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-Hospital Outpatient Departments and Ambulatory Surgical Centers
Services on or after January 1, 2004

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

(a) "Adjusted Conversion Factor" is determined as follows: unadjusted conversion factor x (1-labor-related share + (labor-related share x wage index)). For each update, the unadjusted conversion factor for the preceding period is adjusted by the rate of change in the market basket inflation factor. The market basket inflation factor and labor-related share are specified in the Federal Register notices announcing revisions in the Medicare payment rates. See Section 9789.39(b) for the unadjusted conversion factor, market basket inflation factor, and labor-related share by date of service.

For services rendered on or after February 15, 2006, in accordance with Section 411 of Pub. L. 108-173 and the final rule published in the Federal Register of November 10, 2005 (CMS-1501-FC, 70 FR 68516) at page 68556, the "Adjusted Conversion Factor" for a rural Sole Community Hospital (SCH) includes an adjustment factor of 1.071, which document is incorporated by reference and will be made available upon request to the Administrative Director.

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

(c) "Ambulatory Surgical Center (ASC)" means any surgical clinic as defined in the California Health and Safety Code Section 1204, subdivision (b)(1), any ambulatory surgical center that is certified to participate in the Medicare program under Title XVIII (42 U.S.C. SEC. 1395 et seq.) of the federal Social Security Act, or any surgical clinic accredited by an accrediting agency as approved by the Licensing Division of the Medical Board of California pursuant to Health and Safety Code Sections 1248.15 and 1248.4 to use anesthesia, except local anesthesia or peripheral nerve blocks, or both, in compliance with the community standard of practice, in doses that, when administered have the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes.

(d) "Ambulatory Surgical Center Payment System" means Medicare's payment system for specific ambulatory surgical center covered surgical procedures published in the Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems final rule for the relevant payment year.

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

(f) "APC Payment Rate" means CMS' hospital outpatient prospective payment system rate. The APC payment rate is specified in the Federal Register notices announcing revisions in the Medicare payment rates. See Section 9789.39(b) for the Federal Register reference to the APC payment rate by date of service.

(g) "APC Relative Weight" means CMS' APC relative weight as set forth in CMS' hospital outpatient prospective payment system. The APC relative weight is specified in the Federal Register notices announcing revisions in the Medicare payment rates. See Section 9789.39(b) for the Federal Register reference to the APC relative weight by date of service.

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

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

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

(k) “Facility Only Services” means services, defined by Medicare, that rarely or are never performed in the non-facility setting, and are not: 1. emergency room visits; 2. Surgical procedures; or 3. An integral part of the emergency room visit or surgical procedure, in accordance with section 9789.32. See section 9789.39(b) for the CMS Physician Fee Schedule Relative Value File which contains the description of the Facility Only Services by date of service.

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

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

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

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

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

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

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

(s) “Labor-related Share” means the portion of the payment rate that is attributable to labor and labor-related cost determined by CMS, pursuant to Section 1833(t)(2)(D) of the Social Security Act and as specified in the Federal Register notices announcing revisions in the Medicare payment rates. See Section 9789.39(b) for the Federal Register reference that references the labor-related share by date of service.

(t) "Market Basket Inflation Factor" means the market basket percentage change determined by CMS as set forth in the Federal Register notices announcing revisions in the Medicare payment rates. See Section 9789.39(b) for the Federal Register reference to the market basket inflation factor by date of service.

(u) “Other Services” means Hospital Outpatient Department Services rendered on or after September 1, 2014, but before December 15, 2016, to hospital outpatients and payable under the CMS hospital outpatient prospective payment system that are not: 1. Surgical procedures; 2. Emergency room visits; 3. Facility Only Services; or 4. An integral part of the surgical procedure, emergency room visit or Facility Only Service.

For services rendered on or after December 15, 2016, “Other Services” means Hospital Outpatient Department Services rendered to hospital outpatients and payable under the CMS hospital outpatient prospective payment system that are not: 1. Surgical procedures; 2. Emergency room visits; or 3. An integral part of the surgical procedure or emergency room visit.

(v) “Outlier Threshold” means the Medicare outlier threshold used in determining high cost outlier payments.

(w) “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 outpatient department or ambulatory surgical center.

(x) “OMFS RBRVS” means the Official Medical Fee Schedule for physician and non-physician practitioner services in accordance with sections 9789.12 through 9789.19.

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

(z) "Total Operating Costs" means the direct cost incurred in providing care to patients. Included in operating cost are: salaries and wages, rent or mortgage, employee benefits, supplies, equipment purchase and maintenance, professional fees, advertising, overhead, etc. It does not include start up costs.

(aa) "Wage Index" means CMS' wage index for urban, rural and hospitals that are reclassified as described in CMS' Hospital Outpatient Prospective Payment System (HOPPS) and wage index values as specified in the Hospital Inpatient Prospective Payment Systems set forth in the Federal Register notices announcing revisions in the Medicare payment rates. See Section 9789.39(b) for the Federal Register reference that contains description of the wage index and wage index values by date of service.

(ab) For services payable under Sections 9789.30 through 9789.39, "Workers' Compensation Multiplier" means the multiplier to the Medicare rate adopted by the AD in accordance with Labor Code Section 5307.1, or the multiplier that includes an extra percentage reimbursement for high cost outlier cases, by date of service.

Date of Service	Hospital Outpatient Department Services that are: Surgical Procedures; Emergency Room visits; or services that are an integral part of the surgical procedure or emergency room visit Multipliers (A) Medicare multiplier; (B) multiplier that includes an extra percentage reimbursement for high cost outlier cases	Ambulatory Surgical Centers Surgical Procedures Multipliers (A) Medicare multiplier; (B) multiplier that includes an extra percentage reimbursement for high cost outlier cases	Hospital Outpatient Department Services (as defined in Section 9789.30(q)) that are Facility Only Services (as defined in Section 9789.30(k)) Multiplier (B) multiplier that includes an extra percentage reimbursement for high cost outlier cases	Hospital Outpatient Department Services (as defined in Section 9789.30(q)) that are Other Services (as defined in Section 9789.30(u)) Multiplier (B) multiplier that includes an extra percentage reimbursement for high cost outlier cases
Before January 1, 2013	(A) 120%; (B) 122%	(A) 120%; (B) 122%	Not applicable. Payable under Sections 9789.10 and 9789.11	Not applicable. Payable under Sections 9789.10 and 9789.11
On or after January 1, 2013, but before September 1, 2014	(A) 120%; (B) 122%	(A) 80%; (B) 82%	Not applicable. Payable under Sections 9789.10 and 9789.11	Not applicable. Payable under Sections 9789.10 and 9789.11
On or after September 1, 2014, but before December 15, 2016	(B) 121.2%	(B) 80.81%	(B) 101.01%	Not applicable. Payable under Section 9789.32(c)
On or after December 15, 2016	(B) 117.8%	(B) 80.81%	Not applicable. These services are payable as “Other Services”.	(B) 101.01%

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

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

(a) The Administrative Director incorporates by reference, the Centers for Medicare and Medicaid Services' (CMS) Hospital Outpatient Prospective Payment System (HOPPS) certain addenda published in the Federal Register notices announcing revisions in the Medicare payment rates. See Section 9789.39(b) for the adopted payment system addenda by date of service.

(b) For services rendered on or after July 15, 2005, the Administrative Director incorporates by reference, the Centers for Medicare and Medicaid Services' (CMS) Hospital Inpatient Prospective Payment Systems (IPPS) certain tables published in the Federal Register notices announcing revisions in the Medicare payment rates. See Section 9789.39(b) for the adopted payment system tables by date of service.

(c) For services rendered on or after July 15, 2005, the Administrative Director incorporates by reference, the Hospital Inpatient Prospective Payment Systems (IPPS) "Payment Impact File" published by the federal Centers for Medicare & Medicaid Services (CMS) in effect as of the date the Administrative Director Order becomes effective, which document is found at http://www.cms.hhs.gov/AcuteInpatientPPS/.

(d) For services rendered on or after September 1, 2014, but before December 15, 2016, the Administrative Director incorporates by reference, the Medicare Physician Fee Schedule "Relative Value File" published by the federal Centers for Medicare & Medicaid Services (CMS), which document is found at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html?redirect=/PhysicianFeeSched/. See Section 9789.39(b) for the adopted Relative Value File by date of service.

(e) For services rendered on or after December 15, 2016, the Administrative Director incorporates by reference the Centers for Medicare and Medicaid Services' (CMS) Ambulatory Surgical Centers Payment System particular columns of certain addenda published in the Federal Register notices announcing revisions in the Medicare payment rates. See Section 9789.39(b) for the adopted payment system addenda by date of service.

(f) The Administrative Director incorporates by reference certain sections of the Centers for Medicare and Medicaid Services' (CMS) Claims Processing Manual, Chapter 4. See Section 9789.39(b) for the adopted sections of Chapter 4, by date of service.

(g) The Administrative Director incorporates by reference certain sections of the Centers for Medicare and Medicaid Services' Integrated Outpatient Code Editor (I/OCE) CMS Specifications. See Section 9789.39(b) for the adopted sections of I/OCE CMS Specifications, by date of service.

(h) The Administrative Director incorporates by reference the American Medical Associations' "Current Procedural Terminology," 4th Edition, annual revision in effect as of the date the Administrative Director Order becomes effective. Copies of the Current Procedural Terminology may be purchased from the American Medical Association:

Order Department
American Medical Association
P.O. Box 930876
Atlanta, GA 31193-0876

Or over the internet at: www.amapress.com
Or through the American Medical Association's toll free order line: (800) 621-8335.

(i) The Administrative Director incorporates by reference CMS' Alphanumeric "Healthcare Common Procedure Coding System (HCPCS)" annual revision in effect as of the date the Administrative Director Order becomes effective. Copies of the Healthcare Common Procedure Coding System (HCPCS) may be purchased from the American Medical Association:

Order Department
American Medical Association
P.O. Box 930876
Atlanta, GA 31193-0876

Or over the internet at: www.amapress.com
Or through the American Medical Association's toll free order line: (800) 621-8335.

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

Section 9789.32. Outpatient Hospital Departments and Ambulatory Surgical Centers Fee Schedule — Applicability.

(a) Sections 9789.30 through 9789.39 shall be applicable to the maximum allowable fees for emergency room visits and surgical procedures provided on an outpatient basis rendered on or after July 1, 2004, but before September 1, 2014. Sections 9789.30 through 9789.39 shall be applicable to the maximum allowable fees for emergency room visits, surgical procedures, and Facility Only Services provided on an outpatient basis rendered on or after September 1, 2014, but before December 15, 2016. Sections 9789.30 through 9789.39 shall be applicable to the maximum allowable fees for services provided on an outpatient basis and payable under the Medicare (CMS) HOPPS rendered on or after December 15, 2016. For purposes of this section, emergency room visits and surgical procedures shall be defined by HCPCS codes set forth in section 9789.39(b) by date of service. A supply, drug, device, blood product and biological is considered an integral part of an emergency room visit, or surgical procedure, or, if applicable, Facility Only Service, or if applicable and only if rendered on or after December 15, 2016, Other Service if:

(1)

Date of Service	Supply, Drug, Device, Blood Product, or Biological
For services rendered before March 1, 2008	The item has a status code N and is packaged into the APC payment for the emergency room visit or surgical procedure (in which case no additional fee is allowable).

For services rendered on or after March 1, 2008 but before March 1, 2009	The item has a status code N or Q and is packaged into the APC payment for the emergency room visit or surgical procedure (in which case no additional fee is allowable).
For services rendered on or after March 1, 2009 but before September 1, 2014	The item has a status code N, Q1, Q2, or Q3 and is packaged into the APC payment for the emergency room visit or surgical procedure (in which case no additional fee is allowable).
For services rendered on or after September 1, 2014 but before December 15, 2016	The item has a status code N, Q1, Q2, or Q3 and is packaged into the APC payment for the emergency room visit, surgical procedure, or Facility Only Service (in which case no additional fee is allowable).
For services rendered on or after December 15, 2016	The item has a status code N, Q1, Q2, or Q3 and is packaged into the APC payment for the emergency room visit, surgical procedure, or Other Service (in which case no additional fee is allowable).

(2)

Date of Service	**Supply, Drug, Device, Blood Product, or Biological**
For services rendered before March 1, 2009	The item is furnished in conjunction with an emergency room visit or surgical procedure and has been assigned Status Code G, H or K.
For services rendered on or after March 1, 2009 but before September 1, 2014	The item is furnished in conjunction with an emergency room visit or surgical procedure and has been assigned status code G, H, K, R, or U.
For services rendered on or after September 1, 2014 but before December 15, 2016	The item is furnished in conjunction with an emergency room visit, surgical procedure, or Facility Only Service, and has been assigned status code G, H, K, R, or U.
For services rendered on or after December 15, 2016	The item is furnished in conjunction with an emergency room visit, surgical procedure, or Other Service and has been assigned status code G, H, K, R, or U.

(b) Sections 9789.30 through 9789.39 apply to any hospital outpatient department as defined in Section 9789.30(p) and any ASC as defined in Section 9789.30(c).

(c) This subsection (c) is inapplicable for dates of services on or after December 15, 2016. Depending on date of service, the maximum allowable fees for services, drugs and supplies furnished by hospitals that do not meet the requirements in (a) for a facility fee payment and are not bundled in the APC payment rate for services in (a) will be determined as follows:

(1)(A) For services rendered before September 1, 2014, the maximum allowable hospital outpatient facility fees for professional medical services which are performed by physicians and other licensed health care providers to hospital outpatients shall be paid according to Section 9789.10 and Section 9789.11.

(B) For Other Services rendered on or after September 1, 2014, but before December 15, 2016, to hospital outpatients, the maximum allowable hospital outpatient facility fees shall be paid according to the OMFS RBRVS.

(i) If the Other Service has a Professional Component/Technical Component under the OMFS RBRVS, the hospital outpatient facility fee shall be the Technical Component amount determined according to the OMFS RBRVS.

(ii) For Other Services, which do not meet the requirement in (i), the hospital outpatient facility fee shall be determined based solely on the non-facility practice expense relative value units applicable under the OMFS RBRVS.

The base facility fee is calculated as follows: Non-Facility Site of Service Practice Expense (PE) Relative Value Unit (RVU) * Statewide Geographic Adjustment Factor (GAF) for PE * RBRVS Conversion Factor (CF) = Base facility fee.

(d) Hospital Outpatient Departments and ASCs should utilize other applicable parts of the OMFS to determine maximum allowable fees for services or goods not covered by the Hospital Outpatient Departments and Ambulatory Surgical Centers fee schedule (Sections 9789.30 through 9789.39).

(1) The fees for any physician and non-physician practitioner professional services shall be determined in accordance with the OMFS RBRVS.

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

(3) The maximum allowable fee for drugs not otherwise covered by a Medicare fee schedule payment for facility services shall be determined pursuant to Labor Code Section 5307.1, or, where applicable, Section 9789.40.

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

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

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

(e) For services rendered before September 1, 2014, only hospitals may charge or collect a facility fee for emergency room visits. Only hospital outpatient departments and ambulatory surgical centers as defined in Section 9789.30(p) and Section 9789.30(c) may charge or collect a facility fee for surgical services provided on an outpatient basis.

For services rendered on or after September 1, 2014, but before December 15, 2016, only hospitals may charge or collect a facility fee for emergency room visits, Facility Only Services, and Other Services. Only hospital outpatient departments and ambulatory surgical centers as defined in Section 9789.30(p) and Section 9789.30(c) may charge or collect a facility fee for surgical services provided on an outpatient basis. Facility fees are not payable to an ambulatory surgical center for any services that are not an integral part of a surgical service.

For services rendered on or after December 15, 2016, only hospitals as defined in Section 9789.30(p) may charge or collect a facility fee for Hospital Outpatient Department Services rendered to a hospital outpatient and payable under the Medicare (CMS) HOPPS. Ambulatory surgical centers as defined in Section 9789.30(c) may charge or collect a facility fee for only surgical services or services that are an integral part of the surgical service provided on an outpatient basis and payable under the Medicare (CMS) HOPPS. Facility fees are not payable to an ambulatory surgical center for any services that are not an integral part of a surgical service. Only ambulatory surgical centers may charge or collect a facility fee for its services.

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

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

(h) Out of state hospital outpatient departments and ambulatory surgical centers are exempt from this fee schedule.

(i) Hospital outpatient departments and ambulatory surgical centers billing for facility fees and other services under this Section shall be submitted in accordance with the e-billing regulations beginning with Section 9792.5.0 or the standardized paper billing regulations beginning with Section 9792.5.2.

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

Section 9789.33. Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule — Determination of Maximum Reasonable Fee.

(a) In accordance with section 9789.32, the maximum allowable payment for hospital outpatient department or ambulatory surgical center facility fees for services provided on an outpatient basis and payable under the Medicare (CMS) HOPPS, shall be determined based on the following. In accordance with Section 9789.30(ab), an extra percentage reimbursement shall be used in lieu of an additional payment for high cost outlier cases.

Standard payment.

Date of Service	Status Code Indicators	Hospital Outpatient Department Services that are: Surgical procedures; Emergency Room Visits; or services that are an integral part of the surgical procedure or emergency room visit	Ambulatory Surgical Centers surgical procedures	Hospital Outpatient Department Services (as defined in Section 9789.30(q)) that are Facility Only Services (as defined in Section 9789.30(k))	Hospital Outpatient Department Services (as defined in Section 9789.30(q)) that are Other Services (as defined in Section 9789.30(u))
For services rendered before March 1, 2008	"S", "T", "X", or "V"	APC relative weight x adjusted conversion factor x 1.22 workers' compensation multiplier, pursuant to Section 9789.30(ab). See Section 9789.39(b) for the APC relative weight by date of service.	APC relative weight x adjusted conversion factor x 1.22 workers' compensation multiplier, pursuant to Section 9789.30(ab). See Section 9789.39(b) for the APC relative weight by date of service.	Not applicable. Payable under Sections 9789.10 and 9789.11.	Not applicable. Payable under Sections 9789.10 and 9789.11.
For services rendered on or after March 1, 2008 but before March 1, 2009	"S", "T", "X", or "V", or "Q". Status code indicator "Q" must qualify for separate payment.	APC relative weight x adjusted conversion factor x 1.22 workers' compensation multiplier, pursuant to Section 9789.30(ab). See Section 9789.39(b) for the APC relative weight by date of service.	APC relative weight x adjusted conversion factor x 1.22 workers' compensation multiplier, pursuant to Section 9789.30(ab). See Section 9789.39(b) for the APC relative weight by date of service.	Not applicable. Payable under Sections 9789.10 and 9789.11.	Not applicable. Payable under Sections 9789.10 and 9789.11.

Date of Service	Status Code Indicators	Hospital Outpatient Department Services that are: Surgical procedures; Emergency Room Visits; or services that are an integral part of the surgical procedure or emergency room visit	Ambulatory Surgical Centers surgical procedures	Hospital Outpatient Department Services (as defined in Section 9789.30(q)) that are Facility Only Services (as defined in Section 9789.30(k))	Hospital Outpatient Department Services (as defined in Section 9789.30(q)) that are Other Services (as defined in Section 9789.30(u))
For services rendered on or after March 1, 2009 but before January 1, 2013	"S", "T", "X", or "V", "Q1", Q2", or "Q3". Status code indicators "Q1", "Q2", and "Q3" must qualify for separate payment.	APC relative weight x adjusted conversion factor x 1.22 workers' compensation multiplier, pursuant to Section 9789.30(ab). See Section 9789.39(b) for the APC relative weight by date of service.	APC relative weight x adjusted conversion factor x 1.22 workers' compensation multiplier, pursuant to Section 9789.30(ab). See Section 9789.39(b) for the APC relative weight by date of service.	Not applicable. Payable under Sections 9789.10 and 9789.11.	Not applicable. Payable under Sections 9789.10 and 9789.11.
For services rendered on or after January 1, 2013 but before September 1, 2014	"S", "T", "X", or "V", "Q1", Q2", or "Q3". Status code indicators "Q1", "Q2", and "Q3" must qualify for separate payment.	APC relative weight x adjusted conversion factor x 1.22 workers' compensation multiplier, pursuant to Section 9789.30(ab). See Section 9789.39(b) for the APC relative weight by date of service.	APC relative weight x adjusted conversion factor x 0.82 workers' compensation multiplier, pursuant to Section 9789.30(ab). See Section 9789.39(b) for the APC relative weight by date of service.	Not applicable. Payable under Sections 9789.10 and 9789.11.	Not applicable. Payable under Sections 9789.10 and 9789.11
For services rendered on	"S", "T", "X", or "V", "Q1",	APC relative weight x ad-	APC relative weight x ad-	APC relative weight x ad-	Payable under Section 9789.32(c)

Date of Service	Status Code Indicators	Hospital Outpatient Department Services that are: Surgical procedures; Emergency Room Visits; or services that are an integral part of the surgical procedure or emergency room visit	Ambulatory Surgical Centers surgical procedures	Hospital Outpatient Department Services (as defined in Section 9789.30(q)) that are Facility Only Services (as defined in Section 9789.30(k))	Hospital Outpatient Department Services (as defined in Section 9789.30(q)) that are Other Services (as defined in Section 9789.30(u))
or after September 1, 2014 but before December 15, 2016	Q2", or "Q3". Status code indicators "Q1", "Q2", and "Q3" must qualify for separate payment.	justed conversion factor x 1.212 workers' compensation multiplier, pursuant to Section 9789.30(ab). See Section 9789.39(b) for the APC relative weight by date of service.	justed conversion factor x 0.8081 workers' compensation multiplier, pursuant to Section 9789.30(ab). See Section 9789.39(b) for the APC relative weight by date of service.	justed conversion factor x 1.0101 workers' compensation multiplier, pursuant to Section 9789.30(ab). See Section 9789.39(b) for the APC relative weight by date of service.	
For services rendered on or after December 15, 2016	"S," "T," "V," "Q1," Q2," "Q3," "J1," or "J2." Status code indicators must qualify for separate payment.	APC relative weight x adjusted conversion factor x 1.178 workers' compensation multiplier, pursuant to Section 9789.30(ab). See Section 9789.39(b) for the APC relative weight by date of service.	APC relative weight x adjusted conversion factor x 0.8081 workers' compensation multiplier, pursuant to Section 9789.30(ab). See Section 9789.39(b) for the APC relative weight by date of service.	Not applicable. These services are payable as "Other Services".	APC relative weight x adjusted conversion factor x 1.0101 workers' compensation multiplier, pursuant to Section 9789.30(ab). See Section 9789.39(b) for the APC relative weight by date of service.

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

For services rendered before February 15, 2006, Table B in Section 9789.35 contains an "adjusted conversion factor" which incorporates the standard conversion factor, wage index and inflation factor.

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

The maximum payment rate for the listed hospital outpatient departments can be determined according to Table B and subdivision (a).

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

APC payment rate x workers’ compensation multiplier pursuant to Section 9789.30(ab), by date of service.

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

Documented paid cost, plus an additional 10% of the hospital outpatient department’s or ASC’s documented paid cost, net of immediate and anticipated price adjustments based upon the hospital outpatient department’s or ASC’s prior calendar year’s usage for comparable devices, not to exceed a maximum of $ 250.00, plus any sales tax and/or shipping and handling charges actually paid.

(3) Procedure codes for drugs and biologicals with status code indicator "K," unless rendered on or after December 15, 2016, and packaged into a procedure with a status code indicator “J1” or “J2,” in which case no additional fee is allowable:

APC payment rate x workers’ compensation multiplier pursuant to Section 9789.30(ab), by date of service.

(4) For services rendered on or after March 1, 2009: Procedure codes for blood and blood products with status code indicator “R,” unless rendered on or after December 15, 2016, and packaged into a procedure with a status code indicator “J1” or “J2,” in which case no additional fee is allowable:

APC relative weight x adjusted conversion factor x workers’ compensation multiplier pursuant to Section 9789.30(ab), by date of service. See section 9789.39(b) for APC relative weight by date of service.

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

Documented paid cost, plus an additional 10% of the hospital outpatient department’s or ASC’s documented paid cost, net of immediate and anticipated price adjustments based

upon the hospital outpatient department's or ASC's prior calendar year's usage for comparable devices, not to exceed a maximum of $ 250.00, plus any sales tax and/or shipping and handling charges actually paid.

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

APC relative weight x adjusted conversion factor x workers' compensation multiplier pursuant to Section 9789.30(ab), by date of service. See section 9789.39(b) for APC relative weight by date of service.

(b) ***This section (b) is inapplicable for dates of service on or after September 1, 2014.*** Alternative payment methodology. In lieu of the maximum allowable fees set forth under (a), the maximum allowable fees for a facility meeting the requirements in subdivisions (c)(1) through (c)(5) will be determined as follows:

(1) Standard payment.

(A) For services rendered before March 1, 2008, CTP codes 99281-99285 and CPT codes 10021-69990 with status code indicators "S", "T", "X" or "V":

For services rendered on or after March 1, 2008, use: CPT codes 99281-99285 and CPT codes 10021-69990 with status code indicators "S", "T", "X", "V", or "Q". Status code indicator "Q" must qualify for separate payment.

For services rendered on or after March 1, 2009, use: CPT codes 99281-99285 and CPT codes 10021-69990 with status code indicators "S", "T", "X", "V", "Q1", "Q2", or "Q3". Status code indicators "Q1", "Q2", and "Q3" must qualify for separate payment.

For services rendered before January 1, 2013: APC relative weight x adjusted conversion factor x 1.20 workers' compensation multiplier, pursuant to Section 9789.30(ab). See Section 9789.39(b) for the APC relative weight by date of service.

For services rendered on or after January 1, 2013 and before September 1, 2014: APC relative weight x adjusted conversion factor x 1.20 workers' compensation multiplier for hospital outpatient departments and 0.80 workers' compensation multiplier for ambulatory surgical centers, pursuant to Section 9789.30(ab).

For services rendered on or after February 15, 2006 and before September 1, 2014, by rural SCH hospitals, use: APC relative weight x adjusted conversion factor x 1.071x 1.20 workers' compensation multiplier, pursuant to Section 9789.30(ab). See Section 9789.39(b) for the APC relative weight by date of service.

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

For services rendered before January 1, 2013: APC payment rate x 1.20 workers' compensation multiplier pursuant to Section 9789.30(ab).

For services rendered on or after January 1, 2013 and before September 1, 2014: APC payment rate x 1.20 workers' compensation multiplier for hospital outpatient departments and 0.80 workers' compensation multiplier for ambulatory surgical centers, pursuant to Section 9789.30(ab).

(C) Procedure codes for devices with status code indicator "H" for services rendered before September 1, 2014:

Documented paid cost, plus an additional 10% of the hospital outpatient department's or ASC's documented paid cost, net of immediate and anticipated price adjustments based upon the hospital outpatient department's or ASC's prior calendar year's usage for comparable devices, not to exceed a maximum of $ 250.00, plus any sales tax and/or shipping and handling charges actually paid.

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

For services rendered before January 1, 2013: APC payment rate x 1.20 workers' compensation multiplier pursuant to Section 9789.30(ab).

For services rendered on or after January 1, 2013 and before September 1, 2014: APC payment rate x 1.20 workers' compensation multiplier for hospital outpatient departments and 0.80 workers' compensation multiplier for ambulatory surgical centers, pursuant to Section 9789.30(ab).

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

For services rendered before January 1, 2013: APC relative weight x adjusted conversion factor x 1.20 workers' compensation multiplier pursuant to Section 9789.30(ab). See section 9789.39(b) for APC relative weight by date of service.

For services rendered on or after January 1, 2013 and before September 1, 2014: APC relative weight x adjusted conversion factor x 1.20 workers' compensation multiplier for hospital outpatient departments and 0.80 workers' compensation multiplier for ambulatory surgical centers, pursuant to Section 9789.30(ab). See section 9789.39(b) for APC relative weight by date of service.

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

Documented paid cost, plus an additional 10% of the hospital outpatient department's or ASC's documented paid cost, net of immediate and anticipated price adjustments based upon the hospital outpatient department's or ASC's prior calendar year's usage for comparable devices, not to exceed a maximum of $ 250.00, plus any sales tax and/or shipping and handling charges actually paid.

For services rendered on or after April 15, 2010 and before January 1, 2013: Procedure codes for brachytherapy services with status code indicator "U":

APC relative weight x adjusted conversion factor x 1.20 workers' compensation multiplier pursuant to Section 9789.30(ab). See section 9789.39(b) for APC relative weight by date of service.

For services rendered on or after January 1, 2013 and before September 1, 2014: APC relative weight x adjusted conversion factor x 1.20 workers' compensation multiplier for hospital outpatient departments and 0.80 workers' compensation multiplier for ambulatory surgical centers, pursuant to Section 9789.30(ab). See section 9789.39(b) for APC relative weight by date of service.

(2) Additional payment for high cost outlier case:
[(Facility charges x cost-to-charge ratio) - (standard payment x 2.6)] x .50

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

For services rendered on or after July 15, 2005, the outlier threshold is specified in the Federal Register notices announcing revisions in the Medicare payment rates. See Section 9789.39(b) for the Federal Register reference that defines the outlier threshold by date of service.

(3) For services rendered before March 1, 2009: In determining the additional payment, the facility's charges and payment for devices with status code indicator "H" shall be excluded from the computation.

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

For services rendered on or after April 15, 2010 and before September 1, 2014: In determining the additional payment, the facility's charges and payment for devices with status code indicator “H” shall be excluded from the computation.

(c) ***This section (c) is inapplicable for dates of service on or after September 1, 2014.*** The following requirements shall be met for election of the alternative payment methodology:

(1) A facility seeking to be paid for high cost outlier cases under subdivision 9789.33(b) must file a written election using DWC Form 15 "Election for High Cost Outlier," contained in Section 9789.37 with the Division of Workers' Compensation, Medical Unit (Attention: OMFS-Outpatient). P.O. Box 71010, Oakland, CA 94612. The form must be post-marked by March 1 of each year and shall be effective for one year commencing with services furnished on or after April 1 of the year in which the election is made.

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

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

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

(5) The cost-to-charge ratio applicable to an ambulatory surgery center shall be the ratio of the facility's total operating costs to total gross charges during the preceding calendar

year. Total Operating Costs are the direct costs incurred in providing care to patients. Included in operating cost are: salaries and wages, rent or mortgage, employee benefits, supplies, equipment purchase and maintenance, professional fees, advertising, overhead, etc. It does not include start up costs. Total gross charges are defined as the facility's total usual and customary charges to all patients and third-party party payers before reductions for contractual allowances, bad debts, courtesy allowances and charity care. The facility's election form, as contained in Section 9789.37 shall include a completed Annual Utilization Report of Specialty Clinics filed with Office of Statewide Health Planning and Development (OSHPD) for the preceding calendar year, which is incorporated by reference. The facility's election form shall further include the facility's total operating costs during the preceding calendar year, the facility's total gross charges during the preceding calendar year, and a certification under penalty of perjury signed by the Chief Executive Officer and a Certified Public Accountant, as to the accuracy of the information. Upon request from the Administrative Director, an independent audit may be conducted at the expense of the ASC. (Note: While ASCs may not typically file Annual Utilization Report of Specialty Clinics with OSHPD, any ASC applying for the alternative payment methodology must file the equivalent, subject to the Division of Workers' Compensation's audit.) A copy of the Annual Utilization Report of Specialty Clinics may be obtained at OSHPD's website at http://www.oshpd.ca.gov/HID/HID/clinic/util/index.htm#Forms or upon request to the Division of Workers' Compensation, Medical Unit (Attention: OMFS-Outpatient), P.O. Box 71010, Oakland, CA 94612.

(6) Before April 1 of each year the AD shall post a list of those facilities that have elected to be paid under this paragraph and the facility-specific cost-to-charge ratio that shall be used to determine additional fees allowable for high cost outlier cases. The list shall be posted on the Division of Workers' Compensation website: http://www.dir.ca.gov/dwc/dwc_home_page.htm or is available upon request to the Division of Workers' Compensation, Medical Unit (Attention: OMFS-Outpatient), P.O. Box 71010, Oakland, CA 94612.

(d) ***This section (d) is inapplicable for dates of service on or after September 1, 2014.*** Any ambulatory surgical center that believes its cost-to-charge ratio in connection with its election to participate in the alternative payment methodology for high cost outlier cases under Section 9789.33(b) was erroneously determined because of error in tabulating data may request the Administrative Director for a re-determination of its cost-to-charge ratio. Such requests shall be in writing, shall state the alleged error, and shall be supported by written documentation. Within 30 days after receiving a complete written request, the Administrative Director shall make a redetermination of the cost-to-charge ratio or reaffirm the published cost-to-charge ratio.

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

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

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

(h) The maximum allowable fee shall be determined without regard to the cost items specified in 42 C.F.R. § 419.2(c)(1), (2), (3), (4), and (6), as contained in Section 9789.38 Appendix X. Cost item set forth at 42 C.F.R. § 419.2(c)(5), as contained in Section 9789.38 Appendix X, is payable pursuant to Section 9789.32(c)(1). Cost items set forth at 42 C.F.R. § 419.2(c)(7) and (8), as contained in Section 9789.38 Appendix X, are payable pursuant to Section 9789.32(c)(2).

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

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

Section 9789.34. Table A.

For services rendered on or after January 1, 2004, the "adjusted conversion factor" and wage index values are incorporated by reference, for services rendered by hospital outpatient departments not listed in Section 9789.35 (Table B) and services rendered by ambulatory surgical centers on or after the date the Administrative Director Order becomes effective, and are available at http://www.dir.ca.gov/dwc/OMFS9904.htm, or upon request to the Administrative Director at:

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

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

Section 9789.35. Table B.

For services rendered on or after January 1, 2004, the "adjusted conversion factor" and hospital-specific wage index values for listed hospital outpatient departments, are incorporated by reference, for services rendered on or after the date the Administrative Director Order becomes effective, and are available at http://www.dir.ca.gov/dwc/OMFS9904.htm, or upon request to the Administrative Director at:

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

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

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

Sections 9789.30 through 9789.39 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 Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule shall be effective every year on March 1.

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

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

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

ELECTION FOR HIGH COST OUTLIER

Labor Code § 5307.1; Title 8, California Code of Regulations § 9789.37 ***This Section 9789.37 is inapplicable for dates of service on or after September 1, 2014.***
For the 12 month period commencing on April 1, 20____.

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

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

Hospital Outpatient Department Cost-to-Charge Ratio

Pursuant to Section 9789.33(c)(4), the cost-to-charge ratio applicable to a hospital outpatient department participating in the Medicare program shall be the hospital's cost-to-charge ratio used by the Medicare fiscal intermediary to determine high cost outlier payments under 42 CFR 419.43(d). List below the cost-to-charge ratio being used by the intermediary for services furnished on February 15 of the year this election is filed:
5. Cost-to-charge ratio _____

_____ Signature and Title

_____ Date

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

Pursuant to Section 9789.33(c)(5), the cost-to-charge ratio applicable to an ambulatory surgery center shall be the ratio of the facility's total operating costs to total gross charges during the preceding calendar year. Total gross charges is defined as the facility's total usual and customary charges to patients and third-party payers before reductions for contractual allowances, bad debts, courtesy allowances and charity care.

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

7. Attach completed Annual Utilization Report of Specialty Clinics (OSHPD) which is incorporated by reference, and may be obtained at OSHPD's website at http://www.oshpd.ca.gov/HID/HID/clinic/util/index.htm#Forms or is available upon request to the Administrative Director at: Division of Workers' Compensation (Attention: OMFS-Outpatient), P.O. Box 71010, Oakland, CA 94612.

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

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

_____ Signature, Chief Executive Officer

_____ Date

_____ Signature, Certified Public Accountant

_____ Date

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

Section 9789.38. Appendix X.

The federal regulations as incorporated by reference and/or referred to in Sections 9789.30 through 9789.37 are set forth below in numerical order. See Section 9789.39(a), for the Code of Federal Regulations reference for effective date, revisions, and amendments by date of service.

42 C.F.R. § 419.2

Basis of payment.

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

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

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

(2) Use of recovery room;

(3) Use of an observation bed;

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

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

(6) Intraocular lenses (IOLs);

(7) Incidental services such a venipuncture;

(8) Capital-related costs;

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

(10) Durable medical equipment that is implantable;

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

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

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

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

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

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

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

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

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

(7) Organ acquisition costs paid under Part B.

(8) Corneal tissue acquisition costs.

42 C.F.R. § 419.32

Calculation of prospective payment rates for hospital outpatient services.

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

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

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

(ii) For calendar year 2001 --

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

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

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

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

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

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

(d) Budget neutrality.

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

(2) In determining adjustments for 2004 and 2005, CMS will not take into account any additional expenditures per section 1833(t)(14) of the Act that would not have been made but for enactment of section 621 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

42 C.F.R. § 419.43

Adjustments to national program payment and beneficiary copayment amounts.

(a) General rule. CMS determines national prospective payment rates for hospital outpatient department services and determines a wage adjustment factor to adjust the portion of the APC payment and national beneficiary copayment amount attributable to labor-related costs for relative differences in labor and labor-related costs across geographic regions in a budget neutral manner.

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

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

(d) Outlier adjustment -- (1) General rule. Subject to paragraph (d)(4) of this section, CMS provides for an additional payment for a hospital outpatient service (or group of services) not excluded under paragraph (f) of this section for which a hospital's charges, adjusted to cost, exceed the following:

(i) A fixed multiple of the sum of --

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

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

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

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

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

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

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

(B) For 2004 and thereafter, 3.0 percent.

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

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

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

(e) Budget neutrality. CMS establishes payment under paragraph (d) of this section in a budget-neutral manner excluding services and groups specified in paragraph (f) of this section.

(f) Excluded services and groups. Drugs and biologicals that are paid under a separate APC and devices of brachytherapy, consisting of a seed or seeds (including radioactive source) are excluded from qualification for outlier payments.

42 C.F.R. § 419.44

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

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

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

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

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

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

42 C.F.R. § 419.62

Transitional pass-through payments: General rules.

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

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

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

(2) The applicable percentages are as follows:

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

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

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

42 C.F.R. § 419.64

Transitional pass-through payments: drugs and biologicals.

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

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

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

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

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

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

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

(b) Cost. CMS determines the cost of a drug or biological to be not insignificant if it meets the following requirements:

(1) Services furnished before January 1, 2003. The expected reasonable cost of a drug or biological must exceed 10 percent of the applicable APC payment amount for the service related to the drug or biological.

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

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

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

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

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

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

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

(d) Amount of pass-through payment. (1) Subject to any reduction determined under § 419.62(b), the pass-through payment for a drug or biological as specified in section 1842(o)(1)(A) and (o)(1)(D)(i) of the Act is 95 percent of the average wholesale price of the

drug or biological minus the portion of the APC payment CMS determines is associated with the drug or biological.

(2) Subject to any reduction determined under § 419.62(b), the pass-through payment for a drug or biological as specified in section 1842(o)(1)(B) and (o)(1)(E)(i) of the act is 85 percent of the average wholesale price, determined as of April 1, 2003, of the drug or biological minus the portion of the APC payment CMS determines is associated with the drug or biological.

42 C.F.R. § 419.66

Transitional pass-through payments: medical devices.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) A device of brachytherapy.

(2) A device of temperature-monitored cryoablation.

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

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

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

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

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

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

Section 9789.39. Update Table by Date of Service.

(a) Federal Regulations by Date of Service

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

	Services Occurring On or After 7/15/2005	Services Occurring On or After 2/15/2006	Services Occurring On or After 3/1/2007	Services Occurring On or After 3/1/2008
Title 42, Code of Federal Regulations, §419.2				
Title 42, Code of Federal Regulations, §419.32				
Title 42, Code of Federal Regulations, §419.43		As amended; effective January 1, 2006	As amended; effective January 1, 2007	As amended; effective January 1, 2008
Title 42, Code of Federal Regulations, §419.44				Amended; effective January 1, 2008
Title 42, Code of Federal Regulations, §419.62				
Title 42, Code of Federal Regulations, §419.64	As amended; effective January 1, 2005			
Title 42, Code of Federal Regulations, §419.66		As amended; effective January 1, 2006		

	Services Occurring On or After 3/1/2009	Services Occurring On or After 4/15/2010	Services Occurring On or After 9/15/2011	Services Occurring On or After 3/1/2012
Title 42, Code of Federal				

Regulations, §419.2				
Title 42, Code of Federal Regulations, §419.32			As amended; effective January 1, 2011	As amended; effective January 1, 2012
Title 42, Code of Federal Regulations, §419.43	As amended; effective January 1, 2009		As amended; effective January 1, 2011	As amended; effective January 1, 2012
Title 42, Code of Federal Regulations, §419.44				
Title 42, Code of Federal Regulations, §419.62				
Title 42, Code of Federal Regulations, §419.64		As amended; effective January 1, 2010		
Title 42, Code of Federal Regulations, §419.66		As amended; effective January 1, 2010		

	Services Occurring On or After 4/1/2013	Services Occurring On or After 12/1/2014	Services Occurring On or After December 15, 2016	Services Occurring On or After June 1, 2017
Title 42, Code of Federal Regulations, §419.2	As amended; effective January 1, 2013	As amended; effective January 1, 2014	As amended; effective January 1, 2016	As amended; effective January 1, 2016
Title 42, Code of Federal Regulations, §419.32	As amended; effective January 1, 2013	As amended; effective January 1, 2014	As amended; effective January 1, 2016	As amended; effective January 1, 2017
Title 42, Code of Federal Regulations, §419.43			As amended; effective January 1, 2012	As amended; effective January 1, 2017
Title 42, Code of Federal Regulations, §419.44			As amended; effective January 1, 2016	As amended; effective January 1, 2017

Title 42, Code of Federal Regulations, §419.62			Effective January 1, 2004	Effective January 1, 2004
Title 42, Code of Federal Regulations, §419.64			As amended; effective January 1, 2015	As amended; effective January 1, 2015
Title 42, Code of Federal Regulations, §419.66		As amended; effective January 1, 2014	As amended; effective January 1, 2016	As amended; effective January 1, 2017

	Services Occurring On or After March 15, 2018	Services Occurring On or After February 15, 2019		
Title 42, Code of Federal Regulations, §419.2	As amended; effective January 1, 2016	As amended; effective January 1, 2016		
Title 42, Code of Federal Regulations, §419.32	As amended; effective January 1, 2018	As amended; effective January 1, 2019		
Title 42, Code of Federal Regulations, §419.43	As amended; effective January 1, 2017	As amended; effective January 1, 2017		
Title 42, Code of Federal Regulations, §419.44	As amended; effective January 1, 2017	As amended; effective January 1, 2017		
Title 42, Code of Federal Regulations, §419.62	Effective January 1, 2004	Effective January 1, 2004		
Title 42, Code of Federal Regulations, §419.64	As amended; effective January 1, 2015	As amended; effective January 1, 2015		
Title 42, Code of Federal Regulations, §419.66	As amended; effective January 1, 2017	As amended; effective January 1, 2017		

Title 42, Code of Federal Regulations, §419.71	Effective January 1, 2018	Effective January 1, 2018		

(b) Update factors and Federal Register Notices by Date of Service

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

	Services Occurring On or After 1/1/2004	Services Occurring On or After 7/15/2005	Services Occurring On or After 2/15/2006	Services Occurring On or After 3/1/2007
Applicable FR Notices	(A) November 7, 2003 (CMS-1471-FC; 68 FR 63398); (B) December 31, 2003 (CMS-1471-CN; 68 FR 75442); (C) January 6, 2004 (CMS-1371-IFC; 69 FR 820); (D) August 1, 2003 (CMS-1470-F; 68 FR 45346); (E) August 11, 2003 (CMS-1470-F; 68 FR 47637)	(A) November 15, 2004 (CMS-1427-FC; 69 FR 65681); (B) December 30, 2004 (CMS-1427-CN; 69 FR 78315; (C) August 11, 2004 (CMS-1428-F; 69 FR 48916); (D) December 30, 2004 (CMS-1482-F2; 69 FR 78526	(A) November 10, 2005 (CMS-1501-FC; 70 FR 68515); (B) December 23, 2005 (CMS-1501-CN2; 70 FR 76176); (C) August 12, 2005 (CMS-1500-F; 70 FR 47278); (D) September 30, 2005 (CMS-1500-CN; 70 FR 57161)	(A) November 24, 2006 (CMS-1506-FC; 71 FR 67960); (B) August 18, 2006 (CMS-1488-F; 71 FR 47870) (C) October 11, 2006 (CMS-1488-N; 71 FR 59886)
APC Payment Rate	Addendum B (A) beginning on page 63488 conformed to comply with (B) beginning on page 75442 and (C) beginning on page 820	Addendum B (A) beginning on page 65887	Addendum B (A) beginning on page 68752	Addendum B (A) beginning on page 68283

	Services Occurring On or After 1/1/2004	Services Occurring On or After 7/15/2005	Services Occurring On or After 2/15/2006	Services Occurring On or After 3/1/2007
APC Relative Weight	Addendum B (A) beginning on page 63488 conformed to comply with (B) beginning on page 75442 and (C) beginning on page 820	Addendum B (A) beginning on page 65887	Addendum B (A) beginning on page 68752	Addendum B (A) beginning on page 68283
Emergency Department HCPCS Codes	99281-99285	99281-99285	99281-99285	99281-99285
HOPPS Addenda	Addenda A, B, D1, D2, E, H, I, and J (A) beginning at page 63478; as changed by (B) beginning at page 75442; and (C) beginning at page 820	Addenda A, B, D1, D2, and E (A) beginning at page 65864	Addenda A, B, D1, D2, E and L (A) beginning at page 68729; and correction (B) beginning at page 76176	Addenda A, B, D1, D2, E, and L (A) beginning at page 68231
IPPS Tables		Tables $4A_1$, $4A_2$, $4B_1$, $4B_2$, $4C_1$, $4C_2$, and 4J (D) beginning at page 78619	Tables 4A, 4B, 4C, and 4J (D) beginning at page 57163; and Tables 4A, 4B, 4C, and 4J (C) beginning on page 47580	Tables 4A-1, 4A-2, 4B-1, 4B-2, 4C-1, 4C-2, and 4J (C) beginning at page 59975
Labor-related Share	60% ((A) page 63458)	60% ((A) beginning at page 65842)	60% ((A) beginning at page 68551)	60% ((A) beginning at page 68003)
Market Basket Inflation Factor	3.4% (D) page 45346	3.3% (C) page 49274	3.7% (C) page 47492	3.4% (B) page 48146
Outlier Threshold		$1,175 (A) at page 65846	$1,250 (A) at page 68565	$1,825 (A) at page 68012

	Services Occurring On or After 1/1/2004	Services Occurring On or After 7/15/2005	Services Occurring On or After 2/15/2006	Services Occurring On or After 3/1/2007
Surgical Procedure HCPCS	10021-69990	10021-69990	10021-69990	10021-69990
Conversion Factor adjusted for inflation factor	$53.924 (2003 unadjusted conversion factor of 52.151 x estimated inflation factor of 1.034)	$55.703 (2004 unadjusted conversion factor of $53.924 x estimated inflation factor of 1.033)	$57.764 (2005 unadjusted conversion factor of $55.703 x estimated inflation factor of 1.037)	$59.728 (2006 unadjusted conversion factor of $57.764 x estimated inflation factor of 1.034)
Wage Index	Addenda H through J (A) beginning at page 63682	Referenced in Addenda H through J (B) beginning at page 78316; wage index values are specified in Tables $4A_1$ through $4C_2$ (D) beginning at page 78619	Referenced in (A) beginning at page 68551; wage index values are specified in Tables 4A through 4C (D) beginning at page 57163; and as specified in Tables 4A through 4C (C) beginning at page 47580	Referenced in (A) beginning at page 68003; wage index values are specified in Tables 4A-1 through 4C-2 (C) beginning at page 59975

	Services Occurring On or After 3/1/2008	Services Occurring On or After 3/1/2009	Services Occurring On or After 4/15/2010	Services Occurring On or After 9/15/2011
Applicable FR Notices	(A) November 27, 2007 (CMS-1392-FC; CMS-1533-F2; 72 FR 66580); (B) August 22, 2007 (CMS-1533-FC; 72 FR 47130); (C) October 10, 2007 (CMS-1533-CN2; 72 FR 57634); (D) November 6,	(A) November 18, 2008 (CMS-1404-FC; 73 FR 68502); (B) August 19, 2008 (CMS-1390-F; 73 FR 48434); (C) October 3, 2008 (CMS-1390-CN; 73 FR 57541); (D) October 3, 2008 (CMS-1390-N; 73 FR	(A) November 20, 2009 (CMS-1414-FC; 74 FR 60316); (B) December 31, 2009 (CMS-1414-CN; 74 FR 69502); (C) August 27, 2009 (CMS-1406-F; 74 FR 43754); (D) October 7, 2009 (CMS-1406-CN; 74 FR 51496)	(A) November 24, 2010 (CMS-1504-FC; 75 FR 71800); (B) March 11, 2011 (CMS-1504-CN; 76 FR 13292); (C) August 16, 2010 (CMS-1498-F; 75 FR 50042); (D) October 1, 2010 (CMS-1498-F; 75 FR 60640)

	Services Occurring On or After 3/1/2008	Services Occurring On or After 3/1/2009	Services Occurring On or After 4/15/2010	Services Occurring On or After 9/15/2011
	2007 (CMS-1533-CN3; 72 FR 62585); (E) November 27, 2007 (CMS-1392-FC; CMS-1533-F2; 72 FR 66580); (F) February 22, 2008 (CMS-1392-CN; CMS-1533-CN)	57888); (E) December 3, 2008 (CMS-1390-N2; 73 FR 73656); (F) January 26, 2009 (CMS-1404-CN; 74 FR 4343)		
APC Payment Rate	Addendum B (A) beginning on page 66993 conformed to comply with correction published in (F) beginning on page 9863	Addendum B (A) beginning on page 68934 conformed to comply with correction published in (F) beginning on page 4344	Addendum B (A) beginning on page 60752 conformed to comply with correction published in (B) page 69503	Addendum B (A) beginning on page 72331 conformed to comply with correction published in (B) page 13295
APC Relative Weight	Addendum B (A) beginning on page 66993 conformed to comply with correction published in (F) beginning on page 9863	Addendum B (A) beginning on page 68934 conformed to comply with correction published in (F) beginning on page 4344	Addendum B (A) beginning on page 60752 conformed to comply with correction published in (B) page 69503	Addendum B (A) beginning on page 72331 conformed to comply with correction published in (B) page 13295
Emergency Department HCPCS Codes	99281-99285	99281-99285	99281-99285	99281-99285
HOPPS Addenda	Addenda A, B, D1, D2, E, L, and M (A) beginning at page 66934; and correc-	Addenda A, B, D1, D2, E, L, and M (A) beginning at page 68816; and corrections to addenda A and	Addenda A, B, D1, D2, E, L, and M (A) beginning at page 60682; and corrections to addenda B and E	Addenda A, B, D1, D2, E, L, and M (A) beginning at page 72268; and corrections to addendum B (B) on page 13295

	Services Occurring On or After 3/1/2008	Services Occurring On or After 3/1/2009	Services Occurring On or After 4/15/2010	Services Occurring On or After 9/15/2011
	tions to addenda A, B, D2, and M (F) beginning at page 9862	B (F) beginning at page 4343	(B) beginning at page 69503	
IPPS Tables	Tables 4A, 4B, and 4C (C) beginning at page 57698 and Table 4J (B) beginning at page 47531 and correction (C) beginning at page 57726	Tables 4A, 4B, 4C, and 4J (C) beginning at page 57956; and Tables 2 and 4J (E) beginning at page 73657	Tables 2, 4A, 4B, 4C, and 4J (C) beginning at page 44032; as changed by correction to Tables 2, 4A, 4B, 4C, and 4J (D) beginning at page 51499	Tables 2, 4A, 4B, 4C, and 4J (C) beginning at page 50451
Labor-related Share	60% ((A) beginning at page 66678)	60% ((A) beginning at page 68585)	60% ((A) beginning at page 60419)	60% ((A) beginning at page 71877)
Market Basket Inflation Factor	3.3% (B) page 47415	3.6% (B) page 48759	2.1% (C) page 44002	2.6% (C) page 50422
Outlier Threshold	$1,575 (A) at page 66686	$1,800 (A) at page 68594	$2,175 (A) at page 60428	$2,025 (A) at page 71889
Surgical Procedure HCPCS	10021-69990	10021-69990	10021-69990	10021-69990
Conversion Factor adjusted for inflation factor	$61.699 (2007 unadjusted conversion factor of $59.728 x estimated inflation factor of 1.033)	$63.920 (2008 unadjusted conversion factor of $61.699 x estimated inflation factor of 1.036)	$65.262 (2009 unadjusted conversion factor of $63.920 x estimated inflation factor of 1.021)	$66.959 (2010 unadjusted conversion factor of $65.262 x estimated inflation factor of 1.026)
Wage Index	Referenced in (A) beginning at page 66678; wage index values are specified in Tables 4A through 4C (C) beginning at page 57698	Referenced in (A) beginning at page 68585; wage index values are specified in Tables 4A through 4C (D) beginning at page 57956	Referenced in (A) beginning at page 60419; wage index values are specified in Tables 4A through 4C (D) beginning at page 51505; and as specified	Referenced in (A) beginning at page 71877; wage index values are specified in Tables 4A through 4C (C) beginning at page 50511

	Services Occurring On or After 3/1/2008	Services Occurring On or After 3/1/2009	Services Occurring On or After 4/15/2010	Services Occurring On or After 9/15/2011
			in Tables 4A through 4C (C) beginning at page 44085	

	Services Occurring On or After 3/1/2012	Services Occurring On or After 9/1/2012	Services Occurring On or After 4/1/2013	Services Occurring On or After 9/1/2014
Applicable FR Notices	(A) November 30, 2011 (CMS-1525-FC; 76 FR 74122); (B) January 4, 2012 (CMS-1525-CN; 77 FR 217); (C) August 18, 2011 (CMS-1518-F; 76 FR 51476); (D) September 26, 2011 (CMS-1518-CN3; 76 FR 59263)	(A) November 30, 2011 (CMS-1525-FC; 76 FR 74122); (B) January 4, 2012 (CMS-1525-CN; 77 FR 217); (C) August 18, 2011 (CMS-1518-F; 76 FR 51476); (D) September 26, 2011 (CMS-1518-CN3; 76 FR 59263); (E) April 24, 2012 (CMS-1525-CN2; 77 FR 24409)	(A) November 15, 2012 (CMS-1589-FC; 77 FR 68210)	
APC Payment Rate	Addendum B (A) conformed to comply with correction published in (B) found on CMS website at: http://www.cms.gov/HospitalOutpatientPPS	Addendum B (A) conformed to comply with corrections published in (B) and (E) found on CMS website at: http://www.cms.gov/Hospital-OutpatientPPS	Addendum B (A) found on CMS website at: http://www.cms.gov/Hospital-OutpatientPPS	
APC Relative Weight	Addendum B (A) conformed to comply with correction	Addendum B (A) conformed to comply with corrections	Addendum B (A) found on CMS website at: http://www.cms.	

	Services Occurring On or After 3/1/2012	Services Occurring On or After 9/1/2012	Services Occurring On or After 4/1/2013	Services Occurring On or After 9/1/2014
	published in (B) found on CMS website at: http://www.cms.gov/HospitalOutpatientPPS	published in (B) and (E) found on CMS website at: http://www.cms.gov/Hospital-OutpatientPPS	gov/Hospital-OutpatientPPS	
Emergency Department HCPCS Codes	99281-99285	99281-99285	99281-99285	99281-99285, 99291, 99292, G0380-G0384, G0390
Facility Only Services				Services with a "NA" in the column labeled "Non-Facility NA Indicator" of the Medicare Physician Fee Schedule Relative Value File for Calendar Year 2014 (RVU14A), located at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFee-Sched/PFS-Relative-Value-Files.html
HOPPS Addenda	Addenda A, B, D1, D2, E, L, and M (A) and corrections to addenda (B) found on CMS website at: http://www.cms.gov/HospitalOutpatientPPS	Addenda A, B, D1, D2, E, L, and M (A and E) and corrections to addenda (A) and (B) found on CMS website at: http://www.cms	Addenda A, B, D1, D2, E, L, and M (A) found on CMS website at: http://www.cms.gov/Hospital-OutpatientPPS	

	Services Occurring On or After 3/1/2012	Services Occurring On or After 9/1/2012	Services Occurring On or After 4/1/2013	Services Occurring On or After 9/1/2014
		.gov/Hospital-OutpatientPPS		
IPPS Tables	Tables 2, 4A, 4B, 4C, and 4J (C) and correction (D) found on CMS website at: http://www.cms.hhs.gov/AcuteInpatientPPS/.		Tables 2, 4A, 4B, 4C, and 4J (C) and correction (D) found on CMS website at: http://www.cms.hhs.gov/AcuteInpatientPPS/.	
Labor-related Share	60% ((A) beginning at page 74191)		60% (A) beginning at page 68285	
Market Basket Inflation Factor	3.0% (A) page 74189		2.6% (A) page 68215	
Medicare Physician Fee Schedule Relative Value File				Calendar Year 2014 (RVU14A), located at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html
Outlier Threshold	$2,025 (B) at page 222		$2,025 (A) page 68297	
Surgical Procedure HCPCS	10021-69990	10021-69990	10021-69990	10021-69990, G0413
Conversion Factor adjusted for inflation factor	$68.968 (2011 unadjusted conversion factor of $66.959 x estimated inflation factor of 1.03)		$70.761 (2012 unadjusted conversion factor of $68.968 x estimated inflation factor of 1.026)	

	Services Occurring On or After 3/1/2012	Services Occurring On or After 9/1/2012	Services Occurring On or After 4/1/2013	Services Occurring On or After 9/1/2014
Wage Index	Referenced in (A) beginning at page 74191; wage index values are specified in Tables 4A through 4C (C) found on the CMS web site at: http://www.cms.gov/AcuteInpatientPPS/		Referenced in (A) beginning at page 68285; wage index values are specified in Tables 4A through 4C found on the CMS website at: http://www.cms.gov/AcuteInpatientPPS/	

	Services Occurring On or After 12/1/2014	Services Occurring On or After December 15, 2016 and Mid-year Updates	Services Occurring On or After June 1, 2017 and Mid-year Updates	Services Occurring On or After March 15, 2018 and Mid-year Updates
Applicable FR Notices	(A) December 10, 2013 (CMS-1601-FC; 78 FR 74826) (B) August 19, 2013 (CMS-1599-F; 78 FR 50496) (C) October 3, 2013 (CMS-1599-CN2; 78 FR 61197) (D) October 3, 2013 (CMS-1599-IFC; 78 FR 61191)	(A) November 13, 2015 (CMS-1633-FC; 80 FR 70298) (B) August 17, 2015 (CMS-1632-F; 80 FR 49326) (C) October 5, 2015 (CMS-1632-CN; 80 FR 60055)	(A) November 14, 2016 (CMS-1656-FC; 81 FR 79562) (B) January 3, 2017 (CMS-1656-CN; 82 FR 24) (C) August 22, 2016 (CMS-1655-F; 81 FR 56762) (D) October 5, 2016 (CMS-1655-F Correction; 81 FR 68947)	(A) December 14, 2017 (CMS-1678-FC; 82 FR 59216, Republication) (B) December 27, 2017 (CMS-1678-CN; 82 FR 61184) (C) August 14, 2017 (CMS-1677-F; 82 FR 37990) (D) October 4, 2017 (CMS-1677-CN; 82 FR 46138; Final rule; correction)

	Services Occurring On or After 12/1/2014	Services Occurring On or After December 15, 2016 and Mid-year Updates	Services Occurring On or After June 1, 2017 and Mid-year Updates	Services Occurring On or After March 15, 2018 and Mid-year Updates
	(E) January 2, 2014 (CMS-1599-CN3; 79 FR 61) (F) January 10, 2014 (CMS-1599-CN4; 79 FR 1741) (G) March 14, 2014 (CMS-1599-IFC2; 79 FR 15022) (H) June 17, 2014; (CMS-1599-N; 79 FR 34444)			
Ambulatory Surgical Centers Payment System Addenda		For services rendered on or after December 15, 2016, Column A, of Addendum AA, entitled, "HCPCS Code" and Column A, of Addendum EE, entitled, "HCPCS Code" located in "July 2016 ASC Approved HCPCS Code and Payment	For services occurring on or after June 1 2017, Column A, of Addendum AA, entitled, "HCPCS Code" and Column A, of Addendum EE, entitled, "HCPCS Code" located in "April 2017 ASC Approved HCPCS Code and Payment Rates" (april_2017_asc_addenda_rev_20170329)	For services occurring on or after March 15, 2018, Column A, of Addendum AA, entitled, "HCPCS Code" and Column A, of Addendum EE, entitled, "HCPCS Code" located in "Correction Notice Addendum AA, BB, DD1, DD2, EE" (CMS-1678-CN-ASC-Addendum-AA-BB-DD1-DD2-EE.zip)

	Services Occurring On or After 12/1/2014	Services Occurring On or After December 15, 2016 and Mid-year Updates	Services Occurring On or After June 1, 2017 and Mid-year Updates	Services Occurring On or After March 15, 2018 and Mid-year Updates
		Rates" found on CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html	For services occurring on or after July 1 2017, Column A, of Addendum AA, entitled, "HCPCS Code" and Column A, of Addendum EE, entitled, "HCPCS Code" located in "July 2017 ASC Approved HCPCS Code and Payment Rates" (july_2017_asc_addenda1) For services occurring on or after October 1 2017, Column A, of Addendum AA, entitled, "HCPCS Code" and Column A, of Addendum EE, entitled, "HCPCS Code" located in "October 2017 ASC Approved HCPCS Code and Payment Rates" (october_2017_asc_addenda) Access the files on CMS website at: https://www.cms.	For services occurring on or after April 1, 2018, Column A, of Addendum AA, entitled, "HCPCS Code" and Column A, of Addendum EE, entitled, "HCPCS Code" located in "April 2018 ASC Approved HCPCS Code and Payment Rates - Updated 03/21/2018" (april_2018_asc_addenda_updated_04_01_2018b.xlsx) For services occurring on or after July 1, 2018, Column A, of Addendum AA, entitled, "HCPCS Code" and Column A, of Addendum EE, entitled, "HCPCS Code" located in "July 2018 ASC Approved HCPCS Code and Payment Rates - Updated 06/28/2018" (july_2018_asc_addenda_updated_06_28_2018.xlsx)

	Services Occurring On or After 12/1/2014	Services Occurring On or After December 15, 2016 and Mid-year Updates	Services Occurring On or After June 1, 2017 and Mid-year Updates	Services Occurring On or After March 15, 2018 and Mid-year Updates
			gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html	For services occurring on or after October 1, 2018, Column A, of Addendum AA, entitled, "HCPCS Code" and Column A, of Addendum EE, entitled, "HCPCS Code" located in "October 2018 ASC Approved HCPCS Code and Payment Rates" (oct_2018_asc_addenda_updated_09_19_2018.09212018cb.xlsx) Access the files on CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html
APC Payment Rate	Addendum B (A) found on CMS website at: http://www.cms.gov/HospitalOutpatientPPS	For services rendered on or after December 15, 2016, Addendum B, dated July 2016, (A) found on CMS website at:	For services occurring on or after June 1, 2017, Addendum B, dated April 2017 (- updated: 03/28/2017; april_2017_web_addendum_b.03.28.17)	For services occurring on or after March 15, 2018, Addendum B (CMS-1678-CN-2018-OPPS-Addendum-B.zip; 2018 CN Addendum B.11.29.17)

	Services Occurring On or After 12/1/2014	Services Occurring On or After December 15, 2016 and Mid-year Updates	Services Occurring On or After June 1, 2017 and Mid-year Updates	Services Occurring On or After March 15, 2018 and Mid-year Updates
		http://www.cms.gov/HospitalOutpatientPPS	For services occurring on or after July 1, 2017, Addendum B, dated July 2017 (july_2017_web_addendum_b.06.13.17) For services occurring on or after October 1, 2017, Addendum B, dated October 2017 (october_2017_web_addendum_a.09.14.17) - found on CMS website at: http://www.cms.gov/HospitalOutpatientPPS	For services occurring on or after April 1, 2018, Addendum B, dated April 2018 (2018_april_web_addendum_b.03.19.18final.xlsx) For services occurring on or after July 1, 2018, Addendum B – Updated 6/27/2018 (july_addendum_b.07.01.18revised06272018.xlsx) For services occurring on or after October 1, 2018, Addendum B (2018_october_web_addendum_b.10.01.18no340brem.xlsx) Access the files on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html?redirect=/HospitalOutpatientPPS/

	Services Occurring On or After 12/1/2014	Services Occurring On or After December 15, 2016 and Mid-year Updates	Services Occurring On or After June 1, 2017 and Mid-year Updates	Services Occurring On or After March 15, 2018 and Mid-year Updates
APC Relative Weight	Addendum B (A) found on CMS website at: http://www.cms.gov/HospitalOutpatientPPS	For services rendered on or after December 15, 2016, Addendum B, dated July 2016, (A) found on CMS website at: http://www.cms.gov/HospitalOutpatientPPS	For services occurring on or after June 1, 2017, Addendum B, dated April 2017 (- updated: 03/28/2017; april_2017_web_addendum_b.03.28.17) For services occurring on or after July 1, 2017, Addendum B, dated July 2017 (july_2017_web_addendum_b.06.13.17) For services occurring on or after October 1, 2017, Addendum B, dated October 2017 (october_2017_web_addendum_a.09.14.17) - found on CMS website at: http://www.cms.gov/HospitalOutpatientPPS	For services occurring on or after March 15, 2018, Addendum B (CMS-1678-CN-2018-OPPS-Addendum-B.zip; 2018 CN Addendum B.11.29.17) For services occurring on or after April 1, 2018, Addendum B, dated April 2018 (2018_april_web_addendum_b.03.19.18final.xlsx) For services occurring on or after July 1, 2018, Addendum B – Updated 6/27/2018 (july_addendum_b.07.01.18revised06272018.xlsx) For services occurring on or after October 1, 2018, Addendum B (2018_october_web_addendum_b.10.01.18no340brem.xlsx) Access the files on the CMS website at:

	Services Occurring On or After 12/1/2014	Services Occurring On or After December 15, 2016 and Mid-year Updates	Services Occurring On or After June 1, 2017 and Mid-year Updates	Services Occurring On or After March 15, 2018 and Mid-year Updates
				https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html?redirect=/HospitalOutpatientPPS/
Composite APCs (codes assigned status indicator "Q1," "Q2," "Q3," or "Q4") payment rules				For services occurring on or after March 15, 2018, payment rules are: • Medicare Claims Processing Manual, Chapter 4, sections 10.2.1, 10.2.2, 10.4, and 10.4.1 • CMS 2018 OPPS Addendum D1 • CMS 2018 OPPS Addendum M (corrected 12/4/2017) • Integrated OCE (IOCE) CMS Specifications V19.0 (effective 01/01/2018), sections 10 – 12, 20 For services occurring on or after April 1, 2018,

	Services Occurring On or After 12/1/2014	Services Occurring On or After December 15, 2016 and Mid-year Updates	Services Occurring On or After June 1, 2017 and Mid-year Updates	Services Occurring On or After March 15, 2018 and Mid-year Updates
				payment rules are: • Medicare Claims Processing Manual, Chapter 4, sections 10.2.1, 10.2.2, 10.4, and 10.4.1 • CMS 2018 OPPS Addendum D1 • CMS 2018 OPPS Addendum M (corrected 12/4/2017) • IOCE Quarterly Data Files V19.1 [ZIP, 46MB] (IntegOCEspecsV19.1.pdf), sections 6.4.1, 6.4.3, 6.4.5, and 6.5 For services occurring on or after July 1, 2018, payment rules are: • Medicare Claims Processing Manual, Chapter 4, sections 10.2.1, 10.2.2, 10.4, and 10.4.1 • CMS 2018 OPPS Addendum D1 • CMS 2018 OPPS Addendum

	Services Occurring On or After 12/1/2014	Services Occurring On or After December 15, 2016 and Mid-year Updates	Services Occurring On or After June 1, 2017 and Mid-year Updates	Services Occurring On or After March 15, 2018 and Mid-year Updates
				M (corrected 12/4/2017) • Revised IOCE Quarterly Data Files V19.2.R1 [ZIP, 9MB], sections 5.4.1, 5.4.3, 5.4.5, and 5.5 For services occurring on or after October 1, 2018, payment rules are: • Medicare Claims Processing Manual, Chapter 4, sections 10.2.1, 10.2.2, 10.4, and 10.4.1 • CMS 2018 OPPS Addendum D1 • CMS 2018 OPPS Addendum M (corrected 12/4/2017) • IOCE Quarterly Data Files V19.3 [ZIP, 55MB], sections 5.4.1, 5.4.3, 5.4.5, and 5.5 A copy of the IOCE is posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm#6

	Services Occurring On or After 12/1/2014	Services Occurring On or After December 15, 2016 and Mid-year Updates	Services Occurring On or After June 1, 2017 and Mid-year Updates	Services Occurring On or After March 15, 2018 and Mid-year Updates
				Access documents on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html?redirect=/HospitalOutpatientPPS/ and https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html
Comprehensive APCs (codes assigned status indicator "J1" or "J2") payment rules				For services occurring on or after March 15, 2018, payment rules are: • Medicare Claims Processing Manual, Chapter 4, sections 10.2.3, 10.4, 290.5.2, and 290.5.3 • CMS 2018 OPPS Addendum D1 • CMS 2018 OPPS Addendum J (Revised 1/25/2018)

	Services Occurring On or After 12/1/2014	Services Occurring On or After December 15, 2016 and Mid-year Updates	Services Occurring On or After June 1, 2017 and Mid-year Updates	Services Occurring On or After March 15, 2018 and Mid-year Updates
				• Integrated OCE (IOCE) CMS Specifications V19.0 (effective 01/01/2018), sections 7, 21, and Appendix L For services occurring on or after April 1, 2018, payment rules are: • Medicare Claims Processing Manual, Chapter 4, sections 10.2.3, 10.4, 290.5.2, and 290.5.3 • CMS 2018 OPPS Addendum D1 • CMS 2018 OPPS Addendum J (Revised 1/25/2018) • IOCE Quarterly Data Files V19.1 [ZIP, 46MB] (IntegOCEspecsV19.1.pdf), sections 6.6.1, 6.6.1.1, 6.6.2, 6.6.3, 6.6.4, 6.6.4.1, and 6.6.4.2 For services occurring on or after

	Services Occurring On or After 12/1/2014	Services Occurring On or After December 15, 2016 and Mid-year Updates	Services Occurring On or After June 1, 2017 and Mid-year Updates	Services Occurring On or After March 15, 2018 and Mid-year Updates
				July 1, 2018, payment rules are: • Medicare Claims Processing Manual, Chapter 4, sections 10.2.3, 10.4, 290.5.2, and 290.5.3 • CMS 2018 OPPS Addendum D1 • CMS 2018 OPPS Addendum J (Revised 1/25/2018) • Revised IOCE Quarterly Data Files V19.2.R1 [ZIP, 9MB], sections 5.6.1, 5.6.1.1, 5.6.2, 5.6.3, 5.6.4, 5.6.4.1, and 5.6.4.2 For services occurring on or after October 1, 2018, payment rules are: • Medicare Claims Processing Manual, Chapter 4, sections 10.2.3, 10.4, 290.5.2, and 290.5.3 • CMS 2018 OPPS Addendum D1

	Services Occurring On or After 12/1/2014	Services Occurring On or After December 15, 2016 and Mid-year Updates	Services Occurring On or After June 1, 2017 and Mid-year Updates	Services Occurring On or After March 15, 2018 and Mid-year Updates
				• CMS 2018 OPPS Addendum J (Revised 1/25/2018) • IOCE Quarterly Data Files V19.3 [ZIP, 55MB], sections 5.6.1, 5.6.1.1, 5.6.2, 5.6.3, 5.6.4, 5.6.4.1, and 5.6.4.2 A copy of the IOCE is posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm#6 Access documents on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html?redirect=/HospitalOutpatientPPS/ and https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-

	Services Occurring On or After 12/1/2014	Services Occurring On or After December 15, 2016 and Mid-year Updates	Services Occurring On or After June 1, 2017 and Mid-year Updates	Services Occurring On or After March 15, 2018 and Mid-year Updates
				Items/CMS018912.html
Emergency Department HCPCS Codes	99281-99285, 99291, 99292, G0380-G0384, G0390	99281-99285, 99291, 99292, G0380-G0384, G0390	99281-99285, 99291, 99292, G0380-G0384, G0390	99281-99285, 99291, 99292, G0380-G0384, G0390
Facility Only Services	Services with a "NA" in the column labeled "Non-Facility NA Indicator" of the Medicare Physician Fee Schedule Relative Value File, by date of service, as adopted and incorporated by reference in the Official Medical Fee Schedule (OMFS) Physician Fee Schedule (Title 8 CCR sections 9789.12.1, et seq.). The (OMFS) Physician Fee Schedule is located at: http://www.dir.ca.gov/dwc/OMFS9904.htm and the Medicare Physician	Not applicable for services rendered on or after December 15, 2016	Not applicable for services rendered on or after December 15, 2016	Not applicable for services rendered on or after December 15, 2016

	Services Occurring On or After 12/1/2014	Services Occurring On or After December 15, 2016 and Mid-year Updates	Services Occurring On or After June 1, 2017 and Mid-year Updates	Services Occurring On or After March 15, 2018 and Mid-year Updates
	Fee Schedule Relative Value File is located at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html			
Film X-ray services and X-rays taken using computed radiography technology/cassette-based imaging payment reductions				For services occurring on or after March 15, 2018, use modifier "FX" to report X-rays taken using film, which requires a 20 percent payment reduction for such service. Use modifier "FY" to report X-rays taken using computed radiography technology/cassette-based imaging which requires a 7 percent payment reduction for such service. Apply payment rules set forth in: • December 14, 2017 (CMS-1678-FC; 82 FR

	Services Occurring On or After 12/1/2014	Services Occurring On or After December 15, 2016 and Mid-year Updates	Services Occurring On or After June 1, 2017 and Mid-year Updates	Services Occurring On or After March 15, 2018 and Mid-year Updates
				59216, Republished, section X.E., pages 59391 through 59393) • Medicare Claims Processing Manual, Chapter 4, section 20.6.14 (effective 01/01/2018) and section 20.6.15 (effective 01/01/2018) • CFR section 419.71 For services occurring on or after April 1, 2018, use modifier “FX” to report X-rays taken using film, which requires a 20 percent payment reduction for such service. Use modifier “FY” to report X-rays taken using computed radiography technology/cassette-based imaging which requires a 7 percent payment reduction for such service. Apply payment rules set forth in: • December 14, 2017 (CMS-

	Services Occurring On or After 12/1/2014	Services Occurring On or After December 15, 2016 and Mid-year Updates	Services Occurring On or After June 1, 2017 and Mid-year Updates	Services Occurring On or After March 15, 2018 and Mid-year Updates
				1678-FC; 82 FR 59216, Republished, section X.E., pages 59391 through 59393) • Medicare Claims Processing Manual, Chapter 4, section 20.6.14 (effective 01/01/2018) and section 20.6.15 (effective 01/01/2018) • CFR section 419.71 • CMS' April 2018 Update of the Hospital Outpatient Prospective Payment System (OPPS) CR 10515 Revised March 22, 2018, Transmittal R4005CP, section 6 For services occurring on or after July 1, 2018, use modifier "FX" to report X-rays taken using film, which requires a 20 percent payment reduction for such service. Use modifier "FY" to report X-rays

	Services Occurring On or After 12/1/2014	Services Occurring On or After December 15, 2016 and Mid-year Updates	Services Occurring On or After June 1, 2017 and Mid-year Updates	Services Occurring On or After March 15, 2018 and Mid-year Updates
				taken using computed radiography technology/cassette-based imaging which requires a 7 percent payment reduction for such service. Apply payment rules set forth in: • December 14, 2017 (CMS-1678-FC; 82 FR 59216, Republished, section X.E., pages 59391 through 59393) • Medicare Claims Processing Manual, Chapter 4, section 20.6.14 (effective 01/01/2018) and section 20.6.15 (effective 01/01/2018) • CFR section 419.71 • CMS' April 2018 Update of the Hospital Outpatient Prospective Payment System (OPPS) CR 10515 Revised March 22, 2018, Transmittal R4005CP, section 6

	Services Occurring On or After 12/1/2014	Services Occurring On or After December 15, 2016 and Mid-year Updates	Services Occurring On or After June 1, 2017 and Mid-year Updates	Services Occurring On or After March 15, 2018 and Mid-year Updates
				For services occurring on or after October 1, 2018, use modifier “FX” to report X-rays taken using film, which requires a 20 percent payment reduction for such service. Use modifier “FY” to report X-rays taken using computed radiography technology/cassette-based imaging which requires a 7 percent payment reduction for such service. Apply payment rules set forth in: • December 14, 2017 (CMS-1678-FC; 82 FR 59216, Republished, section X.E., pages 59391 through 59393) • Medicare Claims Processing Manual, Chapter 4, section 20.6.14 (effective 01/01/2018) and section 20.6.15 (effective 01/01/2018)

	Services Occurring On or After 12/1/2014	Services Occurring On or After December 15, 2016 and Mid-year Updates	Services Occurring On or After June 1, 2017 and Mid-year Updates	Services Occurring On or After March 15, 2018 and Mid-year Updates
				• CFR section 419.71 • CMS' April 2018 Update of the Hospital Outpatient Prospective Payment System (OPPS) CR 10515 Revised March 22, 2018, Transmittal R4005CP, section 6 Access the Medicare Claims Processing Manual on the CMS website at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html
HOPPS Addenda	Addenda A, B, D1, D2, E, L, M, and P (A) found on CMS website at: http://www.cms.gov/HospitalOutpatientPPS	Addenda A, B, D1, D2, E, J, L, and M (A) found on CMS website at: http://www.cms.gov/HospitalOutpatientPPS	For services occurring on or after June 1, 2017 addenda~~,~~: • A (April 2017 - updated 3/20/2017; april_2017_web_addendum_a_03202017) • B (April 2017 - updated	For services occurring on or after March 15, 2018 addenda: • A (2018 CN Addendum A.11.29.17) • B (2018 CN Addendum B.11.29.17) • D1 (2018 Final Addendum 2018, NFRM

	Services Occurring On or After 12/1/2014	Services Occurring On or After December 15, 2016 and Mid-year Updates	Services Occurring On or After June 1, 2017 and Mid-year Updates	Services Occurring On or After March 15, 2018 and Mid-year Updates
			3/28/2017; april_2017_web_addendum_b.03.28.17) • D1 (2017 Final Addendum D1.10.11.16) • D2 (2017 Final Addendum D2.10.11.16) • E (2017 Final Addendum E.10.20.16) • J (2017 NFRM Addendum J 2016 12.05.16) • L (2017 Final OPPS Addendum L) • M (2017 Final Addendum M.10.20.16) • P (2017 Final Addendum P) For services occurring on or after July 1, 2017, addenda: • A (July 2017; july_2017_web_addendum_a.06.13.17) • B (July 2017; july_2017_web_addendum_b.06.13.17)	Addendum D1.10.18.17) • D2 (2018 Final Addendum, 2018 NFRM Addendum D2.10.18.17) • E (2018 Final Addendum, 2018 NFRM Addendum E.10.18.17) • J (2018 NFRM Addendum J Revised 01-25-2018) • L (2018 Final Addendum, 2018 NFRM Addendum L_final) • M (2018 CN Addendum M.12.04.17) • P (2018 NFRM CN Addendum P 11 20 17) For services occurring on or after April 1, 2018 addenda: • A (April 2018; 2018_april_web_addendum_a.03.19.18final.xlsx) • B (April 2018; 2018_april_web

	Services Occurring On or After 12/1/2014	Services Occurring On or After December 15, 2016 and Mid-year Updates	Services Occurring On or After June 1, 2017 and Mid-year Updates	Services Occurring On or After March 15, 2018 and Mid-year Updates
			• D1 (2017 Final Addendum D1.10.11.16) • D2 (2017 Final Addendum D2.10.11.16) • E (2017 Final Addendum E.10.20.16) • J (2017 NFRM Addendum J 2016 12.05.16) • L (2017 Final OPPS Addendum L) • M (2017 Final Addendum M.10.20.16) • P (2017 Final Addendum P) For services occurring on or after October 1, 2017, addenda: • A (October 2017; october_2017_web_addendum_a.09.14.17) • B (October 2017; october_2017_web_addendum_b.09.14.17)	_addendum_b.03.19.18final.xlsx) • D1 (2018 Final Addendum 2018, NFRM Addendum D1.10.18.17) • D2 (2018 Final Addendum, 2018 NFRM Addendum D2.10.18.17) • E (2018 Final Addendum, 2018 NFRM Addendum E.10.18.17) • J (2018 NFRM Addendum J Revised 01-25-2018) • L (2018 Final Addendum, 2018 NFRM Addendum L_final) • M (2018 CN Addendum M.12.04.17) • P (2018 NFRM CN Addendum P 11 20 17) For services occurring on or after July 1, 2018 addenda: • A (July 2018 – Updated 6/27/2018;

	Services Occurring On or After 12/1/2014	Services Occurring On or After December 15, 2016 and Mid-year Updates	Services Occurring On or After June 1, 2017 and Mid-year Updates	Services Occurring On or After March 15, 2018 and Mid-year Updates
			• D1 (2017 Final Addendum D1.10.11.16) • D2 (2017 Final Addendum D2.10.11.16) • E (2017 Final Addendum E.10.20.16) • J (2017 NFRM Addendum J 2016 12.05.16) • L (2017 Final OPPS Addendum L) • M (2017 Final Addendum M.10.20.16) • P (2017 Final Addendum P) Access the files on the CMS website at: http://www.cms.gov/HospitalOutpatientPPS	july_addendum_a.07.01.18revised06272018.xlsx) • B (July 2018 – Updated 6/27/2018; july_addendum_b.07.01.18revised06272018.xlsx) • D1 (2018 Final Addendum 2018, NFRM Addendum D1.10.18.17) • D2 (2018 Final Addendum, 2018 NFRM Addendum D2.10.18.17) • E (2018 Final Addendum, 2018 NFRM Addendum E.10.18.17) • J (2018 NFRM Addendum J Revised 01-25-2018) • L (2018 Final Addendum, 2018 NFRM Addendum L_final) • M (2018 CN Addendum M.12.04.17)

	Services Occurring On or After 12/1/2014	Services Occurring On or After December 15, 2016 and Mid-year Updates	Services Occurring On or After June 1, 2017 and Mid-year Updates	Services Occurring On or After March 15, 2018 and Mid-year Updates
				• P (2018 NFRM CN Addendum P 11 20 17) For services occurring on or after October 1, 2018 addenda: • A (October 2018; 2018_october_web_addendum_a.10.01.18no_340brem.xlsx) • B (October 2018; 2018_october_web_addendum_b.10.01.18no340brem.xlsx) • D1 (2018 Final Addendum 2018, NFRM Addendum D1.10.18.17) • D2 (2018 Final Addendum, 2018 NFRM Addendum D2.10.18.17) • E (2018 Final Addendum, 2018 NFRM Addendum E.10.18.17) • J (2018 NFRM Addendum J Revised 01-25-2018)

	Services Occurring On or After 12/1/2014	Services Occurring On or After December 15, 2016 and Mid-year Updates	Services Occurring On or After June 1, 2017 and Mid-year Updates	Services Occurring On or After March 15, 2018 and Mid-year Updates
				• L (2018 Final Addendum, 2018 NFRM Addendum L_ final) • M (2018 CN Addendum M.12.04.17) • P (2018 NFRM CN Addendum P 11 20 17) Access the files on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html
IPPS Tables	Tables 2, 4A, 4B, 4C, and 4J (B) found on CMS website at: http://www.cms.hhs.gov/AcuteInpatientPPS/.	Tables 2 and 3 found on CMS website at: http://www.cms.hhs.gov/AcuteInpatientPPS/.	Tables 2 and 3 (CMS 1655-F and CN FY 2017 Tables 2 and 3) found on CMS website at: http://www.cms.hhs.gov/AcuteInpatientPPS/	Tables 2 and 3 (CMS-1677-F; CMS-1677-CN) found at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page.html?DLSort=0&DLEntries=10&DLPage

	Services Occurring On or After 12/1/2014	Services Occurring On or After December 15, 2016 and Mid-year Updates	Services Occurring On or After June 1, 2017 and Mid-year Updates	Services Occurring On or After March 15, 2018 and Mid-year Updates
				=1&DLSortDir=ascending
Labor-related Share	60% ((A) beginning at page 74950)	60% ((A) beginning at page 70359)	60% ((A) beginning at page 79597)	60% ((A) beginning at page 59258)
Market Basket Inflation Factor	2.5% (A) page 74949	2.4% (A) page 70351	2.7% (A) page 79595	2.7% (A) page 59222)
Medicare Physician Fee Schedule Relative Value File	Medicare Physician Fee Schedule Relative Value File, by date of service, as adopted and incorporated by reference in the Official Medical Fee Schedule (OMFS) Physician Fee Schedule (Title 8 CCR sections 9789.12.1, et seq.). The (OMFS) Physician Fee Schedule is located at: http://www.dir.ca.gov/dwc/OMFS9904.htm and the Medicare Physician Fee Schedule Relative Value File is located at:	Not applicable for services rendered on or after December 15, 2016	Not applicable for services rendered on or after December 15, 2016	Not applicable for services rendered on or after December 15, 2016

	Services Occurring On or After 12/1/2014	Services Occurring On or After December 15, 2016 and Mid-year Updates	Services Occurring On or After June 1, 2017 and Mid-year Updates	Services Occurring On or After March 15, 2018 and Mid-year Updates
	http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html			
Surgical Procedure HCPCS	10021-69990, G0413	HCPCS codes listed in column A of July 2016 CMS' Ambulatory Surgical Center Payment System (ASC) Addendum AA, column A of July 2016 CMS' ASC Addendum EE, and CPT codes 21811-21813, but, excluding HCPCS codes listed on CMS' HOPPS Addendum E as an inpatient only procedure.	For services rendered on or after June 1, 2017, HCPCS codes listed in column A of April 2017 CMS' Ambulatory Surgical Center Payment System (ASC) Addendum AA, column A of April 2017 CMS' ASC Addendum EE, and CPT codes 21811-21813, and 36415, but, excluding HCPCS codes listed on CMS' 2017 HOPPS Addendum E as an inpatient only procedure. ASC Addenda AA and EE may be found in: April 2017 - april_2017_asc_a	For services rendered on or after March 15, 2018, HCPCS codes listed in column A of January 2018 CMS' Ambulatory Surgical Center Payment System (ASC) corrected Addendum AA, column A of January 2018 CMS' ASC corrected Addendum EE, and CPT codes 21811-21813, and 36415, but, excluding HCPCS codes listed on CMS' 2018 HOPPS Addendum E as an inpatient only procedure. ASC Addenda AA and EE may be found in: "Correc-

	Services Occurring On or After 12/1/2014	Services Occurring On or After December 15, 2016 and Mid-year Updates	Services Occurring On or After June 1, 2017 and Mid-year Updates	Services Occurring On or After March 15, 2018 and Mid-year Updates
			ddenda_rev_20170329, at: (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html) 2017 HOPPS Addendum E (2017 Final Addendum E.10.20.16) is found at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1656-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending For services rendered on or after July 1, 2017, HCPCS codes listed in column A of July 2017 CMS' Ambulatory	tion Notice Addendum AA, BB, DD1, DD2, EE" (CMS-1678-CN-ASC-Addendum-AA-BB-DD1-DD2-EE.zip) at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html 2018 HOPPS Addendum E (2018 NFRM Addendum E.10.18.17) is found at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1678-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending For services rendered on or after April 1, 2018,

	Services Occurring On or After 12/1/2014	Services Occurring On or After December 15, 2016 and Mid-year Updates	Services Occurring On or After June 1, 2017 and Mid-year Updates	Services Occurring On or After March 15, 2018 and Mid-year Updates
			Surgical Center Payment System (ASC) Addendum AA, column A of July 2017 CMS' ASC Addendum EE, and CPT codes 21811-21813, and 36415, but, excluding HCPCS codes listed on CMS' 2017 HOPPS Addendum E as an inpatient only procedure. ASC Addenda AA and EE may be found in: July 2017 - July_2017_asc_addenda1: (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html) 2017 HOPPS Addendum E (2017 Final Addendum E.10.20.16) is found at: https://www.cms.gov/Medicare/Medicare-	HCPCS codes listed in column A, of April 2018 CMS' Ambulatory Surgical Center Payment System (ASC) Addendum AA, Column A, of April 2018 CMS' ASC Addendum EE, and CPT codes 21811-21813, and 36415, but, excluding HCPCS codes listed on CMS' 2018 HOPPS Addendum E as an inpatient only procedure. ASC Addenda AA and EE may be found in: "April 2018 ASC Approved HCPCS Code and Payment Rates - Updated 03/21/2018" (april_2018_asc_addenda_updated_04_01_2018b.xlsx) at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPay-

	Services Occurring On or After 12/1/2014	Services Occurring On or After December 15, 2016 and Mid-year Updates	Services Occurring On or After June 1, 2017 and Mid-year Updates	Services Occurring On or After March 15, 2018 and Mid-year Updates
			Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1656-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending For services rendered on or after October 1, 2017, HCPCS codes listed in column A of October 2017 CMS' Ambulatory Surgical Center Payment System (ASC) Addendum AA, column A of October 2017 CMS' ASC Addendum EE, and CPT codes 21811-21813, and 36415, but, excluding HCPCS codes listed on CMS' 2017 HOPPS Addendum E as an inpatient only procedure. ASC Addenda AA and EE may be	ment/11_Addenda_Updates.html 2018 HOPPS Addendum E (2018 NFRM Addendum E.10.18.17) is found at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1678-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending For services rendered on or after July 1, 2018, HCPCS codes listed in column A, of July 2018 CMS' Ambulatory Surgical Center Payment System (ASC) Addendum AA, Column A, of July 2018 CMS' ASC Addendum EE, and CPT codes 21811-21813, and

	Services Occurring On or After 12/1/2014	Services Occurring On or After December 15, 2016 and Mid-year Updates	Services Occurring On or After June 1, 2017 and Mid-year Updates	Services Occurring On or After March 15, 2018 and Mid-year Updates
			found in: October 2017 - october_2017_asc_addenda: (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html) 2017 HOPPS Addendum E (2017 Final Addendum E.10.20.16) is found at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1656-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending	36415, but, excluding HCPCS codes listed on CMS' 2018 HOPPS Addendum E as an inpatient only procedure. ASC Addenda AA and EE may be found in: "July 2018 ASC Approved HCPCS Code and Payment Rates – Updated 06/28/2018" (july_2018_asc_addenda_updated_06_28_2018.xlsx) at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html 2018 HOPPS Addendum E (2018 NFRM Addendum E.10.18.17) is found at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-

	Services Occurring On or After 12/1/2014	Services Occurring On or After December 15, 2016 and Mid-year Updates	Services Occurring On or After June 1, 2017 and Mid-year Updates	Services Occurring On or After March 15, 2018 and Mid-year Updates
				Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1678-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending For services rendered on or after October 1, 2018, HCPCS codes listed in column A, of October 2018 CMS' Ambulatory Surgical Center Payment System (ASC) Addendum AA, Column A, of October 2018 CMS' ASC Addendum EE, and CPT codes 21811-21813, and 36415, but, excluding HCPCS codes listed on CMS' 2018 HOPPS Addendum E as an inpatient only procedure. ASC Addenda AA and EE may be found in: "October

	Services Occurring On or After 12/1/2014	Services Occurring On or After December 15, 2016 and Mid-year Updates	Services Occurring On or After June 1, 2017 and Mid-year Updates	Services Occurring On or After March 15, 2018 and Mid-year Updates
				2018 ASC Approved HCPCS Code and Payment Rates" (oct_2018_asc_addenda_updated_09_19_2018.09212018cb.xlsx) at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html 2018 HOPPS Addendum E (2018 NFRM Addendum E.10.18.17) is found at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1678-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending

	Services Occurring On or After 12/1/2014	Services Occurring On or After December 15, 2016 and Mid-year Updates	Services Occurring On or After June 1, 2017 and Mid-year Updates	Services Occurring On or After March 15, 2018 and Mid-year Updates
Conversion Factor adjusted for inflation factor	$72.530 (2013 unadjusted conversion factor of $70.761 x estimated inflation factor of 1.025)	$76.424 (2015 unadjusted conversion factor of $74.633 x estimated inflation factor of 1.024)	$78.488 (2016 unadjusted conversion factor of $76.424 x estimated inflation factor of 1.027)	$80.607 (2017 unadjusted conversion factor of $78.488 x estimated inflation factor of 1.027)
Wage Index	Referenced in (A) beginning at page 74952; wage index values are specified in Tables 4A through 4C (B) found on the CMS web site at: http://www.cms.gov/AcuteInpatientPPS/	Referenced in (A) beginning at page 70359; wage index values are specified in Table 2 (B) found on the CMS website at http://www.cms.gov/AcuteInpatientPPS/	Referenced in (A) beginning at page 79597; wage index values are specified in Table 2 (D) found on the CMS website at http://www.cms.gov/AcuteInpatientPPS/	Referenced in (A) beginning at page 59261; wage index values are specified in Table 2 (D) found on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page.html?DLSort=0&DLEntries=10&DLPage=1&DLSortDir=ascending

	Services Occurring On or After February 15, 2019 and Mid-year Updates
Applicable FR Notices	(A) November 21, 2018 (CMS-1695-FC; 83 FR 58818) (B) December 28, 2018 (CMS-1695-CN2; 83 FR 67083) (C) August 17, 2018 (CMS-1694-F; 83 FR 41144) (D) October 3, 2018 (CMS-1694-CN2; 83 FR 49836)
Ambulatory Surgical Centers Payment System Addenda	For services occurring on or after February 15, 2019, Column A, of Addendum AA, entitled, “HCPCS Code” and Column A, of Addendum EE, entitled, “HCPCS Code” located in “January 2019 ASC Approved HCPCS Code and Payment Rates - Updated 01/29/2019” (jan_2019_asc_addenda_1_28_19.xlsx)

	Services Occurring On or After February 15, 2019 and Mid-year Updates
	For services occurring on or after April 1, 2019, Column A, of Addendum AA, entitled, “HCPCS Code” and Column A, of Addendum EE, entitled, “HCPCS Code” located in “April 2019 ASC Approved HCPCS Code and Payment Rates – Updated 3/28/2019” (Apr_2019_ASC_Addenda_3_27_2019) For services occurring on or after July 1, 2019, Column A, of Addendum AA, entitled, “HCPCS Code” and Column A, of Addendum EE, entitled, “HCPCS Code” located in “July 2019 ASC Approved HCPCS Code and Payment Rates – Updated 06/27/2019” (July_2019_ASC_Addenda.06262019.xlsx) For services occurring on or after October 1, 2019, Column A, of Addendum AA, entitled, “HCPCS Code” and Column A, of Addendum EE, entitled, “HCPCS Code” located in “October 2019 ASC Approved HCPCS Code and Payment Rates CORRECTIONS - Updated 10/15/2019” (October_2019_ASC_Addenda.CORRECTED.10152019.xlsx) Note: Access the files on CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html
APC Payment Rate	For services occurring on or after February 15, 2019, Addendum B, dated January 2019 (january_2019_opps_web_addendum_b.12312018.xlsx) For services occurring on or after April 1, 2019, Addendum B, dated April 2019 (2019_April_Web_Addendum_B.03222019.xlsx) For services occurring on or after July 1, 2019, Addendum B, dated July 2019 (July_2019_Web_Addendum_B.06212019.xlsx) For services occurring on or after October 1, 2019, Addendum B – Correction, dated October 2019 (2019_October_Web_Addendum_B.CORRECTED.09292019.xlsx)
APC Relative Weight	For services occurring on or after February 15, 2019, Addendum B, dated January 2019 (january_2019_opps_web_addendum_b.12312018.xlsx) For services occurring on or after April 1, 2019, Addendum B, dated April 2019 (2019_April_Web_Addendum_B.03222019.xlsx)

	Services Occurring On or After February 15, 2019 and Mid-year Updates
	For services occurring on or after July 1, 2019, Addendum B, dated July 2019 (July_2019_Web_Addendum_B.06212019.xlsx) For services occurring on or after October 1, 2019, Addendum B - Correction, dated October 2019 (2019_October_Web_Addendum_B.CORRECTED.09292019.xlsx)
Composite APCs (codes assigned status indicator "Q1," "Q2," "Q3," or "Q4") payment rules	For services occurring on or after February 15, 2019, payment rules are: • Medicare Claims Processing Manual, Chapter 4, sections 10.2.1, 10.2.2, 10.4, and 10.4.1 • CMS 2019 OPPS Addendum D1 • CMS 2019 OPPS Addendum M • IOCE Quarterly Data Files V20.0 [ZIP, 52MB], IntegOCEspecsV20.0.pdf, sections 5.4.1, 5.4.3, 5.4.5, and 5.5 For services occurring on or after April 1, 2019, payment rules are: • Medicare Claims Processing Manual, Chapter 4, sections 10.2.1, 10.2.2, 10.4, and 10.4.1 • CMS 2019 OPPS Addendum D1 • CMS 2019 OPPS Addendum M • IOCE Quarterly Data Files V20.1 [ZIP, 50MB], IntegOCEspecsV20.1.pdf, sections 5.4.1, 5.4.3, 5.4.5, and 5.5 For services occurring on or after July 1, 2019, payment rules are: • Medicare Claims Processing Manual, Chapter 4, sections 10.2.1, 10.2.2, 10.4, and 10.4.1 • CMS 2019 OPPS Addendum D1 • CMS 2019 OPPS Addendum M • IOCE Quarterly Data Files V20.2 [ZIP, 50MB], IntegOCEspecsV20.2.pdf, sections 5.4.1, 5.4.3, 5.4.5, and 5.5 For services occurring on or after October 1, 2019, payment rules are: • Medicare Claims Processing Manual, Chapter 4, sections 10.2.1, 10.2.2, 10.4, and 10.4.1 • CMS 2019 OPPS Addendum D1 • CMS 2019 OPPS Addendum M • IOCE Quarterly Data Files V20.3 [ZIP, 50 MB] IntegOCEspecsV20.3.pdf, sections 4.4.1, 4.4.3, 4.4.5, and 4.5 Note: A copy of the IOCE is posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm#6

	Services Occurring On or After February 15, 2019 and Mid-year Updates
	Access documents on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html?redirect=/HospitalOutpatientPPS/ and CMS Claims Processing Manual at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html
Comprehensive APCs (codes assigned status indicator "J1" or "J2") payment rules	For services occurring on or after February 15, 2019, payment rules are: • Medicare Claims Processing Manual, Chapter 4, sections 10.2.3, 10.4, 290.5.2, and 290.5.3 • CMS 2019 OPPS Addendum D1 • CMS 2019 OPPS Addendum J • IOCE Quarterly Data Files V20.0 [ZIP, 52MB], IntegOCEspecsV20.0.pdf, sections 5.6.1, 5.6.1.1, 5.6.2, 5.6.3, 5.6.4, 5.6.4.1, and 5.6.4.2 For services occurring on or after April 1, 2019, payment rules are: • Medicare Claims Processing Manual, Chapter 4, sections 10.2.3, 10.4, 290.5.2, and 290.5.3 • CMS 2019 OPPS Addendum D1 • CMS 2019 OPPS Addendum J • IOCE Quarterly Data Files V20.1 [ZIP, 50MB], IntegOCEspecsV20.1.pdf, sections 5.6.1, 5.6.1.1, 5.6.2, 5.6.3, 5.6.4, 5.6.4.1, and 5.6.4.2 For services occurring on or after July 1, 2019, payment rules are: • Medicare Claims Processing Manual, Chapter 4, sections 10.2.3, 10.4, 290.5.2, and 290.5.3 • CMS 2019 OPPS Addendum D1 • CMS 2019 OPPS Addendum J • IOCE Quarterly Data Files V20.2 [ZIP, 50MB], IntegOCEspecsV20.2.pdf, sections 5.6.1, 5.6.1.1, 5.6.2, 5.6.3, 5.6.4, 5.6.4.1, and 5.6.4.2 For services occurring on or after October 1, 2019, payment rules are: • Medicare Claims Processing Manual, Chapter 4, sections 10.2.3, 10.4, 290.5.2, and 290.5.3 • CMS 2019 OPPS Addendum D1 • CMS 2019 OPPS Addendum J • IOCE Quarterly Data Files V20.3 [ZIP, 50 MB] IntegOCEspecsV20.3.pdf, sections 4.6.1, 4.6.1.1, 4.6.2, 4.6.3, 4.6.4, 4.6.4.1, and 4.6.4.2 Note: A copy of the IOCE is posted on the DWC website: http://www.dir.ca.gov/dwc/OMFS9904.htm#6

	Services Occurring On or After February 15, 2019 and Mid-year Updates
	Access documents on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html And CMS Claims Processing Manual at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending
Emergency Department HCPCS Codes	99281-99285, 99291, 99292, G0380-G0384, G0390
Facility Only Services	Not applicable for services rendered on or after December 15, 2016
Film X-ray services and X-rays taken using computed radiography technology/cassette-based imaging payment reductions	Use modifier "FX" to report X-rays taken using film, which requires a 20 percent payment reduction for such service. Use modifier "FY" to report X-rays taken using computed radiography technology/cassette-based imaging which requires a 7 percent payment reduction for such service. Apply payment rules set forth in: • December 14, 2017 (CMS-1678-FC; 82 FR 59216, Republished, section X.E., pages 59391 through 59393) • Medicare Claims Processing Manual, Chapter 4, section 20.6.14 (effective 01/01/2018) and section 20.6.15 (effective 01/01/2018) • CFR section 419.71 • CMS' April 2018 Update of the Hospital Outpatient Prospective Payment System (OPPS) CR 10515 Revised March 22, 2018, Transmittal R4005CP, section 6 Access the Medicare Claims Processing Manual on the CMS website at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html
HOPPS Addenda	For services occurring on or after February 15, 2019 addenda: • A (January 2019; january_2019_opps_web_addendum_a.12312018.xlsx) • B (January 2019; january_2019_opps_web_addendum_b.12312018.xlsx) • D1 (CY2019 NFRM OPPS Addenda; CY2019 NFRM Addendum D1.11012018.xlsx) • D2 (CY2019 NFRM OPPS Addenda; CY2019 NFRM Addendum D2.11012018.xlsm) • E (CY2019 NFRM OPPS Addenda; CY2019 NFRM Addendum E.11012018.xlsx) • J (CY2019 NFRM OPPS Addenda; CY2019 NFRM Addendum J.11012018.xls)

	Services Occurring On or After February 15, 2019 and Mid-year Updates
	• L (CY2019 NFRM OPPS Addenda; CY2019 NFRM Addendum L.11012018.xlsx) • M (CY2019 NFRM OPPS Addenda; CY2019 NFRM Addendum M.11012018.xlsx) • P (2019 CN2 OPPS Addenda; 2019 CN2 Addendum P.12212018.xlsx) For services occurring on or after April 1, 2019 addenda: • A (April 2019; 2019_April_Web_Addendum_A.03222019.xlsx) • B (April 2019; 2019_April_Web_Addendum_B.03222019.xlsx) • D1 (CY2019 NFRM OPPS Addenda; CY2019 NFRM Addendum D1.11012018.xlsx) • D2 (CY2019 NFRM OPPS Addenda; CY2019 NFRM Addendum D2.11012018.xlsm) • E (CY2019 NFRM OPPS Addenda; CY2019 NFRM Addendum E.11012018.xlsx) • J (CY2019 NFRM OPPS Addenda; CY2019 NFRM Addendum J.11012018.xls) • L (CY2019 NFRM OPPS Addenda; CY2019 NFRM Addendum L.11012018.xlsx) • M (CY2019 NFRM OPPS Addenda; CY2019 NFRM Addendum M.11012018.xlsx) • P (2019 CN2 OPPS Addenda; 2019 CN2 Addendum P.12212018.xlsx) For services occurring on or after July 1, 2019 addenda: • A (July 2019; July_2019_Web_Addendum_A.06212019.xlsx) • B (July 2019; July_2019_Web_Addendum_B.06212019.xlsx) • D1 (CY2019 NFRM OPPS Addenda; CY2019 NFRM Addendum D1.11012018.xlsx) • D2 (CY2019 NFRM OPPS Addenda; CY2019 NFRM Addendum D2.11012018.xlsm) • E (CY2019 NFRM OPPS Addenda; CY2019 NFRM Addendum E.11012018.xlsx) • J (CY2019 NFRM OPPS Addenda; CY2019 NFRM Addendum J.11012018.xls) • L (CY2019 NFRM OPPS Addenda; CY2019 NFRM Addendum L.11012018.xlsx) • M (CY2019 NFRM OPPS Addenda; CY2019 NFRM Addendum M.11012018.xlsx) • P (2019 CN2 OPPS Addenda; 2019 CN2 Addendum P.12212018.xlsx) For services occurring on or after October 1, 2019 addenda:

	Services Occurring On or After February 15, 2019 and Mid-year Updates
	• A (October 2019; 2019_October_Web_Addendum_A.CORRECTED.09292019.xlsx) • B (October 2019; 2019_October_Web_Addendum_B.CORRECTED.09292019.xlsx) • D1 (CY2019 NFRM OPPS Addenda; CY2019 NFRM Addendum D1.11012018.xlsx) • D2 (CY2019 NFRM OPPS Addenda; CY2019 NFRM Addendum D2.11012018.xlsm) • E (CY2019 NFRM OPPS Addenda; CY2019 NFRM Addendum E.11012018.xlsx) • J (CY2019 NFRM OPPS Addenda; CY2019 NFRM Addendum J.11012018.xls) • L (CY2019 NFRM OPPS Addenda; CY2019 NFRM Addendum L.11012018.xlsx) • M (CY2019 NFRM OPPS Addenda; CY2019 NFRM Addendum M.11012018.xlsx) • P (2019 CN2 OPPS Addenda; 2019 CN2 Addendum P.12212018.xlsx) Note: Access the files on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html
IPPS Tables	FY 2019 Tables 2, 3 and 4 (Wage Index Tables) (Final Rule and Correction Notice) [ZIP, 1MB] found at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2019-IPPS-Final-Rule-Home-Page-Items/FY2019-IPPS-Final-Rule-Tables.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending
Labor-related Share	60% (A) beginning at page 58863
Market Basket Inflation Factor	2.9% (A) page 58822
Medicare Physician Fee Schedule Relative Value File	Not applicable for services rendered on or after December 15, 2016
Surgical Procedure HCPCS	For services rendered on or after February 15, 2019, HCPCS codes listed in column A, of CMS' Ambulatory Surgical Center Payment System (ASC) "Jan 2019 ASC AA," Column A, of CMS' ASC "Jan 2019

	Services Occurring On or After February 15, 2019 and Mid-year Updates
	ASC EE, and CPT codes 21811-21813, 33289, and 36415, but, excluding HCPCS codes listed on CMS' 2019 HOPPS Addendum E as an inpatient only procedure. ASC Addenda AA and EE may be found in: "January 2019 ASC Approved HCPCS Code and Payment Rates - Updated 01/29/2019" (jan_2019_asc_addenda_1_28_19.xlsx) at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html 2019 HOPPS Addendum E (CY2019 NFRM Addendum E.11012018.xlsx) is found at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1695-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending For services rendered on or after April 1, 2019, HCPCS codes listed in column A, of CMS' Ambulatory Surgical Center Payment System (ASC) "Apr 2019 ASC AA," Column A, of CMS' ASC "Apr 2019 ASC EE," and CPT codes 21811-21813, 33289, and 36415, but, excluding HCPCS codes listed on CMS' 2019 HOPPS Addendum E as an inpatient only procedure. ASC Addenda AA and EE may be found in: "April 2019 ASC Approved HCPCS Code and Payment Rates – Updated 3/28/19" (Apr_2019_ASC_Addenda_3_27_2019) at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html 2019 HOPPS Addendum E (CY2019 NFRM Addendum E.11012018.xlsx) is found at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1695-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending For services rendered on or after July 1, 2019, HCPCS codes listed in column A, of CMS' Ambulatory Surgical Center Payment System (ASC) "Jul 2019 ASC AA," Column A, of CMS' ASC "Jul 2019 ASC EE," and CPT codes 21811-21813, 33289, and 36415, but, excluding HCPCS codes listed on CMS' 2019 HOPPS Addendum E as an inpatient only procedure. ASC Addenda AA and EE may be found in: "July 2019 ASC Approved HCPCS Code and Payment Rates – Updated 06/27/2019" (July_2019_ASC_Addenda.06262019.xlsx) at:

	Services Occurring On or After February 15, 2019 and Mid-year Updates
	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html 2019 HOPPS Addendum E (CY2019 NFRM Addendum E.11012018.xlsx) is found at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1695-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending For services rendered on or after October 1, 2019, HCPCS codes listed in column A, of CMS' Ambulatory Surgical Center Payment System (ASC) "Oct 2019 ASC AA," Column A, of CMS' ASC "Oct 2019 ASC EE," and CPT codes 21811-21813, 33289, and 36415, but, excluding HCPCS codes listed on CMS' 2019 HOPPS Addendum E as an inpatient only procedure. ASC Addenda AA and EE may be found in: "October 2019 ASC Approved HCPCS Code and Payment Rates CORRECTIONS - Updated 10/15/2019" (October_2019_ASC_Addenda.CORRECTED.10152019.xlsx) at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html 2019 HOPPS Addendum E (CY2019 NFRM Addendum E.11012018.xlsx) is found at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1695-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending
Conversion Factor adjusted for inflation factor	$82.945 (2018 unadjusted conversion factor of $80.607 x estimated inflation factor of 1.029)
Wage Index	Referenced in (A) beginning at page 58876; wage index values are specified in Table 2 (C) and (D) found on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2019-IPPS-Final-Rule-Home-Page-Items/FY2019-IPPS-Final-Rule-Tables.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending

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