

- (b) For each subgroup in DRG 386 as described in paragraphs (B)(3) to (B)(3)(b) of this rule, and for each subgroup of DRG 387 as described in paragraphs (B)(4) to (B)(4)(b) of this rule, the geometric mean charge was calculated.
- (c) For DRGs 388, 389, and 390, the geometric mean charge was calculated three times to determine a geometric mean charge specific to hospitals with a level I nursery, hospitals with a level II nursery, and hospitals with a level III nursery. For example, three geometric mean charges were calculated for DRG 388, one reflecting data from hospitals with a level I nursery; one reflecting data from hospitals with a level II nursery; and one reflecting data from hospitals with a level III nursery.
- (d) For DRGs 425 to 435, two geometric mean charges were calculated for each DRG in this category. One geometric mean charge was calculated using the charge for each case within these DRGs from hospitals which have a psychiatric unit distinct part. A "psychiatric unit distinct part" is one which is recognized and excluded from the prospective payment system under medicare as described in rule 5101:3-2-02 of the Administrative Code and where the hospital has notified the department of medicare's certification and the change was implemented in the system prior to June 30, 1996. A second geometric mean charge was calculated for each DRG 425 to 435 using data from all other hospitals (hospitals which do not have a recognized psychiatric unit distinct part under medicare). In accordance with rule 5101:3-2-03 of the Administrative Code, the department does not pay for DRG 436 and DRG 437.
- (e) No cases were grouped by the medicare fiscal year 1998 ~~1993~~ grouper into DRGs 6, 275, 306, 307, 314, 319, 329, 330, 342, 347, 349, 351, 411, 412, 457, and 465. The geometric mean charge for these DRGs is the geometric mean charge that was used for these DRGs prior to the effective date of this rule.
- (2) Calculation of the statewide geometric mean length of stay for each DRG.
- (a) For DRGs 1 to 385, 391 to 424, 439 to 503 ~~490~~, the geometric mean length of stay was calculated using all cases within each of these DRGs as determined in paragraph (C) of this rule.
- (b) For each subgroup in DRG 386 as described in paragraphs (B)(3) to (B)(3)(b) of this rule and for each subgroup of DRG 387 as described in paragraphs (B)(4) to (B)(4)(b) of this rule, the geometric mean length of stay was calculated.
- (c) For DRGs 388, 389, and 390, the geometric mean length of stay was calculated three times to determine geometric mean length of stay specific to hospitals with a level I nursery, hospitals with a level II nursery, and hospitals with a level III nursery. For example, three geometric mean lengths of stay were calculated for DRG 388; one geometric mean length of stay was calculated using all cases in

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DRG 388 within a hospital which has a level I nursery; one geometric mean length of stay was calculated based on data from hospitals with a level II nursery; and one geometric mean length of stay was calculated based on data from hospitals with a level III nursery.

- (d) For DRGs 425 to 435, the geometric mean length of stay was calculated two times for each of these DRGs to reflect the difference in the geometric mean length of stay in hospitals with and without psychiatric unit distinct parts. To determine the geometric mean length of stay for cases treated in hospitals with no distinct part psychiatric unit, the geometric mean length of stay was calculated using all cases in these hospitals. To determine the geometric mean length of stay for cases in hospitals with psychiatric unit distinct parts, the geometric mean length of stay was calculated using all cases in these hospitals.
- (e) No cases were grouped by the medicare fiscal year 1998 ~~1993~~ grouper into DRGs 6, 275, 306, 307, 314, 319, 329, 330, 342, 347, 349, 351, 411, 412, 457, and 465. The geometric mean length of stay for these DRGs is the geometric mean length of stay that was used for these DRGs prior to the effective date of this rule.
- (3) Deletion of outlier cases.
- (a) For each DRG and each subgroup within DRGs 386 to 390 and 425 to 435, a standard deviation for charge and length of stay was calculated based upon the cases used in the calculation of the geometric mean as described in paragraphs(D)(1) to (D)(2)(d) of this rule.
- (b) Cases which had charges or reflected a length of stay that was two standard deviations above the geometric mean as calculated in paragraphs (D)(1) to (D)(2)(d) of this rule were deleted except for DRGs 385 to 390. For DRGs 385 to 390 cases which had charges or reflected a length of stay that is one standard deviation above the geometric mean as calculated in paragraphs (D)(1) to (D)(2)(d) of this rule were deleted.
- (4) Recalculation of geometric mean length of stay and geometric mean charge for each DRG and subgroups in DRGs 386 to 390 and 425 to 435 was done excluding outlier cases as described in paragraphs (D)(3)(a) and (D)(3)(b) of this rule.
- (5) Computation of the arithmetic mean charge for each DRG.

Computation of the arithmetic mean charge for each DRG and subgroups was calculated using all cases as described in paragraphs (C)(1) to (C)(2)(b) of this rule, excluding outlier cases, as described in paragraphs (D)(3)(a) and (D)(3)(b) of this rule.

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- (a) For DRGs 1 to 385, 391 to 424, and 439 to ~~503~~ 490, the arithmetic mean charge was determined for each of these DRGs using the total Charge per case for each DRG for all hospitals excluding outlier cases.
- (b) For each subgroup in DRG 386 as described in paragraphs (B)(3) to (B)(3)(b) of this rule, and for each subgroup of DRG 387 as described in paragraphs (B)(4) to (B)(4)(b) of this rule, the arithmetic mean Charge was determined excluding outlier cases.
- (c) For DRGs 388, 389, and 390, three separate arithmetic means were calculated for each DRG using data specific to either hospitals with a level I nursery, with a level II nursery, or hospitals with a level III nursery unit. In each instance, the claims used within a DRG, and within a specific level nursery, excluded outlier cases.
- (d) For DRGs 425 to ~~435~~ 437, two arithmetic mean charges were calculated for each DRG in this category. One arithmetic mean charge was calculated using the total charge for each case within these DRGs, excluding outlier cases, from hospitals which had a psychiatric unit distinct part. A second arithmetic mean Charge was calculated for DRGs 425 to ~~435~~ 437 using data, excluding outlier cases, from all other hospitals (hospitals which did not have a recognized psychiatric unit distinct part under medicare).
- (e) No cases were grouped by the medicare fiscal year ~~1998~~ 1993 grouper into DRGs ~~6, 275, 306, 307, 314, 319, 329, 330, 342, 347, 349, 351, 411, 412, 457,~~ and 465. The arithmetic mean charge for these DRGs is the arithmetic mean charge that was used for these DRGs prior to the effective date of this rule.

~~(6) Calculation of the statewide arithmetic mean charge per discharge.~~

~~The statewide arithmetic mean charge per discharge was calculated using the total allowable charge for all cases used in the calculation described in paragraphs (D)(5) to (D)(5)(d) of this rule.~~

~~(7) Computation of the relative weight for each DRG and DRG subgroups.~~

(6) Calculation of the statewide arithmetic mean charge per discharge.

The statewide arithmetic mean charge per discharge was calculated using the total allowable charge for all cases used in the calculation described in paragraphs (D)(5) to (D)(5)(d) of this rule.

(7) Computation of the relative weight for each DRG and DRG subgroups.

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The relative weight of each DRG is a function of the relationship between the arithmetic mean charge per DRG and DRG subgroups and the arithmetic mean charge across all cases. To determine the relative weight, the arithmetic mean charge for each DRG and DRG subgroup calculated as described in paragraphs (D)(5)(a) to (D)(5)(d) of this rule was divided by the statewide arithmetic mean charge per discharge as described in paragraph (D)(6) of this rule.

(E) Relative weights for small cell DRGs.

When ten or less claims grouped into a DRG, the department established relative weights taking into consideration the weights that previously were used for the DRG, AS WELL AS THE DRG CASE MIX. The relative weights, as found in Appendix A of this rule, were established for these infrequent DRGs; WHEN TEN OR LESS CLAIMS GROUPED INTO A NEW DRG, THE DEPARTMENT USED RELATIVE WEIGHTS CURRENTLY USED BY MEDICARE.

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LOW VOLUME RELATIVE WEIGHTS  
DRG RELATIVE WEIGHT

6	0.72008
9	1.87150
22	2.07037
38	0.58622
39	1.08186
40	1.06323
51	0.79258
56	0.67207
59	0.54530
61	1.29872
72	0.90629
86	0.88336
103	20.86350
117	1.77863
118	3.33083
194	1.78049
199	3.13416
201	3.45416
232	1.54798
246	0.51262
262	0.85388
275	0.58483
268	0.92016
291	0.60217
293	2.10199
306	2.69508
307	2.03966
312	1.12544
313	0.82681
314	0.64883
317	0.43421
319	0.67612
327	0.56921
328	0.85594
329	0.63439
330	0.54521
334	2.57398
335	2.26150
338	1.74693
339	0.97021
342	0.63254
343	0.41282
344	3.65732
345	1.09993

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LOW VOLUME RELATIVE WEIGHTS  
DRG RELATIVE WEIGHT

346	1.56107
347	1.10284
348	0.69172
349	0.77441
351	0.49131
362	0.66552
402	1.25889
407	2.51142
411	0.67401
412	0.90919
432.1	1.16245
441	1.25240
456	1.06062
457	3.29358
465	0.58758
476	3.99415
496	5.67340
501	2.84460

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EFFECTIVE DATE: 2/1/00

RULE REVIEW: \_\_\_\_\_

CERTIFICATION: \_\_\_\_\_

\_\_\_\_\_

DATE

Promulgated Under RC Chapter 119.

Statutory Authority RC Section 5111.02

Rule Amplifies RC Sections 5111.01 and 5111.02

Prior Effective Dates: 10/4/84, 7/3/86, 10/19/87, 9/3/91 (Emer.), 11/10/91, 1/20/95, 1/1/98

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 Supersedes  
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Approval Date: MAY 25 2000  
 Effective Date: 2-1-00

5101:3-2-074 Basic methodology for determining prospective payment rates.

(A) General description.

Except as provided in paragraph (B) of this rule, in computing the payment rate, the average cost per discharge determined and adjusted as described in paragraphs (D) to (G)(3)(b) of this rule is multiplied by the relative weight for the DRG as described in rule 5101:3-2-073 of the Administrative Code. Applicable allowances for capital and medical education, as described in this rule, are added after the average cost per discharge component is multiplied by the relative weight. The components of the prospective payment rates for each recipient discharged from a hospital are:

- (1) The DRG assigned to that discharge;
- (2) The adjusted inflated average cost per discharge component described in paragraphs (D) to (G)(3)(b) of this rule;
- (3) Relative weights defined in rule 5101:3-2-073 of the Administrative Code for each DRG;
- (4) An allowance for capital described in rule 5101:3-2-076 of the Administrative Code;
- (5) For certain hospitals, a medical education allowance as described in rule 5101:3-2-077 of the Administrative Code.

(B) Payment rates.

Payment rates consist of the components described in paragraphs (A) to (A)(5) of this rule, subject to special payment provisions for certain types of cases, as described in rules 5101:3-2-079 and 5101:3-2-0711 of the Administrative Code.

(C) Determination of average cost per discharge component.

- (1) For children's hospitals as defined in rule 5101:3-2-072 of the Administrative Code, the average cost per discharge component is one hundred per cent hospital specific and is determined in accordance with paragraphs (D) to (G)(3)(b) of this rule.
- (2) For out-of-state hospitals for discharges on or after July 1, 1990, the average cost per discharge component is determined in accordance with the methodology described in paragraphs (C)(1) to (C)(3)(b) of rule 5101:3-2-072 of the Administrative Code.
- (3) For hospitals other than those identified in paragraphs (C)(1) and (C)(2) of this rule, the average cost per discharge component will be one hundred per cent of the peer group average costs per discharge determined in accordance with paragraphs (E) to (G)(3)(a) of this rule using the peer groups defined in rule 5101:3-2-072 of the Administrative Code.

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## (D) Calculation of hospital-specific adjusted average cost per discharge.

Unless otherwise indicated, two types of source documents are used to obtain information needed to calculate the hospital-specific average cost per discharge defined in this rule. Those documents are the ODHS 2930 "Cost Report" and the HCFA 2552-85, as submitted to the department as required in rule 5101:3-2-23 of the Administrative Code. The ODHS 2930 will be adjusted by the department in accordance with rules 5101:3-2-22, 5101:3-2-23, and 5101:3-2-24 of the Administrative Code using data made available to the department as of June 15, 1987. The documents used are those reflecting costs associated with the hospital's 1985 or 1986 fiscal year reporting period. For purposes of this rule, the 1985 cost report will be used for those hospitals with fiscal periods ending September thirtieth, October thirty-first, or December thirty-first; the 1986 cost report will be used for those hospitals with fiscal periods ending March thirty-first, May thirty-first, June thirtieth, or August thirty-first. The hospital-specific average cost per discharge component is calculated in accordance with the provisions set forth in paragraphs (D)(1) to (D)(13) of this rule.

- (1) For those hospitals that have merged since the end of the fiscal year period specified in paragraph (D) of this rule and had the same fiscal reporting period, the cost reports for the hospitals will be combined. ODHS will combine the total cost, total charges, total days, medicaid charges, and medicaid discharges for the hospitals. A new report will be prepared by ODHS for the merged hospital.
- (2) For those hospitals that have merged since the end of the fiscal year period specified in paragraph (D) of this rule and had different fiscal reporting periods, the procedures described in paragraphs (D)(3) to (D)(13)(d) of this rule will be followed. At that point, the average cost per discharge for the hospitals will be combined by:
  - (a) Multiplying the average cost per discharge for each hospital derived from paragraph (D)(12)(g) of this rule, as applicable, by the number of discharges for each hospital derived from paragraph (D)(11)(a) of this rule. Round the result to the nearest whole dollar.
  - (b) Sum the products.
  - (c) Divide the resulting sum by the sum of the hospital's discharges. Round the result to the nearest whole penny.

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- (3) The case-mix computation for merged providers will be performed by combining the hospital's claim records as described in paragraphs (D)(13) to (D)(13)(d) of this rule.
- (4) Determination of medicaid inpatient cost adjusted to remove the cost of blood replaced by patient donors.
- (a) Identify medicaid inpatient service cost on ODHS 2930, schedule H, section I, line 1, column 12.
- (b) Identify cost of blood replaced by donor for medicaid inpatients on ODHS 2930, schedule H, section I, line 2, column 12.
- (c) Subtract the amount identified in paragraph (D)(4)(b) of this rule from the amount identified in paragraph (D)(4)(a) of this rule.
- (5) Determination of medicaid inpatient cost adjusted to include PSRO/UR cost separately identified.
- (a) Identify PSRO/UR cost on ODHS 2930, schedule H, section I, line 3, column 12.
- (b) Add the amount derived from paragraph (D)(5)(a) of this rule to the amount described in paragraph (D)(4)(c) of this rule.
- (6) Determination of medicaid inpatient cost adjusted to include the cost of malpractice insurance.
- (a) Identify the hospital's malpractice insurance premium cost on HCFA 2552-85, worksheet D-8, part II, line 11, for the hospital's fiscal reporting period ending in 1986.
- (b) Compute the hospital's per cent of medicaid inpatient charges to total charges.
- (i) Identify medicaid inpatient charges on ODHS 2930, schedule H, section I, line 11, column 12.
- (ii) Identify total charges for all patients on ODHS 2930, schedule A, line 101B, column 1.

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- (iii) Divide the amount identified in paragraph (D)(6)(b)(i) of this rule by the amount identified in paragraph (D)(6)(b)(ii) of this rule. Round the result to six decimal places.
  - (c) For those hospitals whose fiscal year ends on or prior to December 31, 1985, divide the amount identified in paragraph (D)(6)(a) of this rule by the appropriate deflation factor described in paragraph (G)(1) of this rule. Round to the nearest whole dollar.
  - (d) Multiply the amount identified in paragraph (D)(6)(a) or (D)(6)(c) of this rule, as applicable, by the percentage derived from paragraph (D)(6)(b)(iii) of this rule. Round the result to the nearest dollar.
  - (e) Add the amount computed in paragraph (D)(6)(d) of this rule to the amount derived in paragraph (D)(5)(b) of this rule.
- (7) Determination of medicaid inpatient cost adjusted to remove the direct cost of medical education.
- (a) Identify the hospital direct medical education on the HCFA 2552-85, worksheet B, part I, line 95, columns 20, 21, 22, 23, and 24.
  - (b) Multiply the sum of the amounts in paragraph (D)(7)(a) of this rule by the percentage derived from paragraph (D)(6)(b)(iii) of this rule. Round the result to the nearest dollar.
  - (c) Subtract the amount computed in paragraph (D)(7)(b) of this rule from the amount computed in paragraph (D)(6)(e) of this rule.
- (8) Determination of medicaid inpatient cost adjusted to remove capital-related cost.
- (a) Identify the hospital capital-related cost on the HCFA 2552-85, worksheet B, part II, line 95, column 25.
  - (b) Multiply the amount in paragraph (D)(8)(a) of this rule by the percentage derived from paragraph (D)(6)(b)(iii) of this rule. Round the result to the nearest dollar.
  - (c) Subtract the amount derived from paragraph (D)(8)(b) of this rule from the amount derived from paragraph (D)(7)(c) of this rule.

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Approval Date: \_\_\_\_\_  
 Effective Date: 1-1-00