for IPPS FY 2006 Final Rule.

For discharges on or after December 1, 2006, the operating cost-to-charge ratio for each hospital is indicated by the OPCCR (from provider specific file; ratio of Medicare operating costs to Medicare covered charges) location published in the Impact file FY2007 Final Rule (October 2006). The capital cost-to-charge ratio for each hospital is indicated by the CPCCR (from provider specific file; ratio of Medicare capital costs to Medicare covered charges) location published in the Impact file FY2007 Final Rule (October 2006).

For discharges on or after January 1, 2008, the operating cost-to-charge ratio for each hospital is indicated by the OPCCR (from provider specific file; ratio of Medicare operating costs to Medicare covered charges) location published in the Impact file for IPPS FY 2008 Final Rule - November 2007 FY 2008 Final Notice Data. The capital cost-to-charge ratio for each hospital is indicated by the

~~CPCCR (from provider specific file; ratio of Medicare capital costs to Medicare covered charges) location published in the Impact file for IPSS FY 2008 Final Rule—November 2007 FY 2008 Final Notice Data.~~

~~For discharges on or after December 1, 2008, the operating cost to charge ratio for each hospital is indicated by the Operating CCR (from provider specific file; ratio of Medicare operating costs to Medicare covered charges) location published in the Impact file for FY 2009 Final Rule (September 2008). The capital cost to charge ratio for each hospital is indicated by the Capital CCR (from provider specific file; ratio of Medicare capital costs to Medicare covered charges) location published in the Impact file for FY 2009 Final Rule (September 2008).~~

~~For discharges on or after December 1, 2009, the operating cost to charge ratio for each hospital is indicated by the Operating CCR (from provider specific file; ratio of Medicare operating costs to Medicare covered charges) location published in the Impact file for FY 2010; Correction Notice. The capital cost to charge ratio for each hospital is indicated by the Capital CCR (from provider specific file; ratio of Medicare capital costs to Medicare covered charges) location published in the Impact file for FY 2010; Correction Notice.~~

(g) "Cost outlier case" means a hospitalization for which the hospital's costs, ~~as defined in subdivision (e) above,~~ exceeds the cost outlier threshold.

(h) "Cost outlier threshold" means the sum of the Inpatient Hospital Fee Schedule payment amount, the payment for new medical services and technologies reimbursed under ~~subdivision Section 9789.22(g j) of Section 9789.22,~~ the hospital specific outlier factor, and when applicable, any additional allowance for spinal hardware under section 9789.22(g) or (h).

(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"~~ "Hospital" 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~~ hospital 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) Unless otherwise provided by applicable provisions of this fee schedule, "Inpatient Hospital Fee Schedule maximum payment amount" is that amount determined by multiplying the DRG weight x hospital composite factor x 1.20 and by making any adjustments required in Section 9789.22.

(o) "Labor-related portion" is that portion of operating costs attributable to labor costs, as specified in the Federal Register notices announcing revisions in the Medicare payment rates. See Section

~~9789.25(b) for the Federal Register reference that defines the labor-related portion by date of discharge, 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.~~

~~For discharges on or after November 29, 2004, for wage indexes greater than 1.0, the labor-related portion is 71.066 percent of the standard operating rate, as published by CMS in the Federal Register of August 11, 2004 (CMS-1428-F, 69 FR 48916) at page 49070, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director. For wage indexes less than or equal to 1.0, the labor-related portion is 62 percent of the standard operating rate, as stated in *Title 42, Code of Regulations, Section 412.64(h)(3)*, as it is in effect on October 1, 2004, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.~~

~~———— For discharges on or after December 1, 2005, for wage indexes greater than 1.0, the labor-related portion is 69.731 percent of the standard operating rate, as published by CMS in the Federal Register of August 12, 2005 (CMS-1500-F, 70 FR 47278) at page 47393, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director. For wage indexes less than or equal to 1.0, the labor-related portion is 62 percent of the standard operating rate, as stated in *Title 42, Code of Regulations, Section 412.64(h)(3)*, as it is in effect on October 1, 2004, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.~~

~~For discharges on or after December 1, 2006 for wage indexes greater than 1.0, the labor-related portion is 69.731 percent of the standard operating rate, as published by CMS in the Federal Register of August 18, 2006 (CMS-1488-F, 71 FR 47870) at page 48029, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director. For wage indexes less than or equal to 1.0, the labor-related portion is 62 percent of the standard operating rate, as stated in *Title 42, Code of Regulations, Section 412.64(h)(3)*, as it is in effect on October 1, 2004, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.~~

~~———— For discharges on or after January 1, 2008, for wage indexes greater than 1.0, the labor-related portion is 69.731 percent of the standard operating rate, as published by CMS in the Federal Register of August 22, 2007 (CMS-1533-FC, 72 FR 47130) at page 47344, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director. For wage indexes less than or equal to 1.0, the labor-related portion is 62 percent of the standard operating rate, as stated in *Title 42, Code of Regulations, Section 412.64(h)(3)*, as it is in effect on October 1, 2004, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.~~

~~———— For discharges on or after December 1, 2008, for wage indexes greater than 1.0, the labor-related portion is 69.731 percent of the standard operating rate, as published by CMS in the Federal Register of August 19, 2008 (CMS-1390-F, 73 FR 48434) at page 48592, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director. For wage indexes less than or equal to 1.0, the labor-related portion is 62 percent of the standard operating rate, as stated in *Title 42, Code of Regulations, Section 412.64(h)(3)*, as it is in effect on October 1,~~

~~2004, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.~~

~~———— For discharges on or after December 1, 2009, for wage indexes greater than 1.0, the labor-related portion is 68.802 percent of the standard operating rate, as published by CMS in the Federal Register of August 27, 2009 (CMS-1406-F, 74 FR 43754) at page 43856, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director. For wage indexes less than or equal to 1.0, the labor-related portion is 62 percent of the standard operating rate, as stated in Title 42, Code of Regulations, Section 412.64(h)(3), as it is in effect on October 1, 2004, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.~~

(p) As stated in Title 42, Code of Federal Regulations, Section 412.316(b), for discharges before January 1, 2008, "Large urban add-on" means an additional 3% of what would otherwise be payable to the hospital located in large urban areas. The "large urban add-on" adjustment was eliminated for discharges on or after January 1, 2008. See Section 9789.25(a) for the Code of Federal Regulations reference for effective date, revisions, and amendments by date of discharge. The "large urban add-on" is indicated in the annual Payment Impact File for each Medicare payment update. See Section 9789.25(c) for the variable name on the Payment Impact File by date of discharge.

(p q) "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 r) "Operating outlier factor" means ((fixed loss cost outlier threshold x ((labor-related portion x operating 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 published in the Payment Impact File for each Medicare payment update, is specified as the wage index in the Federal Register notices announcing revisions in the Medicare payment rates. See Section 9789.25(c) for the variable name on the Payment Impact File by date of discharge and see Section 9789.25(b) for the Federal Register reference that defines the wage index by date of discharge. at positions 253-262, is specified as the wage index 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 documents is are hereby incorporated by reference and will be made available upon request to the Administrative Director.

~~For discharges on or after November 29, 2004, the "operating wage index" is indicated by the final wage index location published in the FY2005 Final Rule Impact File, and is specified as the wage index in the Federal Register of December 30, 2004 at Vol. 69 FR 78526 (CMS-1428-F2)(correcting the final rule published on August 11, 2004 (CMS-1428-F; 69 FR 48916) and correcting the correction to the final rule published on October 7, 2004 (CMS-1428-CN2; 69 FR 60242)), Table 4A₁ beginning on page 78619 for urban areas by MSA, Table 4A₂ beginning on page 78637 for urban areas by CBSA; Table 4B₁ beginning on page 78660 for rural areas by MSA and Table 4B₂ beginning on page 78661 for rural areas by CBSA; and Table 4C₁ beginning on page 78662 for reclassified hospitals by MSA and Table 4C₂ beginning on page 78665 for reclassified hospitals by CBSA, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.~~

For discharges on or after December 1, 2005, the "operating wage index " is indicated by the post reclass wage index location published in the Impact File for IPPS FY 2006 Final Rule, and is specified as the wage index in the Federal Register of September 30, 2005 at Vol. 70 FR 57161 (CMS 1500 CN) (correcting the final rule published on August 12, 2005 at Vol. 70 FR 47278 (CMS 1500 F)), on page 57163 for Table 4A for certain urban areas by CBSA, Table 4B for certain rural areas by CBSA, and Table 4C for certain reclassified hospitals by CBSA; and as specified in the final rule published on August 12, 2005 (CMS 1500 F; 70 FR 47278), Table 4A beginning on page 47580 for urban areas by CBSA; Table 4B beginning on page 47603 for rural areas by CBSA; and Table 4C beginning on page 47604 for reclassified hospitals by CBSA, which documents are hereby incorporated by reference and will be made available upon request to the Administrative Director.

For discharges on or after December 1, 2006, the "operating wage index " is indicated by the post reclass wage index_a and post reclass wage index_b locations published in the Impact file FY2007 Final Rule (October 2006). The wage index is specified in the Federal Register of October 11, 2006 at Vol. 71 FR 59886 (CMS 1488 N) (additional notice to the final rule published on August 18, 2006 (CMS 1488 F; 71 FR 47870)), Table 4A-1 beginning on page 59975 for urban areas by CBSA for discharges effective December 1, 2006 through March 31, 2007, Table 4A-2 beginning on page 59998 for certain urban areas by CBSA for discharges effective April 1, 2007; Table 4B-1 beginning on page 59998 for rural areas by CBSA for discharges effective December 1, 2006 through March 31, 2007, Table 4B-2 beginning on page 59999 for certain rural areas by CBSA for discharges effective April 1, 2007; and Table 4C-1 beginning on page 59999 for reclassified hospitals by CBSA for discharges effective December 1, 2006 through March 31, 2007, and Table 4C-2 beginning on page 60003 for certain reclassified hospitals by CBSA for discharges effective April 1, 2007, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

For discharges on or after January 1, 2008, the "operating wage index " is indicated by the post reclass wage index location published in the Impact file for IPPS FY 2008 Final Rule—November 2007 FY 2008 Final Notice Data, and is specified as the wage index in the Federal Register of October 10, 2007 at Vol. 72 FR 57634 (CMS 1533-CN2) (correcting the final rule published on August 22, 2007 (CMS 1533-FC; 72 FR 47130)), Table 4A beginning on page 57698 for urban areas by CBSA; Table 4B beginning on page 57721 for rural areas by CBSA; and Table 4C beginning on page 57722 for reclassified hospitals by CBSA, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

For discharges on or after December 1, 2008, the "operating wage index " is indicated by the post reclass wage index location published in the Impact file for FY 2009 Final Rule (September 2008), and is specified as the wage index in the Federal Register of October 3, 2008 at Vol. 73 FR 57888 (CMS-1390-N) (notice to the final rule published on August 19, 2008 (CMS-1390-F; 73 FR 48434)), Table 4A beginning on page 57956 for urban areas by CBSA and by state; Table 4B beginning on page 57961 for rural areas by CBSA and by state; and Table 4C beginning on page 57962 for reclassified hospitals by CBSA and by state, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

For discharges on or after December 1, 2009, the "operating wage index " is indicated by the post reclass wage index location published in the Impact file for FY 2010; Correction Notice, and is specified as the wage index in the Federal Register of October 7, 2009 at Vol. 74 FR 51496 (CMS-

~~1406-CN) (correcting the final rule published on August 27, 2009 at Vol. 74 FR 43754 (CMS-1406-F)), Table 4A beginning on page 51505 for certain urban areas by CBSA and by state, Table 4B on page 51506 for certain rural areas by CBSA and by state, and Table 4C on page 51506 for certain reclassified hospitals by CBSA and state; and as specified in the Federal Register of August 27, 2009 at Vol. 74 FR 43754 (CMS-1406-F), Table 4A beginning on page 44085 for urban areas by CBSA and by state; Table 4B beginning on page 44091 for rural areas by CBSA and by state; and Table 4C beginning on page 44091 for reclassified hospitals by CBSA and by state, which documents are 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.

For discharges on or after November 29, 2004, the nonlabor-related portion is determined by the following formula as modified by Section 403 of Public Law 108-173 amended sSections 1886(d)(3)(E) of the Social Security Act, and as stated in Title 42, Code of Regulations, Section 412.64(h), as it is in effect on October 1, 2004, which document is hereby incorporated by reference and will be made available upon request of ~~to~~ to the Administrative Director:

100% - labor-related portion (%).

(~~rs~~) "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~~ hospital in California is contained in Section 9789.23.

(~~st~~) "Payment Impact File" means the Prospective Payment System Payment Impact File published by CMS, for each Medicare update. See Section 9789.25(c) for references to the Payment Impact File by date of discharge. FY 2004 Prospective Payment System Payment Impact File (October 2003 Update) (IMPFIE04) 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.red.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>.

For discharges on or after November 29, 2004, the impact file is entitled "FY 2005 Final Impact (as of Dec. 30, 2004)", 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://www.cms.hhs.gov/providers/hipps/hist_impact_94-04.asp. A paper copy of the "FY 2005 Final Impact (as of Dec. 30, 2004)" is available from the Administrative Director upon request.

For discharges on or after December 1, 2005, the impact file is entitled "Impact File for IPSS FY 2006 Final Rule", 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://www.cms.hhs.gov/providers/hipps/ippspufs.asp>. A paper copy of the "Impact File for IPSS FY 2006 Final Rule" is available from the Administrative Director upon request.

——— For discharges on or after December 1, 2006, the impact file is entitled “Impact File for IPPS FY 2007 Final Rule October 2006”, 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://www.cms.hhs.gov/AcuteInpatientPPS/>. A paper copy of the “Impact File for IPPS FY 2007 Final Rule October 2006” is available from the Administrative Director upon request.

——— For discharges on or after January 1, 2008, the impact file is entitled “Impact file for IPPS FY 2008 Final Rule November 2007 FY 2008 Final Notice Data”, 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://www.cms.hhs.gov/AcuteInpatientPPS/>. A paper copy of the “Impact file for IPPS FY 2008 Final Rule November 2007 FY 2008 Final Notice Data” is available from the Administrative Director upon request.

——— For discharges on or after December 1, 2008, the impact file is entitled “Impact file for FY 2009 Final Rule (September 2008)”, 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://www.cms.hhs.gov/AcuteInpatientPPS/>. A paper copy of the “Impact file for FY 2009 Final Rule (September 2008)” is available from the Administrative Director upon request.

——— For discharges on or after December 1, 2009, the impact file is entitled “Impact file for FY 2010; Correction Notice”, 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://www.cms.hhs.gov/AcuteInpatientPPS/>. A paper copy of the “Impact file for FY 2010; Correction Notice” is available from the Administrative Director upon request.

(u) “Price adjustment” means any and all price reductions, offsets, discounts, rebates, adjustments, and or refunds which accrue to or are factored into the final net cost to the hospital.

(tv) “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.

(w) “Spinal hardware,” as used in Section 9789.22, means a permanently implantable device surgically implanted, embedded, inserted, or otherwise applied to a human body in the course of complex spinal surgery.

The device must be intended to function for more than one year and throughout the useful life of the device, to assist, restore, or replace, or otherwise therapeutically influence the function of the spine. The term, spinal hardware, does not apply to any device which is intended for temporary purposes or intended for removal.

The device must be: (1) recognized in the official United States Pharmacopoeia-National Formulary, or any supplement to it; and (2) is reasonably required to cure or relieve the injured worker from the effects of his or her injury pursuant to Labor Code Section 4600.

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) Unless otherwise provided by applicable provisions of this fee schedule, the Mmaximum payment for inpatient medical services shall be determined by multiplying 1.20 by the product of the health facility's hospital's composite factor and the applicable DRG weight and by making any adjustments required by this fee schedule. The fee determined under this subdivision shall be a global fee, constituting the maximum reimbursement to a ~~health facility~~ hospital for inpatient medical services not exempted under this section. However, preadmission services rendered by a ~~health facility~~ hospital more than 24 hours before admission are separately reimbursable.

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

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

(d) The maximum payment shall cover all items and services provided to hospital inpatients other than professional services provided by physicians and other practitioners that are payable under the Official Medical Fee Schedule section beginning at Section 9789.10. Billing for payments shall originate from hospitals and payment may be made only to hospitals for the covered items and services, including any spinal hardware separately payable under Sections 9789.22 (g) or (h).

~~(d e)~~ Health facilities Hospitals billing for fees under this section shall present with their bill the name and address of the ~~facility~~ hospital, the ~~facility's~~ hospital'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. When applicable, documentation of the costs of implanted spinal hardware shall be submitted in accordance with Section 9789.22(h).

(e f) (1) Additional allowance for cost outlier cases exclusive of complex spinal surgery cases involving spinal hardware reimbursed under Section 9789.22(h). The higher costs for cost outlier cases that do not involve complex spinal surgery reimbursed under Section 9789.22(h) Cost Outlier cases. Inpatient services for cost outlier cases, shall be reimbursed as follows:

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

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

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

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

~~(5) For purposes of determining whether a case qualifies as a cost outlier case under this subdivision, charges for implantable hardware and/or instrumentation reimbursed under subsection (f) is excluded from the calculation of costs. If an admission for DRGs 496, 497, 498, 519, 520, 531 and 532 qualifies as a cost outlier case, any implantable hardware and/or instrumentation shall be separately reimbursed under subsection (f).~~

~~For discharges on or after December 1, 2005, as modified in the Federal Register of August 12, 2005 (CMS-1500-F; 70 FR 47278) on page 47308, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director: For purposes of determining whether a case qualifies as a cost outlier case under this subdivision, charges for implantable hardware and/or instrumentation reimbursed under subsection (f) is excluded from the calculation of costs. If an admission for DRGs 496, 497, 498, 519, 520, 531, 532, and 546 qualifies as a cost outlier case, any implantable hardware and/or instrumentation shall be separately reimbursed under subsection (f).~~

~~For discharges on or after January 1, 2008, as indicated in the Crosswalk from CMS DRGs to Medicare Severity DRGs, FY 2008 Final Rule, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director: For purposes of determining whether a case qualifies as a cost outlier case under this subdivision, charges for implantable hardware and/or instrumentation reimbursed under subsection (f) are excluded from the calculation of costs. If an admission for Medicare Severity DRGs 028, 029, 030, 453, 454, 455, 456, 457, 458, 459, 460, 471, 472, and 473 qualifies as a cost outlier case, any implantable hardware and/or instrumentation shall be separately reimbursed under subsection (f).~~

(2) Additional allowance for cost outlier cases involving complex spinal surgery. The higher costs of a case involving spinal hardware reimbursed under Section 9789.22(h) shall be reimbursed using the following method. This method is optional for other cases involving complex spinal surgery and may be elected by a hospital on a case-by-case basis in lieu of the method in Section 9789.22(f)(1). A hospital electing this method for other complex spinal surgery cases must document the cost of any spinal hardware as required under Section 9789.22(h). The method is as follows:

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

Step 2: Determine total costs. Total Costs = (total charges – charges for any spinal hardware) x (total cost-to-charge ratio) + documented paid cost of any spinal hardware, plus an additional 10% of the hospital's documented paid cost, net of immediate and anticipated price adjustments, not to exceed a maximum of \$250.00, plus any sales tax and/or shipping and handling charges actually paid.

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

If costs determined in Step 2 exceed the outlier threshold, the case is a cost outlier case. The additional allowance for the outlier case equals 0.8 x (costs - cost outlier threshold).

~~(f) Implantable medical devices, hardware, and instrumentation for DRGs 496, 497, 498, 519, 520, 531 and 532 shall be separately reimbursed at the provider's documented paid cost, plus an additional 10% of the provider's documented paid cost, net of discounts and rebates, not to exceed a maximum of \$ 250.00, plus any sales tax and/or shipping and handling charges actually paid. For purposes of this subdivision, a device is an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar related article, including a component part, or accessory which is: (1) recognized in the official National Formulary, or the United States Pharmacopoeia, or any supplement to them; (2) intended for use in the cure, mitigation, treatment, or prevention of disease; or (3) intended to affect the structure or any function of the body, and which does not achieve any of its primary intended purposes through chemical action within or on the body and which is not dependent upon being metabolized for the achievement of any of its primary intended purposes.~~

~~For discharges on or after December 1, 2005, as modified in the Federal Register of August 12, 2005 (CMS 1500 F; 70 FR 47278) on page 47308, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director: Implantable medical devices, hardware, and instrumentation for DRGs 496, 497, 498, 519, 520, 531, 532, and 546 shall be separately reimbursed at the provider's documented paid cost, plus an additional 10% of the provider's documented paid cost, net of discounts and rebates, not to exceed a maximum of \$250.00, plus any sales tax and/or shipping and handling charges actually paid. For purposes of this subdivision, a device is an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar related article, including a component part, or accessory which is: (1) recognized in the official National Formulary, or the United States Pharmacopoeia, or any supplement to them; (2) intended for use in the cure, mitigation, treatment, or prevention of disease; or (3) intended to affect the structure or any function of the body, and which does not achieve any of its primary intended purposes through chemical action within or on the body and which is not dependent upon being metabolized for the achievement of any of its primary intended purposes.~~

~~For discharges on or after January 1, 2008, as indicated in the Crosswalk from CMS DRGs to Medicare Severity DRGs, FY 2008 Final Rule, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director: Implantable medical devices, hardware, and instrumentation for Medicare Severity DRGs 028, 029, 030, 453, 454, 455, 456, 457, 458, 459, 460, 471, 472, and 473 shall be separately reimbursed at the provider's documented paid cost, plus an additional 10% of the provider's documented paid cost, net of discounts and rebates, not to exceed a maximum of \$250.00, plus any sales tax and/or shipping and handling charges actually paid. For purposes of this subdivision, a device is an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar related article, including a component part, or accessory which is: (1) recognized in the official National Formulary, or the United States Pharmacopoeia, or any supplement to them; (2) intended for use in the cure, mitigation, treatment, or prevention of disease; or (3) intended to affect the structure or any function of the body, and which does not achieve any of its primary intended purposes through chemical action within or on the body and which is not dependent upon being metabolized for the achievement of any of its primary intended purposes.~~

(g) Additional allowance for spinal hardware used in complex spinal surgery:

(1) For discharges occurring before December 15, 2010, costs for spinal hardware used during complex spinal surgery shall be separately reimbursed at the hospital's documented paid cost, plus an additional 10% of the hospital's documented paid cost, net of price adjustments, not to exceed a maximum of \$250.00, plus any sales tax and/or shipping and handling charges actually paid.

(2)(A) For discharges occurring on or after December 15, 2010, an additional allowance of \$2,925 shall be made for discharges assigned to MS-DRGs 453, 454, 455, 456, 457, 458, 459, and 460 and an additional allowance of \$625 shall be made for discharges assigned to MS-DRGs 028, 029, 030, 471, 472, and 473.

(B) Effective with each update in the composite rate, the additional allowance in Section 9789.22(g)(2)(A) shall be adjusted by the rate of change in the hospital operating market basket.

(h) Alternate Payment Methodology. Effective December 15, 2010, for discharges assigned only to complex spinal surgery cases as defined in Section 9789.21(d), in lieu of the Inpatient Hospital Fee Schedule maximum payment allowed under Section 9789.22(a) and additional allowance under Section 9789.22(g)(2), the hospital may make one annual election encompassing all complex spinal surgery cases pursuant to Section 9789.22(i) for an alternate maximum payment allowance and additional allowance to be determined as follows:

(A) Multiplier x DRG weight x hospital specific composite factor plus the additional allowance for documented paid cost for spinal hardware, plus an additional 10% of the hospital's documented paid cost, net of immediate and anticipated price adjustments, not to exceed a maximum of \$250.00, plus any sales tax and/or shipping and handling charges actually paid.

The multiplier shall be as follows: For discharges occurring on or after December 15, 2010, the multiplier shall be 1.0. For discharges occurring on or after the effective date of the 2012 annual update, the multiplier shall be 0.8.

(B) The hospital shall submit documentation that includes for each spinal hardware item: (1) a description; (2) the name of the manufacturer, the manufacturer's supply code, and the item's unique identifier; (3) the charge included in the hospital's bill; (4) the hospital's documented paid cost net of immediate price adjustments and anticipated price adjustments based upon the hospital's prior calendar year's usage for comparable spinal hardware; and (5) any sales tax and/or shipping and handling charges actually paid. The operative report of the patient's medical record must be submitted by the hospital and clearly document the spinal hardware items that were implanted for each discharge, and a responsible hospital official shall certify that the documentation accurately reflects the complete list of spinal hardware items utilized for the patient and accurately reflects the patient's spinal hardware costs by including the following sentence: "I hereby certify under penalty of perjury that the following is the true and correct actual cost and list of the items meeting the criteria in Title 8, California Code of Regulations Section 9789.22(h)."

(i) The following requirements shall be met for an annual election of the alternative allowance methodology set forth in Section 9789.22(h):

(1) A hospital seeking alternative maximum payment allowance under Section 9789.22(h) must file a written election with the Administrative Director which states the hospital is making an annual election for alternative maximum payment allowance and additional allowance for spinal hardware used in all complex spinal surgery cases pursuant to Title 8 California Code of Regulations, Section

9789.22(h). The written election shall be submitted to the Division of Workers' Compensation, Medical Unit (Attention: OMFS-Inpatient), P.O. Box 71010, Oakland, CA 94612. The written election must be post-marked by December 15 of each year and shall be effective for one year commencing with discharges on or after January 1 following the month of December in which the election is made.

(2) The maximum payment allowed to a hospital that does not file a timely election satisfying the requirements set forth in this subdivision shall be determined under Section 9789.22(a) and additional allowance for spinal hardware used in complex spinal surgery shall be determined under Section 9789.22(g)(2).

(3) Before January 1 of each year the Administrative Director shall post a list of those hospitals that have elected to be paid under Section 9789.22(h) on the Division of Workers' Compensation website: http://www.dir.ca.gov/DWC/dwc_home_page.htm and will be made available upon request to the Division of Workers' Compensation, Medical Unit (Attention: OMFS - Inpatient), P.O. Box 71010, Oakland, CA 94612.

(g j) "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 and Section 412.88 (effective September 7, 2001 and revised as of October 1, 2003); Section 412.88 (effective September 7, 2001 and amended August 1, 2002 and August 1, 2003 and revised as of October 1, 2003), which document is hereby incorporated by reference and will be made available upon request to the Administrative Director. See Section 9789.25(a) for the Code of Federal Regulations reference for the effective date, revisions, and amendments by date of discharge.

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

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

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

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

~~(h k) Sole Community Hospitals: If a hospital meets the criteria for sole community hospitals, under Title 42, Code of Federal Regulations §412.92(a), effective October 1, 2002 and revised as of October 1, 2003, and has been classified by CMS as a sole community hospital, its payment rates are determined under Title 42, Code of Federal Regulations § 412.92(d), effective October 1, 2002 and as revised as of October 1, 2003, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director. See Section 9789.25(a) for the Code of Federal Regulations reference for the effective date, revisions, and amendments by date of discharge.~~

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

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

~~(i l) Transfers~~

~~(1) Inpatient services provided by a health facility hospital transferring an inpatient to another hospital are exempt from the maximum reimbursement formula set forth in subdivision Section 9789.22(a). Maximum reimbursement for inpatient medical services of a health facility hospital 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 § Section 9789.22(a). However, the first day of the stay in the transferring hospital shall be reimbursed at twice the per diem amount and the hospital shall receive the additional allowances under either Sections 9789.22(g) or (h) and under Section 9789.22 (j) when applicable. The per diem rate is determined by dividing the maximum reimbursement as determined under Title 8, California Code of Regulations §Section 9789.22(a) by the average length of stay for that specific DRG. However, if an admission to a health facility hospital transferring a patient is exempt from the maximum reimbursement formula set forth in subdivision Section 9789.22(a) because it satisfies one or more of the requirements of Title 8, California Code of Regulations § Section 9789.22(j m), 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~~ § Section 9789.22(a).

(2) Post-acute care transfers exempt from the maximum reimbursement set forth in ~~subdivision~~ Section 9789.22(a).

(A) When an acute care patient is discharged to a post-acute care provider which is a rehabilitation hospital or distinct part rehabilitation unit of an acute care hospital or a long-term hospital, and the patient's discharge is assigned to one of the ~~following~~ qualifying DRGs as specified in the Federal Register,: 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 Section 9789.22(f)(1) of this section~~. See Section 9789.25(b) for the Federal Register reference that contains the qualifying DRGs for a given discharge.

~~For discharges on or after July 15, 2005, as specified in the Federal Register of October 7, 2004 (CMS 1428 CN2, 69 FR 60242) beginning on page 60246, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director: When an acute care patient is discharged to a post-acute care provider which is a rehabilitation hospital or distinct part rehabilitation unit of an acute care hospital or a long-term hospital, and the patient's discharge is assigned to one of the following qualifying DRGs: 12, 14, 24, 25, 88, 89, 90, 113, 121, 122, 127, 130, 131, 236, 239, 277, 278, 294, 296, 297, 320, 321, 395, 429, 468, 541 or 542; payment to the transferring hospital shall be made as set forth in subdivision (i)(1) of this section.~~

~~For discharges on or after December 1, 2005: When an acute care patient is discharged to a post-acute care provider which is a rehabilitation hospital or distinct part rehabilitation unit of an acute care hospital or a long-term hospital, and the patient's discharge is assigned to one of the qualifying DRGs designated with a "yes" in "FY06 Final Rule Post-acute Care DRG" column in Table 5 of the Federal Register published on August 12, 2005, (CMS 1500 F; Vol. 70, FR 47278), beginning on page 47617; and the correction notice published on September 30, 2005 in the Federal Register (CMS 1500 CN; Vol. 70, FR 57161), beginning on page 57163, which documents are hereby incorporated by reference and will be made available upon request to the Administrative Director, payment to the transferring hospital shall be made as set forth in subdivision (i)(1) of this section.~~

~~For discharges on or after December 1, 2006: When an acute care patient is discharged to a post-acute care provider which is a rehabilitation hospital or distinct part rehabilitation unit of an acute care hospital or a long-term hospital, and the patient's discharge is assigned to one of the qualifying DRGs designated with a "yes" in the "FY 07 Final Rule Post-acute Care DRG" column in Table 5 of the addendum to the notice published on October 11, 2006, (CMS 1488 N; Vol. 71, FR 59886), beginning on page 60013, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director, payment to the transferring hospital shall be made as set forth in subdivision (i)(1) of this section.~~

~~For discharges on or after March 1, 2007: When an acute care patient is discharged to a post-acute care provider which is a rehabilitation hospital or distinct part rehabilitation unit of an acute care hospital or a long-term hospital, and the patient's discharge is assigned to one of the qualifying DRGs designated with a "yes" in the "FY 07 Final Rule Post-acute Care DRG" column in Table 5 of the addendum to the notice published on October 11, 2006 (CMS 1488 N; Vol. 71, FR 59886), beginning on page 60013; and Correction of Notice published on January 5, 2007 (CMS 1488 CN2; Vol. 72, No.~~

3, FR 569), beginning on page 573, which documents are hereby incorporated by reference and will be made available upon request to the Administrative Director, payment to the transferring hospital shall be made as set forth in subdivision (i)(1) of this section.

~~For discharges on or after January 1, 2008: When an acute care patient is discharged to a post acute care provider which is a rehabilitation hospital or distinct part rehabilitation unit of an acute care hospital or a long term hospital, and the patient's discharge is assigned to one of the qualifying Medicare Severity DRGs designated with a "yes" in the "FY08 Final Rule Post-Acute DRG" column in Table 5 of the addendum to the final rule published in the Federal Register on August 22, 2007, (CMS-1533-FC; Vol. 72, FR 47130), beginning on page 47539; and correction published in the Federal Register on October 10, 2007, (CMS-1533-CN2; Vol. 72, FR 57634), on page 57727, which documents are hereby incorporated by reference and will be made available upon request to the Administrative Director, payment to the transferring hospital shall be made as set forth in subdivision (i)(1) of this section.~~

~~For discharges on or after December 1, 2008: When an acute care patient is discharged to a post acute care provider which is a rehabilitation hospital or distinct part rehabilitation unit of an acute care hospital or a long term hospital, and the patient's discharge is assigned to one of the qualifying Medicare Severity DRGs designated with a "yes" in the "FY09 Final Rule Post-Acute DRG" column in Table 5 of the addendum to the final rule published in the Federal Register on August 19, 2008, (CMS-1390-F; Vol. 73 FR 48434), beginning on page 48899, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director, payment to the transferring hospital shall be made as set forth in subdivision (i)(1) of this section.~~

~~For discharges on or after December 1, 2009: When an acute care patient is discharged to a post acute care provider which is a rehabilitation hospital or distinct part rehabilitation unit of an acute care hospital or a long term hospital, and the patient's discharge is assigned to one of the qualifying Medicare Severity DRGs designated with a "yes" in the "FY 2010 Final Rule Post-Acute DRG" column in Table 5 of the addendum to the final rule published in the Federal Register on August 27, 2009, (CMS-1406-F; Vol. 74 FR 43754), beginning on page 44126, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director, payment to the transferring hospital shall be made as set forth in subdivision (i)(1) of this section.~~

(B) When an acute care patient is discharged to a post-acute care provider and the patient's discharge is assigned to one of the following qualifying DRGs as specified in the Federal Register, 209, 240 or 241, the payment to the transferring hospital is 50% of the amount paid under subdivision Section 9789.22(a) of this section, plus 50% of the per diem, set forth in subdivision Section 9789.22(f)(1)(1) for each day, up to the full DRG amount. See Section 9789.25(b) for the Federal Register reference that contains the qualifying DRGs for a given discharge.

~~For discharges on or after December 1, 2005 as specified in the Federal Register of August 12, 2005 (CMS-1500-F; 70 FR 47278), beginning on page 47617; and the correction notice published on September 30, 2005 in the Federal Register (CMS-1500-CN; Vol. 70, FR 57161), beginning on page 57163, which documents are hereby incorporated by reference and will be made available upon request to the Administrative Director: When an acute care patient is discharged to a post acute care provider and the patient's discharge is assigned to one of the following qualifying DRGs 7, 8, 210, 211, 233, 234, 471, 497, 498, 544, 545, 549, or 550, the payment to the transferring hospital is 50% of the amount paid~~

under subdivision (a) of this section, plus 50% of the per diem, set forth in subdivision (i)(1) for each day, up to the full DRG amount.

~~For discharges on or after December 1, 2006, as specified in the Federal Register of October 11, 2006, (CMS 1488-N; Vol. 71, FR 59886), beginning on page 60013, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director: When an acute care patient is discharged to a post-acute care provider and the patient's discharge is assigned to one of the following qualifying DRGs 7, 8, 210, 211, 233, 234, 471, 497, 498, 545, 549, or 550, the payment to the transferring hospital is 50% of the amount paid under subdivision (a) of this section, plus 50% of the per diem, set forth in subdivision (i)(1) for each day, up to the full DRG amount.~~

~~For discharges on or after March 1, 2007, as specified in the Federal Register of October 11, 2006 (CMS 1488-N; Vol. 71, FR 59886), beginning on page 60013; and Correction of Notice published on January 5, 2007 (CMS 1488-CN2; Vol. 72, No. 3, FR 569), beginning on page 573, which documents are hereby incorporated by reference and will be made available upon request to the Administrative Director: When an acute care patient is discharged to a post-acute care provider and the patient's discharge is assigned to one of the following qualifying DRGs 7, 8, 210, 211, 233, 234, 471, 497, 498, 544, 545, 549, or 550, the payment to the transferring hospital is 50% of the amount paid under subdivision (a) of this section, plus 50% of the per diem, set forth in subdivision (i)(1) for each day, up to the full DRG amount.~~

~~For discharges on or after January 1, 2008: When an acute care patient is discharged to a post-acute care provider and the patient's discharge is assigned to one of the qualifying Medicare Severity DRGs designated with a "yes" in the "FY08 Final Rule Special Pay DRG" column in Table 5 of the addendum to the final rule published in the Federal Register on August 27, 2007, (CMS 1533-FC, Vol. 72, FR 47130), beginning on page 47539; and correction published in the Federal Register on October 10, 2007, (CMS 1533-CN2; Vol. 72, FR 57634) on page 57727, which documents are hereby incorporated by reference and will be made available upon request to the Administrative Director, the payment to the transferring hospital is 50% of the amount paid under subdivision (a) of this section, plus 50% of the per diem, set forth in subdivision (i)(1) for each day, up to the full DRG amount.~~

~~For discharges on or after December 1, 2008: When an acute care patient is discharged to a post-acute care provider and the patient's discharge is assigned to one of the qualifying Medicare Severity DRGs designated with a "yes" in the "FY09 Final Rule Special Pay DRG" column in Table 5 of the addendum to the final rule published in the Federal Register on August 19, 2008, (CMS 1390-F; Vol. 73 FR 48434), beginning on page 48899, which is incorporated by reference and will be made available upon request to the Administrative Director, the payment to the transferring hospital is 50% of the amount paid under subdivision (a) of this section, plus 50% of the per diem, set forth in subdivision (i)(1) for each day, up to the full DRG amount.~~

~~For discharges on or after December 1, 2009: When an acute care patient is discharged to a post-acute care provider and the patient's discharge is assigned to one of the qualifying Medicare Severity DRGs designated with a "yes" in the "FY2010 Final Rule Special Pay DRG" column in Table 5 of the addendum to the final rule published in the Federal Register on August 27, 2009, (CMS 1406-F; Vol. 74 FR 43754), beginning on page 44126, which is incorporated by reference and will be made available upon request to the Administrative Director, the payment to the transferring hospital is 50% of the~~

~~amount paid under subdivision (a) of this section, plus 50% of the per diem, set forth in subdivision (i)(1) for each day, up to the full DRG amount.~~

(j m) The following are exempt from the maximum reimbursement formula set forth in ~~subdivision~~ Section 9789.22(a) and are paid on a reasonable cost basis.

(1) Critical access hospitals;

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

(3) Cancer hospitals as defined by *Title 42, Code of Federal Regulations, Section 412.23(f)*, ~~effective date October 1, 2002 and as revised as of October 1, 2003, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director. See Section 9789.25(a) for the Code of Federal Regulations reference for the effective date, revisions, and amendments by date of discharge;~~

(4) Veterans Administration hospitals-;

(5) Long term care hospitals as defined by *Title 42, Code of Federal Regulations, Section 412.23(e)*, ~~effective date October 1, 2002 and as revised as of October 1, 2003, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director. See Section 9789.25(a) for the Code of Federal Regulations reference for the effective date, revisions, and amendments by date of discharge;~~

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

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

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

(8) Out of state hospitals.

~~(k n) For discharges occurring before December 15, 2010, A health facility a hospital~~ that is not listed on the Medicare Cost Report should notify the Administrative Director and provide in writing the following information: OSHPD Licensure number, Medicare provider number, physical location, number of beds, and, if applicable, average FTE residents in approved training programs. If a hospital has been in operation for more than one year, information should also be provided on the percentage of inpatient days attributable to Medicaid patients.

For discharges occurring on or after December 15, 2010, a hospital that is not listed in Section 9789.23, may notify the Administrative Director and provide in writing the following Medicare information: Medicare provider number, physical location, county code, hospital specific operating and capital CCRs, and DSH and/or IME adjustments, if applicable.

(f o) Any ~~health care facility~~ hospital 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.

§9789.23. Hospital Cost to Charge Rations, Hospital Specific Outliers, and Hospital Composite Factors.

There are no proposed changes to this section.

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

There are no proposed changes to this section.

§9789.25. Federal Regulations, Federal Register Notices, and Payment Impact File by Date of Discharge.

(a) Federal Regulations by Date of Discharge

(1) The Federal Regulations can be accessed at: <http://www.cms.gov/AcuteInpatientPPS/> and the referenced sections are incorporated by reference and will be made available upon request to the Administrative Director.

	<u>Discharges Occurring On or After 1/1/2004</u>	<u>Discharges Occurring On or After 11/29/2004</u>	<u>Discharges Occurring On or After 12/1/2005</u>	<u>Discharges Occurring On or After 12/1/2006</u>
<u>Title 42, Code of Federal Regulations, §412.23(e)</u>	<u>Effective date October 1, 2002 and revised as of October 1, 2003</u>			
<u>Title 42, Code of Federal</u>	<u>Effective October 1,</u>			

<u>Regulations, §412.23(f)</u>	<u>2002 and revised as of October 1, 2003</u>			
<u>Title 42, Code of Federal Regulations Section 412.87</u>	<u>Effective September 7, 2001 and revised as of October 1, 2003</u>	<u>Amended; effective October 1, 2004</u>		
<u>Title 42, Code of Federal Regulations Section 412.88</u>	<u>Effective September 7, 2001 and amended August 1, 2002 and August 1, 2003 and revised as of October 1, 2003</u>	<u>Amended; effective October 1, 2004</u>		
<u>Title 42, Code of Federal Regulations §412.92(a)</u>	<u>Effective October 1, 2002 and revised as of October 1, 2003</u>		<u>Amended; effective October 1, 2005</u>	
<u>Title 42, Code of Federal Regulations §412.92(d)</u>	<u>Effective October 1, 2002 and revised as of October 1, 2003</u>		<u>Amended; effective October 1, 2005</u>	
<u>Title 42, Code of Federal Regulations Section 412.316(b)</u>	<u>Effective November 11, 2003, large urban add-on is an additional 3%</u>	<u>Amended; effective October 1, 2004, large urban add-on is an additional 3%</u>	<u>Amended; effective October 1, 2004, large urban add-on is an additional 3%</u>	<u>Amended; effective October 1, 2006, large urban add-on is an additional 3%</u>

	<u>Discharges Occurring On</u>	<u>Discharges Occurring On or</u>	<u>Discharges Occurring On or</u>	
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	<u>or After 1/1/2008</u>	<u>After 12/1/2008</u>	<u>After 12/1/2009</u>	
<u>Title 42, Code of Federal Regulations, §412.23(e)</u>			<u>Amended; effective October 1, 2009</u>	
<u>Title 42, Code of Federal Regulations, §412.23(f)</u>				
<u>Title 42, Code of Federal Regulations Section 412.87</u>		<u>Amended; effective October 1, 2008</u>	<u>Amended; effective October 1, 2009</u>	
<u>Title 42, Code of Federal Regulations Section 412.88</u>	<u>Amended; effective October 1, 2007</u>			
<u>Title 42, Code of Federal Regulations Section 412.92(a)</u>				
<u>Title 42, Code of Federal Regulations Section 412.92(d)</u>		<u>Amended; effective October 1, 2008</u>		
<u>Title 42, Code of Federal Regulations Section 412.316(b)</u>	<u>Amended; effective October 1, 2007, large urban add-on is eliminated</u>			

(b) Federal Register Notices by Date of Discharge

(1) The Federal Register Notices can be accessed at: <http://www.cms.gov/AcuteInpatientPPS/> and the referenced sections are incorporated by reference and will be made available upon request to the Administrative Director.

	<u>Discharges Occurring On or After 1/1/2004</u>	<u>Discharges Occurring On or After 11/29/2004</u>	<u>Discharges Occurring On or After 7/1/2005</u>	<u>Discharges Occurring On or After 12/1/2005</u>
<u>Applicable FR Notices</u>	(A) <u>August 1, 2003 (CMS-1470-F; 68 FR 45346) final rule</u> (B) <u>October 6, 2003 (CMS-1470-CN; 68 FR 57732) correction notice</u>	(A) <u>August 11, 2004 (CMS-1428-F; 69 FR 48916) final rule</u> (B) <u>October 7, 2004 (CMS-1428-CN2; 69 FR 60242) correction notice</u> (C) <u>69 FR 78526 (CMS-1428-F2) correction notice</u>	(A) <u>August 11, 2004 (CMS-1428-F; 69 FR 48916) final rule</u> (B) <u>October 7, 2004 (CMS-1428-CN2; 69 FR 60242) correction notice</u> (C) <u>69 FR 78526 (CMS-1428-F2) correction notice</u>	(A) <u>August 12, 2005 (CMS-1500-F; 70 FR 47278) final rule</u> (B) <u>September 30, 2005 70 FR 57161 (CMS-1500-CN) correction notice</u>
<u>Capital wage index</u>	<u>Tables 4A-4C beginning on (A) page 57736</u>	<u>Tables 4A₁ - 4C₂ beginning on (C) page 78619</u>		<u>Tables 4A-4C beginning on (A) page 47580 as corrected by Tables 4A -4C beginning on (B) page 57163</u>
<u>Capital market basket</u>	<u>Not applicable</u>	<u>0.7% ((A) page 49285)</u>		<u>0.8% ((A) page 47500)</u>
<u>Capital standard federal payment rate</u>	<u>\$414.18 ((B) page 57735, Table 1D)</u>	<u>\$416.73 (\$413.83 x 1.007)</u>		<u>\$420.06 (\$416.73 x 1.008)</u>
<u>Complex Spinal Surgery DRGs</u>	<u>496, 497, 498, 519, 520, 531,532</u>			<u>496, 497, 498, 519, 520, 531, 532, 546 (page 47308 of (A))</u>
<u>Fixed Loss Outlier Threshold</u>	<u>\$ 31,000 ((A) page 45477)</u>	<u>\$ 25,800 ((A) page 49278)</u>		<u>\$23,600 ((A) page 47494)</u>
<u>Labor-Related National Standard Operating Rate</u>	<u>\$3,136.39 ((B) page 57735, Table 1A)</u>	<u>\$4,569.83 (\$4,423.84 x 1.033)</u>		<u>\$4,738.91 (\$4,569.83 x 1.037)</u>

	<u>Discharges Occurring On or After 1/1/2004</u>	<u>Discharges Occurring On or After 11/29/2004</u>	<u>Discharges Occurring On or After 7/1/2005</u>	<u>Discharges Occurring On or After 12/1/2005</u>
<u>Operating Wage Index</u>	<u>Tables 4A-4C beginning on (A) page 57736; PIF: Operating Wage Index location (WIGRN)</u>	<u>Tables 4A₁ - 4C₂ beginning on (C) page 78619; PIF: Final Wage Index location (WIGRN)</u>		<u>Tables 4A-4C beginning on (A) page 47580 as corrected by Tables 4A -4C beginning on (B) page 57163; PIF: Post Reclass Wage Index location</u>
<u>Labor-Related Portion</u>	<u>Table 1A beginning on B page 57735</u>	<u>For wage indexes greater than 1.0, the labor-related portion is 71.066% of the standard operating rate. For wage indexes less than or equal to 1.0, the labor-related portion is 62 %. (A) page 49070</u>		<u>For wage indexes greater than 1.0, the labor-related portion is 69.731% of the standard operating rate. For wage indexes less than or equal to 1.0, the labor-related portion is 62 %. (A) page 47393</u>
<u>Post-acute care transfer to a rehabilitation hospital or unit or long-term hospital qualifying DRGs</u>	<u>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 (A) beginning at page 45413</u>		<u>DRGs 12, 14, 24, 25, 88, 89, 90, 113, 121, 122, 127, 130, 131, 236, 239, 277, 278, 294, 296, 297, 320, 321, 395, 429, 468, 541 or 542 (B) beginning at page 60246</u>	<u>DRGs designated with a “yes” in “FY06 Final Rule Post-acute Care DRG” column in Table 5 (A) beginning at page 47617 and (B) beginning at page 57163</u>
<u>Post-acute care transfer qualifying DRGs</u>	<u>DRGs 209, 210 or 211 (A) beginning at page 45413</u>			<u>DRGs 7, 8, 210, 211, 233, 234, 471, 497, 498, 544, 545, 549, or 550 (A) beginning at page 47617 and (B) beginning at page 57163</u>

	<u>Discharges</u> <u>Occurring On or</u> <u>After</u> <u>12/1/2006</u>	<u>Discharges</u> <u>Occurring On or</u> <u>After 3/1/2007</u>	<u>Discharges</u> <u>Occurring On or</u> <u>After</u> <u>1/1/2008</u>	<u>Discharges</u> <u>Occurring On or</u> <u>After</u> <u>12/1/2008</u>
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<u>Applicable FR Notices</u>	<u>(A) August 18, 2006 (CMS-1488-F; 71 FR 47870)</u> <u>(B) October 11, 2006 (CMS-1488-N; 71 FR 59886)</u> <u>additional notice</u>	<u>(A) August 18, 2006 (CMS-1488-F; 71 FR 47870)</u> <u>(B) October 11, 2006 (CMS-1488-N; 71 FR 59886)</u> <u>additional notice</u> <u>(C) January 5, 2007 (CMS-1488-CN2; 72 fr 569)</u> <u>correction notice</u>	<u>(A) August 22, 2007 (CMS-1533-FC; 72 FR 47130)</u> <u>final rule</u> <u>(B) October 10, 2007 72 FR 57634 (CMS-1533-CN2)</u> <u>correction notice</u>	<u>(A) August 19, 2008 (CMS-1390-F; 73 FR 48434)</u> <u>final rule</u> <u>(B) October 3, 2008 73 FR 57888 (CMS-1390-N)</u> <u>correction notice</u>
<u>Capital wage index</u>	<u>Tables 4A-1 - 4C-1 (for discharges before 4/1/2007) and Tables 4A-2-4C2 (for discharges occurring on or after 4/1/2007) beginning on (B) page 59975</u>		<u>Tables 4A -4C beginning on (B) page 57698</u>	<u>Tables 4A-4C beginning on (B) page 57956</u>
<u>Capital market basket</u>	<u>1.10% ((A) page 48163)</u>		<u>1.3% ((A) page 47426)</u>	<u>1.4% ((A) page 48776)</u>
<u>Capital standard federal payment rate</u>	<u>\$424.68 (\$420.06 x 1.0110)</u>		<u>\$430.20 (\$424.68 x 1.013)</u>	<u>\$436.22 (\$430.20 x 1.014)</u>
<u>Complex Spinal Surgery DRGs</u>			<u>028, 029, 030, 453, 454, 455, 456, 457, 458, 459, 460, 471, 472, 473</u>	
<u>Fixed Loss Outlier Threshold</u>	<u>\$24,485 ((A) page 59890)</u>		<u>\$22,185 ((A) Page 66887)</u>	<u>\$20,045 ((A) page 57891)</u>
<u>Labor-Related National Standard Operating Rate</u>	<u>\$4,900.03 (\$4,738.91 x 1.034)</u>		<u>\$5,061.73 (\$4,900.03 x 1.033)</u>	<u>\$5,243.95 (\$5,061.73 x 1.036)</u>

<u>Operating Wage Index</u>	<u>Tables 4A-1 - 4C-1 (for discharges before 4/1/2007) and Tables 4A-2-4C2 (for discharges occurring on or after 4/1/2007) beginning on (B) page 59975; PIF: Post Reclass Wage Index a (for first half FY 2007) and Post Reclass Wage Index b (for second half FY 2007)</u>		<u>Tables 4A -4C beginning on (B) page 57698; PIF: Post Reclass Wage Index location</u>	<u>Tables 4A-4C beginning on (B) page 57956; PIF: Post Reclass Wage Index location</u>
<u>Labor-Related Portion</u>	<u>For wage indexes greater than 1.0, the labor-related portion is 69.731% of the standard operating rate. For wage indexes less than or equal to 1.0, the labor-related portion is 62 %. (A) page 48029</u>		<u>For wage indexes greater than 1.0, the labor-related portion is 69.731% of the standard operating rate. For wage indexes less than or equal to 1.0, the labor-related portion is 62%. (A) page 47344</u>	<u>For wage indexes greater than 1.0, the labor-related portion is 69.731% of the standard operating rate. For wage indexes less than or equal to 1.0, the labor-related portion is 62%. (A) page 48592</u>
<u>Post-acute care transfer to a rehabilitation hospital or unit or long-term hospital qualifying DRGs</u>	<u>DRGs designated with a “yes” in the “FY 07 Final Rule Post -acute Care DRG” column in Table 5 (B) beginning at page 60013</u>	<u>DRGs designated with a “yes” in the “FY 07 Final Rule Post -acute Care DRG” column in Table 5 (B) beginning at page 60013 and (C) beginning at page 573</u>	<u>Medicare Severity DRGs designated with a “yes” in the “FY08 Final Rule Post-Acute DRG” column in Table 5 (A) beginning at page 47539 and (B) at page 57727</u>	<u>Medicare Severity DRGs designated with a “yes” in the “FY09 Final Rule Post-Acute DRG” column in Table 5 (A) beginning at page 48899</u>

<u>Post-acute care transfer qualifying DRGs</u>	<u>DRGs 7, 8, 210, 211, 233, 234, 471, 497, 498, 545, 549, or 550 (B) beginning at page 60013</u>	<u>DRGs 7, 8, 210, 211, 233, 234, 471, 497, 498, 544, 545, 549, or 550 (B) beginning at page 60013 and (C) beginning at page 573</u>	<u>Medicare-Severity DRGs designated with a “yes” in the “FY08 Final Rule Special Pay DRG” column in Table 5 (A) beginning at page 47539 and (B) at page 57727</u>	<u>Medicare-Severity DRGs designated with a “yes” in the “FY09 Final Rule Special Pay DRG” column in Table 5 (A) beginning at page 48899</u>
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	<u>Discharges Occurring On or After 12/1/2009</u>			
<u>Applicable FR Notices</u>	<u>(A) August 27, 2009 (CMS-1406-F;FR 43754) final rule (B) October 7, 2009 (CMS-1406-CN ;74 FR 51496) correction notice</u>			
<u>Capital wage index</u>	<u>Tables 4A-4C beginning on page (A)44085 as corrected by Tables 4A-4C beginning on (B) page 51505 for certain areas</u>			
<u>Capital market basket</u>	<u>1.2% ((B) page 51498)</u>			
<u>Capital standard federal payment rate</u>	<u>\$441.46 (\$436.22 x 1.012)</u>			
<u>Complex Spinal Surgery DRGs</u>				
<u>Fixed Loss Outlier Threshold</u>	<u>\$23,140 ((A) page 44011)</u>			
<u>Labor-Related</u>	<u>\$5,354.08</u>			

	<u>Discharges Occurring On or After 12/1/2009</u>			
<u>National Standard Operating Rate</u>	<u>(\$5,243.95 x 1.021)</u>			
<u>Operating Wage Index</u>	<u>Tables 4A-4C beginning on page (A)44085 as corrected by Tables 4A-4C beginning on (B) page 51505 for certain areas; PIF: Post Reclass Wage Index location</u>			
<u>Labor-Related Portion</u>	<u>For wage indexes greater than 1.0, the labor-related portion is 68.802% of the standard operating rate. For wage indexes less than or equal to 1.0, the labor-related portion is 62%. (A) page 43856</u>			
<u>Post-acute care transfer to a rehabilitation hospital or unit or long-term hospital qualifying DRGs</u>	<u>Medicare-Severity DRGs designated with a “yes” in the “FY 2010 Final Rule Post-Acute DRG” column in Table 5 (A) beginning at page 44126</u>			
<u>Post-acute care transfer qualifying DRGs</u>	<u>Medicare-Severity DRGs designated with a “yes” in the “FY2010 Final Rule Special Pay DRG” column in</u>			

	<u>Discharges Occurring On or After 12/1/2009</u>			
	<u>Table 5 (A) beginning at page 44126</u>			

(c) Payment Impact File by Date of Discharge

(1) The Payment Impact File can be accessed at: <http://www.cms.gov/AcuteInpatientPPS/> and the referenced sections are incorporated by reference and will be made available upon request to the Administrative Director.

	<u>Discharges Occurring On or After 1/1/2004</u>	<u>Discharges Occurring On or After 11/29/2004</u>	<u>Discharges Occurring On or After 12/1/2005</u>	<u>Discharges Occurring On or After 12/1/2006</u>
<u>Applicable Payment Impact File (PIF)</u>	<u>FY2004 Final Rule Impact File</u>	<u>FY2005 Final Rule Impact File</u>	<u>FY2006 Final Rule Impact File</u>	<u>FY2007 Final Rule Impact File</u>
<u>Capital geographic adjustment factor</u>	<u>PIF: Capital Wage Index</u>	<u>PIF:POST RECLASS GAF</u>	<u>PIF:WICGRN</u>	<u>PIF:Post Reclass GAF a (for first half FY 2007) and Post Reclass GAF b (for capital second half FY 2007)</u>
<u>Large Urban Add-on</u>	<u>PIF: Post-Reclassification Urban/Rural location</u>	<u>PIF: Standardized payment location</u>	<u>PIF:URSPA</u>	<u>PIF:URSPA</u>
<u>Capital Disproportionate Share Adjustment Factor</u>	<u>PIF: Capital Disproportionate Share Adjustment location (DSHCPG)</u>	<u>PIF: Capital Disproportionate Share (DSH) Adjustment location (CAPITAL DSH ADJ.)</u>	<u>PIF: Capital Disproportionate Share (DSH) Adjustment location (DSHCPG)</u>	<u>PIF: Capital Disproportionate Share (DSH) Adjustment location (DSHCPG)</u>
<u>Capital Indirect Medical Education Adjustment Factor</u>	<u>PIF: Capital IME Adjustment location (TCHCP)</u>	<u>PIF: IME adjustment factor for capital PPS location (IME ADJUSTMENT-CAPITAL)</u>	<u>PIF: IME adjustment factor for capital PPS location (TCHCP)</u>	<u>PIF: IME adjustment factor for capital PPS location (TCHCP)</u>

	<u>Discharges Occurring On or After 1/1/2004</u>	<u>Discharges Occurring On or After 11/29/2004</u>	<u>Discharges Occurring On or After 12/1/2005</u>	<u>Discharges Occurring On or After 12/1/2006</u>
<u>Operating Wage Index</u>	<u>Tables 4A-4C beginning on (A) page 57736; PIF: Operating Wage Index location (WIGRN)</u>	<u>Tables 4A₁ - 4C₂ beginning on (C) page 78619; PIF: Final Wage Index location (WIGRN)</u>	<u>Tables 4A-4C beginning on (A) page 47580 as corrected by Tables 4A -4C beginning on (B) page 57163; PIF: Post Reclass Wage Index location</u>	<u>Tables 4A-1 - 4C-1 (for discharges before 4/1/2007) and Tables 4A-2-4C2 (for discharges occurring on or after 4/1/2007) beginning on (B) page 59975; PIF: Post Reclass Wage Index a (for first half FY 2007) and Post Reclass Wage Index b (for second half FY 2007)</u>
<u>Operating Disproportionate Share Adjustment Factor</u>	<u>PIF: Operating DSH Adjustment Factor location (DSHOPG)</u>	<u>PIF: Operating Disproportionate Share (DSH) Adjustment Factor location (OPERATING DSH ADJ.)</u>	<u>PIF: Operating Disproportionate Share (DSH) Adjustment Factor location (DSHOPG)</u>	<u>PIF: Operating Disproportionate Share (DSH) Adjustment Factor location (DSHOPG)</u>
<u>Operating Indirect Medical Education Adjustment</u>	<u>PIF: Operating IME Adjustment location (TCHOP)</u>	<u>PIF: IME Adjustment Factor for Operating PPS location (IME ADJUSTMENT OPERATING)</u>	<u>PIF: IME Adjustment Factor for Operating PPS location (TCHOP)</u>	<u>PIF: IME Adjustment Factor for Operating PPS location (TCHOP)</u>
<u>Sole Community Hospital – Hospital Specific Rate</u>	<u>PIF: Hospital - Specific Rate location (HSPPUB)</u>	<u>PIF: Sole Community Hospital Cost/Case 1982/1987 and Sole Community Hospital Cost/Case 1996 locations</u>	<u>PIF: 82/87 Hospital Specific Rate Updated to FY 2006 (OLDHSPPS) and 1996 Hospital Specific Rate Updated to FY 2006 (HSP96) locations</u>	<u>PIF: 82/87/96 Hospital Specific Rate Updated to FY 2007 for SCH Providers location (HSP Rate)</u>

	<u>Discharges Occurring On or After 1/1/2004</u>	<u>Discharges Occurring On or After 11/29/2004</u>	<u>Discharges Occurring On or After 12/1/2005</u>	<u>Discharges Occurring On or After 12/1/2006</u>
<u>Cost-to-Charge Ratio</u>	<u>PIF: Operating Cost-to-Charge Ratio location (OPCCR) and Capital Cost-to-Charge location (CPCCR)</u>	<u>PIF: Operating Cost-to-Charge Ratio location (OPCCR) and Capital Cost-to-Charge location (CPCCR)</u>	<u>PIF: Operating Cost-to-Charge Ratio location (OPCCR) and Capital Cost-to-Charge location (CPCCR)</u>	<u>PIF: Operating Cost-to-Charge Ratio location (OPCCR) and Capital Cost-to-Charge location (CPCCR)</u>

	<u>Discharges Occurring On or After 1/1/2008</u>	<u>Discharges Occurring On or After 12/1/2008</u>	<u>Discharges Occurring On or After 12/1/2009</u>	
<u>Applicable Payment Impact File (PIF)</u>	<u>FY2008 Final Rule</u>	<u>FY2009 Final Rule</u>	<u>FY2010 Correction Notice</u>	
<u>Capital Geographic Adjustment Factor</u>	<u>Post Reclass GAF</u>	<u>Post Reclass GAF</u>	<u>Post Reclass GAF</u>	
<u>Capital Disproportionate Share Adjustment Factor</u>	<u>PIF: Capital Disproportionate Share (DSH) Adjustment location (DSHCPG)</u>	<u>PIF: Capital Disproportionate Share (DSH) Adjustment location (DSHCPG)</u>	<u>PIF: Capital Disproportionate Share (DSH) Adjustment location (DSHCPG)</u>	
<u>Capital Indirect Medical Education Adjustment Factor</u>	<u>PIF: IME adjustment factor for capital PPS location (TCHCP)</u>	<u>PIF: IME adjustment factor for capital PPS location (TCHCP)</u>	<u>PIF: IME adjustment factor for capital PPS location (TCHCP)</u>	
<u>Operating Wage Index</u>	<u>Tables 4A -4C beginning on (B) page 57698; PIF: Post Reclass Wage Index location</u>	<u>Tables 4A-4C beginning on (B) page 57956; PIF: Post Reclass Wage Index location</u>	<u>Tables 4A-4C beginning on page (A)44085 as corrected by Tables 4A-4C beginning on (B) page 51505 for certain areas; PIF: Post Reclass Wage Index location</u>	
<u>Operating Disproportionate Share Adjustment Factor</u>	<u>PIF: Operating Disproportionate Share (DSH) Adjustment Factor location (DSHOPG)</u>	<u>PIF: Operating Disproportionate Share (DSH) Adjustment Factor location (DSHOPG)</u>	<u>PIF: Operating Disproportionate Share (DSH) Adjustment Factor location (DSHOPG)</u>	
<u>Operating Indirect Medical Education Adjustment</u>	<u>PIF: IME Adjustment Factor for Operating PPS location (TCHOP)</u>	<u>PIF: IME Adjustment Factor for Operating PPS location (TCHOP)</u>	<u>PIF: IME Adjustment Factor for Operating PPS location</u>	

			<u>(TCHOP)</u>	
<u>Sole Community Hospital – Hospital Specific Rate</u>	<u>PIF: 82/87/96 Hospital Specific Rate Updated to FY 2008 for SCH Providers location (HSP Rate)</u>	<u>PIF: 82/87/96 Hospital Specific Payment (HSP) Rate Updated to FY 2009 for SCH Providers location (HSP Rate)</u>	<u>PIF: 82/87/96 Hospital Specific Payment (HSP) Rate Updated to FY 2010 for SCH Providers location (FY10HSP Rate)</u>	
<u>Cost-to-Charge Ratio</u>	<u>PIF: Operating Cost-to-Charge Ratio location (OPCCR) and Capital Cost-to-Charge location (CPCCR)</u>	<u>PIF: Operating Cost-to-Charge Ratio location (Operating CCR) and Capital Cost-to-Charge location (Capital CCR)</u>	<u>PIF: Operating Cost-to-Charge Ratio location (Operating CCR) and Capital Cost-to-Charge location (Capital CCR)</u>	

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