Title 8. Industrial Relations
Division 1. Department Of Industrial Relations
Chapter 4.5. Division Of Workers' Compensation
Subchapter 1. Administrative Director -- Administrative Rules
Article 5.3 Official Medical Fee Schedule

§ 9789.10. Physician Services Rendered on or After July 1, 2004, but Before January 1, 2014-Definitions.

(a) "Basic value" means the unit value for an anesthesia procedure that is set forth in the Official Medical Fee Schedule 2003.

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

(c) "Conversion factor" or "CF" means the factor set forth below for the applicable OMFS section:

Evaluation and Management	$ 8.50
Medicine	$ 6.15
Surgery	$ 153.00
Radiology	$ 12.50
Pathology	$ 1.50
Anesthesia	$ 34.50

(d) "CPT®" means the procedure codes set forth in the American Medical Association's Physicians' Current Procedural Terminology (CPT) 1997, copyright 1996, American Medical Association, or the Physicians' Current Procedural Terminology (CPT) 1994, copyright 1993, American Medical Association.

(e) "Medicare rate" means the physician fee schedule rate derived from the Resource Based Relative Value Scale and related data, adopted for the Calendar Year 2004, published in the Federal Register on January 7, 2004, Volume 69, No. 4, pages 1117 through 1242 (CMS-1372-IFC), as amended by CMS Manual System, Pub. 100-04 Medicare Claims Processing, Transmittal 105 (February 20, 2004). The Medicare rate for each procedure is derived by the Administrative Director utilizing the non-facility rate (or facility rate if no non-facility rate exists), and a weighted average geographic adjustment factor of 1.063.

(f) "Modifying units" means the anesthesia modifiers and qualifying circumstances as set forth in the Official Medical Fee Schedule 2003.

(g) "Official Medical Fee Schedule" or "OMFS" means Article 5.3 of Subchapter 1 of Chapter 4.5 of Title 8, California Code of Regulations (Sections 9789.10 - 9789.111), adopted pursuant to *Section 5307.1 of the Labor Code* for all medical services, goods, and treatment provided pursuant to *Labor Code Section 4600*.

(h) "Official Medical Fee Schedule 2003" or "OMFS 2003" means the Official Medical Fee Schedule incorporated into Section 9791.1 in effect on December 31, 2003, which consists of the OMFS book revised April 1, 1999 and as amended for dates of service on or after July 12, 2002.

(i) "Percentage reduction calculation" means the factor set forth in Table A for each procedure code which will result in a reduction of the OMFS 2003 rate by 5%, or a lesser percent so that the reduction results in a rate that is no lower than the Medicare rate.

(j) "Physician service" means professional medical service that can be provided by a physician, as defined in *Section 3209.3 of the Labor Code*, and is subject to reimbursement under the Official Medical Fee Schedule. For purposes of the OMFS, "physician service" includes service rendered by a physician or by a non-physician who is acting under the supervision, instruction, referral or prescription of a physician, including but not limited to a physician assistant, nurse practitioner, clinical nurse specialist, and physical therapist.

(k) "RVU" means the relative value unit for a particular procedure that is set forth in the Official Medical Fee Schedule 2003.

(l) "Time value" means the unit of time indicating the duration of an anesthesia procedure that is set forth in the Official Medical Fee Schedule 2003.

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

§ 9789.11. Physician Services Rendered on or After July 1, 2004, but Before January 1, 2014.

(a) Except as specified below, or otherwise provided in this Article, the ground rule materials set forth in each individual section of the OMFS 2003 are applicable to physician services rendered on or after July 1, 2004, but before January 1, 2014.

(1) The OMFS 2003's "General Information and Instructions" section is not applicable. The "General Information and Instructions, Effective for Dates of Service on or after July 1, 2004," are incorporated by reference and will be made available on the Division of Workers' Compensation Internet site http://www.dir.ca.gov/DWC/OMFS9904.htm or upon request to the Administrative Director at:

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

(b) Except as specified in this section, or otherwise provided in this Article, for physician services rendered on or after July 1, 2004, but before January 1, 2014, the maximum allowable reimbursement amount set forth in the OMFS 2003 for each procedure code is reduced by five (5) percent, except that those procedures that are reimbursed under OMFS 2003 at a rate between 100% and 105% of the Medicare rate will be reduced between zero and 5% so that the OMFS reimbursement will not fall below the Medicare rate. The reduction rate for each procedure is set forth as the adjustment factor in Table A. Reimbursement for procedures that are reimbursed under OMFS 2003 at a rate below the Medicare rate will not be reduced.

(c)(1) Table A, "OMFS Physician Services Fees for Services Rendered on or after July 1, 2004," which sets forth each individual procedure code with its corresponding relative value, conversion

factor, percentage reduction calculation (between 0 and 5.0%), and maximum reimbursable fee, is incorporated by reference.

(2) Table A, "OMFS Physician Services Fees for Services Rendered on or after January 14, 2005," which sets forth each individual procedure code with its corresponding relative value, conversion factor, percentage reduction calculation (between 0 and 5.0%), and maximum reimbursable fee, is incorporated by reference.

(3) Table A, "OMFS Physician Services Fees for Services Rendered on or after May 14, 2005," which sets forth each individual procedure code with its corresponding relative value, conversion factor, percentage reduction calculation (between 0 and 5.0%), and maximum reimbursable fee, is incorporated by reference.

(4) Table A and its addenda may be obtained from the Division of Workers' Compensation Internet site http://www.dir.ca.gov/DWC/OMFS9904.htm or upon request to the Administrative Director at:

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

(d)(1) Except as specified in this section, or otherwise provided in this Article, except for anesthesia services, to determine the maximum allowable reimbursement for a physician service rendered on or after July 1, 2004, but before January 1, 2014, the following formula is utilized: RVU x conversion factor x percentage reduction calculation = maximum reasonable fee before application of ground rules. Applicable ground rules set forth in the OMFS 2003 and the "General Information and Instructions, Effective for Dates of Service on or after July 1, 2004," are then applied to calculate the maximum reasonable fee.

(2) Except as specified in this section, or otherwise provided in this Article, to determine the maximum allowable reimbursement for anesthesia services (CPT Codes 00100 through 01999) rendered after January 1, 2004, but before January 1, 2014, the following formula is utilized: (basic value + modifying units (if any) + time value) x (conversion factor x .95) = maximum reasonable fee.

(e) Except as specified in this section, or otherwise provided in this Article, the following procedures in the Pathology and Laboratory section (both professional and technical component), rendered after January 1, 2004, but before January 1, 2014, will be reimbursed under this section: CPT Codes 80500, 80502; 85060 through 85102; 86077 through 86079; 87164; and 88000 through 88399. All other pathology and laboratory services will be reimbursed pursuant to Section 9789.50, including but not limited to: CPT Codes 80002 through 80440; 81000 through 85048; 85130 through 86063; 86140 through 87163; 87166 through 87999; and 89050 through 89399.

(f) Except as specified in this section, or otherwise provided in this Article, for physician services rendered on or after February 15, 2007, but before January 1, 2014, the maximum allowable reimbursement amounts for procedure codes 99201 through 99205 and 99211 through 99215 are set forth in the February, 2007 Addendum to Table A, "OMFS Physician Services Fees for Services Rendered on or after February 15, 2007." The February, 2007 Addendum to Table A, "OMFS Physician Services Fees for Services Rendered on or after February 15, 2007", which sets forth

individual procedure codes with the corresponding maximum reimbursable fees, is incorporated by reference.

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

§9789.20. General Information for Inpatient Hospital Fee Schedule—Discharge On or After July 1, 2004.

(a) This Inpatient Hospital Fee Schedule section of the Official Medical Fee Schedule covers charges made by a hospital for inpatient services provided by the hospital.

(b) Charges by a hospital for the professional component of medical services for physician services rendered on or after January 1, 2014, shall be paid according to Sections 9789.12.1 through 9789.19. Services rendered on or after July 1, 2004 but before January 1, 2014 shall be paid according to Sections 9789.10 through 9789.11. Services rendered after January 1, 2004 but before July 1, 2004 are governed by the “emergency” regulations that were effective on January 2, 2004. Services rendered on or before January 1, 2004 will be paid according to Section 9790, et seq.

(c) Sections 9789.20 through 9789.25 shall apply to all bills for inpatient services with a date of discharge on or after July 1, 2004. Services for discharges after January 1, 2004, but before July 1, 2004 are governed by the "emergency" regulations that were effective on January 2, 2004. Bills for services with date of admission on or before December 31, 2003 will be reimbursed in accordance with Section 9792.1.

(d) The Inpatient Hospital Fee schedule shall be adjusted to conform to any relevant changes in the Medicare payment schedule, including mid-year changes no later than 60 days after the effective date of those changes. Updates shall be posted on the Division of Workers' Compensation webpage at http://www.dir.ca.gov/DWC/dwc_home_page.htm. The annual updates to the Inpatient Hospital Fee schedule shall be effective every year on December 1.

(e) Any document incorporated by reference in Sections 9789.20 through 9789.25 is available from the Division of Workers' Compensation Internet site (http://www.dir.ca.gov/dwc/dwc_home_page.htm) or upon request to the Administrative Director at:

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

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

§9789.21. Definitions for Inpatient Hospital Fee Schedule.

(a) "Average length of stay" means the geometric mean length of stay for a diagnosis-related group assigned by CMS.

(b) "Capital outlier factor" means for discharges occurring after January 1, 2004 and before January 1, 2008, the fixed loss cost outlier threshold x capital wage index x large urban add-on x (capital cost-to-charge ratio/total cost-to-charge ratio).

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

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

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

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

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

(d) For discharges before January 1, 2014, “Complex spinal surgery” is defined by the DRG to which a patient is assigned and is used to determine whether any additional payment is allowed for spinal devices used during the spinal surgery. See Section 9789.25(b) for the DRGs that define complex spinal surgery by date of discharge.

(e) "Composite factor" means the standard OMFS rate calculated by the administrative director for a hospital by adding the hospital-adjusted rates for prospective operating costs and for prospective capital costs. It excludes the DRG weight and any applicable payments for outlier cases, spinal devices used in complex spinal surgery, and new technology.

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

(A) For discharges after January 1, 2004 and before January 1, 2008, the hospital-adjusted rate for prospective capital costs is determined by the following formula: Capital standard federal payment rate x capital geographic adjustment factor x large urban add-on x [1 + capital disproportionate share adjustment factor + capital indirect medical education adjustment factor].

For discharges on or after January 1, 2008, the hospital-adjusted rate for prospective capital costs is determined by the following formula as modified by Title 42, Code of Federal Regulations, Section 412.316(b), as it is in effect on November 11, 2003, amended October 1, 2004, amended

October 1, 2006, and amended as of October 1, 2007, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director: Capital standard federal payment rate x capital geographic adjustment factor x [1 + capital disproportionate share adjustment factor + capital indirect medical education adjustment factor].

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

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

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

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

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

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

(2) The hospital-adjusted rate for prospective operating costs is determined by the following formula:

(A) [(Labor-related national standardized amount x operating wage index) + nonlabor-related national standardized amount] x [1 + operating disproportionate share adjustment factor + operating indirect medical education adjustment].

For discharges on or after November 29, 2004, the hospital-adjusted rate for prospective operating costs is determined by the following formula as modified by Section 403 of Public Law 108-173 amended Sections 1886(d)(3)(E) of the Social Security Act, and as stated in Title 42, Code of Regulations, Section 412.64(h)(3), which document is hereby incorporated by reference and will be made available upon request to the Administrative Director and in conformance with California Labor Code Section 5307.1(g)(1)(A)(i). See Section 9789.25(a) for the Federal Regulation reference for the effective date, revisions, and amendments by date of discharge:

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

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

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

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

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

(B) The "labor-related national standardized amount" is $ 3,136.39 for discharges occurring on or after January 1, 2004 and before November 29, 2004. For each update in the composite factor, the labor-related national standardized amount for the preceding period is adjusted by the rate of change in the operating market basket. See Section 9789.25(b) for the labor-related national standard operating rate for discharges occurring on or after November 29, 2004 by date of discharge.

(C) The "operating wage index" is published in the Payment Impact File for each Medicare payment update. See Section 9789.25(c) for the variable name on the Payment Impact File by date of discharge.

(D) The "nonlabor-related national standardized amount" is $ 1,274.85, as published by CMS in the Federal Register of October 6, 2003 (correcting the publication of August 1, 2003), at Vol. 68, page 57735, Table 1A, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director and as modified by Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, §401, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

For discharges on or after November 29, 2004, the nonlabor-related portion is that portion of operating costs attributable to nonlabor costs, and is determined by the following formula as modified by Section 403 of Public Law 108-173 amended sections 1886(d)(3)(E) of the Social Security Act, and as stated in Title 42, Code of Regulations, Section 412.64(h) which documents are hereby incorporated by reference and will be made available upon request to the Administrative Director. See Section 9789.25(a) for the Federal Regulation reference for the effective date, revisions, and amendments by date of discharge:

100% - labor-related portion (%).

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

For discharges on or after March 5, 2015, the OMFS “operating disproportionate share (DSH) adjustment factor” is determined by the following formula:

OMFS operating DSH adjustment factor equals the sum of a) the Medicare DSH operating adjustment and b) 3 * the Medicare DSH operating adjustment * the Uncompensated Care adjustment).

The Medicare DSH operating adjustment is published in the Payment Impact File for each Medicare payment update, as amended by section 3133 of the Affordable Care Act, and set forth by new section 1886(r) of the Social Security Act, and as implemented in Title 42, Code of Regulations, Section 412.106, which documents are incorporated by reference and will be made available upon request to the Administrative Director. See Section 9789.25(a) for the Federal Regulation reference for the effective date, revisions, and amendments by date of discharge. See Section 9789.25(c) for the variable name on the Payment Impact File by date of discharge.

The Uncompensated Care adjustment factor reflects the change in percentage of uninsured individuals and additional Medicare adjustments, as defined in Section 1886(r) of the Social Security Act, as implemented in Title 42, Code of Regulations, Section 412.106, and as published by CMS in the Federal Register, which documents are incorporated by reference and will be made available upon request to the Administrative Director. See Section 9789.25(a) for the Federal Regulation reference for the effective date, revisions, and amendments by date of discharge. See Section 9789.25(b) for the Uncompensated Care adjustment factor for discharges occurring on or after March 5, 2015, by date of discharge.

(F) The "operating indirect medical education adjustment" is published in the Payment Impact File for each Medicare payment update, and as modified by Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, §502, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director. See Section 9789.25(c) for the variable name on the Payment Impact File by date of discharge.

(G) For sole community hospitals, the operating component of the composite rate shall be the higher of the prospective operating costs determined using the formula in Section 9789.21(e)(2) or the hospital-specific rate published in the Payment Impact File for each Medicare payment update. See Section 9789.25(c) for the variable name on the Payment Impact File by date of discharge.

(3) A table of composite factors for each hospital in California is contained in Section 9789.23. The sole community hospital composite factors that incorporate the operating component specified in Section 9789.21(e)(2)(G) are listed in italics in the column headed "Composite" set forth in Section 9789.23.

(f) "Costs" means the total billed charges for an admission, excluding non-medical charges such as television and telephone charges, charges for Durable Medical Equipment for in home use, charges for implantable medical devices, hardware, and/or instrumentation reimbursed under subdivision (g) of Section 9789.22, multiplied by the hospital's total cost-to-charge ratio plus the hospital's documented paid spinal device costs, plus an additional 10% of the hospital's documented paid cost, net of discounts and rebates, not to exceed a maximum of $250.00, plus any sales tax and/or shipping and handling charges actually paid.

(g) "Cost-to-charge ratio" means the sum of the hospital specific operating cost-to-charge ratio and the hospital specific capital cost-to-charge ratio. The operating cost-to-charge ratio and capital cost-to-charge ratio for each hospital are published in the Payment Impact File for each Medicare payment update. See Section 9789.25(c) for the variable names on the Payment Impact File by date of discharge.

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

(i) "Cost outlier threshold" means the sum of the Inpatient Hospital Fee Schedule payment amount, the payment for new medical services and technologies reimbursed under Section 9789.22(h), the hospital specific outlier factor, and any additional allowance for spinal devices under section 9789.22(g)(2).

(j) "Diagnosis Related Group (DRG)" means the inpatient classification scheme used by CMS for hospital inpatient reimbursement. The DRG system classifies patients based on principal diagnosis, surgical procedure, age, presence of comorbidities and complications and other pertinent data.

(k) "DRG weight" means the weighting factor for a diagnosis-related group assigned by CMS for the purpose of determining payment under Medicare. Section 9789.24 lists the DRG weights and geometric mean lengths of stay as assigned by CMS.

(l) "FY" means the CMS fiscal year October 1 through September 30.

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

(n) "Inpatient" means a person who has been admitted to a hospital for the purpose of receiving inpatient services. A person is considered an inpatient when he or she is formally admitted as an inpatient with the expectation that he or she will remain at least overnight and occupy a bed, even if it later develops that such person can be discharged or is transferred to another facility and does not actually remain overnight.

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

(p) "Labor-related portion" is that portion of operating costs attributable to labor costs, as specified in the Federal Register notices announcing revisions in the Medicare payment rates. See Section 9789.25(b) for the Federal Register reference that defines the labor-related portion by date of discharge.

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

(r) "Medical services" means those goods and services provided pursuant to Article 2 (commencing with Section 4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code.

(s) "Operating outlier factor" means ((fixed loss cost outlier threshold x ((labor-related portion x operating wage index) + nonlabor-related portion)) x (operating cost-to-charge ratio/ total cost-to-charge ratio)).

(1) The wage index, also referred to as operating wage index published in the Payment Impact File for each Medicare payment update, is specified as the wage index in the Federal Register notices announcing revisions in the Medicare payment rates. See Section 9789.25(c) for the variable name on

the Payment Impact File by date of discharge and see Section 9789.25(b) for the Federal Register reference that defines the wage index by date of discharge.

(2) The nonlabor-related portion is that portion of operating costs attributable to nonlabor costs as defined in the Federal Register of October 6, 2003 (correcting the publication of August 1, 2003), at Vol. 68, page 57735, Table 1A, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

For discharges on or after November 29, 2004, the nonlabor-related portion is determined by the following formula as modified by Section 403 of Public Law 108-173 amended Sections 1886(d)(3)(E) of the Social Security Act, and as stated in Title 42, Code of Regulations, Section 412.64(h) which document is hereby incorporated by reference and will be made available upon request to the Administrative Director. See Section 9789.25(a) for the Federal Regulation reference for the effective date, revisions, and amendments by date of discharge:

100% - labor-related portion (%).

(t) "Outlier factor" means the sum of the capital outlier factor and the operating outlier factor. A table of hospital specific outlier factors for each hospital in California is contained in Section 9789.23.

(u) "Payment Impact File" means the Prospective Payment System Payment Impact File published by CMS, for each Medicare update. See Section 9789.25(c) for references to the Payment Impact File by date of discharge.

(v) “Spinal device” means a medical device that is an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar related article, including a component part, or accessory which is: (1) recognized in the official National Formulary, or the United States Pharmacopoeia, or any supplement to them; (2) intended for use in the cure, mitigation, treatment, or prevention of disease; or (3) intended to affect the structure or any function of the body, and which does not achieve any of its primary intended purposes through chemical action within or on the body and which is not dependent upon being metabolized for the achievement of any of its primary intended purposes.

(w) "Professional Component" means the charges associated with a professional service provided to a patient by a hospital based physician. This component is billed separately from the inpatient charges.

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

§9789.22. Payment of Inpatient Hospital Services.

(a) Unless otherwise provided by applicable provisions of this fee schedule, the maximum payment for inpatient medical services shall be determined by multiplying 1.20 by the product of the hospital’s composite factor and the applicable DRG weight and by making any adjustments required by this fee schedule. The fee determined under this subdivision shall be a global fee, constituting the maximum reimbursement to a hospital for inpatient medical services not exempted under this section. However,

preadmission services rendered by a hospital more than 24 hours before admission are separately reimbursable.

(b) The maximum payment for inpatient medical services includes reimbursement for all of the inpatient operating costs specified in Title 42, Code of Federal Regulations, Section 412.2(c), which is incorporated by reference and will be made available upon request to the Administrative Director, and the inpatient capital-related costs specified in Title 42, Code of Federal Regulations, Section 412.2(d), which is incorporated by reference and will be made available upon request to the Administrative Director. See Section 9789.25(a) for the Code of Federal Regulations reference for the effective date, revisions, and amendments by date of discharge.

(c) The maximum payment shall include the cost items specified in Title 42, Code of Federal Regulations, Section 412.2(e)(1), (2), (3), and (5), which is incorporated by reference and will be made available upon request to the Administrative Director. The maximum allowable fees for cost item set forth at 42 C.F.R. Section 412.2(e)(4), "the acquisition costs of hearts, kidneys, livers, lungs, pancreas, and intestines (or multivisceral organ) incurred by approved transplantation centers," shall be based on the documented paid cost of procuring the organ or tissue. See Section 9789.25(a) for the Code of Federal Regulations reference for the effective date, revisions, and amendments by date of discharge.

(d) The maximum payment shall cover all items and services provided to hospital inpatients other than professional services provided by physicians and other practitioners that are payable under the Official Medical Fee Schedule - physicians fee schedule section in effect at the time the service was rendered (see Section 9789.111(a)). Except for services paid under the physicians fee schedule, all billing for payments shall originate from hospitals and payment may be made only to hospitals for the covered items and services, including any spinal device separately payable under Sections 9789.22(g).

(e) Hospitals billing for fees 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.

(f) (1) Cost Outlier cases.

(A) Unless otherwise provided, except for inpatient services provided by a hospital transferring an inpatient to another hospital or post-acute care provider in accordance with section 9789.22(j), inpatient services for cost outlier cases, shall be reimbursed as follows:

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

Step 2: Determine costs according to section 9789.21(f).

Step 3: Determine outlier threshold. Outlier threshold = (Inpatient Hospital Fee Schedule payment amount + hospital specific outlier factor + any new technology pass-through payment determined under Section 9789.22(h) + any additional allowance for spinal devices under Section 9789.22(g)(2)).

(B) Inpatient services provided by a hospital transferring an inpatient to another hospital subject to section 9789.22(j)(1) for cost outlier cases, shall be reimbursed as follows:

Step 1: Determine the Inpatient Hospital Fee Schedule maximum payment amount according to section 9789.22(j)(1).

Step 2: Determine costs according to section 9789.21(f).

Step 3: Determine outlier threshold. Outlier threshold = ((Inpatient Hospital Fee Schedule payment amount + hospital specific outlier factor) ÷ geometric length of stay for the DRG x (the actual length of stay for the case + one day)) + any new technology pass-through payment + any additional allowance for spinal devices under Section 9789.22(g)(2). The outlier threshold determined under this subdivision shall not exceed the amount determined under subdivision (A) of this section.

Inpatient services provided by the receiving hospital (final discharging hospital) subject to section 9789.22(j)(1) for cost outlier cases shall be reimbursed according to subdivision (A) of this section.

(C) Inpatient services provided by a hospital transferring an inpatient to a post-acute care provider subject to section 9789.22(j)(2)(A) for cost outlier cases, shall be reimbursed according to subdivision (B).

(D) Inpatient service discharges assigned to a special pay DRG provided by a hospital transferring an inpatient to a post-acute care provider subject to section 9789.22(j)(2)(B) for cost outlier cases, shall be reimbursed as follows:

Step 1: Determine the Inpatient Hospital Fee Schedule maximum payment amount according to section 9789.22(j)(2)(B).

Step 2: Determine costs according to section 9789.21(f).

Step 3: Determine outlier threshold. Outlier threshold = (Inpatient Hospital Fee Schedule payment amount + hospital specific outlier factor) x 0.5 + ((Inpatient Hospital Fee Schedule payment amount + hospital specific outlier factor) x 0.5 ÷ the geometric mean length of stay x the actual length of stay plus one day) + any new technology pass-through payment determined under Section 9789.22(h) + any additional allowance for spinal devices under Section 9789.22(g)(2). The outlier threshold determined under this subdivision shall not exceed the amount determined under subdivision (A) of this section.

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

(3) For discharges before January 1, 2013, for purposes of determining whether a case qualifies as a cost outlier case under this subdivision, charges for implantable spinal device and/or instrumentation reimbursed under subsection (g)(1) is excluded from the calculation of costs. If an admission for a complex spinal surgery DRG qualifies as a cost outlier case, any implantable spinal device and/or instrumentation shall be separately reimbursed under subsection (g)(1).

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

(1) For discharges occurring before January 1, 2013, costs for spinal devices used during complex spinal surgery DRGs shall be separately reimbursed at the hospital's documented paid cost, plus an additional 10% of the hospital's documented paid cost, net of discounts and rebates, not to exceed a maximum of $250.00, plus any sales tax and/or shipping and handling charges actually paid.

(2) For discharges occurring on or after January 1, 2013 but before January 1, 2014, an additional allowance of $9,140 shall be made for spinal devices used during complex spinal surgery MS-DRGs 453, 454, and 455; an additional allowance of $3,170 shall be made for spinal devices used during

complex spinal surgery MS-DRG 456; and an additional allowance of $670 shall be made for spinal devices used during complex spinal surgery MS-DRGs 028, 029, and 030.

(3) For discharges occurring on or after January 1, 2014, complex spinal surgery DRGs shall not receive any additional or separate reimbursement for spinal devices, unless the Administrative Director extends section 9789.22(g)(2) to discharges occurring on or after January 1, 2014, in accordance with Labor Code Section 5307.1(m) through a later enacted regulation.

(h) "New technology pass-through": Additional payments will be allowed for new medical services and technologies as provided by CMS and set forth in Title 42, Code of Federal Regulations Sections 412.87 and Section 412.88 which document is hereby incorporated by reference and will be made available upon request to the Administrative Director. See Section 9789.25(a) for the Code of Federal Regulations reference for the effective date, revisions, and amendments by date of discharge.

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

(j) Transfers

(1) Inpatient services provided by a hospital transferring an inpatient to another hospital are exempt from the maximum reimbursement formula set forth in Section 9789.22(a). Maximum reimbursement for inpatient medical services of a hospital transferring an inpatient to another hospital shall be a per diem rate for each day of the patient's stay in that hospital, not to exceed the amount that would have been paid under Section 9789.22(a). However, the first day of the stay in the transferring hospital shall be reimbursed at twice the per diem amount and the hospital shall receive the additional allowances under Sections 9789.22(g) and (h) when applicable. The per diem rate is determined by dividing the maximum reimbursement as determined under Section 9789.22(a) by the average length of stay (as defined in Section 9789.21(a)) for that specific DRG. However, if an admission to a hospital transferring a patient is exempt from the maximum reimbursement formula set forth in Section 9789.22(a) because it satisfies one or more of the requirements of Section 9789.22(k), this subdivision shall not apply. Inpatient services provided by the hospital receiving the patient shall be reimbursed under the provisions of Section 9789.22(a).

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

(A) When an acute care patient is discharged to a post-acute care provider which is a rehabilitation hospital or distinct part rehabilitation unit of an acute care hospital or a long-term hospital, and the patient's discharge is assigned to one of the qualifying DRGs as specified in the Federal Register, payment to the transferring hospital shall be made as set forth in Section 9789.22(j)(1). See Section 9789.25(b) for the Federal Register reference that contains the qualifying DRGs for a given discharge.

(B) When an acute care patient is discharged to a post-acute care provider and the patient's discharge is assigned to one of the qualifying special pay DRGs as specified in the Federal Register, the payment to the transferring hospital is 50% of the amount paid under Section 9789.22(a), plus 50% of

the per diem, set forth in Section 9789.22(j)(1) for each day, up to the full DRG amount. See Section 9789.25(b) for the Federal Register reference that contains the qualifying DRGs for a given discharge.

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

(1) Critical access hospitals;

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

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

(4) Veterans Administration hospitals;

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

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

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

(8) Out of state hospitals.

(l) For discharges occurring before January 1, 2013, a hospital that is not listed on the Medicare Cost Report should notify the Administrative Director and provide in writing the following information: OSHPD Licensure number, Medicare provider number, physical location, number of beds, and, if applicable, average FTE residents in approved training programs. If a hospital has been in operation for more than one year, information should also be provided on the percentage of inpatient days attributable to Medicaid patients.

For discharges occurring on or after January 1, 2013, a hospital that is not listed in Section 9789.23, may notify the Administrative Director and provide in writing the following Medicare information: Medicare provider number, physical location, county code, hospital specific operating and capital CCRs, and DSH and/or IME adjustments, if applicable.

(m) Any hospital that believes its composite factor or hospital specific outlier factor was erroneously determined because of an error in tabulating data may request the Administrative Director for a re-determination of its composite factor or hospital specific outlier factor. Such requests shall be in writing, shall state the alleged error, and shall be supported by written documentation. Within 30 days after receiving a complete written request, the Administrative Director shall make a redetermination of the composite factor or hospital specific outlier factor or reaffirm the published factor.

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

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

For discharges on or after January 1, 2004, hospital cost to charge ratios, hospital specific outliers, and hospital composite factors by date of discharge, are incorporated by reference, and are available at http://www.dir.ca.gov/dwc/OMFS9904.htm#4, or upon request to the Administrative Director at:

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

Full Payment Impact File (impfile04zip) at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html?redirect=/AcuteInpatientPPS/ (Section 9789.23 reflects the modifications of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, sections 402, 402 and 502, section 3133 of the Affordable Care Act, and section 1886(r) of the Social Security Act, which documents are hereby incorporated by reference and will be made available upon request to the Administrative Director.)
Record layout at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html?redirect=/AcuteInpatientPPS/.
Composite Rate (in italics) reflects Sole Community Hospital adjustment. See Section 9789.25(a) for the Code of Federal Regulations reference for the effective date, revisions, and amendments by date of discharge, and see Section 9789.25(c) for references to the Payment Impact File by date of discharge.

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

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

(a) Federal Regulations by Date of Discharge

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

	Discharges Occurring On or After 1/1/2004	Discharges Occurring On or After 11/29/2004	Discharges Occurring On or After 12/1/2005	Discharges Occurring On or After 12/1/2006

Title 42, Code of Federal Regulations, §412.2	Effective October 1, 2003			
Title 42, Code of Federal Regulations, §412.23(e)	Effective date October 1, 2002 and revised as of October 1, 2003			
Title 42, Code of Federal Regulations, §412.23(f)	Effective October 1, 2002 and revised as of October 1, 2003			
Title 42, Code of Federal Regulations Section 412.64	Effective October 1, 2004			
Title 42, Code of Federal Regulations Section 412.87	Effective September 7, 2001 and revised as of October 1, 2003	Amended; effective October 1, 2004		
Title 42, Code of Federal Regulations Section 412.88	Effective September 7, 2001 and amended August 1, 2002 and August 1, 2003 and revised as of October 1, 2003	Amended; effective October 1, 2004		
Title 42, Code of Federal Regulations §412.92(a)	Effective October 1, 2002 and revised as of October 1, 2003		Amended; effective October 1, 2005	
Title 42, Code of Federal	Effective October 1,		Amended; effective	

Regulations §412.92(d)	2002 and revised as of October 1, 2003		October 1, 2005	
Title 42, Code of Federal Regulations Section 412.316(b)	Effective November 11, 2003, large urban add-on is an additional 3%	Amended; effective October 1, 2004, large urban add-on is an additional 3%	Amended; effective October 1, 2004, large urban add-on is an additional 3%	Amended; effective October 1, 2006, large urban add-on is an additional 3%

	Discharges Occurring On or After 1/1/2008	Discharges Occurring On or After 12/1/2008	Discharges Occurring On or After 12/1/2009	Discharges Occurring On or After 3/01/2011
Title 42, Code of Federal Regulations, §412.2				Amended; effective October 1, 2010
Title 42, Code of Federal Regulations, §412.23(e)			Amended; effective October 1, 2009	Amended; effective October 1, 2010
Title 42, Code of Federal Regulations, §412.23(f)				
Title 42, Code of Federal Regulations Section 412.64				
Title 42, Code of Federal Regulations Section 412.87		Amended; effective October 1, 2008	Amended; effective October 1, 2009	
Title 42, Code of Federal Regulations Section 412.88	Amended; effective October 1, 2007			
Title 42, Code of Federal				

Regulations Section 412.92(a)				
Title 42, Code of Federal Regulations Section 412.92(d)		Amended; effective October 1, 2008		
Title 42, Code of Federal Regulations Section 412.316(b)	Amended; effective October 1, 2007, large urban add-on is eliminated			

	Discharges Occurring On or After 12/01/2011	Discharges Occurring On or After 03/15/2013	Discharges Occurring On or After 3/5/2015	
Title 42, Code of Federal Regulations, §412.2				
Title 42, Code of Federal Regulations, §412.23(e)	Amended; effective October 1, 2011			
Title 42, Code of Federal Regulations, §412.23(f)				
Title 42, Code of Federal Regulations, §412.64	Amended; effective October 1, 2011	Amended	Amended	
Title 42, Code of Federal Regulations Section 412.87				
Title 42, Code of Federal Regulations Section 412.88				

	Discharges Occurring On or After 12/01/2011	Discharges Occurring On or After 03/15/2013	Discharges Occurring On or After 3/5/2015	
Title 42, Code of Federal Regulations Section 412.92(a)				
Title 42, Code of Federal Regulations Section 412.92(d)				
Title 42, Code of Federal Regulations Section 412.106			Amended; effective October 1, 2013	
Title 42, Code of Federal Regulations Section 412.316(b)				

(b) Federal Register Notices by Date of Discharge

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

	Discharges Occurring On or After 1/1/2004	Discharges Occurring On or After 11/29/2004	Discharges Occurring On or After 7/1/2005	Discharges Occurring On or After 12/1/2005

	Discharges Occurring On or After 1/1/2004	Discharges Occurring On or After 11/29/2004	Discharges Occurring On or After 7/1/2005	Discharges Occurring On or After 12/1/2005
Applicable FR Notices	(A) August 1, 2003 (CMS-1470-F; 68 FR 45346) final rule (B) October 6, 2003 (CMS-1470-CN; 68 FR 57732) correction notice	(A) August 11, 2004 (CMS-1428-F; 69 FR 48916) final rule (B) October 7, 2004 (CMS-1428-CN2; 69 FR 60242) correction notice (C) 69 FR 78526 (CMS-1428-F2) correction notice	(A) August 11, 2004 (CMS-1428-F; 69 FR 48916) final rule (B) October 7, 2004 (CMS-1428-CN2; 69 FR 60242) correction notice (C) 69 FR 78526 (CMS-1428-F2) correction notice	(A) August 12, 2005 (CMS-1500-F; 70 FR 47278) final rule (B) September 30, 2005 70 FR 57161 (CMS-1500-CN) correction notice
Capital wage index	Tables 4A-4C beginning on (A) page 57736	Tables $4A_1$ - $4C_2$beginning on (C) page 78619		Tables 4A-4C beginning on (A) page 47580 as corrected by Tables 4A -4C beginning on (B) page 57163
Capital market basket	Not applicable	0.7% ((A) page 49285)		0.8% ((A) page 47500)
Capital standard federal payment rate	$414.18 ((B) page 57735, Table 1D)	$416.73 ($413.83 x 1.007)		$420.06 ($416.73 x 1.008)
Complex Spinal Surgery DRGs	496, 497, 498, 519, 520, 531,532			496, 497, 498, 519, 520, 531, 532, 546 (page 47308 of (A))
Fixed Loss Outlier Threshold	$ 31,000 ((A) page 45477)	$ 25,800 ((A) page 49278)		$23,600 ((A) page 47494)
Labor-Related National Standard Operating Rate	$3,136.39 ((B) page 57735, Table 1A)	$4,569.83 ($4,423.84 x 1.033)		$4,738.91 ($4,569.83 x 1.037)

	Discharges Occurring On or After 1/1/2004	Discharges Occurring On or After 11/29/2004	Discharges Occurring On or After 7/1/2005	Discharges Occurring On or After 12/1/2005
Operating Wage Index	Tables 4A-4C beginning on (A) page 57736; PIF: Operating Wage Index location (WIGRN)	Tables $4A_1$ - $4C_2$beginning on (C) page 78619; PIF: Final Wage Index location (WIGRN)		Tables 4A-4C beginning on (A) page 47580 as corrected by Tables 4A -4C beginning on (B) page 57163; PIF: Post Reclass Wage Index location
Labor-Related Portion	Table 1A beginning on B page 57735	For wage indexes greater than 1.0, the labor-related portion is 71.066% of the standard operating rate. For wage indexes less than or equal to 1.0, the labor-related portion is 62 %. (A) page 49070		For wage indexes greater than 1.0, the labor-related portion is 69.731% of the standard operating rate. For wage indexes less than or equal to 1.0, the labor-related portion is 62 %. (A) page 47393
Post-acute care transfer to a rehabilitation hospital or unit or long-term hospital qualifying DRGs	DRGs 12, 14, 24, 25, 89, 90, 113, 121, 122, 130, 131, 236, 239, 243, 263, 264, 277, 278, 296, 297, 320, 321, 429, 462, 483, or 468 (A) beginning at page 45413		DRGs 12, 14, 24, 25, 88, 89, 90, 113, 121, 122, 127, 130, 131, 236, 239, 277, 278, 294, 296, 297, 320, 321, 395, 429, 468, 541 or 542 (B) beginning at page 60246	DRGs designated with a “yes” in “FY06 Final Rule Post-acute Care DRG” column in Table 5 (A) beginning at page 47617 and (B) beginning at page 57163
Post-acute care transfer qualifying DRGs	DRGs 209, 210 or 211 (A) beginning at page 45413			DRGs 7, 8, 210, 211, 233, 234, 471, 497, 498, 544, 545, 549, or 550 (A) beginning at page 47617 and (B) beginning at page 57163

	Discharges Occurring On or After 12/1/2006	Discharges Occurring On or After 3/1/2007	Discharges Occurring On or After 1/1/2008	Discharges Occurring On or After 12/1/2008

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

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

Post-acute care transfer qualifying DRGs	DRGs 7, 8, 210, 211, 233, 234, 471, 497, 498, 545, 549, or 550 (B) beginning at page 60013	DRGs 7, 8, 210, 211, 233, 234, 471, 497, 498, 544, 545, 549, or 550 (B) beginning at page 60013 and (C) beginning at page 573	Medicare-Severity DRGs designated with a "yes" in the "FY08 Final Rule Special Pay DRG" column in Table 5 (A) beginning at page 47539 and (B) at page 57727	Medicare-Severity DRGs designated with a "yes" in the "FY09 Final Rule Special Pay DRG" column in Table 5 (A) beginning at page 48899

	Discharges Occurring On or After 12/1/2009	Discharges Occurring On or After 3/01/2011	Discharges Occurring On or After 12/01/2011	Discharges Occurring On or After 1/1/2013 but Before 1/1/2014
Applicable FR Notices	(A)August 27, 2009 (CMS-1406-F;FR 43754) final rule (B) October 7, 2009 (CMS-1406-CN ;74 FR 51496) correction notice	(A) August 16, 2010 (CMS-1498-F; FR 50042) final Rule (B) October 1, 2011 (CMS-1498-F; 75 FR 60640) correction	(A) August 18, 2011 (CMS-1518-F; FR 51476) final Rule (B) September 26, 2011 (CMS-1518-CN3; 76 FR 59263) correction	
Capital wage index	Tables 4A-4C beginning on page (A)44085 as corrected by Tables 4A-4C beginning on (B) page 51505 for certain areas	Tables 4A-C Beginning on page (A) 50511	Tables 4A-C at https://www.cms.gov/AcuteInpatientPPS/01_overview.asp	
Capital market basket	1.2% ((B) page 51498)	1.2%, (A) page 50442	1.5%, (A) page 51806	
Capital standard federal payment rate	$441.46 ($436.22 x 1.012)	$446.75 ($441.46 X 1.012	$453.46 (446.75 X 1.015)	
Complex Spinal Surgery DRGs				028, 029, 030, 453, 454, 455, 456
Fixed Loss Outlier Threshold	$23,140 ((A) page 44011)	$23,075, (A) page 50441	$22,385, (A) page 51795	

	Discharges Occurring On or After 12/1/2009	Discharges Occurring On or After 3/01/2011	Discharges Occurring On or After 12/01/2011	Discharges Occurring On or After 1/1/2013 but Before 1/1/2014
Labor-Related National Standard Operating Rate	$5,354.08 ($5,243.95 x 1.021)	$5,493.28 ($5,354.08 x 1.026)	$5,658.08 ($5,493.28 x 1.03)	
Operating Wage Index	Tables 4A-4C beginning on page (A)44085 as corrected by Tables 4A-4C beginning on (B) page 51505 for certain areas; PIF: Post Reclass Wage Index location	Tables 4A-C Beginning on page (A) 50511; PIF: FY 2011 Wage Index Location	Tables 4A-C at https://www.cms.gov/AcuteInpatientPPS/01_overview.asp;PIF: FY 2012 Wage Index Location	
Labor-Related Portion	For wage indexes greater than 1.0, the labor-related portion is 68.802% of the standard operating rate. For wage indexes less than or equal to 1.0, the labor-related portion is 62%. (A) page 43856	For wage indexes greater than 1.0, the labor-related portion is 68.8% of the standard operating rate. For wage indexes less than or equal to 1.0, the labor-related portion is 62% (A) page 50422	For wage indexes greater than 1.0, the labor-related portion is 68.8% of the standard operating rate. For wage indexes less than or equal to 1.0, the labor-related portion is 62% (A) page 51786	
Post-acute care transfer to a rehabilitation hospital or unit or long-term hospital qualifying DRGs	Medicare-Severity DRGs designated with a “yes” in the “FY 2010 Final Rule Post-Acute DRG” column in Table 5 (A) beginning at page 44126	Medicare-Severity DRGs designated With a “yes” in the “FY 2011 Final Rule Post-Acute DRG” Column in Table 5 (A) beginning at page 50547	Medicare-Severity DRGs designated With a “yes” in the “FY 2012 Final Rule Post-Acute DRG” Column in Table 5 https://www.cms.gov AcuteInpatientPPS/	
Post-acute care transfer qualifying DRGs	Medicare-Severity DRGs designated with a “yes” in the “FY2010 Final Rule Special Pay	Medicare-Severity DRGs designated With a “yes” in the “FY 2011 Final Rule Special Pay	Medicare-Severity DRGs designated With a “yes” in the “FY 2012 Final Rule Special Pay	

	Discharges Occurring On or After 12/1/2009	Discharges Occurring On or After 3/01/2011	Discharges Occurring On or After 12/01/2011	Discharges Occurring On or After 1/1/2013 but Before 1/1/2014
	DRG" column in Table 5 (A) beginning at page 44126	DRG" column in Table 5 (A) Beginning at page 50547	DRG" column in Table 5 https://www.cms.gov AcuteInpatientPPS/	

	Discharges Occurring On or After 3/15/2013	Discharges Occurring On or After 3/5/2015		
Applicable FR Notices	(A)August 31, 2012 (CMS-1588-F; 77 FR 53258) final rule (B) October 3, 2012 (CMS-1588-CN2;77 FR 60315; correction notice) (C) October 29, 2012 (CMS-1588-CN3; 77 FR 65495; correction notice)	(A) August 19, 2013 (CMS-1599-F; 78 FR 50496) Final Rule (B) October 3, 2013 (CMS-1599-CN2; 78 FR 61197; corrections) (C) October 3, 2013 (CMS-1599-IFC; 78 FR 61191; interim final rule) (D) January 2, 2014 (CMS-1599-CN3; 79 FR 61; corrections) (E) January 10, 2014 (CMS-1599-CN4; 79 FR 1741; corrections) (F) March 18, 2014 (CMS-1599-IFC2; 79 FR 15022; Interim final rule		
Capital wage index	Tables 4A-C at https://www.cms.gov/AcuteInpatientPPS/01_overview.asp	Tables 4A – 4C-CN2 at https://www.cms.gov/AcuteInpatientPPS/01_overview.asp		
Capital market basket	1.2% (A) page 53703	1.2% (A) page 50507		

	Discharges Occurring On or After 3/15/2013	Discharges Occurring On or After 3/5/2015		
Capital standard federal payment rate	$458.90 ($453.46 x 1.012)	$464.41 ($458.90 x 1.012)		
Complex Spinal Surgery DRGs				
Fixed Loss Outlier Threshold	$21,821 ((A) page 53696)	$21,748 ((A) page 50983		
Labor-Related National Standard Operating Rate	$ 5,805.19 ($5,658.08 x 1.026)	$5,950.32 ($5,805.19 x 1.025)		
Operating Wage Index	Tables 4A-C at https://www.cms.gov/AcuteInpatientPPS/01_overview.asp; PIF: FY 2013 Wage Index Location	Tables 4A-C at https://www.cms.gov/AcuteInpatientPPS/01_overview.asp; PIF: FY 2014 Wage Index Location		
Labor-Related Portion	For wage indexes greater than 1.0, the labor-related portion is 68.8% of the standard operating rate. For wage indexes less than or equal to 1.0, the labor-related portion is 62% (A) page 53685	For wage indexes greater than 1.0, the labor-related portion is 69.6% of the standard operating rate. For wage indexes less than or equal to 1.0, the labor-related portion is 62% (A) page 50972		
Post-acute care transfer to a rehabilitation hospital or unit or long-term hospital qualifying DRGs	Medicare-Severity DRGs designated With a “yes” in the “FY 2013 Final Rule Post-Acute DRG” Column in Table 5 https://www.cms.gov/AcuteInpatientPPS/	Medicare-Severity DRGs designated With a “yes” in the “FY 2014 FR Post-Acute DRG” Column in Table 5 https://www.cms.gov/AcuteInpatientPPS/		
Post-acute care transfer qualifying	Medicare-Severity DRGs designated With a “yes” in the	Medicare-Severity DRGs designated With a “yes” in the		

	Discharges Occurring On or After 3/15/2013	Discharges Occurring On or After 3/5/2015		
DRGs	"FY 2013 Final Rule Special Pay DRG" column in Table 5 https://www.cms.gov/AcuteInpatientPPS/	"FY 2014 FR Special Pay DRG" column in Table 5 https://www.cms.gov/AcuteInpatientPPS/		
Uncompensated Care Adjustment		0.943 (A) page 50634		

(c) Payment Impact File by Date of Discharge

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

	Discharges Occurring On or After 1/1/2004	Discharges Occurring On or After 11/29/2004	Discharges Occurring On or After 12/1/2005	Discharges Occurring On or After 12/1/2006
Applicable Payment Impact File (PIF)	FY2004 Final Rule Impact File	FY2005 Final Rule Impact File	FY2006 Final Rule Impact File	FY2007 Final Rule Impact File
Capital geographic adjustment factor	PIF: Capital Wage Index	PIF:POST RECLASS GAF	PIF:WICGRN	PIF:Post Reclass GAF_a (for first half FY 2007) and Post Reclass GAF_b (for capital second half FY 2007)
Large Urban Add-on	PIF: Post-Reclassification Urban/Rural location	PIF: Standardized payment location	PIF:URSPA	PIF:URSPA

	Discharges Occurring On or After 1/1/2004	Discharges Occurring On or After 11/29/2004	Discharges Occurring On or After 12/1/2005	Discharges Occurring On or After 12/1/2006
Capital Disproportionate Share Adjustment Factor	PIF: Capital Disproportionate Share Adjustment location (DSHCPG)	PIF: Capital Disproportionate Share (DSH) Adjustment location (CAPITAL DSH ADJ.)	PIF: Capital Disproportionate Share (DSH) Adjustment location (DSHCPG)	PIF: Capital Disproportionate Share (DSH) Adjustment location (DSHCPG)
Capital Indirect Medical Education Adjustment Factor	PIF: Capital IME Adjustment location (TCHCP)	PIF: IME adjustment factor for capital PPS location (IME ADJUSTMENT-CAPITAL)	PIF: IME adjustment factor for capital PPS location (TCHCP)	PIF: IME adjustment factor for capital PPS location (TCHCP)
Operating Wage Index	Tables 4A-4C beginning on (A) page 57736; PIF: Operating Wage Index location (WIGRN)	Tables $4A_1$ - $4C_2$beginning on (C) page 78619; PIF: Final Wage Index location (WIGRN)	Tables 4A-4C beginning on (A) page 47580 as corrected by Tables 4A -4C beginning on (B) page 57163; PIF: Post Reclass Wage Index location	Tables 4A-1 - 4C-1 (for discharges before 4/1/2007) and Tables 4A-2-4C2 (for discharges occurring on or after 4/1/2007) beginning on (B) page 59975; PIF: Post Reclass Wage Index_a (for first half FY 2007) and Post Reclass Wage Index_b (for second half FY 2007)
Operating Disproportionate Share Adjustment Factor	PIF: Operating DSH Adjustment Factor location (DSHOPG)	PIF: Operating Disproportionate Share (DSH) Adjustment Factor location (OPERATING DSH ADJ.)	PIF: Operating Disproportionate Share (DSH) Adjustment Factor location (DSHOPG)	PIF: Operating Disproportionate Share (DSH) Adjustment Factor location (DSHOPG)
Operating Indirect Medical Education Adjustment	PIF: Operating IME Adjustment location (TCHOP)	PIF: IME Adjustment Factor for Operating PPS location (IME ADJUSTMENT OPERATING)	PIF: IME Adjustment Factor for Operating PPS location (TCHOP)	PIF: IME Adjustment Factor for Operating PPS location (TCHOP)

	Discharges Occurring On or After 1/1/2004	Discharges Occurring On or After 11/29/2004	Discharges Occurring On or After 12/1/2005	Discharges Occurring On or After 12/1/2006
Sole Community Hospital – Hospital Specific Rate	PIF: Hospital - Specific Rate location (HSPPUB)	PIF: Sole Community Hospital Cost/Case 1982/1987 and Sole Community Hospital Cost/Case 1996 locations	PIF: 82/87 Hospital Specific Rate Updated to FY 2006 (OLDHSPPS) and 1996 Hospital Specific Rate Updated to FY 2006 (HSP96) locations	PIF: 82/87/96 Hospital Specific Rate Updated to FY 2007 for SCH Providers location (HSP Rate)
Cost-to-Charge Ratio	PIF: Operating Cost-to-Charge Ratio location (OPCCR) and Capital Cost-to-Charge location (CPCCR)	PIF: Operating Cost-to-Charge Ratio location (OPCCR) and Capital Cost-to-Charge location (CPCCR)	PIF: Operating Cost-to-Charge Ratio location (OPCCR) and Capital Cost-to-Charge location (CPCCR)	PIF: Operating Cost-to-Charge Ratio location (OPCCR) and Capital Cost-to-Charge location (CPCCR)

	Discharges Occurring On or After 1/1/2008	Discharges Occurring On or After 12/1/2008	Discharges Occurring On or After 12/1/2009	Discharges Occurring On or After 3/01/2011
Applicable Payment Impact File (PIF)	FY2008 Final Rule	FY2009 Final Rule	FY2010 Correction Notice	FY 2011 Final Rule
Capital Geographic Adjustment Factor	Post Reclass GAF	Post Reclass GAF	Post Reclass GAF	FY 2011 GAF
Capital Disproportionate Share Adjustment Factor	PIF: Capital Disproportionate Share (DSH) Adjustment location (DSHCPG)	PIF: Capital Disproportionate Share (DSH) Adjustment location (DSHCPG)	PIF: Capital Disproportionate Share (DSH) Adjustment location (DSHCPG)	PIF: Capital Disproportionate Share (DSH) adjustment location (DSHCPG)
Capital Indirect Medical Education Adjustment Factor	PIF: IME adjustment factor for capital PPS location (TCHCP)	PIF: IME adjustment factor for capital PPS location (TCHCP)	PIF: IME adjustment factor for capital PPS location (TCHCP)	PIF: IME adjustment factor for capital PPS location (TCHCP)
Operating Wage Index	Tables 4A -4C beginning on (B) page 57698; PIF: Post Reclass Wage Index location	Tables 4A-4C beginning on (B) page 57956; PIF: Post Reclass Wage Index location	Tables 4A-4C beginning on page (A)44085 as corrected by Tables 4A-4C beginning on (B) page 51505 for certain areas; PIF: Post Reclass Wage Index location	Tables 4A-C Beginning on page (A) 50511; PIF: FY 2011 Wage Index Location
Operating Disproportionate Share Adjustment Factor	PIF: Operating Disproportionate Share (DSH) Adjustment Factor location (DSHOPG)	PIF: Operating Disproportionate Share (DSH) Adjustment Factor location (DSHOPG)	PIF: Operating Disproportionate Share (DSH) Adjustment Factor location (DSHOPG)	PIF: Operating Disproportionate Share (DSH) Adjustment Factor location (DSHOPG)
Operating Indirect Medical Education Adjustment	PIF: IME Adjustment Factor for Operating PPS location (TCHOP)	PIF: IME Adjustment Factor for Operating PPS location (TCHOP)	PIF: IME Adjustment Factor for Operating PPS location	PIF: IME Adjustment Factor for Operating PPS location (TCHOP)

			(TCHOP)	
Sole Community Hospital – Hospital Specific Rate	PIF: 82/87/96 Hospital Specific Rate Updated to FY 2008 for SCH Providers location (HSP Rate)	PIF: 82/87/96 Hospital Specific Payment (HSP) Rate Updated to FY 2009 for SCH Providers location (HSP Rate)	PIF: 82/87/96 /06 Hospital Specific Payment (HSP) Rate Updated to FY 2010 for SCH Providers location (FY10HSP Rate)	PIF: 82/87/96/06 Hospital Specific Payment (HSP) Rate Updated to FY2011 for SCH Providers location (FY11 HSP Rate)
Cost-to-Charge Ratio	PIF: Operating Cost-to-Charge Ratio location (OPCCR) and Capital Cost-to-Charge location (CPCCR)	PIF: Operating Cost-to-Charge Ratio location (Operating CCR) and Capital Cost-to-Charge location (Capital CCR)	PIF: Operating Cost-to-Charge Ratio location (Operating CCR) and Capital Cost-to-Charge location (Capital CCR)	PIF: Operating Cost-to-Charge Ratio location (Operating CCR) and Capital Cost-to-Charge location (Capital CCR)

	Discharges Occurring On or After 12/01/2011	Discharges Occurring On or After 03/15/2013	Discharges Occurring On or After 3/5/2015	
Applicable Payment Impact File (PIF)	FY 2012 Final Rule-IPPS Impact File	FY 13 FR Impact File – updated October 2012	FY 2014 Impact file-updated January 2014 to reflect changes from the September 2013 correction notice and interim final rule with comment	
Capital Geographic Adjustment Factor	FY 2012 GAF	FY 2013 GAF	FY 2014 GAF-Updated September 2013	
Capital Disproportionate Share Adjustment Factor	PIF: Capital Disproportionate Share (DSH) adjustment location (DSHCPG)	PIF: Capital Disproportionate Share (DSH) adjustment location (DSHCPG)	PIF: Capital Disproportionate Share (DSH) adjustment location (DSHCPG)	
Capital Indirect	PIF: IME	PIF: IME adjustment	PIF: IME	

	Discharges Occurring On or After 12/01/2011	Discharges Occurring On or After 03/15/2013	Discharges Occurring On or After 3/5/2015	
Medical Education Adjustment Factor	adjustment factor for capital PPS location (TCHCP)	factor for capital PPS location (TCHCP)	adjustment factor for capital PPS location (TCHCP)	
Operating Wage Index	Tables 4A-C at https://www.cms.gov/AcuteInpatientPPS/01_overview.asp;PIF: FY 2012 Wage Index Location	Tables 4A-C at https://www.cms.gov/AcuteInpatientPPS/01_overview.asp; PIF: FY 2013 Wage Index Location	Tables 4A-C-CN2 at https://www.cms.gov/AcuteInpatientPPS/01_overview.asp; PIF: FY 2014 Wage Index Location	
Operating Disproportionate Share Adjustment Factor	PIF: Operating Disproportionate Share (DSH) Adjustment Factor location (DSHOPG)	PIF: Operating Disproportionate Share (DSH) Adjustment Factor location (DSHOPG)	PIF: Operating Disproportionate Share Hospital (DSH) Adjustment Factor Location (DSHOPG)	
Operating Indirect Medical Education Adjustment	PIF: IME Adjustment Factor for Operating PPS location (TCHOP)	PIF: IME Adjustment Factor for Operating PPS location (TCHOP)	PIF: IME Adjustment Factor for Operating PPS location (TCHOP)	
Sole Community Hospital – Hospital Specific Rate	PIF: 82/87/96/06 Hospital Specific Payment (HSP) Rate Updated to FY2012 for SCH Providers location (FY12 HSP Rate)	PIF: 82/87/96/06 Hospital Specific Payment (HSP) Rate Updated to FY2013 for SCH Providers location (FY13 HSP Rate)	PIF: 82/87/96/06 Hospital Specific Payment (HSP) Rate Updated to FY2014 for SCH and MDH Providers with the -0.2% adjustment for presumptive inpatient hospital status policy. Location (FY14 HSP Rate)	

	Discharges Occurring On or After 12/01/2011	Discharges Occurring On or After 03/15/2013	Discharges Occurring On or After 3/5/2015	
Cost-to-Charge Ratio	PIF: Operating Cost-to-Charge Ratio location (Operating CCR) and Capital Cost-to-Charge location (Capital CCR)	PIF: Operating Cost-to-Charge Ratio location (Operating CCR) and Capital Cost-to-Charge location (Capital CCR)	PIF: Operating Cost-to-Charge Ratio location (Operating CCR) and Capital Cost-to-Charge location (Capital CCR)	

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

§ 9789.50. Pathology and Laboratory.

(a) Effective for services after January 1, 2004, the maximum reasonable fees for pathology and laboratory services shall not exceed one hundred twenty (120) percent of the rate for the same procedure code in the CMS' Clinical Diagnostic Laboratory Fee Schedule, as established by Sections 1833 and 1834 of the Social Security Act *(42 U.S.C. §§ 1395l* and 1395m) and applicable to California. The Clinical Diagnostic Laboratory Fee Schedule, which can be found on the CMS Internet Website (http://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/Clinicallabfeesched/index.html) is incorporated by reference and will be made available on the Division of Workers' Compensation's Internet Website (http://www.dir.ca.gov/dwc/dwc_home_page.htm) or upon request to the Administrative Director at:

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

(b) The following procedures in the Special Services and Reports section of the OMFS 2003 will not be valid for services rendered after January 1, 2004: CPT Codes 99000, 99001, 99017, 99019, 99020, 99021, 99026, and 99027.

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

§ 9789.60. Durable Medical Equipment, Prosthetics, Orthotics, Supplies.

(a) For services, equipment, or goods provided after January 1, 2004, the maximum reasonable reimbursement for durable medical equipment, supplies and materials, orthotics, prosthetics, and

miscellaneous supplies and services shall not exceed one hundred twenty (120) percent of the rate set forth in the CMS' Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS) Fee Schedule, as established by Section 1834 of the Social Security Act *(42 U.S.C. § 1395m)* and applicable to California. The DMEPOS Fee Schedule, which can be found on the CMS Internet Website (http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html) is incorporated by reference and will be made available on the Division of Workers' Compensation's Internet Website (http://www.dir.ca.gov/DWC/dwc_home_page.htm) or upon request to the Administrative Director at:

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

(b) The following procedures in the Special Services and Reports section of the OMFS 2003 will not be valid for services rendered after January 1, 2004: CPT Code 99002.

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

§ 9789.70. Ambulance Services.

(a) The maximum reasonable fee for ambulance services rendered after January 1, 2004 shall not exceed 120% of the applicable fee for the Calendar Year 2004 set forth in CMS's Ambulance Fee Schedule, which is established pursuant to Section 1834 of the Social Security Act *(42 U.S.C. § 1395m)* and applicable to California. The Ambulance Fee Schedule, which can be found at the CMS Internet Website (http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/) is incorporated by reference and will be made available on the Division of Workers' Compensation's Internet Website (http://www.dir.ca.gov/DWC/dwc_home_page.htm) or upon request to the Administrative Director at:

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

(c) This section is not applicable to services provided by any air ambulance provider which at the time of service is an "air carrier" as defined in Title *49* U.S.C.A. Section 40102, a part of the Airline Deregulation Act of 1978 as amended.

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

§ 9789.110. Update of Rules to Reflect Changes in the Medicare Payment System.

The OMFS shall be adjusted within 60 days to conform to any relevant changes in the Medicare and Medi-Cal payment systems as required by law. The Administrative Director shall determine the effective date of the change and issue an order informing the public of the change and the effective date. Such order shall be posted on the Division's Internet Website: http://www.dir.ca.gov/dwc/dwc_home_page.htm.

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

§ 9789.111. Effective Date of Fee Schedule Provisions.

(a) The Resource Based Relative Value Scale (RBRVS)-based OMFS for Physician Services (Sections 9789.12.1 – 9789.19) are effective for services rendered on or after January 1, 2014. The OMFS regulations for Physician Services (Sections 9789.10-9789.11) are effective for services rendered on or after July 1, 2004, but before January 1, 2014. Services rendered after January 1, 2004, but before July 1, 2004 are governed by the "emergency" regulations that were effective on January 2, 2004. The OMFS for physician services set forth in Article 5.5 (Sections 9790, et seq.), is applicable only for services rendered on or before January 1, 2004, unless otherwise specified in this Subchapter (Subchapter 1. Administrative Director – Administrative Rules).

(b) The OMFS regulations for Inpatient Services (Sections 9789.20-9789.25) are effective for inpatient hospital admissions with dates of discharge on or after July 1, 2004. Services for discharges after January 1, 2004, but before July 1, 2004 are governed by the "emergency" regulations that were effective on January 2, 2004. The OMFS for inpatient services set forth in Article 5.5 (Sections 9790, et seq.), is applicable only to bills for services with date of admission on or before December 31, 2003, unless otherwise specified in this Subchapter (Subchapter 1. Administrative Director – Administrative Rules).

(c) The OMFS regulations for Outpatient Services (Sections 9789.30-9789.39) are effective for services rendered on or after July 1, 2004. Services rendered after January 1, 2004, but before July 1, 2004 are governed by the "emergency" regulations that were effective on January 2, 2004.

(d) The OMFS regulation for pharmacy (Section 9789.40) is effective for services rendered after January 1, 2004.

(e) The OMFS regulation for Pathology and Laboratory (Section 9789.50) is effective for services rendered after January 1, 2004.

(f) The OMFS regulation for Durable Medical Equipment, Prosthetics, Orthotics, Supplies (Section 9789.60) is effective for services rendered after January 1, 2004.

(g) The OMFS regulation for Ambulance Services (Section 9789.70) is effective for services rendered after January 1, 2004.

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

Title 8. Industrial Relations
Division 1. Department Of Industrial Relations
Chapter 4.5. Division Of Workers' Compensation
Subchapter 1. Administrative Director -- Administrative Rules
Article 5.5 Application of the Official Medical Fee Schedule (Treatment)

§ 9790. Authority.

The rules and regulations contained in this Article are adopted pursuant to the authority contained in Sections 133, 4603.5, 307.1 and 5307.3 of the California Labor Code. Sections 9790.1 – 9792.1 and Appendices A-C, contained in this Article, are not applicable for physician services rendered and inpatient hospital facility services for discharges after January 1, 2004, unless otherwise specified in this Subchapter 1. Administrative Director – Administrative Rules.

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