California Code of Regulations
Title 8, Division 1, Chapter 4.5, Subchapter 1, Article 5.5

§9792.1 - Payment of Inpatient Services of Health Facilities.

(a) Maximum reimbursement for inpatient medical services shall be determined by multiplying 1.20 by the product of the health facility's composite factor and the applicable DRG weight or revised DRG weight if a revised weight has been adopted by the administrative director. The fee determined under this subdivision shall be a global fee, constituting the maximum reimbursement to a health facility for inpatient medical services not exempted under this section. However, preadmission services rendered by a health facility more than 24 hours before admission are separately reimbursable.

(b) Health facilities billing for fees under this section shall present with their bill the name and address of the facility, the facility's Medicare ID number, and the applicable DRG codes.

(c) The following are exempt from the maximum reimbursement formula set forth in subdivision (a):

(1) Inpatient services for admissions where the length of stay exceeds the day outlier threshold established by the Health Care Financing Administration for the diagnosis-related group.

(2) Inpatient services for the following diagnoses: Psychiatry (DRGs 424-432), Substance Abuse (DRGs 433-437), Organ Transplants (DRGs 103, 302, 480, 481, 495), Rehabilitation (DRG 462 and inpatient rehabilitation services provided in any rehabilitation center that is authorized by the Department of Health Services in accordance with Title 22, §§ 70301 - 70603 of the California Code of Regulations to provide rehabilitation services), Tracheostomies (DRGs 482, 483), and Burns (DRGs 456-460, 472, 475).

(3) Inpatient services provided by a Level I or Level II trauma center, as defined in Title 22, California Code of Regulations sections 100260, 100261, to a patient with an immediately life threatening or urgent injury.

(4) Inpatient services provided by a health facility for which there is no composite factor.

(5) Inpatient services provided by a health facility located outside the State of California.

(6) The cost of durable medical equipment provided for use at home.

(7) Inpatient services provided by a health facility transferring an inpatient to another hospital. Maximum reimbursement for inpatient medical services of a health facility transferring an inpatient to another hospital shall be a per diem rate for each day of

the patient's stay in that hospital, not to exceed the amount that would have been paid under Title 8, California Code of Regulations §9792.1(a). However, the first day of the stay in the transferring hospital shall be reimbursed at twice the per diem amount. The per diem rate is determined by dividing the maximum reimbursement as determined under Title 8, California Code of Regulations §9792.1(a) by the average length of stay for that specific DRG. However, if an admission to a health facility transferring a patient is exempt from the maximum reimbursement formula set forth in subdivision (a) because it satisfies one or more of the requirements of Title 8, California Code of Regulations §9792.1(c)(1) through (c)(5), subdivision (c)(7) shall not apply. Inpatient services provided by the hospital receiving the patient shall be reimbursed under the provisions of Title 8, California Code of Regulations §9792.1(a).

(8) Implantable hardware and/or instrumentation for DRGs 496 through 500, where the admission occurs on or after April 13, 2001. Implantable hardware and/or instrumentation for DRGs 496 through 500, where the admission occurs on or after April 13, 2001, shall be separately reimbursed at the provider's documented paid cost, plus an additional 10% of the provider's documented paid cost not to exceed a maximum of $250.00, plus any sales tax and/or shipping and handling charges actually paid.

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

(e) This section, except as provided in subsection (c)(8), shall apply to covered inpatient hospital stays for which the day of admittance is on or after April 1, 1999.

(f) Subsection (c)(8) shall remain in effect only through December 31, 2001, and shall not apply to admissions occurring on or after January 1, 2002.

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