

**STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION**

INITIAL STATEMENT OF REASONS

**Subject Matter of Regulations: Official Medical Fee Schedule
Inpatient Hospital Fee Schedule
Discharge on or after January 1, 2004**

**TITLE 8, CALIFORNIA CODE OF REGULATIONS
SECTIONS 9789.20, 9789.21, 9789.22, and 9789.25**

AN IMPORTANT PROCEDURAL NOTE ABOUT THIS RULEMAKING:

The Inpatient Hospital Fee Schedule component of the Official Medical Fee Schedule "establish(es) or fix(es) rates, prices, or tariffs" within the meaning of Government Code section 11340.9(g) and is therefore not subject to Chapter 3.5 of the Administrative Procedure Act (commencing at Government Code section 11340) relating to administrative regulations and rulemaking.

This rulemaking proceeding to amend the Inpatient Hospital Fee Schedule is being conducted under the Administrative Director's rulemaking power under Labor Code sections 133, 4603.5, 5307.1 and 5307.3. This regulatory proceeding is subject to the procedural requirements of Labor Code sections 5307.1 and 5307.4.

This Initial Statement of Reasons and the accompanying Notice of Rulemaking are being prepared to comply with the procedural requirements of Labor Code section 5307.4 and for the convenience of the regulated public to assist the regulated public in analyzing and commenting on this non-APA rulemaking proceeding.

BACKGROUND TO REGULATORY PROCEEDING

In 2003, the Legislature enacted Senate Bill 228 (Alarcon, Chapter 639, Statutes of 2003; SB 228) as part of workers' compensation reform legislation intended to reduce unnecessary medical and litigation expenses, among other things, in workers' compensation cases in California.

As one of its provisions, the bill substantially amended Labor Code section 5307.1, which provided for the Administrative Director to adopt a medical fee schedule for workers' compensation claims which would establish maximum reasonable fees. Labor Code section 5307.1, as amended by SB 228, provides that, commencing January 1, 2004, all fees shall be paid in accordance with the fee-related structure and rules of the relevant Medicare payment systems and that the maximum reasonable fees shall be 120 percent of

the estimated aggregate fees prescribed in the Medicare payment system before the application of the inflation factor set forth in the statute.

SB 228 further provided for a separate reimbursement for implantable medical devices, hardware, and instrumentation for six different Diagnostic Related Groups (DRGs). (Lab. Code, § 5318(a).) In 2007, Medicare refined and revised its DRG system known as the Medicare Severity DRG system (MS-DRG) resulting in fourteen different MS-DRGs subject to Labor Code section 5318. The MS-DRG system was incorporated into the OMFS Inpatient Hospital Fee Schedule effective December 1, 2007. SB 228 also provided that the pass-through section would only be operative until the Administrative Director adopts a regulation specifying separate reimbursement, if any, for implantable medical hardware or instrumentation for complex spinal surgeries. (Lab. Code, § 5318(b).)

On January 2, 2004, to comply with the requirements of Labor Code sections 5307.1 and 5318, through emergency rulemaking, the Administrative Director adopted an Inpatient Hospital Fee Schedule section of the Official Medical Fee (OMF) Schedule (set forth in 8 C.C.R sections 9789.20-24) for fees in accordance with the Medicare payment system. A Certificate of Compliance was filed on April 30, 2004, and the Inpatient Hospital Fee Schedule regulations became effective on June 15, 2004. The Labor Code section 5318 pass-through methodology was incorporated as part of this fee schedule.

Labor Code section 5307.1 further provides that the Administrative Director shall adjust the Inpatient Hospital Fee Schedule to conform to any relevant changes in the Medicare payment system by issuing an order, exempt from Labor Code sections 5307.3 and 5307.4 and the rulemaking provisions of the Administrative Procedure Act (Chapter 3.2 (commencing with section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), informing the public of the changes and their effective date.

Sections 9789.20 through 9789.24 set forth the general information, definitions and payment schedule for the Inpatient Hospital Fee Schedule section of the Official Medical Fee schedule. The proposed amendments to the Inpatient Hospital Fee Schedule section of the Official Medical Fee Schedule regulations address only sections 9792.20, 9792.21, and 9792.22, which are intended to revise the methodology for reimbursement of implantable spinal hardware used in complex spinal surgeries, and make minor revisions to conform to the proposed changes in reimbursement, and to update or clarify sections of the Inpatient Hospital Fee Schedule. The Administrative Director also proposes to adopt section 9789.25 which provides for the updates to the federal regulation, federal register, and payment impact file references made in the Inpatient Hospital Fee Schedule updates by Order of the Administrative Director, in order to conform to changes in the Medicare payment system as required by Labor Code section 5307.1. (Lab. Code, §§5307.1(g)(1), 5307.1(g)(2).)

NECESSITY

The Division has determined that amendment to the Inpatient Hospital Fee Schedule is necessary to address the duplicate reimbursement of a portion of the costs for implantable spinal hardware used in complex spinal surgeries which is included in the standard reimbursement for the procedure and is reimbursed a second time as part of the pass-through payment amount. As early as December 2001, a study by Gerald Kominiski and Laura Gardner raised the concern that a pass-through payment for costs of implantable hardware and/or instrumentation used in spinal surgeries can result in a duplication of payment because such costs are factored into the hospital-specific composite factor which Medicare calculates based on each hospital's reported operating and capital costs.¹ According to a July 2009 RAND study, based on average device costs for Medicare patients, the hardware pass-through involves at least \$60 million in additional allowances.² A later March 2010 study by the California Workers' Compensation Institute revealed that in 2008, pass-through payments added \$55 million "to the basic inpatient hospital facility fee payments for workers' compensation spinal surgeries". This study also compared claims paid under workers' compensation to those paid under other systems (e.g. Medicare, Medi-Cal, private coverage, and other government programs) and found that workers' compensation had the highest spinal implant utilization rate and the highest average number of implant procedures.³ The CWCI Bulletin which summarized their study concluded that "[t]his finding suggests that by providing duplicate payments for spinal hardware, the pass-through may encourage the use of spinal surgery in workers' compensation, while creating a disincentive to manage the selection and cost of the implantable devices, hardware or instrumentation."⁴

According to a 2008 article by Stuart D. Colburn, including Texas, there were five states that closely followed a Medicare payment based system, and of the five, only California and Texas allowed for carve-outs for implants. Colburn also noted that the Texas Division of Workers' Compensation claimed they were aware and acknowledged the concern that because of allowing a carve-out for implants, "hospitals and physicians will choose implantables not in the best interests of the patient but rather in the best financial interests of the hospital or physician", and would therefore, be closely monitoring the implantable device costs.⁵

The Inpatient Hospital Fee Schedule is adapted from the Medicare Inpatient Prospective Payment System, where a predetermined maximum allowable fee is established for each patient admission based on the diagnosis-related group (DRG) to which the patient is assigned. Each DRG is assigned a relative weight which reflects the average resources or

¹ Kominiski, Gerald and Gardner, Laura, *Inpatient Hospital Fee Schedule and Outpatient Surgery Study*, UCLA School of Public Health and Axiomedics Research, Inc., December 2001, p. 48.

² Wynn, Barbara O., *Regulatory Actions that Could Reduce Unnecessary Medical Expenses Under California's Workers' Compensation Program*, Prepared for the Commission on Health, Safety and Workers' Compensation, the RAND Institute for Civil Justice and RAND Health, July 2009, p. 2.

³ Ireland, Johh, Swedlow, Alex, and Ramirez, Brenda, *Surgical Instrumentation Pass-Through Payments for Back Surgeries in the California Workers' Compensation System*, California Workers' Compensation Institute, March 2010, pp. 3-5.

⁴ California Workers' Compensation Institute Bulletin, No. 10-09, March 29, 2010.

⁵ Colburn, Stuart D., *Texas Health Facility Fees: Rules 134.403 and 134.404 (Inpatient & Outpatient Hospital Fee Guidelines)*, LexisNexis Expert Commentaries: Larson Series, 2008, p. 4-5.

costs to treat patients assigned to that DRG relative to patients in other DRGs. The resources and costs take into consideration the patient's principal diagnosis, comorbidities and complications, surgical procedures, and cost of devices and instrumentation used to treat the patient. The premise of a prospective payment system such as the Medicare Inpatient Prospective Payment System is that a hospital will profit on some cases and absorb losses on others but that on average the payment is appropriate for an efficient hospital.

The OMFS Inpatient Hospital Fee Schedule standard allowance for a discharge is approximately 120 percent of the Medicare allowable payment for comparable services. Additional allowances are made for discharges with atypically high costs (referred to as outlier cases) and for qualifying new technology. The new technology add-on applies if the new technology costs are not reflected in the data used to establish the DRG relative weights and the estimated costs for patients receiving the new technology show the DRG payment is inadequate. The additional payment is made for two to three years until the data can be evaluated and costs reflected in the DRG relative weights. For example, in 2005, an additional new-technology payment of \$1,955 was made for rhBMP provided in connection with lumbar spinal surgery with an interbody spinal fusion device (InFUSE) or in posterolateral spinal fusions (OP-1 Putty).⁶

In addition to the pre-determined standard payment for complex spinal surgery DRGs, outlier payments, and new technology payments, implantable hardware and/or instrumentation used in these procedures also receive a separate reimbursement at the hospital's documented costs plus an additional 10 percent of the hospital's documented paid cost, net of discounts and rebates, not to exceed \$250, plus any sales tax and/or any shipping and handling charges. Medicare includes these costs in its standard payment rate for complex spinal surgery DRGs.

Over the last seven years, the RAND Institute for Civil Justice and RAND Health (RAND) conducted a series of studies which included an examination of the issue of additional allowances for spinal surgeries. These studies are discussed below:

A **2003 RAND study** concluded that under the policies at that time, California Workers' Compensation Program was paying for the hardware used in back and spinal procedures twice: once through the DRG standard payment and again in the pass-through payment.⁷

The **2005 RAND report** updated analyses from the above referenced 2003 RAND report pertaining to workers' compensation spinal surgery discharges. This study found that on average, workers' compensation patients are less costly (estimated average cost per

⁶ Wynn, Barbara O. and Bergamo, Giacomo, *Payment for Hardware Used in Complex Spinal Procedures under California's Official Medical Fee Schedule for Injured Workers, Working Paper, Prepared for the Commission on Health and Safety and Workers' Compensation and the Division of Workers' Compensation, California Department of Industrial Relations, the RAND Institute for Civil Justice and RAND Health, September 2005, p. 18*

⁷ Wynn, Barbara O., *Adopting Medicare Fee Schedules, Considerations for the California Workers' Compensation Program, Prepared for the California Commission on Health and Safety and Workers' Compensation, the RAND Institute for Civil Justice and RAND Health, 2003, p.27.*

discharge for workers' compensation discharges was \$19,348 and for Medicare discharges, if similarly distributed across spinal surgery DRGs, was an estimated average of \$22,122 per discharge, or 14 percent higher). Furthermore, on average, workers' compensation patients have a shorter length of stay for spinal surgery discharges than Medicare patients. (It should be noted that a March 2010 California Workers' Compensation Institute study of 2008 discharges also found the average length of stay for workers' compensation patients to be shorter than for Medicare patients.⁸) The RAND study also found that payment of 120 percent Medicare rates for spinal surgery discharges in 2003 would have exceeded estimated costs. The estimated payment-to-cost ratio across all of the spinal surgery DRGs was 1.43 (1.51 when no hardware was inserted and 1.33 when hardware was inserted). The average payment-to-cost ratio for each type of hardware was 1.09 or higher.

Although the report found that usage of hardware was "considerably higher" for workers' compensation patients than for Medicare patients for some but not all DRGs, the shorter length of stay generally offset the added costs. Acknowledging that the RAND payment simulation was based on an overall cost-to-charge ratio and therefore, did not reflect the fact that hospital markups may differ for spinal surgeries, RAND found that even when hardware was used, the payment-to-cost ratios were on average above 1.20 for most spinal surgery DRGs, which is comparable to the average ratio of 1.20 for private payors.

Again, RAND concluded under the current policies, the OMFS Inpatient Hospital Fee Schedule "essentially pay for the hardware used in spinal procedures twice: once through the DRG payment and again in the pass-through payment. Specifically, RAND found there is "no support in the data for continuing to pay [pass-through payments] for relatively inexpensive hardware and instrumentation that is used during spinal surgical procedures. If there is a continuing concern that the payment-to-cost ratios are lower when costly hardware is used than when it is not, alternatives to the current pass-through could be considered." Finally, RAND concluded the "cost-based payment plus handling provides no incentive for prudent purchasing and use of hardware."⁹

The **January 2009 RAND** report updated its findings from the earlier 2003 and 2005 RAND reports discussed above. This study used hospital discharge data from 2003 – 2005. As discussed above, the earlier RAND studies found that payments for spinal surgeries were adequate before adding the pass-through payment. Since that time, Medicare refined the logic used to classify spinal surgery discharges in addition to adopting the MS-DRGs, which incorporated better measures of severity into its patient classification system and improved payment accuracy from the previous DRG system used by Medicare. The MS-DRG system was incorporated into the OMFS effective

⁸ Ireland, Johh, Swedlow, Alex, and Ramirez, Brenda, *Surgical Instrumentation Pass-Through Payments for Back Surgeries in the California Workers' Compensation System*, California Workers' Compensation Institute, March 2010, p. 4.

⁹ Wynn, Barbara O. and Bergamo, Giacomo, *Payment for Hardware Used in Complex Spinal Procedures under California's Official Medical Fee Schedule for Injured Workers, Working Paper, Prepared for the Commission on Health and Safety and Workers' Compensation and the Division of Workers' Compensation, California Department of Industrial Relations, the RAND Institute for Civil Justice and RAND Health, September 2005, pp.xii – xiii, 7, 8, 11-12.*

December 1, 2007 update. According to RAND, the estimated payment-to-cost ratios for the four base DRGs that are affected by the pass-through are 1.66 or higher under the MS-DRGs before consideration of the pass-through amounts. The RAND study also states that according to a study for Medicare, device costs represent on average 51 percent of the estimated costs for spinal surgery MS-DRGs in the Major Diagnostic Category (MDC) for Diseases and Disorders of the Musculoskeletal System (MD 8).

Without amending the OMFS Inpatient Hospital Fee Schedule, the pass-through for spinal hardware will result in even more duplication of payments. For example, the MS-DRGs recognize the higher cost of providing a neurostimulator or artificial spinal disc by assigning a discharge with no co-morbidities and complications (CC) to the higher-paying MS-DRG for discharges with a CC.

The RAND report concluded, “The analysis suggests that the payment at 1.2 times the Medicare payment rate is adequate – or more than adequate – to cover the cost of inpatient stays for complex spinal fusion. On average, about 50% of the payment (before the 1.2 multiplier) represents the device costs. Passing through this amount on top of 120 percent of the Medicare payment results in excessive allowances for inpatient spinal surgeries and creates for unnecessary surgery.”¹⁰

A July 2009 study by RAND renews its finding that the “OMFS allowance at 1.2 times the Medicare payment rate is adequate – or more than adequate – to cover the cost of inpatient stays.” In support of this conclusion, the RAND study stated their analysis of 2007 workers’ compensation administrative data and the MS-DRGs showed the estimated average allowance-to-cost ratio for workers’ compensation patients assigned to MS-DRGs for complex spinal surgery was 1.14 before consideration of the pass-through amounts.

The RAND study concluded that “[p]assing through WC device costs on top of 120 percent of the Medicare payment results in paying for the spinal hardware twice, creates incentives for unnecessary device usage, and imposes unnecessary administrative burden.”

The Administrative Director is proposing to adopt a combination of 2 options presented by RAND in this study, “reducing the OMFS multiplier to exclude the amounts implicit for hardware in Medicare’s payment rates and continuing to allow a pass-through or a fixed allowance for spinal hardware.”¹¹

TECHNICAL, THEORETICAL, OR EMPIRICAL STUDIES, REPORTS, OR DOCUMENTS

¹⁰ Wynn, Barbara O., *Inpatient Hospital Services, An Update on Services Provided Under California’s Workers’ Compensation Program, Prepared for the Commission on Health, Safety and Workers’ Compensation*, the RAND Institute for Civil Justice and RAND Health, 2009, pp.21-24.

¹¹ Wynn, Barbara O., *Regulatory Actions that Could Reduce Unnecessary Medical Expenses Under California’s Workers’ Compensation Program, Prepared for the Commission on Health, Safety and Workers’ Compensation*, the RAND Institute for Civil Justice and RAND Health, July 2009, pp. 2-3.

The Division relied upon the following technical, theoretical, or empirical studies, reports, decisions or similar documents in proposing the above-identified regulations:

- (1) Wynn, Barbara O., *Adopting Medicare Fee Schedules, Considerations for the California Workers' Compensation Program, Prepared for the California Commission on Health and Safety and Workers' Compensation*, the RAND Institute for Civil Justice and RAND Health, 2003.
- (2) Wynn, Barbara O. and Bergamo, Giacomo, *Payment for Hardware Used in Complex Spinal Procedures under California's Official Medical Fee Schedule for Injured Workers, Working Paper, Prepared for the Commission on Health and Safety and Workers' Compensation and the Division of Workers' Compensation, California Department of Industrial Relations*, the RAND Institute for Civil Justice and RAND Health, September 2005.
- (3) Wynn, Barbara O., *Inpatient Hospital Services, An Update on Services Provided Under California's Workers' Compensation Program, Prepared for the Commission on Health, Safety and Workers' Compensation*, the RAND Institute for Civil Justice and RAND Health, January 2009.
- (4) Wynn, Barbara O., *Regulatory Actions that Could Reduce Unnecessary Medical Expenses Under California's Workers' Compensation Program, Prepared for the Commission on Health, Safety and Workers' Compensation*, the RAND Institute for Civil Justice and RAND Health, July 2009.
- (5) Dalton, Kathleen, Freeman, Sara, and Bragg, Arnold, *Refining Cost to Charge Ratios for Calculating APC and MS-DRG Relative Payment Weights*, RTI International, July 2008.
- (6) *Orthopedic Network News*, Volume 20, Number 4, October 2009.
- (7) Ireland, John, Swedlow, Alex, and Ramirez, Brenda, *Surgical Instrumentation Pass-Through Payments for Back Surgeries in the California Workers' Compensation System*, California Workers' Compensation Institute, March 2010.
- (8) California Workers' Compensation Institute Bulletin, No. 10-09, March 29, 2010.
- (9) Kominski, Gerald and Gardner, Laura, *Inpatient Hospital Fee Schedule and Outpatient Surgery Study*, UCLA School of Public Health and Axiomedics Research, Inc., December 2001.
- (10) *Medical Device Tracking; Guidance for Industry and FDA Staff*, U.S. Department of Health and Human Services Food and Drug Administration, Center for Devices and Radiological Health, January 25, 2010.
- (11) Title 28 Texas Administrative Code section 134.402.
- (12) Colburn, Stuart D., *Texas Health Facility Fees: Rules 134.403 and 134.404 (Inpatient & Outpatient Hospital Fee Guidelines)*, LexisNexis Expert Commentaries: Larson Series, 2008.
- (13) Federal Register (Vol. 74 FR 43754), August 27, 2009, *Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2010 Rates; and Changes to the Long-Term Care Hospital Prospective Payment System and Rate Years 2010 and 2009 Rates* (CMS-1406-F).
- (14) Texas Department of Insurance, Division of Workers' Compensation, *Hospital Facility Fee Guidelines – Frequently Asked Questions*, Revised June 24, 2008
- (15) Wynn, Barbara O., Memo entitled, *“Impact of Proposed Changes to OMFS*

Allowances for Spinal Hardware Costs”

(16) Wynn, Barbara O., Memo entitled, “*Detailed Explanation of Costs Impacts*”

SPECIFIC TECHNOLOGIES OR EQUIPMENT REQUIRED (if applicable)

No specific technologies or equipment are required by these proposed regulations.

FACTS ON WHICH THE AGENCY RELIES IN SUPPORT OF ITS INITIAL DETERMINATION THAT THE REGULATIONS WILL NOT HAVE A SIGNIFICANT ADVERSE IMPACT ON BUSINESS

The Administrative Director has determined that these proposed regulations will not have a significant adverse impact on business. The proposed regulations will reduce the amount of *duplicate* payment made for spinal hardware used in complex spinal surgeries, which will decrease the overall cost to the workers’ compensation system.

The following is taken from a fiscal impact analysis by Barbara O. Wynn, of RAND¹²: “According to the administrative data maintained by the Office of Statewide Health Planning and Development on 2008 inpatient discharges from California hospitals, 187 hospitals performed 4,915 spinal surgeries on WC patients, although not all of these involved spinal implants. The impact estimate is based on 163 hospitals with 4,721 spinal surgeries. Kaiser hospitals are not included because they do not report charges to OSHPD and without charges, the hardware costs for patients receiving complex spinal surgery cannot be estimated from the OSHPD data.

The proposed policy would allow a hospital to make an annual election to be paid for spinal surgeries based on a) 1.20 x the composite rate + an add-on factor or b) 1.0 x the composite rate + the actual acquisition costs for spinal hardware effective for discharges occurring on or after December 15, 2010 (the 2011 update) and 0.8 x the composite rate + the actual acquisition costs effective for discharges occurring on or after December 15, 2011 (the 2012 update). To estimate the impact in each year, estimates were developed at the discharge level for OMFS allowances based on:

- Current policies (1.2 x OMFS allowance + pass-through amount)
- Proposed add-on amounts to 1.2 x the OMFS allowance (e.g., \$625 for MS-DRGs 28,29,20, 471-473 and \$2,925 for MS-DRGs 453-460 in 2011)
- Proposed option for continued pass-through of spinal hardware costs (e.g., actual acquisition costs plus 1.0 x relative weight x composite rate x 1.0 in 2011 (and 0.8 in 2012)

The OMFS allowances are based on a simulation of 2008 allowances updated by an inflation adjustment factor of 1.082 to account for an 8.2 percent increase in price index used to update the OMFS allowances between 2008- 2011. An additional adjustment factor of 1.03 was applied to estimate 2012 allowances.

¹² Wynn, Barbara O., memo entitled, “*Impact of Proposed Changes to OMFS Allowances for Spinal Hardware Costs*”.

The administrative data does not contain discharge-specific information on device costs. Pass-through cost estimates were based on two approaches, both of which draw from the work by Dalton et al. that estimates device costs as a percentage of total costs per case.¹³

- Method 1 assumes that device costs vary by MS-DRG in relation to total costs per case (e.g., 43 percent of the total costs for a discharge assigned to MS-DRG 453 are attributable to device costs).
- Method 2 assumes that the non-device costs are comparable across hospitals (after accounting for relative differences in the composite factors) and attributes the case-level difference between total costs per case and the estimated average non-device costs per case to device costs (e.g., the 2011 non-device costs for a discharge assigned to MS-DRG 453 are \$26,529. The device costs equal estimated cost for the case (charges x cost-to-charge ratio) minus \$26,529.)

The impact estimate assumes that each hospital would select the allowance option that on average would yield the highest payment. The option that would yield the highest payment was identified on a hospital-by-hospital basis and total hospital-level savings were estimated as the difference between the average allowance under current policies and the average allowance under the assigned option multiplied by the number of 2008 WC discharges with complex spinal surgery. Total savings are the sum of the hospital-specific totals.

In 2011, most hospitals would receive higher payment under the pass-through option. The total estimated reduction in OMFS allowances is \$28.3 million using Method 1 to estimate pass-through costs. Because most hospitals (152 out of 163) would receive a higher payment under the pass-through option, the savings are mostly attributable to the decrease in the multiplier from 1.20 to 1.0. The 2011 estimated OMFS allowances are similar under Method 2 (\$28.4 million). The estimated savings are approximately \$6,000 per discharge under Method 1 (and about \$6,015 under Method 2).

In 2012, the estimated savings increase to \$54.8 million- \$56.8 million using Method 1 and Method 2, respectively to estimate pass-through costs. Under either option, 102 of the 163 hospitals are projected to receive higher payments on average under the pass-through option than the add-on option. On a per discharge basis, the savings nearly double (to \$11,605 using Method 1 and \$12,030 using Method 2) to estimate pass-through costs.

The cost impact methodology has several limitations. First, in the absence of patient-level information on spinal hardware pass-through costs, it is assumed either that device usage rates are comparable across patients (e.g., the proportion of costs attributable to hardware costs is comparable across patients (Method 1)) or that non-device costs are comparable across patients (Method 2). In actuality, there may be significant variation across hospitals and discharges in these costs. Second, the estimates do not account for

13 Dalton, Kathleen, Sara Freeman and Arnold Bragg, Refining Cost to Charge Ratios for Calculating APC and MS-DRG Relative Payment Weights, Research Triangle Park, NC: RTI International, July 2008. Available at http://www.rti.org/reports/cms/HHSM-500-2005-00291/PDF/Refining_Cost_to_Charge_Ratios_200807_Final.pdf

behavioral changes that might occur in the use of spinal hardware under the proposed policies. The add-on payment option provides incentives to eliminate unnecessary use of spinal hardware and may generate additional savings.”

In conclusion, the impacts to the workers’ compensation community will be as follows:

Workers’ compensation insurers, self-insured employers and workers’ compensation third party administrators, will benefit with less administrative burden and, overall, the amount of duplicate payment for spinal hardware should be reduced.

The proposed regulations will allow hospitals to make an annual choice on the payment methodology for determining the maximum allowance for the spinal hardware used in complex spinal hardware. When a hospital receives an additional allowance proscribed by section 9789.22(g), the hospital will not be required to document the cost of the spinal hardware used, thus eliminating the administrative burden of determining the hardware cost. The hospital may, however, make an annual election to use the alternate payment methodology under section 9789.22(h), which provides financial protection for hospitals that systematically use more hardware resulting in higher costs, because the hospital will be paid the actual documented cost of the spinal hardware.

Payers will also be positively impacted because the administrative burden will be reduced when the additional allowance is established by section 9789.22(g), eliminating the need to review the adequacy of documentation provided by the hospital showing the actual cost of the hardware and thereby encouraging incentives for efficiency by hospitals. In addition, if the hospital elects the alternate payment, documented costs and billing must be submitted by the hospital under penalty of perjury to the payer, which will add accuracy and accountability in payments to the hospital.

Injured workers will benefit by receiving better treatment, because reducing the amount of duplicate payment will reduce profit motive and encourage choices of treatment that are in the best interest of the injured worker.

The extent of the impact on an affected hospital is dependent upon the volume and case mix of workers' compensation claims involving complex spinal surgeries performed at a particular hospital.

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

Section 9789.20(c):

Specific Purpose: The purpose of subdivision 9789.20(c) is to identify which sections of Title 8 California Code of Regulations constitute the Inpatient Hospital Fee Schedule. Currently, sections 9789.20 through 9789.24 apply to the Inpatient Hospital Fee Schedule. The amendment to subdivision 9789.20(c) will add section 9789.25 to the

Inpatient Hospital Fee Schedule. This format change will move updates to the federal regulation, federal register, and payment impact file references made in the Inpatient Hospital Fee Schedule updates by Order of the Administrative Director to section 9789.25 in order to conform to changes in the Medicare payment system as required by Labor Code section 5307.1. The purpose is to make the Inpatient Hospital Fee Schedule regulations more readable and understandable.

Necessity: Amendment of subdivision 9789.20(c) is necessary so that the new section 9789.25 will be included in the Inpatient Hospital Fee Schedule.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to incorporate regular updates to the federal regulation, federal register, and payment impact file references made in the Inpatient Hospital Fee Schedule updates.

Section 9789.20(d):

Specific Purpose: The purpose subdivision 9789.20(d) is to specify how the Inpatient Fee Schedule is to be adjusted, the effective date of the updates, and where the updates shall be posted. The amendment to subdivision 9789.20(d) will change the effective date for annual updates from October 1 to December 1 of each year.

Necessity: This amendment is necessary to provide a more realistic effective date given the constraints of when Medicare publishes the final rule and to provide an adequate notice (30-days) to affected parties. Since 2004, depending on the year, Medicare has published its final rule as early as August 1st and as late as August 27th, with an effective date of October 1. It is not unusual for Medicare to publish notices and corrections to its final rule after the final rule is published. In order to give adequate notice to affected parties, the current date of October 1 is unrealistic. The proposed effective date of December 1 is in conformance with Labor Code section 5307.1(g)(1)(A), which states in pertinent part, "Notwithstanding any other provision of law, the official medical fee schedule shall be adjusted to conform to any relevant changes in the Medicare and Medi-Cal payment systems no later than 60 days after the effective date of those changes."

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed effective date.

SECTION 9789.21-Definitions for Inpatient Hospital Fee Schedule –

Section 9789.21(b):

Specific Purpose: Subdivision 9789.21(b) is amended to clarify the effective date of discharge when choosing the formula used to arrive at the capital outlier factor. For discharges occurring on or after January 1, 2004 and before January 1, 2008, a large urban add-on is applied. The large urban add-on was eliminated for discharges on or

after January 1, 2008 by Medicare. The section is further amended for clerical error to substitute the word “of” with the word “to” in the last sentence of the second paragraph.

Necessity: This amendment is necessary to improve the understanding of which formula to use effective on the date of discharge, and to correct the clerical error.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amendments to the definition section of “capital outlier factor”.

Section 9789.21(b)(1):

Specific Purpose: Subdivision 9789.21(b)(1) is amended to move references to the federal regulation, federal register, and payment impact file made in the Inpatient Hospital Fee Schedule updates by Order of the Administrative Director, to section 9789.25. The new language advises that section 9789.25 (b) contains the Federal Register reference.

Necessity: This format change is necessary to make the Inpatient Hospital Fee Schedule regulations more readable and understandable.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amendment to the definition of “capital wage index” subdivision.

Section 9789.21(b)(2):

Specific Purpose: Section 9789.21(b)(2) is amended to move references to the federal regulation, federal register, and payment impact file made in the Inpatient Hospital Fee Schedule updates by Order of the Administrative Director, to section 9789.25. The purpose of the new language is to clarify that for discharges on or before January 1, 2008, the large urban add-on is an additional 3% and the large urban add-on is eliminated for discharges occurring on or after January 1, 2008. The new language also advises that section 9789.25 (a) contains the Federal Regulation reference.

Necessity: This format change is necessary to make the Inpatient Hospital Fee Schedule regulations more readable and understandable and to inform the public the large urban add-on amount so that the appropriate fee payment can be calculated.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amendment to the definition of “large urban add-on” subdivision.

Section 9789.21(b)(3):

Specific Purpose: Section 9789.21(b)(3) is amended to move references to the federal regulation, federal register, and payment impact file made in the Inpatient Hospital Fee Schedule updates by Order of the Administrative Director, to section 9789.25. The new language also advises that section 9789.25 (b) contains the Federal Register reference that defines the fixed loss cost outlier threshold by date of discharge.

Necessity: This format change is necessary to make the Inpatient Hospital Fee Schedule regulations more readable and understandable and to inform the public the large urban add-on amount so that the appropriate fee payment can be calculated.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amendment to the definition of “fixed loss cost outlier threshold” subdivision.

Section 9789.21(d):

Specific Purpose: The addition of section 9789.21(d) is a formatting change which moves “Complex spinal surgery” from section 9789.22 (payment of inpatient hospital services section) to section 9789.21(d), the definition section.

Necessity: This format change is necessary to make the Inpatient Hospital Fee Schedule regulations more readable and understandable.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed added subdivision.

Section 9789.21(e):

Specific Purpose: The amendment changes the numbering of current subdivision (d) to subdivision (e). This subdivision is also amended to: 1. exclude payments for spinal hardware used in complex spinal surgery in addition to payments for outlier cases and new technology when calculating the composite factor; 2. clarify that composite factor means the standard OMFS rate for a hospital; 3. clarify that the prospective operating costs are hospital-adjusted; and 4. substitute “hospital” for “health facility” to conform to the changes made to section 9789.21(l).

Necessity: This section is amended for clarity of the definition of “composite factor” and to conform to changes to section 9789.21(l).

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.21(e)(1):

Specific Purpose: The amendment clarifies that the prospective capital costs are hospital-adjusted.

Necessity: This section is amended for clarity and to conform to changes to section 9789.21(1).

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.21(e)(1)(A):

Specific Purpose: The amendment clarifies the effective date of discharge when choosing the formula used to arrive at the hospital-adjusted rate for prospective capital costs. For discharges on or after January 1, 2004 and before January 1, 2008, a large urban add-on is applied when arriving at the hospital-adjusted rate for prospective capital costs. The large urban add-on was eliminated for discharges on or after January 1, 2008 by Medicare. This subdivision is also amended to clarify that the prospective capital costs are hospital-adjusted; and to correct the term “Capital standard payment rate” to “Capital standard federal payment rate.”

Necessity: This amendment is necessary for clarity of which formula to use effective on the date of discharge and for clarity and consistency in use of terminology.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.21(e)(1)(B):

Specific Purpose: This subdivision is added to define “capital market basket” as the Medicare capital input price index (CIPI) and the capital standard federal payment rate is the capital market basket applied to the capital standard federal payment rate for the preceding period. Labor Code section 5307.1(g)(1)(A)(i) requires the annual inflation adjustment for facility fees for inpatient hospital services be determined solely by the estimated increase in the hospital market basket for the 12 months beginning October 1 of the preceding calendar year.

Necessity: This definition is added for clarity, as it was inadvertently omitted from the current regulation.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed added subdivision.

Section 9789.21(e)(1)(C):

Specific Purpose: The purpose of this subdivision is to define the “capital standard federal payment rate.” This amendment changes the numbering of current subdivision (e)(1)(B) to subdivision (e)(1)(C); clarifies that 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; and moves references to the federal regulation, federal register, and payment impact file made in the Inpatient Hospital Fee Schedule updates by Administrative Director, to section 9789.25. The new language advises that the “capital standard federal payment rate” of \$414.18 is for discharges occurring on or after January 1, 2004 and before November 29, 2004 so that the correct payment can be calculated. The new language also states that for each update in the composite factor, the capital standard payment rate for the preceding period is adjusted by the rate of change in the capital market basket and refers to section 9789.25 (b) which contains the capital standard federal payment rate for discharges on or after November 29, 2004 by date of discharge.

Necessity: This amendment is necessary for clarity and the format change is necessary to make the Inpatient Hospital Fee Schedule regulations more readable and understandable.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.21(e)(1)(D):

Specific Purpose: This amendment changes the numbering of current subdivision (e)(1)(C) to subdivision (e)(1)(D), and moves references to the federal regulation, federal register, and payment impact file made in the Inpatient Hospital Fee Schedule updates by Administrative Director, to section 9789.25. The new language indicates where the capital geographic adjustment factor is found in the Payment Impact File and cross-references the new section 9789.25(c).

Necessity: This amendment is necessary to make the Inpatient Hospital Fee Schedule regulations more readable and understandable.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed added subdivision.

Section 9789.21(e)(1)(E):

Specific Purpose: This amendment changes the numbering of current subdivision (e)(1)(D) to subdivision (e)(1)(E), and moves references to the federal regulation, federal register, and payment impact file made in the Inpatient Hospital Fee Schedule updates by Administrative Director, to section 9789.25. The purpose of the new language is to clarify that for discharges on or before January 1, 2008, the large urban add-on is an

additional 3% and the large urban add-on is eliminated for discharges occurring on or after January 1, 2008.

Necessity: This amendment is necessary to make the Inpatient Hospital Fee Schedule regulations more readable and understandable.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.21(e)(1)(F):

Specific Purpose: This amendment changes the numbering of current subdivision (e)(1)(E) to subdivision (e)(1)(F), and moves references to the federal regulation, federal register, and payment impact file made in the Inpatient Hospital Fee Schedule updates by Administrative Director, to section 9789.25(c).

Necessity: This amendment is necessary to make the Inpatient Hospital Fee Schedule regulations more readable and understandable.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.21(e)(1)(G):

Specific Purpose: This amendment changes the numbering of current subdivision (e)(1)(F) to subdivision (e)(1)(G), and moves references to the federal regulation, federal register, and payment impact file made in the Inpatient Hospital Fee Schedule updates by Administrative Director, to section 9789.25(c).

Necessity: This amendment is necessary to make the Inpatient Hospital Fee Schedule regulations more readable and understandable.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.21(e)(2):

Specific Purpose: This subdivision is amended to clarify that the prospective operating costs are hospital-adjusted.

Necessity: This section is amended for clarity.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.21(e)(2)(A):

Specific Purpose: This subdivision is amended to: 1. clarify that the prospective operating costs are hospital-adjusted; 2. correct the wage-adjusted standard rate formula by substituting “labor-related national” for “OMFS”; and 3. clarify the formula used to calculate the hospital-adjusted rate for prospective operating costs is in conformance with California Labor Code section 5307.1(g)(1)(A)(i).

Necessity: This section is amended for clarity and to correct terminology.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.21(e)(2)(B):

Specific Purpose: This subdivision is amended to clarify that 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, and moves references to the federal regulation, federal register, and payment impact file made in the Inpatient Hospital Fee Schedule updates by Administrative Director, to section 9789.25. The purpose of the new language is to clarify that for discharges on or after January 1, 2004 and before November 29, 2004, the amount is \$3,136.39. The added language advises how the amount for the preceding period is adjusted and cross-references section 9789.25(b) for the rate for discharges occurring on or after November 29, 2004.

Necessity: This amendment is necessary for clarity and to make the Inpatient Hospital Fee Schedule regulations more readable and understandable.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.21(e)(2)(C):

Specific Purpose: This amendment moves references to the federal regulation, federal register, and payment impact file made in the Inpatient Hospital Fee Schedule updates by Administrative Director, to section 9789.25 (c) and advises that the operating wage index can be found in section 9789.25(c) for the variable name on the Payment Index File by date of discharge.

Necessity: This amendment is necessary to make the Inpatient Hospital Fee Schedule regulations more readable and understandable.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.21(e)(2)(E):

Specific Purpose: This amendment moves references to the federal regulation, federal register, and payment impact file made in the Inpatient Hospital Fee Schedule updates by Administrative Director, to section 9789.25. The new language clarifies that 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 and incorporates the document by reference. The revised subdivision cross-references section 9789.25(c), which lists for the variable name on the Payment Impact File by date of discharge.

Necessity: This amendment is necessary to make the Inpatient Hospital Fee Schedule regulations more readable and understandable.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.21(e)(2)(F):

Specific Purpose: This amendment moves references to the federal regulation, federal register, and payment impact file made in the Inpatient Hospital Fee Schedule updates by Administrative Director, to section 9789.25. The new language clarifies that 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 and incorporates the document by reference. The revisions also cross-reference section 9789.25(c), which lists the variable name on the Payment Impact File by date of discharge.

Necessity: This amendment is necessary to make the Inpatient Hospital Fee Schedule regulations more readable and understandable.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.21(e)(2)(G):

Specific Purpose: This amendment moves references to the federal regulation, federal register, and payment impact file made in the Inpatient Hospital Fee Schedule updates by

Administrative Director, to section 9789.25. The new language clarifies the reference to the formula in section 9789.21(e)(2) and cross-references section 9789.25(c) which lists the variable name on the Payment Impact File by date of discharge.

Necessity: This amendment is necessary to make the Inpatient Hospital Fee Schedule regulations more readable and understandable.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.21(e)(3):

Specific Purpose: This subdivision is amended to substitute “hospital” for “health facility” and to change a citation to conform to the changed numbering of this section.

Necessity: This section is amended to conform a citation to changed numbering, and to conform to changes to section 9789.21(l).

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.21(e):

Specific Purpose: The current section 9789.21(e) “Costs” is rescinded.

Necessity: The section is rescinded because section 9789.22(f) provides formulas used to determine costs.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.21(f):

Specific Purpose: This amendment moves references to the federal regulation, federal register, and payment impact file made in the Inpatient Hospital Fee Schedule updates by Administrative Director, to section 9789.25.

Necessity: This amendment is necessary to make the Inpatient Hospital Fee Schedule regulations more readable and understandable.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.21(g):

Specific Purpose: This subdivision is amended to reflect the rescission of subdivision (e).

Necessity: This amendment is necessary to conform to rescission of subdivision (e).

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.21(h):

Specific Purpose: This subdivision is amended to conform to changes made in payment methodology for spinal hardware used in complex spinal surgeries. Subdivision (h) is amended to include additional allowance for spinal hardware under section 9789.22(g) or (h) in calculating the cost outlier threshold, and substitutes “Section 9789.22(g)” for “subdivision (j)” to conform to the numbering changes.

Necessity: This amendment is necessary to conform to the changes made in payment methodology for spinal hardware used in complex spinal surgeries as set forth in sections 9789.22.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.21(l):

Specific Purpose: This subdivision is amended to change the term from “health facility” to “hospital”. Where used in the Inpatient Hospital Fee Schedule, the term “hospital” is substituted for “health facility”.

Necessity: This amendment is necessary for clarity, as there has been confusion in the workers’ compensation community regarding who can bill and be reimbursed for medical services under the Inpatient Hospital Fee Schedule, particularly regarding hardware and devices used during complex spinal surgery. A July 2009 RAND report found the following: “Further, if the pass-through is continued, the regulations should clarify that the hospital must bill for any items qualifying for the pass-through payment. Under Medicare rules, a hospital must provide all services required during a hospital stay either directly or under arrangements in which the hospital pays for services provided by an outside supplier and includes the costs in its bill. Suppliers have started to bill directly for hardware and devices implanted during complex spinal surgery for WC patients. As a result, the WC program does not benefit from hospital group purchasing and other

activities to reduce device costs and faces additional bill processing costs.”¹⁴ This requirement should enable better oversight and accountability. Since the Inpatient Hospital Fee Schedule applies to hospitals, the term “hospitals” is substituted for “health facility” to eliminate any ambiguity.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.21(m):

Specific Purpose: This subdivision is amended to substitute “hospital” for “health facility”.

Necessity: This section is amended for clarity and to conform to changes to section 9789.21(l).

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.21(n):

Specific Purpose: This subdivision is amended to clarify the formula for “Inpatient Hospital Fee Schedule maximum payment amount” and when it is applicable.

Necessity: This subdivision is amended conform to changes made to the payment methodology for complex spinal surgery cases.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.21(o):

Specific Purpose: This amendment moves references to the federal regulation, federal register, and payment impact file made in the Inpatient Hospital Fee Schedule updates by Administrative Director, to section 9789.25.

Necessity: This amendment is necessary to make the Inpatient Hospital Fee Schedule regulations more readable and understandable.

¹⁴ Wynn, Barbara O., *Regulatory Actions that Could Reduce Unnecessary Medical Expenses Under California’s Workers’ Compensation Program*, Prepared for the Commission on Health, Safety and Workers’ Compensation, the RAND Institute for Civil Justice and RAND Health, July 2009, p. 3.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.21(p):

Specific Purpose: This subdivision is added to define “large urban add-on” as it is used in the Inpatient Hospital Fee Schedule. The subdivision further references section 9789.25(a) for the Code of Federal Regulations reference for effective date, revisions, and amendments by date of discharge. It also indicates that the "large urban add-on" is indicated in the annual Payment Impact File for each Medicare payment update, and references section 9789.25(c) for the variable name on the Payment Impact File by date of discharge.

Necessity: This definition is added for clarity, as it was inadvertently omitted from the current regulation, and to conform with the purpose of new section 9789.25(c).

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed added subdivision.

Section 9789.21(q):

Specific Purpose: This amendment changes the numbering of current subdivision (p) to subdivision (q).

Necessity: This amendment is necessary to conform the Inpatient Hospital Fee Schedule regulations with previous numbering changes.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed added subdivision.

Section 9789.21(r):

Specific Purpose: This amendment changes the numbering of current subdivision (q) to subdivision (r), and clarifies the labor-related portion is applied to the operating wage index when calculating the operating outlier factor.

Necessity: This amendment is necessary for clarity.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.21(r)(1):

Specific Purpose: This amendment moves references to the federal regulation, federal register, and payment impact file made in the Inpatient Hospital Fee Schedule updates by Administrative Director, to section 9789.25.

Necessity: This amendment is necessary to make the Inpatient Hospital Fee Schedule regulations more readable and understandable.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.21(s):

Specific Purpose: This amendment changes the numbering of current subdivision (r) to subdivision (s), and substitutes “hospital” for “health facility”.

Necessity: This amendment is necessary to conform the Inpatient Hospital Fee Schedule regulations with previous numbering changes, and changes to section 9789.21(l).

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.21(t):

Specific Purpose: This amendment changes the numbering of current subdivision (s) to subdivision (t), and moves references to the federal regulation, federal register, and payment impact file made in the Inpatient Hospital Fee Schedule updates by Administrative Director, to section 9789.25.

Necessity: This amendment is necessary to make the Inpatient Hospital Fee Schedule regulations more readable and understandable.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.21(u):

Specific Purpose: This subdivision is added to define “price adjustment” as any and all price reductions, offsets, discounts, rebates, adjustment, and or refunds which accrue to or are factored into the final net cost to the hospital. Where used in this fee schedule, the term “price adjustment” is substituted for “discounts and rebates” as the new definition is more accurate.

Necessity: This subdivision is added for clarity, as the adjustments to the price encompass more than just discounts and rebates. The term also includes price reductions, offsets, adjustments, and refunds.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed added subdivision.

Section 9789.21(v):

Specific Purpose: This amendment changes the numbering of current subdivision (u) to subdivision (v).

Necessity: This amendment is necessary to conform to the changed numbering.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.21(w):

Specific Purpose: This subdivision is added to define “spinal hardware”. A definition of spinal hardware is previously defined in section 9789.22(f) as “device”. Subdivision (w) substitutes “spinal hardware” for “device”, and refines the definition to clarify spinal hardware is a permanently implantable device surgically implanted, embedded, inserted, or otherwise applied to a human body in the course of complex spinal surgery. The device must be intended to function for more than one year and throughout the useful life of the device, to assist, restore, or replace, or otherwise therapeutically influence the function of the spine. The term, spinal hardware, does not apply to any device which is intended for temporary purposes or intended for removal. The device must be recognized in the office United States Pharmacopoeia-National Formulary, or any supplement to it, and be reasonably required to cure or relieve the injured worker from the effects of his or her injury pursuant to Labor Code section 4600.

The definition of spinal hardware was derived from the following sources: Texas §134.402(a)(4)¹⁵, Federal Drug Administration - *Medical Device Tracking; Guidance for Industry and FDA Staff*, Jan. 25, 2010¹⁶, the definition of “device” found in section 9789.22(f) of the current regulation, and Labor Code section 4600.

¹⁵ TX §134.402 states in pertinent part: “(5) “Implantable” means an object or device that is surgically: (A) implanted, (B) embedded, (C) inserted, (D) or otherwise applied...”

¹⁶ FDA, *Medical Device Tracking; Guidance for Industry and FDA Staff* states in pertinent part: “Permanently implantable device (21 CFR 821.3(f)). A permanently implantable device is a device that is intended to be placed into a surgically or naturally formed cavity of the human body for more than one year to continuously assist, restore, or replace the function of an organ system or structure of the human body throughout the useful life of the device. The term does not include any device which is intended and used only for temporary purposes or which is intended for explanation in one year or less.”

Necessity: This amendment is necessary for clarify what qualifies as spinal hardware eligible for additional allowance.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed added subdivision.

SECTION 9789.22-Payment of Inpatient Hospital Services

Specific Purpose:

The purpose of section 9789.22 is to provide the basic procedures for the payment of inpatient hospital services which includes: the formula to determine the maximum payment for inpatient medical services, the type of items and services covered by the Inpatient Hospital Fee Schedule, billing requirements, payment methodologies for additional allowances for cost outlier cases, payment methodologies for additional allowances for spinal hardware used in complex spinal surgery, procedures for making an annual election for alternate payment methodology in determining maximum allowance for all complex spinal surgeries, a new technology pass-through, a modified factor for sole community hospitals, an explanation of how payment for transfers will be calculated, exemptions for certain types of hospitals, and the procedure for a request for redetermination of a hospital's composite factor of hospital specific outlier factor. Section 9789.22 is amended to reflect changes to complex spinal surgery payment methodologies applied in outlier cases and used in determining additional allowances for spinal hardware used.

Necessity:

This section is necessary in order to implement Labor Code sections 5307.1 and 5318. Although Labor Code § 5307.1 requires the Administrative Director to adopt regulations for fees in accordance with the Medicare payment system, Medicare employs many special rules and exceptions to its basic formulaic payment schedule. Also, additional allowances are provided for spinal hardware used in complex spinal surgery cases and different payment methodologies for complex spinal surgery cases are adopted. This section provides the basic formula and sets forth the specific exceptions that apply.

Consideration of Alternatives:

At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the above proposed amendments.

Section 9789.22(a):

Specific Purpose: This subdivision is amended to conform to changes made to the payment methodology for complex spinal surgery cases proposed in sections

9789.22(f)(2), (g), and (h) and substitutes “hospital” for “health facility” to conform to changes made to section 9789.21(l).

Necessity: This amendment is necessary to conform to changes made to section 9789.21(l) and sections 9789.22(f)(2), (g), and (h).

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.22(c):

Specific Purpose: This subdivision is amended to make a minor formatting change. “Section” is substituted for “§”.

Necessity: This subdivision is amended to achieve consistency in formatting through the Inpatient Hospital Fee Schedule regulations.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.22(d):

Specific Purpose: This subdivision is added to clarify professional services are paid under a separate Official Medical Fee Schedule (beginning at section 9789.10) and to clarify that billing for payment under the Inpatient Hospital Fee Schedule shall originate from hospitals and payment may be made only to hospitals for covered items and services including any spinal hardware separately payable under section 9789.22(g) or (h).

Necessity: This amendment is necessary for clarity, as there has been confusion in the workers’ compensation community regarding who can bill and be reimbursed for medical services under the Inpatient Hospital Fee Schedule, particularly regarding hardware and devices used during complex spinal surgery. A July 2009 RAND report found the following: “Further, if the pass-through is continued, the regulations should clarify that the hospital must bill for any items qualifying for the pass-through payment. Under Medicare rules, a hospital must provide all services required during a hospital stay either directly or under arrangements in which the hospital pays for services provided by an outside supplier and includes the costs in its bill. Suppliers have started to bill directly for hardware and devices implanted during complex spinal surgery for WC patients. As a result, the WC program does not benefit from hospital group purchasing and other activities to reduce device costs and faces additional bill processing costs.”¹⁷

¹⁷ Wynn, Barbara O., *Regulatory Actions that Could Reduce Unnecessary Medical Expenses Under California’s Workers’ Compensation Program*, Prepared for the Commission on Health, Safety and Workers’ Compensation, the RAND Institute for Civil Justice and RAND Health, July 2009, p. 3.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed added subdivision.

Section 9789.22(e):

Specific Purpose: This amendment changes the numbering of current subdivision (d) to subdivision (e), conforms with changes made to the payment methodology for complex spinal surgery cases, and substitutes “hospital” for “health facility”. This amendment requires, when applicable, documentation of the costs of implanted spinal hardware be submitted in accordance with section 9789.22(h).

Necessity: This amendment is necessary to conform to changes made to the payment methodologies and documentation requirements for complex spinal surgery cases, and to conform to the change in terminology.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.22(f)(1):

Specific Purpose: This amendment changes the numbering of current subdivision (e) to subdivision (f), and changes the format from current (1)(2) and (3) and (4) to Step 1, Step 2, and Step 3. The current (5) is rescinded because “complex spinal surgery” DRGs are now defined in section 9789.21(d) and listed by date of discharge in section 9789.25(b). This amendment also clarifies that the formula used to calculate additional allowance for cost outlier cases is exclusive of complex surgery cases involving spinal hardware reimbursed under section 9789.22(h).

Necessity: This subdivision is amended as part of the changes being made to payment methodologies for complex spinal surgery cases. This amendment clarifies that the formula set forth in this subdivision pertains to additional allowances for cost outlier cases exclusive of complex spinal surgery cases involving spinal hardware reimbursed under section 9789.22(h). Complex spinal surgery cases reimbursed in accordance with 9789.22(h) must apply the payment methodology set forth in section 9789.22(f)(2), and is optional for all other cases involving complex spinal surgery.

The standard outlier payment policy set forth in this subdivision (9789.22(f)(1)) is that a hospital receives 80% of estimated cost in excess of a cost outlier threshold (which in 2010 is \$23,140 before wage adjustment¹⁸) plus the DRG payment amount. The

¹⁸ Federal Register (Vol. 74 FR 43754), August 27, 2009, *Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2010 Rates; and Changes to the Long-Term Care Hospital Prospective Payment System and Rate Years 2010 and 2009 Rates* (CMS-1406-F), p. 44011

estimated cost is determined by taking the total billed charges and multiplying it by the hospital's total cost-to-charge ratio.

The 2008 report by RTI addressed the hospital industry practice of applying lower markups to expensive medical devices and implantable items, but higher markups for routine medical supplies.¹⁹ This practice raises the concern that applying the hospital's overall cost-to-charge ratio to determine the costs of expensive (lower markup) spinal hardware implantables results in understating the costs and thereby lowering reimbursement amount in complex spinal surgery outlier cases.

The payment methodology in 9789.22(f)(2) addresses the issue of charge compression which is a concern specific to complex spinal surgeries using higher cost spinal hardware, and not necessarily to other hospital medical services which would receive an additional reimbursement under the standard outlier payment policy set forth in this subdivision.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.22(f)(2):

Specific Purpose: This subdivision is added to define the formula used to calculate additional allowance for cost outlier cases involving complex spinal surgery cases. The higher costs of a case involving spinal hardware reimbursed under section 9789.22(h) shall be reimbursed using the method set forth in this subdivision. This method is optional for other cases involving complex spinal surgery and may be elected by a hospital on a case-by-case basis in lieu of the method in section 9789.22(f)(1). Whenever this method is used, the hospital must document the cost of any spinal hardware as required under section 9789.22(h).

Necessity: This subdivision is amended as part of the changes being made to payment methodologies for complex spinal surgery cases. This subdivision provides the formula for determining the additional allowance for complex spinal surgery cost outlier cases involving spinal hardware reimbursed under section 9789.22(h) and when elected by the hospital, for other cases involving complex spinal surgery. The 2008 report by RTI addressed the hospital industry practice of applying lower markups to expensive medical devices and implantable items, but higher markups for routine medical supplies.²⁰ This practice raises the concern that applying the hospital's overall cost-to-charge ratio to determine the costs of expensive (lower markup) spinal hardware implantables results in understating the costs resulting in a lower reimbursement amount in complex spinal surgery outlier cases.

¹⁹ Dalton, Kathleen, Freeman, Sara, and Bragg, Arnold, *Refining Cost to Charge Ratios for Calculating APC and MS-DRG Relative Payment Weights*, RTI International, July 2008, p. 1.

²⁰ Dalton, Kathleen, Freeman, Sara, and Bragg, Arnold, *Refining Cost to Charge Ratios for Calculating APC and MS-DRG Relative Payment Weights*, RTI International, July 2008, p. 1.

The formula in this subdivision takes the issue of charge compression into account when computing the costs for arriving at outlier payments. In this payment methodology, the hospital receives 80% of estimated cost in excess of a cost outlier threshold plus the DRG payment amount. The estimated total cost is determined as follows: (total charges – charges for any spinal hardware) x (total cost-to-charge ratio) + documented paid cost of any spinal hardware, plus an additional 10% of the hospital's documented paid cost, net of immediate and anticipated price adjustments, not to exceed a maximum of \$250.00, plus any sales tax and/or shipping and handling charges actually paid. By excluding the hardware charges from costs estimated using the overall cost-to-charge ratio and adding in actual documented costs, the risk of understating hardware costs because of cost compression is avoided.

Finally, in order to conform with the changes made to the payment methodology for reimbursement of complex spinal surgeries using section 9789.22(h), this formula uses the multipliers set forth in section 9789.22(h)(A), rather than the 1.2 multiplier used in the standard outlier payment policy set forth in section 9789.22(f)(1). The multiplier transitions from 1.0 for discharges effective on or after December 15, 2010, to 0.8 for discharges effective as of the 2012 annual update.

According to the January 2009 RAND report, on average, about 50% of the payment (before the 1.2 multiplier) represents the device costs.²¹ The July 2009 RAND report proposed ways of reducing the duplication of payment for spinal hardware by “reducing the OMFS multiplier to exclude the amounts implicit for hardware in Medicare’s payment rates and continuing to allow a pass-through or a fixed allowance for spinal hardware.”²²

The multipliers used in this formula in conformance with section 9789.22(h)(A) address this issue of duplicate payment for the cost of spinal hardware used in complex spinal surgery cases.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed added subdivision.

Section 9789.22(f):

Specific Purpose: Subdivision 9789.22(f) of the current regulation is rescinded and replaced with subdivisions (g) and (h), which define how additional allowance for spinal hardware used in complex spinal surgery is provided for. The DRGs that define complex spinal surgeries have been moved to the definition section (section 9789.21(d)), and the

²¹ Wynn, Barbara O., *Inpatient Hospital Services, An Update on Services Provided Under California’s Workers’ Compensation Program, Prepared for the Commission on Health, Safety and Workers’ Compensation*, the RAND Institute for Civil Justice and RAND Health, 2009, pp.21-24.

²² Wynn, Barbara O., *Regulatory Actions that Could Reduce Unnecessary Medical Expenses Under California’s Workers’ Compensation Program, Prepared for the Commission on Health, Safety and Workers’ Compensation*, the RAND Institute for Civil Justice and RAND Health, July 2009, pp. 2-3.

definition of “device” is changed to “spinal hardware” and also moved to the definition section (section 9789.21(w)).

Necessity: This subdivision is rescinded and replaced with subdivisions (g) and (h) as part of the changes being made to payment methodologies for complex spinal surgery cases and the reorganization of the regulations by moving definitions of terms to section 9789.21.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed rescission of this subdivision.

Section 9789.22(g):

Specific Purpose: This subdivision is added to provide the payment method of determining additional allowance for spinal hardware used in complex spinal surgery unless the hospital makes a one-time annual election for an alternate maximum payment allowance and additional allowance for spinal hardware used in complex spinal surgery under subdivisions (h) and (i). For discharges occurring before December 15, 2010, costs for spinal hardware used during complex spinal surgery shall be separately reimbursed at the hospital’s documented paid cost, plus an additional 10% of the hospital’s documented paid cost, net of price adjustments, not to exceed a maximum of \$250.00, plus any sales tax and/or shipping and handling charges actually paid.

For discharges occurring on or after December 15, 2010, a new payment method will be applied where an additional allowance of \$2,925 shall be made for discharges assigned to MS-DRGs 453, 454, 455, 456, 457, 458, 459, and 460 and an additional allowance of \$625 shall be made for discharges assigned to MS-DRGs 028, 029, 030, 471, 472, and 473. Effective with each update in the composite rate, the additional allowance shall be adjusted by the rate of change in the hospital operating market basket.

Necessity: Spinal hardware costs are not likely to vary by geographic location. Therefore, providing a flat additional allowance means that a hospital located in a low wage area receives the same additional allowance as hospitals located in high wage areas. This payment methodology is intended to meet the following objectives: 1) recognize that workers’ compensation patients use more hardware than Medicare patients; 2) eliminate some of the duplicate payment for hardware; 3) provide incentives for efficient use of resources; 4) provide financial protection for atypically high cost cases; and 5) reduce administrative burden.

The additional allowances set forth in this subdivision represent the estimated difference in 2009 between the amount implicit for spinal hardware in the Medicare-based OMFS Inpatient Hospital Fee Schedule allowance and the average workers’ compensation spinal hardware device costs updated for inflation to 2010.

To estimate the device costs that are implicit in the standard OMFS allowance for each spinal surgery DRG in 2009, the standard OMFS allowance for the MS-DRG (1.2 x the standard OMFS (capital + operating) rate x the applicable DRG relative weight) was multiplied by the estimated proportion of the Medicare rate that is attributable to device costs. The proportion was derived from estimates made by the July 2008 RTI report²³ of device costs as a percentage of total costs per case. Average device costs were separately calculated for each base DRG by weighting results for each severity-level by the number of workers' compensation discharges assigned to the applicable severity levels in 2008.

Estimated 2009 average device costs for workers' compensation were derived from information on average implant costs for spinal fusions provided in the *Orthopedic Network News* October 2009²⁴. These costs are based on 8,955 cases (regardless of payer) reported by 63 hospitals. The article estimated average implant costs for lumbar fusions was \$14,407 and for cervical spinal fusions was \$5960.

The 2010 additional allowances were calculated as:
(amount implicit in the standard OMFS 2009 allowance - the estimated average workers' compensation device costs) x 1.021 (rate of increase in the operating market basket).

The additional allowances are calculated as follows:

- MS-DRGs 459 and 460 (non-cervical fusions) = $(\$14,407 - 11,544) \times 1.021 = \$2,923$.
- MS-DRGs 471, 472, and 473 (cervical fusions) = $(\$5,960 - 5,350) \times 1.021 = \622 .

Because spinal hardware cost data typically used in MS-DRGs 028 through 030 and 453 through 458 are not readily available, the additional allowance for higher-spinal hardware cost MS-DRGs are based on the higher-spinal hardware cost lumbar fusion MS-DRGs for which information is available using the October 2009 *Orthopedic News* article. Accordingly, the additional allowance for lower-spinal hardware cost MS-DRGs is similarly based on the additional allowance for the lower-spinal hardware cost cervical fusion MS-DRGs. Using this proxy, MS-DRGs 453, 454, 455 (combined anterior/posterior spinal fusion) and MS-DRGs 456, 457, and 458 (spinal fusion except cervical with spinal curvature/malignancy/infection of 9+ fusions) receive the higher-spinal hardware additional allowance and MS-DRGs 028, 029, and 030 receive the lower-spinal hardware additional allowance.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed added subdivision.

Section 9789.22(h):

²³ Dalton, Kathleen, Freeman, Sara, and Bragg, Arnold, *Refining Cost to Charge Ratios for Calculating APC and MS-DRG Relative Payment Weights*, RTI International, July 2008.

²⁴ *Orthopedic Network News*, Volume 20, Number 4, October 2009, p. 7.

Specific Purpose: This subdivision is added to provide an alternate payment method for discharges assigned only to complex spinal surgery cases in lieu of the Inpatient Hospital Fee Schedule maximum payment allowed under section 9789.22(a) and additional allowance under section 9789.22(g)(2). The hospital may make one annual election encompassing all complex spinal surgery cases pursuant to section 9789.22(i) for an alternate maximum payment allowance and additional allowance to be determined as follows: Multiplier x DRG weight x hospital specific composite factor plus the additional allowance for documented paid cost for spinal hardware, plus an additional 10% of the hospital's documented paid cost, net of immediate and anticipated price adjustments, not to exceed a maximum of \$250.00, plus any sales tax and/or shipping and handling charges actually paid.

The multiplier shall be as follows: For discharges occurring on or after December 15, 2010, the multiplier shall be 1.0. For discharges occurring on or after the effective date of the 2012 annual update, the multiplier shall be 0.8.

The hospital would be required to submit documentation itemizing the paid costs for each type of spinal hardware and certify that the documentation accurately reflects the hospital's net costs for the spinal hardware.

Necessity: This subdivision is added as part of the changes being made to payment methodologies for complex spinal surgery cases. Allowing the hospital to make one annual election encompassing all complex spinal surgery cases affords those hospitals with systematically higher costs more protection than the flat additional allowance payment methodology set forth in section 9789.22(g). This is a modification of the Texas workers' compensation payment methodology in that it requires an annual election rather than a case-by-case election as permitted by Texas.²⁵ Allowing the hospital to choose on a case-by-case basis will result in the highest payment amount for each and every case which is contrary to the "averaging" concept embodied in the Medicare DRG-based system. The "averaging" concept is premised on the fact that in some cases the hospitals might be paid less than cost and in other cases more than cost, but that on average the allowance is reasonable and appropriate for an efficient hospital.

With this annual election, each hospital will be able to pick which payment methodology is most likely to result in the highest allowances. A hospital selecting to be paid a pass-through amount would still be eligible for an outlier payment. Allowing an annual election provides financial protection for hospitals that systematically use more spinal hardware. The flat additional allowance will be selected by hospitals who have typically low spinal hardware usage and are already profiting on complex spinal surgery cases. In addition, the administrative burden is reduced for those hospitals electing the flat additional allowance.

The multiplier will transition from the current 1.2 of the Medicare payment rate to 1.0 of the Medicare payment rate for discharges on or after December 15, 2010, and 0.8 of the

²⁵ Texas Department of Insurance, Division of Workers' Compensation, *Hospital Facility Fee Guidelines – Frequently Asked Questions*, Revised June 24, 2008, p. 2.

Medicare payment rate for discharges on or after the effective date of the 2012 annual update. Because the Medicare rates already account for significant spinal hardware costs in the complex spinal surgery DRGs, 80% of the Medicare payment rate plus a pass-through for the documented spinal hardware costs will eliminate some of the duplicate payments allowed by the current regulation, but, on the average, the overall allowance for complex spinal surgeries using spinal hardware should be reasonable. According to the January 2009 RAND report, on average, about 50% of the Medicare payment (before the 1.2 multiplier) represents the device costs.²⁶ The July 2009 RAND report proposed ways of reducing the duplication of payment for spinal hardware by “reducing the OMFS multiplier to exclude the amounts implicit for hardware in Medicare’s payment rates and continuing to allow a pass-through or a fixed allowance for spinal hardware.”²⁷

In order to assure accuracy and accountability of the bills and documents submitted by the hospital, the hospital will be required to certify to the accuracy of the invoice and provide documentation for each spinal hardware item used in complex spinal surgery case. According to an article by Stuart Colburn, the Texas workers’ compensation regulation also requires a health care facility choosing to be reimbursed separately for implantables to include the invoices of the separately implanted devices and the appropriate invoice certification under penalty of perjury.²⁸

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed added subdivision.

Section 9789.22(i):

Specific Purpose: This subdivision is added to set forth the requirements a hospital needs to meet in order to make an annual election of the alternate allowance methodology set forth in section 9789.22(h). The election must be submitted in writing to the Administrative Director and postmarked by December 15 of each year. The election shall be effective for one year commencing with discharges on or after January 1 following the month of December in which the election is made. If the hospital does not file a timely election, the maximum payment allowed to a hospital shall be determined under section 9789.22(a) and additional allowance for spinal hardware used in complex spinal surgery shall be determined under section 9789.22(g)(2). Before January 1 of each year the Administrative Director shall post a list of those hospitals electing to be paid under the alternate payment method set forth in section 9789.22(h).

²⁶ Wynn, Barbara O., *Inpatient Hospital Services, An Update on Services Provided Under California’s Workers’ Compensation Program*, Prepared for the Commission on Health, Safety and Workers’ Compensation, the RAND Institute for Civil Justice and RAND Health, 2009, pp.21-24.

²⁷ Wynn, Barbara O., *Regulatory Actions that Could Reduce Unnecessary Medical Expenses Under California’s Workers’ Compensation Program*, Prepared for the Commission on Health, Safety and Workers’ Compensation, the RAND Institute for Civil Justice and RAND Health, July 2009, pp. 2-3.

²⁸ Colburn, Stuart D., *Texas Health Facility Fees: Rules 134.403 and 134.404 (Inpatient & Outpatient Hospital Fee Guidelines)*, LexisNexis Expert Commentaries: Larson Series, 2008, p. 6.

Necessity: This subdivision is added as part of the changes being made to payment methodologies for complex spinal surgery cases. This subdivision is necessary to ensure that when a hospital seeks to make an annual election for the alternate payment method, the procedure for making such election is clearly understood.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed added subdivision.

Section 9789.22(j):

Specific Purpose: This amendment changes the numbering of current subdivision (g) to subdivision (j) and moves references to the federal regulation, federal register, and payment impact file made in the Inpatient Hospital Fee Schedule updates by Administrative Director, to section 9789.25.

Necessity: This amendment is necessary to make the Inpatient Hospital Fee Schedule regulations more readable and understandable.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.22(k):

Specific Purpose: This amendment changes the numbering of current subdivision (h) to subdivision (k) and moves references to the federal regulation, federal register, and payment impact file made in the Inpatient Hospital Fee Schedule updates by Administrative Director, to section 9789.25.

Necessity: This amendment is necessary to make the Inpatient Hospital Fee Schedule regulations more readable and understandable.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.22(l):

Specific Purpose: This amendment changes the numbering of current subdivision (i) to subdivision (l), moves references to the federal regulation, federal register, and payment impact file made in the Inpatient Hospital Fee Schedule updates by Administrative Director, to section 9789.25, substitutes “hospital” for “health facility”, and makes minor changes to formatting and to citations to conform to changes made in this regulation. In conformance with changes being made to payment methodologies for complex spinal surgery cases, this subdivision is amended to allow the hospital to receive the additional allowances for spinal hardware in accordance with either sections 9789.22(g) or (h) and

new technology pass-through in accordance with section 9789.22(j) for the first day of the stay in the transferring hospital, in addition to being reimbursed at twice the per diem amount.

Necessity: This amendment is necessary to make the Inpatient Hospital Fee Schedule regulations more readable and understandable, and to be in conformance with sections 9789.21(l), 9789.22(g), (h), and 9789.22(j).

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.22(m):

Specific Purpose: This amendment changes the numbering of current subdivision (j) to subdivision (m), moves references to the federal regulation, federal register, and payment impact file made in the Inpatient Hospital Fee Schedule updates by Administrative Director, to section 9789.25, substitutes “hospital” for “health facility”, and makes minor changes to formatting and citations to conform to changes made in this regulation.

Necessity: This amendment is necessary to make the Inpatient Hospital Fee Schedule regulations more readable and understandable, and to be in conformance with changes made to other sections of this regulation.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.22(n):

Specific Purpose: This amendment changes the numbering of current subdivision (k) to subdivision (n), substitutes “hospital” for “health facility”, and changes the information a hospital is required to submit when requesting the Division of Workers’ Compensation to provide them with a hospital specific composite factor or hospital specific outlier factor for discharges occurring on or after December 15, 2010. This amendment requires the hospital to provide the Division of Workers’ Compensation with the Medicare provider number, physical location, county code, hospital specific operating and capital cost-to-charge ratios, and DSH and/or IME adjustments, if applicable.

Necessity: This amendment is necessary to make the Inpatient Hospital Fee Schedule regulations more readable and understandable, and to conform with changes made to section 9789.21(l). The information required to be submitted by a hospital requesting the Division to provide them with a hospital specific composite factor and outlier factor is the necessary for the Division to compute the hospital’s composite and outlier factors.

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

Section 9789.22(o):

Specific Purpose: This amendment changes the numbering of current subdivision (l) to subdivision (o) and substitutes “hospital” for “health facility”.

Necessity: This amendment is necessary to make the Inpatient Hospital Fee Schedule regulations more readable and understandable, and to conform with changes made to section 9789.21(l).

Consideration of Alternatives: At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed amended subdivision.

SECTION 9789.25-Federal Regulations, Federal Register Notices, and Payment Impact File by Date of Discharge

Specific Purpose:

This section is added to provide the updates to the federal regulation, federal register, and payment impact file references made in the Inpatient Hospital Fee Schedule updates by Order of the Administrative Director, in order to conform to changes in the Medicare payment system as required by Labor Code section 5307.1.

Subdivision (a) lists the federal regulations by date of discharge that are referenced in the Inpatient Hospital Fee Schedule updates and are incorporated by reference.

Subdivision (b) lists the federal register notices by date of discharge that are referenced in the Inpatient Hospital Fee Schedule updates and are incorporated by reference.

Subdivision (c) lists the payment impact file by date of discharge referenced in the Inpatient Hospital Fee Schedule updates and are incorporated by reference.

Necessity:

All references to a federal regulation, federal register, or payment impact file made in an Inpatient Hospital Fee Schedule update (by Administrative Order) are moved to this section, so the other sections of the regulation will be more readable and understandable.

Consideration of Alternatives:

At this time, the Administrative Director has not identified any more effective nor any equally effective yet less burdensome alternative to the proposed added section.