Title 8, California Code of Regulations
Chapter 4.5, Division of Workers' Compensation
Subchapter 1
Administrative Director-Administrative Rules
Article 5.3
Official Medical Fee Schedule-Hospital Outpatient Departments and Ambulatory Surgical Centers
Services on or after January 1, 2004

Section 9789.30. Definitions.

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

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

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

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

(d) "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.

(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.

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

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

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

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

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

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

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

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

(~~t~~v) “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.

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

(~~u~~x) "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.

(~~v~~y) "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.

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

(~~x~~aa) For services payable under Sections 9789.30 through 9789.39, ~~rendered before January 1, 2013,~~ "Workers' Compensation Multiplier" means the ~~120% Medicare~~ multiplier to the Medicare rate adopted by the AD in accordance with ~~required by~~ Labor Code Section 5307.1, or the ~~122%~~ multiplier that includes an extra ~~2%~~ percentage reimbursement for high cost outlier cases, by date of service.

Date of Service	Hospital Outpatient Department Services that are: Surgical Procedures; Emergency Room visits; or services that are an integral part of the surgical procedure or emergency room visit Multipliers (A) Medicare multiplier; (B) multiplier that includes an extra percentage reimbursement for high cost outlier cases	Ambulatory Surgical Centers Surgical Procedures Multiplier (A) Medicare multiplier; (B) multiplier that includes an extra percentage reimbursement for high cost outlier cases	Facility Only Services Multiplier (A) Medicare multiplier; (B) multiplier that includes an extra percentage reimbursement for high cost outlier cases
Before January 1, 2013	(A) 120%; (B) 122%	(A) 120%; (B) 122%	Not applicable. Payable under Sections 9789.10 and 9789.11
On or after January 1, 2013, but before	(A) 120%; (B) 122%	(A) 80%; (B) 82%	Not applicable. Payable under Sections

September 1, 2014			9789.10 and 9789.11
On or after September 1, 2014	(B) 121.2%	(B) 80.81%	(B) 101.01%

~~For services rendered in hospital outpatient departments on or after January 1, 2013, 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 January 1, 2013, the Workers' Compensation Multiplier will be 80% Medicare multiplier, or the 82% 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) Hospital Outpatient Prospective Payment System (HOPPS) certain addenda published in the Federal Register notices announcing revisions in the Medicare payment rates. See Section 9789.39(b) for the adopted payment system addenda by date of service.

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

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

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

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

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

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

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

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

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

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

Section 9789.32. Applicability.

(a) Sections 9789.30 through 9789.39 shall be applicable to the maximum allowable fees for emergency room visits and surgical procedures rendered on or after July 1, 2004 and before September 1, 2014. Sections 9789.30 through 9789.39 shall be applicable to the maximum allowable fees for emergency room visits, surgical procedures, and Facility Only Services rendered on or after September 1, 2014. For purposes of this section, emergency room visits ~~shall be defined by CPT codes 99281-99285~~ and surgical procedures shall be defined by ~~CPT~~HCPCS codes ~~10021-69990~~ set forth in section 9789.39(b) by date of service. A facility fee is payable only for the specified emergency room, ~~and~~ surgical codes, Facility Only Services, and for supplies, drugs, devices, blood products and biologicals that are an integral part of the emergency room visit, ~~or~~ surgical procedure, or Facility Only Service. A supply, drug, device, blood product and biological is considered an integral part of an emergency room visit, ~~or~~ surgical procedure, or Facility Only Service if:

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

For services rendered on or after March 1, 2008: the item has a status code N or Q and is packaged into the APC payment for the emergency room visit or surgical procedure (in which case no additional fee is allowable) or,

For services rendered on or after March 1, 2009: the item has a status code N, Q1, Q2, or Q3 and is packaged into the APC payment for the emergency room visit or surgical procedure (in which case no additional fee is allowable) or,

For services rendered on or after September 1, 2014: the item has a status code N, Q1, Q2, or Q3 and is packaged into the APC payment for the emergency room visit, surgical procedure, or Facility Only Service (in which case no additional fee is allowable).

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

For services rendered on or after March 1, 2009: the item is furnished in conjunction with an emergency room visit or surgical procedure and has been assigned status code G, H, K, R, or U.

For services rendered on or after September 1, 2014: the item is furnished in conjunction with an emergency room visit, surgical procedure, or Facility Only Service, and has been assigned status code G, H, K, R, or U.

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

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

(c) The maximum allowable fees for services, drugs and supplies furnished by hospitals and ambulatory surgical centers that do not meet the requirements in (a) for a facility fee payment and are not bundled in the APC payment rate for ~~a surgical service or emergency room visit~~ services in (a) will be determined as follows:

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

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

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

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

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

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

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

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

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

~~(5) The maximum allowable fees for non-surgical ancillary services with a status code indicator "X" shall be determined according to Section 9789.10 and Section 9789.11.~~

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

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

(d) For services rendered before September 1, 2014, only hospitals may charge or collect a facility fee for emergency room visits. Only hospital outpatient departments and ambulatory surgical centers as defined in Section 9789.30(no) and Section 9789.30(c) may charge or collect a facility fee for surgical services provided on an outpatient basis.

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

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

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

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

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

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

Section 9789.33. Determination of Maximum Reasonable Fee.

(a) For Services rendered on or after July 1, 2004, In accordance with section 9789.32, the maximum allowable payment for outpatient facility fees for hospital emergency room services, or for surgical services, or for Facility Only Services performed at a hospital outpatient department, or for surgical services performed at an ambulatory surgical center shall be determined based on the following. In accordance with Section 9789.30(xaa), an extra 2% percentage reimbursement shall be used in lieu of an additional payment for high cost outlier cases.

Standard payment.

Date of Service	Status Code Indicators	Hospital Outpatient Department Services that are: Surgical procedures; Emergency Room Visits; or services that are an integral part of the surgical procedure or emergency room visit	Ambulatory Surgical Centers surgical procedures	Hospital Outpatient Department Facility Only Services
For services rendered before March 1, 2008	"S", "T", "X", or "V"	APC relative weight x adjusted conversion factor x 1.22 workers' compensation multiplier, pursuant to Section 9789.30(aa). See Section 9789.39(b) for the APC relative weight by date of service.	APC relative weight x adjusted conversion factor x 1.22 workers' compensation multiplier, pursuant to Section 9789.30(aa). See Section 9789.39(b) for the APC relative weight by date of service.	Not applicable. Payable under Sections 9789.10 and 9789.11.
For services rendered on or after March 1, 2008	"S", "T", "X", or "V", or "Q". Status code indicator "Q" must qualify for separate payment.	APC relative weight x adjusted conversion factor x 1.22 workers' compensation multiplier, pursuant to Section 9789.30(aa). See Section 9789.39(b) for the APC relative weight by date of service.	APC relative weight x adjusted conversion factor x 1.22 workers' compensation multiplier, pursuant to Section 9789.30(aa). See Section 9789.39(b) for the APC relative weight by date of service.	Not applicable. Payable under Sections 9789.10 and 9789.11.
For services rendered on or after March 1, 2009	"S", "T", "X", or "V", "Q1", Q2", or "Q3". Status code indicators "Q1", "Q2", and "Q3" must qualify for separate payment.	APC relative weight x adjusted conversion factor x 1.22 workers' compensation multiplier, pursuant to Section 9789.30(aa). See Section 9789.39(b) for the APC relative	APC relative weight x adjusted conversion factor x 1.22 workers' compensation multiplier, pursuant to Section 9789.30(aa). See Section 9789.39(b) for the APC relative	Not applicable. Payable under Sections 9789.10 and 9789.11.

Date of Service	Status Code Indicators	Hospital Outpatient Department Services that are: Surgical procedures; Emergency Room Visits; or services that are an integral part of the surgical procedure or emergency room visit	Ambulatory Surgical Centers surgical procedures	Hospital Outpatient Department Facility Only Services
		weight by date of service.	weight by date of service.	
For services rendered on or after January 1, 2013	"S", "T", "X", or "V", "Q1", Q2", or "Q3". Status code indicators "Q1", "Q2", and "Q3" must qualify for separate payment.	APC relative weight x adjusted conversion factor x 1.22 workers' compensation multiplier, pursuant to Section 9789.30(aa). See Section 9789.39(b) for the APC relative weight by date of service.	APC relative weight x adjusted conversion factor x 0.82 workers' compensation multiplier, pursuant to Section 9789.30(aa). See Section 9789.39(b) for the APC relative weight by date of service.	Not applicable. Payable under Sections 9789.10 and 9789.11.
For services rendered on or after September 1, 2014	"S", "T", "X", or "V", "Q1", Q2", or "Q3". Status code indicators "Q1", "Q2", and "Q3" must qualify for separate payment.	APC relative weight x adjusted conversion factor x 1.212 workers' compensation multiplier, pursuant to Section 9789.30(aa). See Section 9789.39(b) for the APC relative weight by date of service.	APC relative weight x adjusted conversion factor x 0.808 workers' compensation multiplier, pursuant to Section 9789.30(aa). See Section 9789.39(b) for the APC relative weight by date of service.	APC relative weight x adjusted conversion factor x 1.010 workers' compensation multiplier, pursuant to Section 9789.30(aa). See Section 9789.39(b) for the APC relative weight by date of service.

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

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

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

~~For services rendered before January 1, 2013: APC relative weight x adjusted conversion factor x 1.22 workers' compensation multiplier, pursuant to Section 9789.30(x). See Section 9789.39(b) for the APC relative weight by date of service.~~

~~For services rendered on or after January 1, 2013: APC relative weight x adjusted conversion factor x 1.22 workers' compensation multiplier for hospital outpatient departments and 0.82 workers' compensation multiplier for ambulatory surgical centers, pursuant to Section 9789.30(x).~~

~~(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:~~ according to Table A and subdivision (a).

~~For services rendered before January 1, 2013: APC relative weight x adjusted conversion factor x 1.22, workers' compensation multiplier pursuant to Section 9789.30(x).~~

~~For services rendered on or after January 1, 2013: APC relative weight x adjusted conversion factor x 1.22 workers' compensation multiplier for non-listed hospital outpatient departments and 0.82 workers' compensation multiplier for ambulatory surgical centers, pursuant to Section 9789.30(x).~~

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

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

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

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

(~~2~~1) Procedure codes for drugs and biologicals with status code indicator "G":

~~For services rendered before January 1, 2013:~~ APC payment rate x ~~1.22~~ workers' compensation multiplier pursuant to Section 9789.30(~~x~~aa), by date of service.

~~For services rendered on or after January 1, 2013: APC payment rate x 1.22 workers' compensation multiplier for hospital outpatient departments and 0.82 workers' compensation multiplier for ambulatory surgical centers, pursuant to Section 9789.30(x).~~

(~~3~~2) Procedure codes for devices with status code indicator "H":

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

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

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

~~For services rendered before January 1:~~ APC payment rate x ~~1.22~~ workers' compensation multiplier pursuant to Section 9789.30(~~x~~aa), by date of service.

~~For services rendered on or after January 1, 2013: APC payment rate x 1.22 workers' compensation multiplier for hospital outpatient departments and 0.82 workers' compensation multiplier for ambulatory surgical centers, pursuant to Section 9789.30(x).~~

(~~5~~4) For services rendered on or after March 1, 2009: Procedure codes for blood and blood products with status code indicator "R":

~~For services rendered before January 1, 2013:~~ APC payment x ~~1.22~~ workers' compensation multiplier pursuant to Section 9789.30(~~x~~aa), by date of service.

~~For services rendered on or after January 1, 2013: APC payment rate x 1.22 workers' compensation multiplier for hospital outpatient departments and 0.82 workers' compensation multiplier for ambulatory surgical centers, pursuant to Section 9789.30(x).~~

(~~6~~5) For services rendered on or after March 1, 2009: Procedure codes for brachytherapy services with status code indicator "U":

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

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

APC payment x ~~1.22~~ workers' compensation multiplier pursuant to Section 9789.30(~~x~~aa), by date of service.

~~For services rendered on or after January 1, 2013: APC payment rate x 1.22 workers' compensation multiplier for hospital outpatient departments and 0.82 workers' compensation multiplier for ambulatory surgical centers, pursuant to Section 9789.30(x).~~

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

(1) Standard payment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

For services rendered before January 1, 2013: APC payment x 1.20 workers’ compensation multiplier pursuant to Section 9789.30(~~x~~aa).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ELECTION FOR HIGH COST OUTLIER

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

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

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

Hospital Outpatient Department Cost-to-Charge Ratio

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

5. Cost-to-charge ratio _____

_____ _____
Signature and Title Date

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

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

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

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

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

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

_____ _____
Signature, Chief Executive Officer Date

_____ _____
Signature, Certified Public Accountant Date

DWC Form 15 (rev. ~~01/01/2013~~ 09/01/2014)

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~~ Update Table by Date of Service.

(a) Federal Regulations by Date of Service

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

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

	Services Occurring On or After 3/1/2009	Services Occurring On or After 4/15/2010	Services Occurring On or After 9/15/2011	Services Occurring On or After 3/1/2012
Title 42, Code of Federal Regulations, §419.2				
Title 42, Code of Federal Regulations, §419.32			As amended; effective January 1, 2011	As amended; effective January 1, 2012
Title 42, Code of Federal Regulations, §419.43	As amended; effective January 1, 2009		As amended; effective January 1, 2011	As amended; effective January 1, 2012
Title 42, Code of Federal Regulations, §419.44				
Title 42, Code of Federal Regulations, §419.62				
Title 42, Code of Federal Regulations, §419.64		As amended; effective January 1, 2010		
Title 42, Code of Federal Regulations, §419.66		As amended; effective January 1, 2010		

	Services Occurring On or After 4/1/2013			
Title 42, Code of Federal Regulations, §419.2	As amended; effective January 1, 2013			
Title 42, Code of Federal Regulations, §419.32	As amended; effective January 1, 2013			
Title 42, Code of Federal Regulations, §419.43				
Title 42, Code of Federal Reg-				

ulations, §419.44				
Title 42, Code of Federal Regulations, §419.62				
Title 42, Code of Federal Regulations, §419.64				
Title 42, Code of Federal Regulations, §419.66				

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

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

	Services Occurring On or After 1/1/2004	Services Occurring On or After 7/15/2005	Services Occurring On or After 2/15/2006	Services Occurring on Or After 3/1/2007
Applicable FR Notices	(A) November 7, 2003 (CMS-1471-FC; 68 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, 2003 (CMS-1470-F; 68 FR 47637)	(A) November 15, 2004 (CMS-1427-FC; 69 FR 65681); (B) December 30, 2004 (CMS-1427-CN; 69 FR 78315; (C) August 11, 2004 (CMS-1428-F; 69 FR 48916); (D) December 30, 2004 (CMS-1482-F2; 69 FR 78526	(A) November 10, 2005 (CMS-1501-FC; 70 FR 68515); (B) December 23, 2005 (CMS-1501-CN2; 70 FR 76176); (C) August 12, 2005 (CMS-1500-F; 70 FR 47278); (D) September 30, 2005 (CMS-1500-CN; 70 FR 57161)	(A) November 24, 2006 (CMS-1506-FC; 71 FR 67960); (B) August 18, 2006 (CMS-1488-F; 71 FR 47870) (C) October 11, 2006 (CMS-CMS-1488-N; 71 FR 59886)
APC Payment Rate	Addendum B (A) beginning on page 63488 conformed to comply with (B) beginning on page 75442 and (C) beginning on page 820	Addendum B (A)beginning on page 65887	Addendum B (A) beginning on page 68752	Addendum B (A) beginning on page 68283
APC Relative Weight	Addendum B (A) beginning on page 63488 conformed to comply with (B) beginning on page 75442 and (C) beginning on page 820	Addendum B (A)beginning on page 65887	Addendum B (A) beginning on page 68752	Addendum B (A) beginning on page 68283
Emergency De-	99281-99285	99281-99285	99281-99285	99281-99285

	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
partment HCPCS Codes				
HOPPS Addenda	Addenda A, B, D1, D2, E, H, I, and J (A) beginning at page 63478; as changed by (B) beginning at page 75442; and (C) beginning at page 820	Addenda A, B, D1, D2, and E (A) beginning at page 65864	Addenda A, B, D1, D2, E and L (A) beginning at page 68729; and correction (B) beginning at page 76176	Addenda A, B, D1, D2, E, and L (A) beginning at page 68231
IPPS Tables		Tables $4A_1$, $4A_2$, $4B_1$, $4B_2$, $4C_1$ $4C_2$ and 4J (D) beginning at page 78619	Tables 4A, 4B, 4C, and 4J (D) beginning at page 57163; and Tables 4A, 4B, 4C, and 4J (C) beginning on page 47580	Tables 4A-1, 4A-2, 4B-1, 4B-2, 4C-1, 4C-2, and 4J (C) beginning at page 59975
Labor-related Share	60% ((A) page 63458)	60% ((A) beginning at page 65842)	60% ((A) beginning at page 68551)	60% ((A) beginning at page 68003)
Market Basket Inflation Factor	3.4% (D) page 45346	3.3% (C) page 49274	3.7% (C) page 47492	3.4% (B) page 48146
Outlier Threshold		$1,175 (A) at page 65846	$1,250 (A) at page 68565	$1,825(A) at page 68012
Surgical Procedure HCPCS	10021-69990	10021-69990	10021-69990	10021-69990
~~Una~~Adjusted 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	Referenced in (A) beginning at page 68551; wage index values are specified in Tables 4A through 4C (D) beginning	Referenced in (A) beginning at page 68003; wage index values are specified in Tables 4A-1 through 4C-2 (C) be-

	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
		$4A_1$ through $4C_2$ (D) beginning at page 78619	at page 57163; and as specified in Tables 4A through 4C (C) beginning at page 47580	ginning at page 59975

	Services Occurring On or After 3/1/2008	Services Occurring On or After 3/1/2009	Services Occurring On or After 4/15/2010	Services Occurring On or After 9/15/2011
Applicable FR Notices	(A) November 27, 2007 (CMS-1392-FC; CMS-1533-F2; 72 FR 66580); (B) August 22, 2007 (CMS-1533-FC; 72 FR 47130); (C) October 10, 2007 (CMS-1533-CN2; 72 FR 57634); (D) November 6, 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)	(A) November 18, 2008 (CMS-1404-FC; 73 FR 68502); (B) August 19, 2008 (CMS-1390-F; 73 FR 48434); (C) October 3, 2008 (CMS-1390-CN; 73 FR 57541); (D) October 3, 2008 (CMS-1390-N; 73 FR 57888); (E) December 3, 2008 (CMS-1390-N2; 73 FR 73656); (F) January 26, 2009 (CMS-1404-CN; 74 FR 4343)	(A) November 20, 2009 (CMS-1414-FC; 74 FR 60316); (B)December 31, 2009 (CMS-1414-CN; 74 FR 69502); (C) August 27, 2009 (CMS-1406-F; 74 FR 43754); (D) October 7, 2009 (CMS-1406-CN; 74 FR 51496)	(A) November 24, 2010 (CMS-1504-FC; 75 FR 71800); (B) March 11, 2011 (CMS-1504-CN; 76 FR 13292); (C) August 16, 2010 (CMS-1498-F; 75 FR 50042); (D) October 1, 2010 (CMS-1498-F; 75 FR 60640)
APC Payment Rate	Addendum B (A) beginning on page 66993 conformed to comply with correction published in (F)	Addendum B (A) beginning on page 68934 conformed to comply with correction published in (F)	Addendum B (A) beginning on page 60752 conformed to comply with correction published in (B)	Addendum B (A) beginning on page 72331 conformed to comply with correction published in (B)

	Services Occurring On or After 3/1/2008	Services Occurring On or After 3/1/2009	Services Occurring On or After 4/15/2010	Services Occurring On or After 9/15/2011
	beginning on page 9863	beginning on page 4344	page 69503	page 13295
APC Relative Weight	Addendum B (A) beginning on page 66993 conformed to comply with correction published in (F) beginning on page 9863	Addendum B (A) beginning on page 68934 conformed to comply with correction published in (F) beginning on page 4344	Addendum B (A) beginning on page 60752 conformed to comply with correction published in (B) page 69503	Addendum B (A) beginning on page 72331 conformed to comply with correction published in (B) page 13295
Emergency Department HCPCS Codes	99281-99285	99281-99285	99281-99285	99281-99285
HOPPS Addenda	Addenda A, B, D1, D2, E, L, and M (A) beginning at page 66934; and 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	Addenda A, B, D1, D2, E, L, and M (A) beginning at page 72268; and corrections to addendum B (B) on page 13295
IPPS Tables	Tables 4A, 4B, and 4C (C) beginning at page 57698 and Table 4J (B) beginning at page 47531 and correction (C) beginning at page 57726	Tables 4A, 4B, 4C, and 4J (C) beginning at page 57956; and Tables 2 and 4J (E)beginning at page 73657	Tables 2, 4A, 4B, 4C, and 4J(C) beginning at page 44032; as changed by correction to Tables 2, 4A, 4B, 4C, and 4J (D) beginning at page 51499	Tables 2, 4A, 4B, 4C, and 4J (C) beginning at page 50451
Labor-related Share	60% ((A) beginning at page 66678)	60% ((A) beginning at page 68585)	60% ((A) beginning at page 60419)	60% ((A) beginning at page 71877)
Market Basket Inflation Factor	3.3% (B) page 47415	3.6% (B) page 48759	2.1% (C) page 44002	2.6% (C) page 50422
Outlier Threshold	$1,575 (A) at page 66686	$1,800 (A) at page 68594	$2,175 (A) at page 60428	$2,025 (A) at page 71889
Surgical Procedure HCPCS	10021-69990	10021-69990	10021-69990	10021-69990
~~Una~~Adjusted Conversion	$61.699 (2007 unadjusted	$63.920 (2008 unadjusted	$65.262 (2009 unadjusted	$66.959 (2010 unadjusted

	Services Occurring On or After 3/1/2008	Services Occurring On or After 3/1/2009	Services Occurring On or After 4/15/2010	Services Occurring On or After 9/15/2011
Factor	conversion factor of $59.728 x estimated inflation factor of 1.033)	conversion factor of $61.699 x estimated inflation factor of 1.036)	conversion factor of $63.920 x estimated inflation factor of 1.021)	conversion factor of $65.262 x estimated inflation factor of 1.026)
Wage Index	Referenced in (A) beginning at page 66678; wage index values are specified in Tables 4A through 4C (C) beginning at page 57698	Referenced in (A beginning at page 68585; wage index values are specified in Tables 4A through 4C (D) beginning at page 57956	Referenced in (A) beginning at page 60419; wage index values are specified in Tables 4A through 4C (D) beginning at page 51505; and as specified in Tables 4A through 4C (C) beginning at page 44085	Referenced in (A) beginning at page 71877; wage index values are specified in Tables 4A through 4C (C) beginning at page 50511

	Services Occurring On or After 3/1/2012	Services Occurring On or After 9/1/2012	Services Occurring On or After 4/1/2013	Services Occurring On or After 09/01/2014
Applicable FR Notices	(A) November 30, 2011 (CMS-1525-FC; 76 FR 74122); (B) January 4, 2012 (CMS-1525-CN; 77 FR 217); (C) August 18, 2011 (CMS-1518-F; 76 FR 51476); (D) September 26, 2011 (CMS-1518-CN3; 76 FR 59263)	(A) November 30, 2011 (CMS-1525-FC; 76 FR 74122); (B) January 4, 2012 (CMS-1525-CN; 77 FR 217); (C) August 18, 2011 (CMS-1518-F; 76 FR 51476); (D) September 26, 2011 (CMS-1518-CN3; 76 FR 59263); (E) April 24, 2012 (CMS-1525-CN2; 77 FR 24409)	(A) November 15, 2012 (CMS-1589-FC; 77 FR 68210)	
APC Payment Rate	Addendum B (A) conformed	Addendum B (A) conformed	Addendum B (A) found on	

	Services Occurring On or After 3/1/2012	Services Occurring On or After 9/1/2012	Services Occurring On or After 4/1/2013	Services Occurring On or After 09/01/2014
	to comply with correction published in (B) found on CMS website at: http://www.cms.gov/HospitalOutpatientPPS	to comply with corrections published in (B) and (E) found on CMS website at: http://www.cms.gov/HospitalOutpatientPPS	CMS website at: http://www.cms.gov/HospitalOutpatientPPS	
APC Relative Weight	Addendum B (A) conformed to comply with correction published in (B) found on CMS website at: http://www.cms.gov/HospitalOutpatientPPS	Addendum B (A) conformed to comply with corrections published in (B) and (E) found on CMS website at: http://www.cms.gov/HospitalOutpatientPPS	Addendum B (A) found on CMS website at: http://www.cms.gov/HospitalOutpatientPPS	
Emergency Department HCPCS Codes	99281-99285	99281-99285	99281-99285	99281-99285, 99291, 99292, G0380-G0384, G0390
Facility Only Services				Services with a "NA" in the column labeled "Non-Facility NA Indicator" of the Medicare Physician Fee Schedule Relative Value File for Calendar Year 2014 (RVU14A), located at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-

	Services Occurring On or After 3/1/2012	Services Occurring On or After 9/1/2012	Services Occurring On or After 4/1/2013	Services Occurring On or After 09/01/2014
				Value-Files.html
HOPPS Addenda	Addenda A, B, D1, D2, E, L, and M (A) and corrections to addenda (B) found on CMS website at: http://www.cms.gov/HospitalOutpatientPPS	Addenda A, B, D1, D2, E, L, and M (A and E) and corrections to addenda (A) and (B) found on CMS website at: http://www.cms.gov/HospitalOutpatientPPS	Addenda A, B, D1, D2, E, L, and M (A) found on CMS website at: http://www.cms.gov/HospitalOutpatientPPS	
IPPS Tables	Tables 2, 4A, 4B, 4C, and 4J (C) and correction (D) found on CMS website at: http://www.cms.hhs.gov/AcuteInpatientPPS/.		Tables 2, 4A, 4B, 4C, and 4J (C) and correction (D) found on CMS website at: http://www.cms.hhs.gov/AcuteInpatientPPS/.	
Labor-related Share	60% ((A) beginning at page 74191)		60% (A) beginning at page 68285	
Market Basket Inflation Factor	3.0% (A) page 74189		2.6% (A) page 68215	
Medicare Physician Fee Schedule Relative Value File				Calendar Year 2014 (RVU14A), located at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html
Outlier	$2,025 (B) at		$2,025 (A) page	

	Services Occurring On or After 3/1/2012	Services Occurring On or After 9/1/2012	Services Occurring On or After 4/1/2013	Services Occurring On or After 09/01/2014
Threshold	page 222		68297	
Surgical Procedure HCPCS	10021-69990	10021-69990	10021-69990	10021-69990, G0413
~~Una~~Adjusted Conversion Factor	$68.968 (2011 unadjusted conversion factor of $66.959 x estimated inflation factor of 1.03)		$70.761 (2012 unadjusted conversion factor of $68.968 x estimated inflation factor of 1.026)	
Wage Index	Referenced in (A) beginning at page 74191; wage index values are specified in Tables 4A through 4C (C) found on the CMS web site at: http://www.cms.gov/AcuteInpatientPPS/		Referenced in (A) beginning at page 68285; wage index values are specified in Tables 4A through 4C found on the CMS web site at: http://www.cms.gov/AcuteInpatientPPS/	

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