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
Discharge on or after January 1, 2004

Section 9789.30. Definitions.

(a) "Adjusted Conversion Factor" ~~means the CMS' conversion factor for 2003 of $52.151 x the market basket inflation factor of 1.034 x (0.4 + (0.6 x wage index)).~~ is determined as follows: unadjusted conversion factor x the market basket inflation 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 July 15, 2005, "Adjusted Conversion Factor" means the OMFS' conversion factor for 2004 of $53.924 x the market basket inflation factor 1.033 x (0.4 + (0.6 x wage index).~~

~~For services rendered on or after February 15, 2006, "Adjusted Conversion Factor" means the OMFS' conversion factor for 2005 of $55.703 x the market basket inflation factor 1.037 x (0.4 + (0.6 x wage index).~~

~~For services rendered on or after March 1, 2007, "Adjusted Conversion Factor" means the OMFS' conversion factor for 2006 of $57.764 x the market basket inflation factor 1.034 x (0.4 + (0.6 x wage index).~~

~~For services rendered on or after March 1, 2008, "Adjusted Conversion Factor" means the OMFS' conversion factor for 2007 of $59.728 x the market basket inflation factor 1.033 x (0.4 + (0.6 x wage index).~~

~~For services rendered on or after March 1, 2009, "Adjusted Conversion Factor" means the OMFS' conversion factor for 2008 of $61.699 x the market basket inflation factor 1.036 x (0.4 + (0.6 x wage index).~~

~~For services rendered on or after April 15, 2010, "Adjusted Conversion Factor" means the OMFS' conversion factor for 2009 of $63.920 x the market basket inflation factor 1.021 x (0.4 + (0.6 x wage index).~~

For services rendered on or after February 15, 2006, in accordance with ~~s~~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) "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.

(e) "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. ~~for Calendar Year 2004 as set forth in the~~

~~Federal Register on November 7, 2003, Volume 68, No. 216, Addendum B, pages 63488 through 63655 conformed to comply with CMS-1471-CN, Federal Register, Volume 68, No. 250 (December 31, 2003), pages 75442 through 75445, and CMS-1371-IFC, Federal Register, Volume 69, No. 3 (January 6, 2004), pages 820 through 844.~~

~~For services rendered on or after July 15, 2005, "APC Payment Rate" means CMS' hospital outpatient prospective payment system rate for Calendar Year 2005 as set forth in the Federal Register on November 15, 2004 (CMS-1427-FC, 69 FR 65682) Addendum B, pages 65887 through 66182.~~

~~For services rendered on or after February 15, 2006, "APC Payment Rate" means CMS' hospital outpatient prospective payment system rate for Calendar Year 2006 as set forth in the Federal Register on November 10, 2005 (CMS-1501-FC, 70 FR 68516), Addendum B, pages 68752 through 68913.~~

~~For services rendered on or after March 1, 2007, "APC Payment Rate" means CMS' hospital outpatient prospective payment system rate for Calendar Year 2007 as set forth in the Federal Register on November 24, 2006 (CMS-1506-FC, 71 FR 67960), Addendum B, pages 68283 through 68384.~~

~~For services rendered on or after March 1, 2008, "APC Payment Rate" means CMS' hospital outpatient prospective payment system rate for Calendar Year 2008 as set forth in the Federal Register on November 27, 2007 (CMS-1392-FC, 72 FR 66580), Addendum B, pages 66993 through 67165 conformed to comply with the correction of the final rule published on February 22, 2008 (CMS-1392-CN, 73 FR 9860), pages 9863 through 9864.~~

~~For services rendered on or after March 1, 2009, "APC Payment Rate" means CMS' hospital outpatient prospective payment system rate for Calendar Year 2009 as set forth in the Federal Register on November 18, 2008 (CMS-1404-FC, 73 FR 68502), Addendum B, pages 68934 through 69269 conformed to comply with correction of the final rule published on January 26, 2009 (CMS-1404-CN, 74 FR 4343), page 4344.~~

~~For services rendered on or after April 15, 2010, "APC Payment Rate" means CMS' hospital outpatient prospective payment system rate for Calendar Year 2010 as set forth in the Federal Register on November 20, 2009 (CMS-1414-FC), 74 FR 60316, Addendum B, pages 60752 through 60918 conformed to comply with correction of the final rule published on December 31, 2009 (CMS-1414-CN, 74 FR 69502), page 69503.~~

(f) "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. ~~for the Calendar Year 2004 as set forth in the Federal Register on November 7, 2003, Volume 68, No. 216, Addendum B, pages 63488 through 63655 conformed to comply with CMS-1471-CN, Federal Register, Volume 68, No. 250 (December 31, 2003), pages 75442 through 75445, and CMS-1371-IFC, Federal Register, Volume 69, No. 3 (January 6, 2004), pages 820 through 844.~~

~~For services rendered on or after July 15, 2005, "APC Relative Weight" means CMS' APC relative weight as set forth in CMS' hospital outpatient prospective payment system for the Calendar Year 2005 as set forth in the Federal Register on November 15, 2004 (CMS-1427-FC, 69 FR 65682) Addendum B, pages 65887 through 66182.~~

~~For services rendered on or after February 15, 2006, "APC Relative Weight" means CMS' APC relative weight as set forth in CMS' hospital outpatient prospective payment system for the Calendar Year 2006 as set forth in the Federal Register on November 10, 2005 (CMS-1501-FC, 70 FR 68516), Addendum B, pages 68752 through 68913.~~

~~For services rendered on or after March 1, 2007, "APC Relative Weight" means CMS' APC relative weight as set forth in CMS' hospital outpatient prospective payment system for the Calendar Year 2007 as set forth in the Federal Register on November 24, 2006 (CMS-1506-FC, 71 FR 67960), Addendum B, pages 68283 through 68384.~~

~~For services rendered on or after March 1, 2008, "APC Relative Weight" means CMS' APC relative weight as set forth in CMS' hospital outpatient prospective payment system for the Calendar Year 2008 as set forth in the Federal Register on November 27, 2007 (CMS-1392-FC, 72 FR 66580), Addendum B, pages 66993 through 67165 conformed to comply with the correction of the final rule published on February 22, 2008 (CMS-1392-CN, 73 FR 9860), pages 9863 through 9864.~~

~~For services rendered on or after March 1, 2009, "APC Relative Weight" means CMS' APC relative weight as set forth in CMS' hospital outpatient prospective payment system for the Calendar Year 2009 as set forth in the Federal Register on November 18, 2008 (CMS-1404-FC, 73 FR 68502), Addendum B, pages 68934 through 69269 conformed to comply with correction of the final rule published on January 26, 2009 (CMS-1404-CN, 74 FR 4343), page 4344.~~

~~For services rendered on or after April 15, 2010, "APC Relative Weight" means CMS' APC relative weight as set forth in CMS' hospital outpatient prospective payment system for the Calendar Year 2010 as set forth in the Federal Register~~

~~on November 20, 2009 (CMS-1414-FC), 74 FR 60316, Addendum B, pages 60752 through 60918 conformed to comply with correction of the final rule published on December 31, 2009 (CMS-1414-CN, 74 FR 69502), page 69503.~~

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

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

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

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

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

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

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

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

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

(p) "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 reference the labor-related share by date of service.

(~~p~~ q) "Market Basket Inflation Factor" means ~~3.4%,~~ the market basket percentage ~~increase~~ change determined by CMS ~~for FY 2004,~~ 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. ~~on August 1, 2003, Volume 68, at page 45346~~.

~~For services rendered on or after July 15, 2005, "Market Basket Inflation Factor" means 3.3%, the market basket percentage increase determined by CMS for FY 2005, as set forth in the Federal Register on August 11, 2004 (CMS-1428-F, 69 FR 48916), at page 49274.~~

~~For services rendered on or after February 15, 2006, "Market Basket Inflation Factor" means 3.7%, the market basket percentage increase determined by CMS for FY 2006, as set forth in the Federal Register on August 12, 2005 (CMS-1500-F, 70 FR 47278), at page 47492.~~

~~For services rendered on or after March 1, 2007, "Market Basket Inflation Factor" means 3.4%, the market basket percentage increase determined by CMS for FY 2007, as set forth in the Federal Register on August 18, 2006 (CMS-1488-F, 71 FR 47870), at page 48146.~~

~~For services rendered on or after March 1, 2008, "Market Basket Inflation Factor" means 3.3%, the market basket percentage increase determined by CMS for FY 2008, as set forth in the Federal Register on August 22, 2007 (CMS-1533-FC, 72 FR 47130), at page 47415.~~

~~For services rendered on or after March 1, 2009, "Market Basket Inflation Factor" means 3.6%, the market basket percentage increase determined by CMS for FY 2009, as set forth in the Federal Register on August 19, 2008 (CMS-1390-F, 73 FR 48434), at page 48759.~~

~~For services rendered on or after April 15, 2010, "Market Basket Inflation Factor" means 2.1%, the market basket percentage increase determined by CMS for FY 2010, as set forth in the Federal Register on August 27, 2009 (CMS-1406-F, 74 FR 43754), at page 44002.~~

(r) "Outlier Threshold" means the Medicare outlier threshold used in determining high cost outlier payments.

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

(t) "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.

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

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

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

~~For services rendered on or after July 15, 2005, "Wage Index" means CMS' wage index for urban, rural and hospitals that are reclassified as described in CMS' 2005 Hospital Outpatient Prospective Payment System (HOPPS) correction to the final rule of November 15, 2004, adopted for the Calendar Year 2005, published in the Federal Register on December 30, 2004 (CMS-1427-CN, 69 FR 78315), Addenda H through J, pages 78316 through 78317. The wage index values are specified in the Hospital Inpatient Prospective Payment Systems published in the Federal Register on December 30, 2004 at Vol. 69 FR 78526 (CMS-1428-F2)(correcting the final rule published on August 11, 2004 (CMS-1428-F; 69 FR 48916) and correcting the correction to the final rule published on October 7, 2004 (CMS-1428-CN2; 69 FR 60242)), Table 4A$_1$ beginning on page 78619 for urban areas by MSA, Table 4A$_2$ beginning on page 78637 for urban areas by CBSA; Table 4B$_1$ beginning on page 78660 for rural areas by MSA and Table 4B$_2$ beginning on page 78661 for rural areas by CBSA; and Table 4C$_1$ beginning on page 78662 for reclassified hospitals by MSA and Table 4C$_2$ beginning on page 78665 for reclassified hospitals by CBSA.~~

~~For services rendered on or after February 15, 2006, "Wage Index" means CMS' wage index for urban, rural and hospitals that are reclassified as described in CMS' 2006 Hospital Outpatient Prospective Payment System (HOPPS) final rule of November 10, 2005, adopted for the Calendar Year 2006, published in the Federal Register (CMS-1501-FC, 70 FR 68516), at pages 68551 through 68552. The wage index values are specified in the Hospital Inpatient Prospective Payment Systems published in the Federal Register on September 30, 2005 at Vol. 70 FR 57161 (CMS-1500-CN) (correcting the final rule published on August 12, 2005 at Vol. 70 FR 47278 (CMS-1500-F)), on page 57163 for Table 4A for certain urban areas by CBSA, Table 4B for certain rural areas by CBSA, and Table 4C for certain reclassified hospitals by CBSA; and as specified in the final rule published on August 12, 2005 (CMS-1500-F; 70 FR 47278), Table 4A beginning on page 47580 for urban areas by CBSA; Table 4B beginning on page 47603 for rural areas by CBSA; and Table 4C beginning on page 47604 for reclassified hospitals by CBSA.~~

~~For services rendered on or after March 1, 2007, "Wage Index" means CMS' wage index for urban, rural and hospitals that are reclassified as described in CMS' 2007 Hospital Outpatient Prospective Payment System (HOPPS) final rule of November 24, 2006, adopted for the Calendar Year 2007, published in the Federal Register (CMS-1506-FC, 71 FR 67960), at pages 68003 through 68004. The wage index values are specified in the Hospital Inpatient Prospective Payment Systems published in the Federal Register on October 11, 2006 at Vol. 71 FR 59886 (CMS-1488-N) (additional notice to the final rule published on August 18, 2006 (CMS-1488-F; 71 FR 47870)), Table 4A-1 beginning on page 59975 for urban areas by CBSA for discharges effective December 1, 2006 through March 31, 2007, Table 4A-2 beginning on page 59998 for certain urban areas by CBSA for discharges effective April 1, 2007; Table 4B-1 beginning on page 59998 for rural areas by CBSA for discharges effective December 1, 2006 through March 31, 2007, Table 4B-2 beginning on page 59999 for certain rural areas by CBSA for discharges effective April 1, 2007; and Table 4C-1 beginning on page 59999 for reclassified hospitals by CBSA for discharges effective December 1, 2006 through March 31, 2007, and Table 4C-2 beginning on page 60003 for certain reclassified hospitals by CBSA for discharges effective April 1, 2007.~~

~~For services rendered on or after March 1, 2008, "Wage Index" means CMS' wage index for urban, rural and hospitals that are reclassified as described in CMS' 2008 Hospital Outpatient Prospective Payment System (HOPPS) final rule of November 27, 2007, adopted for the Calendar Year 2008, published in the Federal Register (CMS-1392-FC, 72 FR 66580), at page 66678. The wage index values are specified in the Hospital Inpatient Prospective Payment Systems~~

~~published in the Federal Register on October 10, 2007 at Vol. 72 FR 57634 (CMS-1533-CN2) (correcting the final rule published on August 22, 2007 (CMS-1533-FC; 72 FR 47130)), Table 4A beginning on page 57698 for urban areas by CBSA; Table 4B beginning on page 57721 for rural areas by CBSA; and Table 4C beginning on page 57722 for reclassified hospitals by CBSA.~~

~~For services rendered on or after March 1, 2009, "Wage Index" means CMS' wage index for urban, rural and hospitals that are reclassified as described in CMS' 2009 Hospital Outpatient Prospective Payment System (HOPPS) final rule of November 18, 2008, adopted for the Calendar Year 2009, published in the Federal Register (CMS-1404-FC, 73 FR 68502), at pages 68585 through 68586. The wage index values are specified in the Hospital Inpatient Prospective Payment Systems published in the Federal Register on October 3, 2008 at Vol. 73 FR 57888 (CMS-1390-N) (notice to the final rule published on August 19, 2008 (CMS-1390-F; 73 FR 48434)), Table 4A beginning on page 57956 for urban areas by CBSA and by state; Table 4B beginning on page 57961 for rural areas by CBSA and by state; and Table 4C beginning on page 57962 for reclassified hospitals by CBSA and by state.~~

~~For services rendered on or after April 15, 2010, "Wage Index" means CMS' wage index for urban, rural and hospitals that are reclassified as described in CMS' 2010 Hospital Outpatient Prospective Payment System (HOPPS) final rule of November 20, 2009, adopted for Calendar Year 2010, published in the Federal Register (CMS-1414-FC, 74 FR 60316), at pages 60419 through 60420. The wage index values are specified in the Hospital Inpatient Prospective Payment Systems published in the Federal Register of October 7, 2009 at Vol. 74 FR 51496 (CMS-1406-CN) (correcting the final rule published on August 27, 2009 at Vol. 74 FR 43754 (CMS-1406-F)), Table 4A beginning on page 51505 for certain urban areas by CBSA and by state, Table 4B on page 51506 for certain rural areas by CBSA and by state, and Table 4C on page 51506 for certain reclassified hospitals by CBSA and state; and as specified in the Federal Register of August 27, 2009 at Vol. 74 FR 43754 (CMS-1406-F), Table 4A beginning on page 44085 for urban areas by CBSA and by state; Table 4B beginning on page 44091 for rural areas by CBSA and by state; and Table 4C beginning on page 44091 for reclassified hospitals by CBSA and by state.~~

(~~u~~ x) For services rendered before March 1, 2011, "Workers' Compensation Multiplier" means the 120% Medicare multiplier required by Labor Code Section 5307.1, or the 122% multiplier that includes an extra 2% reimbursement for high cost outlier cases.

For services rendered in hospital outpatient departments on or after March 1, 2011, workers' compensation multiplier means the 120% Medicare multiplier or the 122% multiplier that includes an extra 2% reimbursement for high cost outlier cases. For services rendered in ambulatory surgical centers on or after March 1, 2011, the workers' compensation multiplier will be 100% Medicare multiplier, or the 102% multiplier that includes an extra 2% reimbursement for high cost outlier cases.

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

Section 9789.31. Adoption of Standards.

(a) The Administrative Director incorporates by reference, the Centers for Medicare and Medicaid Services' (CMS) ~~2004~~ Hospital Outpatient Prospective Payment System (HOPPS) 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. ~~, adopted for the Calendar Year 2004, published in the Federal Register on November 7, 2003, Volume 68, No. 216, Addenda A through J, pages 63478 through 63690 (CMS-1471-FC), as changed by CMS-1471-CN, Federal Register, Volume 68, No. 250 (December 31, 2003), pages 75442 through 75445, and CMS-1371-IFC, Federal Register, Volume 69, No. 3 (January 6, 2004), pages 820 through 844. See http://www.cms.hhs.gov/regulations/hopps/. The payment system includes:~~

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

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

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

~~(4) Addendum D2 "Code Conditions."~~

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

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

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

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

For services rendered on or after July 15, 2005, the Administrative Director incorporates by reference, the Centers for Medicare and Medicaid Services' (CMS) 2005 Hospital Outpatient Prospective Payment System (HOPPS), adopted for the Calendar Year 2005, published in the Federal Register on November 15, 2004, Volume 69, No. 219, Addenda A through E, pages 65864 through 66233 (CMS-1427-FC) including revisions and corrections as of July 15, 2005. See http://www.cms.hhs.gov/HospitalOutpatientPPS/. The payment system includes:

(1) Addendum A "List of Ambulatory Payment Classifications (APCs) with Status Indicators, Relative Weights, Payment Rates, and Copayment Amounts Calendar Year 2005", as revised March 30, 2005.

(2) Addendum B "Payment Status by HCPCS Code and Related Information Calendar Year 2005", as revised March 30, 2005.

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

(4) Addendum D2 "Comment Indicators".

(5) Addendum E "CPT Codes That Are Paid Only As Inpatient Procedures".

For services rendered on or after February 15, 2006, the Administrative Director incorporates by reference, the Centers for Medicare and Medicaid Services' (CMS) 2006 Hospital Outpatient Prospective Payment System (HOPPS), adopted for the Calendar Year 2006, published in the Federal Register on November 10, 2005, Volume 70, No. 217, Addenda A through E, and L, pages 68729 through 68980 (CMS-1501-FC); and correction notice published in the Federal Register on December 23, 2005, Volume 70, No. 246, pages 76176 through 76196 (CMS-1501-CN2). See http://www.cms.hhs.gov/HospitalOutpatientPPS/. The payment system includes:

(1) Addendum A "List of Ambulatory Payment Classifications (APCs) with Status Indicators, Relative Weights, Payment Rates, and Copayment Amounts Calendar Year 2006."

(2) Addendum B "Payment Status by HCPCS Code and Related Information Calendar Year 2006."

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

(4) Addendum D2 "Comment Indicators."

(5) Addendum E "CPT Codes That Are Paid Only As Inpatient Procedures."

(6) Addendum L "Out Migration Wage Adjustment for CY 2006."

For services rendered on or after March 1, 2007, the Administrative Director incorporates by reference, the Centers for Medicare and Medicaid Services' (CMS) 2007 Hospital Outpatient Prospective Payment System (HOPPS), adopted for the Calendar Year 2007, published in the Federal Register on November 24, 2006, Volume 71, No. 226, Addenda A, B, D1, D2, E, and L, found within pages 68231 through 68401 (CMS-1506-FC). See http://www.cms.hhs.gov/HospitalOutpatientPPS/. The payment system includes:

(1) Addendum A "OPPS List of Ambulatory Payment Classifications (APCs) with Status Indicators (SI), Relative Weights, and Copayment Amounts Calendar Year 2007."

(2) Addendum B "Payment Status by HCPCS Code and Related Information Calendar Year 2007."

(3) Addendum D1 "Payment Status Indicators"

(4) Addendum D2 "Comment Indicators."

(5) Addendum E "CPT Codes That Are Paid Only As Inpatient Procedures."

(6) Addendum L "Out Migration Adjustment"

For services rendered on or after March 1, 2008, the Administrative Director incorporates by reference, the Centers for Medicare and Medicaid Services' (CMS) 2008 Hospital Outpatient Prospective Payment System (HOPPS), adopted for the Calendar Year 2008, published in the Federal Register on November 27, 2007, Volume 72, No. 227, Addenda A, B, D1, D2, E, L, and M found within pages 66934 through 67225 (CMS-1392-FC); and correction to the CMS 2008 HOPPS final rule published in the Federal Register on February 22, 2008, Vol. 73, No. 36, Addenda A, B, D2, and M found within pages 9862 through 9864 (CMS-1392-CN). See http://www.cms.hhs.gov/HospitalOutpatientPPS/. The payment system includes:

(1) Addendum A "OPPS APCs for CY 2008."

~~(2) Addendum B "OPPS Payment by HCPCS Code for CY 2008."~~

~~(3) Addendum D1 "OPPS Payment Status Indicators."~~

~~(4) Addendum D2 "OPPS Comment Indicators."~~

~~(5) Addendum E "HCPCS Codes That Are Paid Only as Inpatient Procedures for CY 2008."~~

~~(6) Addendum L "Out Migration Adjustment"~~

~~(7) Addendum M "HCPCS Codes for Assignment to Composite APCs for CY 2008."~~

~~For services rendered on or after March 1, 2009, the Administrative Director incorporates by reference, the Centers for Medicare and Medicaid Services' (CMS) 2009 Hospital Outpatient Prospective Payment System (HOPPS), adopted for the Calendar Year 2009, published in the Federal Register on November 18, 2008, Volume 73, No. 223, Addenda A, B, D1, D2, E, L, and M found within pages 68816 through 69380 (CMS-1404-FC), and correction to Addenda A and B by correction to the final rule published in the Federal Register on January 26, 2009, Vol. 74, No. 15 (CMS-1404-CN) found within pages 4343 through 4344. See http://www.cms.hhs.gov/HospitalOutpatientPPS . The payment system includes:~~

~~(1) Addendum A "Final OPPS APCs for CY 2009".~~

~~(2) Addendum B "Final OPPS Payment By HCPCS Code for CY 2009".~~

~~(3) Addendum D1 "Final OPPS Payment Status Indicators for CY 2009".~~

~~(4) Addendum D2 "Final OPPS Comment Indicators for CY 2009" .~~

~~(5) Addendum E "HCPCS Codes That Are Paid Only as Inpatient Procedures for CY 2009" .~~

~~(6) Addendum L "Out Migration Adjustment".~~

~~(7) Addendum M "HCPCS Codes for Assignment to Composite APCs for CY 2009".~~

~~For services rendered on or after April 15, 2010, the Administrative Director incorporates by reference, the Centers for Medicare and Medicaid Services' (CMS) 2010 Hospital Outpatient Prospective Payment System (HOPPS), adopted for the Calendar Year 2010, published in the Federal Register on November 20, 2009 Volume 74, No. 223, Addenda A, B, D1, D2, E, L, and M found within pages 60682 through 60983 (CMS-1414-FC); and correction to Addenda B and E by correction to the final rule published in the Federal Register on December 31, 2009, Vol. 74, No. 250 (CMS-1414-CN) found on page 69503. See http://www.cms.hhs.gov/HospitalOutpatientPPS . The payment system includes:~~

~~1) Addendum A "Final OPPS APCs for CY 2010"~~

~~2) Addendum B "Final OPPS Payment By HCPCS Code for CY 2010"~~

~~3) Addendum D1 "Final OPPS Payment Status Indicators for CY 2010"~~

~~4) Addendum D2 "Final OPPS Comment Indicators for CY 2010"~~

~~5) Addendum E "HCPCS Codes That Are Paid Only as Inpatient Procedures for CY 2010"~~

~~6) Addendum L "CY 2010 OPPS Out-Migration Adjustment"~~

~~7) Addendum M "HCPCS Codes for Assignment to Composite APCs for CY 2010".~~

(b) For services rendered on or after July 15, 2005, the Administrative Director incorporates by reference, the Centers for Medicare and Medicaid Services' (CMS) ~~FY 2005~~ 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~~., adopted for the Fiscal Year 2005, published in the Federal Register on December 30, 2004 at Vol. 69 FR 78526 (CMS-1428-F2)(correcting the final rule published on August 11, 2004 (CMS-1428-F; 69 FR 48916) and correcting the correction to the final rule published on October 7, 2004 (CMS-1428-CN2; 69 FR 60242)), Table $4A_1$ beginning on page 78619 for urban areas by MSA, Table $4A_2$ beginning on page 78637 for urban areas by CBSA; Table $4B_1$ beginning on page 78660 for rural areas by MSA and Table $4B_2$ beginning on page 78661 for rural areas by CBSA; Table $4C_1$ beginning on page 78662 for reclassified hospitals by MSA and Table $4C_2$ beginning on page 78665 for reclassified hospitals by CBSA; and Table 4J beginning on page 78691.~~

~~For services rendered on or after February 15, 2006, the Administrative Director incorporates by reference the Centers for Medicare and Medicaid Services' (CMS) FY 2006 Hospital Inpatient Prospective Payment Systems (IPPS), adopted for the Fiscal Year 2006, published in the Federal Register on September 30, 2005 at Vol. 70 FR 57161 (CMS-1500-CN) (correcting the final rule published on August 12, 2005 at Vol. 70 FR 47278 (CMS-1500-F)), on page 57163 for Table 4A for certain urban areas by CBSA, Table 4B for certain rural areas by CBSA, Table 4C for certain reclassified hospitals by CBSA, and Table 4J on page 57163 for certain hospitals; and as specified in the final rule published on August 12, 2005 (CMS-1500-F; 70 FR 47278), Table 4A beginning on page 47580 for urban areas by CBSA; Table 4B beginning on page 47603 for rural areas by CBSA; Table 4C beginning on page 47604 for reclassified hospitals by CBSA; and Table 4J beginning on page 47608.~~

~~For services rendered on or after March 1, 2007, the Administrative Director incorporates by reference the Centers for Medicare and Medicaid Services' (CMS) FY 2007 Hospital Inpatient Prospective Payment Systems (IPPS), adopted for the Fiscal Year 2007, published in the Federal Register on October 11, 2006 at Vol. 71 FR 59886 (CMS-1488-N) (additional notice to the final rule published on August 18, 2006 (CMS-1488-F; 71 FR 47870)), Table 4A-1 beginning on page 59975 for urban areas by CBSA for discharges effective December 1, 2006 through March 31, 2007, Table 4A-2 beginning on page 59998 for certain urban areas by CBSA for discharges effective April 1, 2007; Table 4B-1 beginning on page 59998 for rural areas by CBSA for discharges effective December 1, 2006 through March 31, 2007, Table 4B-2 beginning on page 59999 for certain rural areas by CBSA for discharges effective April 1, 2007; Table 4C-1 beginning on page 59999 for reclassified hospitals by CBSA for discharges effective December 1, 2006 through March 31, 2007, and Table 4C-2 beginning on page 60003 for certain reclassified hospitals by CBSA for discharges effective April 1, 2007; and Table 4J beginning on page 60004.~~

~~For services rendered on or after March 1, 2008, the Administrative Director incorporates by reference the Centers for Medicare and Medicaid Services' (CMS) FY 2008 Hospital Inpatient Prospective Payment Systems (IPPS), adopted for the Fiscal Year 2008, published in the Federal Register on October 10, 2007 at Vol. 72 FR 57634 (CMS-1533-CN2) (correcting the final rule published on August 22, 2007 (CMS-1533-FC; 72 FR 47130)), Table 4A beginning on page 57698 for urban areas by CBSA; Table 4B beginning on page 57721 for rural areas by CBSA; Table 4C beginning on page 57722 for reclassified hospitals by CBSA; and Table 4J published in the Federal Register on August 22, 2007, (CMS-1533-FC) beginning on page 47531, and the correction published in the Federal Register on October 10, 2007, (CMS-1533-CN2) beginning on page 57726.~~

~~For services rendered on or after March 1, 2009, the Administrative Director incorporates by reference the Centers for Medicare and Medicaid Services' (CMS) FY 2009 Hospital Inpatient Prospective Payment Systems (IPPS), adopted for the Fiscal Year 2009, published in the Federal Register on October 3, 2008 at Vol. 73 FR 57888 (CMS-1390-N) (notice to the final rule published on August 19, 2008 (CMS-1390-F; 73 FR 48434)), Table 4A beginning on page 57956 for urban areas by CBSA and by state; Table 4B beginning on page 57961 for rural areas by CBSA and by state; Table 4C beginning on page 57962 for reclassified hospitals by CBSA and by state; Table 4J beginning on page 57988; and Table 2 on page 73657, and Table 4J beginning on page 73657 as changed by notice to the final rule published in the Federal Register on December 3, 2008 (CMS-1390-N2, 73 FR 73656).~~

~~For services rendered on or after April 15, 2010, the Administrative Director incorporates by reference the Centers for Medicare and Medicaid Services' (CMS) FY 2010 Hospital Inpatient Prospective Payment Systems (IPPS), adopted for the Fiscal Year 2010, published in the Federal Register on August 27, 2009, Vol.74, No. 165, (CMS-1406-F), Table 2 on pages 44032 through 44078; Table 4A on pages 44085 through 44091; Table 4B on page 44091; Table 4C on pages 44091 through 44095; and Table 4J on pages 44118 through 44125; as changed by correction to the final rule published in the Federal Register on October 7, 2009 (CMS-1406-CN, 74 FR 51496), Table 2 on pages 51499 through 51505; Table 4A on pages 51505 through 51506; Table 4B on page 51506; Table 4C on page 51506; and Table 4J on page 51506 .~~

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

~~For services rendered on or after February 15, 2006, the Administrative Director incorporates by reference the Fiscal Year 2006 Hospital Inpatient Prospective Payment Systems (IPPS) "Payment Impact File" published by the federal Centers for Medicare & Medicaid Services (CMS), which document is found at http://www.cms.hhs.gov/AcuteInpatientPPS/.~~

~~For services rendered on or after March 1, 2007, the Administrative Director incorporates by reference the Fiscal Year 2007 Hospital Inpatient Prospective Payment Systems (IPPS) "Payment Impact File" published by the federal Centers for Medicare & Medicaid Services (CMS), which document is found at http://www.cms.hhs.gov/AcuteInpatientPPS/.~~

~~For services rendered on or after March 1, 2008, the Administrative Director incorporates by reference the Fiscal Year 2008 Hospital Inpatient Prospective Payment Systems (IPPS) "Payment Impact File" published by the federal Centers for Medicare & Medicaid Services (CMS), which document is found at http://www.cms.hhs.gov/AcuteInpatientPPS/.~~

~~For services rendered on or after March 1, 2009, the Administrative Director incorporates by reference the Fiscal Year 2009 Hospital Inpatient Prospective Payment Systems (IPPS) "Payment Impact File" published by the federal Centers for Medicare & Medicaid Services (CMS), which document is found at http://www.cms.hhs.gov/AcuteInpatientPPS/.~~

~~For services rendered on or after April 15, 2010, the Administrative Director incorporates by reference the Fiscal Year 2010 Hospital Inpatient Prospective Payment Systems (IPPS) "Payment Impact File" published by the federal Centers for Medicare & Medicaid Services (CMS), which document is found at http://www.cms.hhs.gov/AcuteInpatientPPS/.~~

(d) The Administrative Director incorporates by reference the American Medical Associations' ~~Physician~~ "Current Procedural Terminology," ~~2004~~ 4th Edition, annual revision in effect for the year that includes the date of service. 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.

~~For services rendered on or after July 15, 2005, the Administrative Director incorporates by reference the American Medical Associations' Physician "Current Procedural Terminology," 4th Edition, Revised 2005.~~

~~For services rendered on or after February 15, 2006, the Administrative Director incorporates by reference the American Medical Associations' Physician "Current Procedural Terminology," 4th Edition, Revised 2006.~~

~~For services rendered on or after March 1, 2007, the Administrative Director incorporates by reference the American Medical Associations' Physician "Current Procedural Terminology," 4th Edition, Revised 2007.~~

~~For services rendered on or after March 1, 2008, the Administrative Director incorporates by reference the American Medical Associations' Physician "Current Procedural Terminology," 4th Edition, Revised 2008.~~

~~For services rendered on or after March 1, 2009, the Administrative Director incorporates by reference the American Medical Associations' Physician "Current Procedural Terminology," 4th Edition, Revised 2009.~~

~~For services rendered on or after April 15, 2010, the Administrative Director incorporates by reference the American Medical Associations' Physician "Current Procedural Terminology," 4th Edition, Revised 2010.~~

(~~e~~e) The Administrative Director incorporates by reference CMS' ~~2004~~ Alphanumeric "Healthcare Common Procedure Coding System (HCPCS)" annual revision in effect for the year that includes the date of service. 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.

~~For services rendered on or after July 15, 2005, the Administrative Director incorporates by reference CMS' 2005 Alphanumeric "Healthcare Common Procedure Coding System (HCP CS)".~~

~~For services rendered on or after February 15, 2006, the Administrative Director incorporates by reference CMS' 2006 Alphanumeric "Healthcare Common Procedure Coding System (HCP CS)".~~

~~For services rendered on or after March 1, 2007, the Administrative Director incorporates by reference CMS' 2007 Alphanumeric "Healthcare Common Procedure Coding System (HCP CS)".~~

~~For services rendered on or after March 1, 2008, the Administrative Director incorporates by reference CMS' 2008 Alphanumeric "Healthcare Common Procedure Coding System (HCPCS)".~~

~~For services rendered on or after March 1, 2009, the Administrative Director incorporates by reference CMS' 2009 Alphanumeric "Healthcare Common Procedure Coding System (HCPCS)".~~

~~For services rendered on or after April 15, 2010, the Administrative Director incorporates by reference CMS' 2010 Alphanumeric "Healthcare Common Procedure Coding System (HCPCS)".~~

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

Section 9789.32. Applicability.

(a) Sections 9789.30 through 9789.3~~8~~9 shall be applicable to the maximum allowable fees for emergency room visits and surgical procedures rendered on or after July 1, 2004. For purposes of this section, emergency room visits shall be defined by CPT codes 99281-99285 and surgical procedures shall be defined by CPT codes 10040-69990. A facility fee is payable only for the specified emergency room and surgical codes and for supplies, drugs, devices, blood products and biologicals that are an integral part of the emergency room visit or surgical procedure. A supply, drug, device, blood product and biological is considered an integral part of an emergency room visit or surgical procedure if:

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

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,

(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.

Payment for other services furnished in conjunction with a surgical procedure or emergency room visit shall be in accordance with subdivision (c) of this Section.

(b) Sections 9789.30 through 9789.3~~8~~9 apply to any hospital outpatient department as defined in Section 9789.30(n) ~~and any hospital outpatient department that is certified to participate in the Medicare program under Title XVIII (42 U.S.C. SEC. 1395 et seq.) of the federal Social Security Act~~ and any ASC as defined in Section 9789.30(c) ~~the California Health and Safety Code Section 1204, subdivision (b)(1), any ambulatory surgical center that is certified to participate in the Medicare program under Title XVIII (42 U.S.C. SEC. 1395 et seq.) of the federal Social Security Act, and any surgical clinic accredited by an accrediting agency as approved by the Licensing Division of the Medical Board of California pursuant to Health and Safety Code Sections 1248.15 and 1248.4, performing procedures and services on an outpatient basis~~.

(c) The maximum allowable fees for services, 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 a surgical service or emergency room visit will be determined as follows:

(1) The maximum allowable fees for professional medical services which are performed by physicians and other licensed health care providers shall be paid according to Section 9789.10 and Section 9789.11.

(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 100% of the fee prescribed by Medi-Cal pursuant to Labor Code Section 5307.1 subdivision (a), 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 fees for non-surgical ancillary services with a status code indicator "X" shall be determined according to Section 9789.10 and Section 9789.11.

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

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

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

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

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

(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 present with their bill the name and physical address of the facility, the facility's Medicare Provider Number or UPIN (or, in the absence of the Medicare number, the OSHPD Facility Number). The bill shall include the dates of service, the diagnosis and current HCPCS codes and charges for each billed service, including HCPCS codes for any items and services that are packaged into the APC payment for a significant procedure.

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

9789.33. Determination of Maximum Reasonable Fee.

(a) For Services rendered on or after July 1, 2004, the maximum allowable payment for outpatient facility fees for hospital emergency room services or for surgical services performed at a hospital outpatient department or at an ambulatory surgical center shall be determined based on the following. ~~The 1.22 factor~~ In accordance with Section 9789.30(x), an extra 2% reimbursement shall be used in lieu of an additional payment for high cost outlier cases.

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

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

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

(APC relative weight x ~~$ 52.151~~ unadjusted conversion factor) x (~~.40~~ 1-labor-related share + ~~.60~~ labor-related share x applicable wage index) x ~~inflation factor of 1.034~~ x ~~1.22~~ applicable workers’ compensation multiplier. See Section 9789.39(b) for the APC relative weight, unadjusted conversion factor, labor-related share, and applicable wage index by date of service. See Section 9789.30(x) for the applicable workers’ compensation multiplier by date of service.

~~For services rendered on or after July 15, 2005, use: (APC relative weight x unadjusted conversion factor) x (.40 + .60 x applicable wage index) x 1.22.~~

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

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

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

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

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

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

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

APC relative weight x adjusted conversion factor x ~~1.22~~ applicable workers' compensation multiplier pursuant to Section 9789.30(x)

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

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

The maximum payment rate for the listed hospital~~s~~ outpatient departments can be determined as follows:

APC relative weight x adjusted conversion factor x ~~1.22~~ applicable workers' compensation multiplier pursuant to Section 9789.30(x)

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

APC payment rate x ~~1.22~~ applicable workers' compensation multiplier pursuant to Section 9789.30(x)

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

Documented paid cost~~s~~, ~~net of discounts and rebates~~, 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.

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

APC payment rate x ~~1.22~~ applicable workers' compensation multiplier pursuant to Section 9789.30(x)

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

APC payment x ~~1.22~~ applicable workers' compensation multiplier pursuant to Section 9789.30(x)

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

Documented paid cost~~s, net of discounts and rebates~~, 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 payment x ~~1.22~~ applicable workers' compensation multiplier pursuant to Section 9789.30(x)

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

(1) Standard payment:

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

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

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

(APC relative weight x ~~$ 52.151~~ unadjusted conversion factor) x (~~.40~~ 1-labor-related share + ~~.60~~ labor-related share x applicable wage index) x ~~inflation factor of 1.034~~ x ~~1.20~~ applicable workers’ compensation multiplier. See Section 9789.39(b) for the APC relative weight, unadjusted conversion factor, labor-related share, and applicable wage index by date of service. See Section 9789.30(x) for the applicable workers’ compensation multiplier by date of service.

~~For services rendered on or after July 15, 2005, use: (APC relative weight x unadjusted conversion factor) x (.40 + .60 x applicable wage index) x 1.20~~

For services rendered on or after February 15, 2006, by rural SCH hospitals, use: (APC relative weight x unadjusted conversion factor x 1.071) x (~~.40~~ 1-labor-related share + ~~.60~~ labor-related share x applicable wage index) x ~~1.20~~ applicable workers’ compensation multiplier. See Section 9789.39(b) for the APC relative weight, unadjusted conversion factor, labor-related share, and applicable wage index by date of service. See Section 9789.30(x) for the applicable workers’ compensation multiplier by date of service.

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

APC payment rate x ~~1.20~~ applicable workers’ compensation multiplier pursuant to Section 9789.30(x)

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

Documented paid cost~~s, net of discounts and rebates~~, 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"

APC payment rate x ~~1.20~~ applicable workers’ compensation multiplier pursuant to Section 9789.30(x)

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

APC payment x ~~1.20~~ applicable workers’ compensation multiplier pursuant to Section 9789.30(x)

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

Documented paid cost~~s, net of discounts and rebates~~, 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 payment x ~~1.20~~ applicable workers’ compensation multiplier pursuant to Section 9789.30(x)

(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.

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

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

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

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

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

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

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

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

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

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

(1) A facility seeking to be paid for high cost outlier cases under subdivision 9789.33(b) must file a written election using DWC Form 15 "Election for High Cost Outlier," contained in Section 9789.37 with the Division of Workers' Compensation, Medical Unit (Attention: OMFS-Outpatient). P.O. Box ~~420603~~ 71010, ~~San Francisco~~ Oakland, CA ~~94142-0603~~ 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 ~~420603~~ 71010, ~~San Francisco~~ Oakland, CA ~~94142-0603~~ 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 ~~420603~~ 71010, ~~San Francisco~~ Oakland, CA ~~94142-0603~~ 94612.

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

(e) The 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.

There are no proposed changes to this section.

Section 9789.35. Table B.

There are no proposed changes to this section.

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

Sections 9789.30 through 9789.3~~8~~9 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 ~~January~~ March 1.

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

ELECTION FOR HIGH COST OUTLIER

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

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

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

Hospital Outpatient Department Cost-to-Charge Ratio

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

5. Cost-to-charge ratio _____

_____ _____
Signature and Title Date

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

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

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

7. Attach completed Annual Utilization Report of Specialty Clinics (OSHPD) which is incorporated by reference, and may be obtained at OSHPD's website at http://www.oshpd.ca.gov/HID/HID/clinic/util/index.htm#Forms or is available upon request to the Administrative Director at: Division of Workers' Compensation (Attention: OMFS-Outpatient), P.O. Box ~~420603~~ 71010, ~~San Francisco~~ Oakland, CA ~~94142~~ 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

DWC Form 15 (12/15/104)

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

8 CCR 9789.38. Appendix X.

The federal regulations as incorporated by reference and/or referred to in Sections 9789.30 through 9789.36 are set forth below in numerical order. 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 branchytherapy, consisting of a seed or seeds (including radioactive source) are excluded from qualification for outlier payments.

~~Effective January 1, 2006, Section 419.43 is amended by adding a new paragraph (g) to read as follows:~~

~~(g) *Payment adjustment for certain rural hospitals.* (1) *General rule.* CMS provides for additional payment for covered hospital outpatient services not excluded under paragraph (g)(4) of this section, furnished on or after January 1, 2006, if the hospital—~~

~~(i) Is a sole community hospital under § 412.92 of this chapter; and~~

~~(ii) Is located in a rural area as defined in § 412.64(b) of this chapter or is treated as being located in a rural area under §412.103 of this chapter.~~

~~(2) *Amount of adjustment.* The amount of the additional payment under paragraph (g)(1) of this section is determined by CMS and is based on the difference between costs incurred by hospitals that meet the criteria in paragraphs (g)(1)(i) and (g)(1)(ii) of this section and costs incurred by hospitals located in urban areas.~~

(3) *Budget neutrality.* CMS establishes the payment adjustment under paragraph (g)(2) of this section in a budget neutral manner, excluding services and groups specified in paragraph (g)(4) of this section.

(4) *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 a radioactive source) are excluded from qualification for the payment adjustment in paragraph (g)(2) of this section.

(5) *Copayment.* The payment adjustment in paragraph (g)(2) of this section is applied before calculating copayment amounts.

(6) *Outliers.* The payment adjustment in paragraph (g)(2) of this section is applied before calculating outlier payments.

Effective January 1, 2007, Section 419.43 is amended by—
_ a. Revising paragraph (f).
_ b. Revising paragraph (g)(1)(i).
_ c. Adding a new paragraph (h).
The revision and addition read as follows:

(f) *Excluded services and groups.* Drugs and biologicals that are paid under a separate APC are excluded from qualification for outlier payments.

(g) * * *

(1) * * *

(i) Is a sole community hospital under § 412.92 of this chapter or is an essential access community hospital under § 412.109 of this chapter; and

* * * * *

(h) *Applicable adjustments to conversion factor for CY 2009 and for subsequent calendar years*—

(1) *General rule.* For CY 2009 and for subsequent calendar years, the applicable adjustment to the conversion factor specified in §419.32(b)(1)(iv) is reduced by 2.0 percentage points for any hospital that fails to meet the standards for reporting of hospital outpatient quality measures as established by the Secretary for the corresponding calendar year.

(2) *Limitation.* Any reduction to a hospital's adjustment to its conversion factor specified in § 419.32(b)(1)(iv) which occurs as a result of paragraph (h)(1) of this section will apply only to the calendar year involved and will not be taken into account in computing that hospital's applicable adjustment for a subsequent calendar year.

(3) *Budget neutrality.* For CY 2009 and for each subsequent calendar year, CMS makes an adjustment to the conversion factor, so that estimated aggregate payments under the OPPS for such calendar year are not affected by any reductions to hospital adjustments which occur as a result of paragraph (h)(1) of this section.

Effective January 1, 2008, Section 419.43 is amended by revising paragraph (g)(4) to read as follows:

(g) * * *

(4) *Excluded services and groups.* Drugs and biologicals that are paid under a separate APC and devices paid under §419.66 are excluded from qualification for the payment adjustment in paragraph (g)(2) of this section.

Effective January 1, 2009, 15. Section 419.43 is amended by—
■ a. In paragraph (d)(1)(i)(B), removing the phrase ''paragraph (e) of this section'' and adding in its place the cross-reference ''§ 419.66''.
■ b. Adding new paragraphs (d)(5) and (d)(6).
■ c. Revising paragraph (f).
■ d. Revising paragraph (g)(4).
■ e. Adding a new paragraph (h)(4).

The additions and revisions read as follows:

(d) * * *

(5) *Cost-to-charge ratios for calculating charges adjusted to cost.* For hospital outpatient services (or groups of services) as defined in paragraph (d)(1) of this section performed on or after January 1, 2009—

(i) CMS may specify an alternative to the overall ancillary cost-to-charge ratio otherwise applicable under paragraph (d)(5)(ii) of this section. A hospital may also request that its Medicare contractor use a different (higher or lower) cost-to-charge ratio based on substantial evidence presented by the hospital. Such a request must be approved by the CMS.

(ii) The overall ancillary cost-to-charge ratio applied at the time a claim is processed is based on either the most recent settled cost report or the most recent tentative settled cost report, whichever is from the latest cost reporting period.

(iii) The Medicare contractor may use a statewide average cost-to-charge ratio if it is unable to determine an accurate overall ancillary cost-to-charge ratio for a hospital in one of the following circumstances:

(A) A new hospital that has not yet submitted its first Medicare cost report. (For purposes of this paragraph, a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with § 489.18 of this chapter.)

(B) A hospital whose overall ancillary cost-to-charge ratio is in excess of 3 standard deviations above the corresponding national geometric mean. This mean is recalculated annually by CMS and published in the annual notice of prospective payment rates issued in accordance with § 419.50(a).

(C) Any other hospital for whom accurate data to calculate an overall ancillary cost-to-charge ratio are not available to the Medicare contractor.

(6) *Reconciliation.* For hospital outpatient services furnished during cost reporting periods beginning on or after January 1, 2009—

(i) Any reconciliation of outlier payments will be based on an overall ancillary cost-to-charge ratio calculated based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the service is settled.

(ii) At the time of any reconciliation under paragraph (d)(6)(i) of this section, outlier payments may be adjusted to account for the time value of any underpayments or overpayments. Any adjustment will be based on a widely available index to be established in advance by CMS, and will be applied from the midpoint of the cost reporting period to the date of reconciliation.

* * * * *

(f) *Excluded services and groups.* The following services or groups are excluded from qualification for the payment adjustment under paragraph (d)(1) of this section:

(1) Drugs and biologicals that are paid under a separate APC; and

(2) Items and services paid at charges adjusted to costs by application of a hospital-specific cost-to-charge ratio.

(g) * * *

(4) *Excluded services and groups.* The following services or groups are excluded from qualification for the payment adjustment in paragraph (g)(2) of this section:

(i) Drugs and biologicals that are paid under a separate APC;

(ii) Devices paid under 419.66; and

(iii) Items and services paid at charges adjusted to costs by application of a hospital-specific cost-to-charge ratio.

* * * * *

(h) * * *

(4) *Beneficiary copayment.* The beneficiary copayment for services to which the adjustment to the conversion factor specified under paragraph (h)(1) of this section applies is the product of the national beneficiary copayment amount calculated under § 419.41 and the ratio of the adjusted conversion factor calculated under paragraph (h)(1) of this section divided by the conversion factor specified under § 419.32(b)(1).

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.]

Effective January 1, 2008, Section 419.44 is amended by –
– a. Revising the section heading.
– b. Revising paragraph (b).
The revisions and addition read as follows:
§ 419.44 Payment reductions for procedures.

* * * * *

(b) *Interrupted procedures.* When a 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 program and beneficiary copayment amounts if the procedure for which anesthesia is planned is discontinued after the induction of anesthesia or after the procedure is started;

(2) One-half the full program and the beneficiary copayment amounts if the procedure for which anesthesia is planned is discontinued after the patient is prepared and taken to the room where the procedure is to be performed but before anesthesia is induced; or

(3) One-half of the full program and beneficiary copayment amounts if a procedure for which anesthesia is not planned is discontinued after the patient is prepared and taken to the room where the procedure is to be performed.

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.

~~Effective January 1, 2005, Section 419.64 is amended by revising paragraph (d) to read as follows:~~

~~(d) *Amount of pass-through payment.* Subject to any reduction determined under § 419.62(b), the pass-through payment for a drug or biological equals the amount determined under section 1842(o) of the Social Security Act, minus the portion of the APC payment amount that CMS determines is associated with the drug or biological.~~

~~Effective January 1, 2010, Section 419.64 is amended by adding new paragraphs (a)(4)(iii) and (a)(4)(iv), to read as follows:~~

~~(a) * * *~~

~~(4) * * *~~

~~(iii) A biological that is not surgically implanted or inserted into the body.~~

~~(iv) A biological that is surgically implanted or inserted into the body, for which pass-through payment as a biological is made on or before December 31, 2009.~~

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.

~~Effective January 1, 2006, Section 419.66 is amended by revising paragraph (e)(1) to read as follows:~~

~~(e) *Criteria for establishing device categories.* * * *~~

~~(1) CMS determines that a device to be included in the category is not appropriately 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.~~

~~Effective January 1, 2010, Section 419.66 is amended by revising paragraph (b)(4)(iii) to read as follows:~~

~~(b) * * *~~

~~(4) * * *~~

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

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. Federal Regulations and Federal Register Notices 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.

Effective Date	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		

Effective Date	Services Occurring On or After 3/1/2009	Services Occurring On or After 4/15/2010		
Title 42, Code of Federal Regulations, §419.2				
Title 42, Code of Federal Reg-				

ulations, §419.32				
Title 42, Code of Federal Regulations, §419.43	As amended; effective January 1, 2009			
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		

(b) 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.

Effective Date	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 RE 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,	(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	(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	(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-CMS-1488-N; 71 FR 59886)

Effective Date	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
	2003 (CMS-1470-F; 68 FR 47637)	78526	FR 57161)	
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
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
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)

Effective Date	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
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
Unadjusted Conversion 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

Effective Date	Services Occurring On or After 3/1/2008	Services Occurring On or After 3/1/2009	Services Occurring On or After 4/15/2010	
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)	(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	(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)	

Effective Date	Services Occurring On or After 3/1/2008	Services Occurring On or After 3/1/2009	Services Occurring On or After 4/15/2010	
	November 6, 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)	(CMS-1390-N; 73 FR 57888); (E) December 3, 2008 (CMS-1390-N2; 73 FR 73656); (F) January 26, 2009 (CMS-1404-CN; 74 FR 4343)	October 7, 2009 (CMS-1406-CN; 74 FR 51496)	
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	
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	
HOPPS Addenda	Addenda A, B, D1, D2, E, L, and M (A) beginning at page 66934; and corrections to addenda A, B, D2, and M (F) beginning at page 9862	Addenda A, B, D1, D2, E, L, and M (A) beginning at page 68816; and corrections to addenda A and B (F) beginning at page 4343	Addenda A, B, D1, D2, E, L, and M (A) beginning at page 60682; and corrections to addenda B and E (B) beginning at page 69503	
IPPS Tables	Tables 4A, 4B, and 4C (C) beginning at page	Tables 4A, 4B, 4C, and 4J (C) beginning at	Tables 2, 4A, 4B, 4C, and 4J(C) beginning	

Effective Date	Services Occurring On or After 3/1/2008	Services Occurring On or After 3/1/2009	Services Occurring On or After 4/15/2010	
	57698 and Table 4J (B) beginning at page 47531 and correction (C) beginning at page 57726	page 57956; and Tables 2 and 4J (E)beginning at page 73657	at page 44032; as changed by correction to Tables 2, 4A, 4B, 4C, and 4J (D) beginning at page 51499	
Labor-related Share	60% ((A) beginning at page 66678)	60% ((A) beginning at page 68585)	60% ((A) beginning at page 60419	
Market Basket Inflation Factor	3.3% (B) page 47415	3.6% (B) page 48759	2.1% (C) page 44002	
Outlier Threshold	$1,575 (A) at page 66686	$1,800 (A) at page 68594	$2,175 (A) at page 60428	
Unadjusted Conversion 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)	
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 in Tables 4A through 4C (C) beginning at page 44085	

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