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 9789.32. Applicability.

(a) Sections 9789.30 through 9789.39 shall be applicable to the maximum allowable fees for emergency room visits and surgical procedures rendered on or after July 1, 2004 and 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 rendered on or after September 1, 2014. 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 facility fee is payable only for the specified emergency room, surgical codes, Facility Only Services, and for supplies, drugs, devices, blood products and biologicals that are an integral part of the emergency room visit, surgical procedure, or Facility Only Service. A supply, drug, device, blood product and biological is considered an integral part of an emergency room visit, surgical procedure, or Facility Only Service if:

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

For services rendered on or after March 1, 2008: 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) or,

For services rendered on or after March 1, 2009: 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) or,

For services rendered on or after 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, surgical procedure, or Facility Only Service (in which case no additional fee is allowable).

(2) 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: 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: 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.

Depending on date of service, payment for other services furnished in conjunction with a surgical procedure, emergency room visit, or Facility Only Service, shall be in accordance with subdivision (c) of this Section.

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

(c) The maximum allowable fees for services, drugs and supplies furnished by hospitals and ambulatory surgical centers 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 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.

(iii) The fees for any physician and non-physician practitioner professional services billed by the hospital shall be calculated in accordance with the OMFS RBRVS, using the OMFS RBRVS total facility relative value units.

(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.

(d) 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(o) 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, 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(o) 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.

(e) 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.

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

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

(h) 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