

(C)(5) of this rule is the final prospective payment rate as described in paragraph (I) of rule 5101:3-2-074 of the Administrative Code, plus the outlier amount. For discharges on or after October 19, 1987, if the total payment exceeds allowable charges, reimbursement is limited to allowable charges. For discharges on or after July 1, 1990, total reimbursement is limited to the lower of allowable claim charges or claim cost. Claim cost is calculated by multiplying allowable claim charges by the hospital specific, medicaid inpatient cost-to-charge ratio, as described in paragraph (B)(2) of rule 5101:3-2-22 of the Administrative Code.

- (5) For hospitals meeting the criteria described in paragraphs (E)(1) and (E)(2) of this rule, payment for cost outlier claims with discharge dates on or after July 1, 1990, will be eighty-five per cent of the product of allowed claim charges times the hospital-specific, medicaid inpatient cost-to-charge ratio as described in paragraph (B)(2) of rule 5101:3-2-22 of the Administrative Code.
- (6) For hospitals meeting the criteria described in paragraph (G) of this rule, payment for cost outlier claims with discharge dates on or after the effective date of this rule will be eighty-five per cent of the product of allowed claim charges times the hospital-specific, medicaid inpatient cost-to-charge ratio as described in paragraph (B)(2) of rule 5101:3-2-22 of the Administrative Code for cases grouping into DRG 488, DRG 489, or DRG 490.
- (D) For admissions on or after October 19, 1987, cases that meet the criteria described in paragraph (A)(7) of this rule will be paid the product of the hospital's allowable charges times the hospital-specific cost-to-charge ratio, as described in paragraph (B)(2) of rule 5101:3-2-22 of the Administrative Code.
- (E) Hospitals that meet the criteria described in paragraphs (E)(1) and (E)(2) of this rule are subject to the special outlier payment policies described in paragraphs (A)(5)(b), (B)(3), and (C)(3) of this rule for discharges on or after February 1, 1988.

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- (1) The hospital-specific outlier per cent as described in paragraph (F)(2)(b) of rule 5101:3-2-074 of the Administrative Code is greater than one standard deviation over the statewide mean outlier per cent as described in paragraph (F)(2)(c) of rule 5101:3-2-074 of the Administrative Code.
 - (2) The hospital's ratio of medicaid, general assistance and Title V inpatient days to total inpatient days as described in paragraph (F)(1)(b) of this rule is greater than one standard deviation above the statewide mean ratio of medicaid, general assistance, and Title V inpatient days to total inpatient days as described in paragraph (F)(2)(c) of this rule.
- (F) The calculations described in paragraphs (F)(1) to (F)(2)(c) of this rule will be performed using ODHS 2930 cost-report data submitted by hospitals as described in rule 5101:3-2-23 of the Administrative Code. For hospitals with fiscal periods ending September thirtieth, October thirty-first, or December thirty-first, the 1985 cost-report is used. For hospitals with fiscal periods ending March thirty-first, May thirty-first, June thirtieth, or August thirty-first, the 1986 cost report is used.
- (1) Determination of each hospital's ratio of medicaid, general assistance, and Title V inpatient days to total inpatient days.
 - (a) Sum the number of days shown on the ODHS 2930, schedule D, section 1, column 6, total, for medicaid, general assistance, and Title V schedules.
 - (b) Divide the sum derived from paragraph (F)(1)(a) of this rule by total inpatient days as reported on the ODHS 2930, schedule D, section 1, column 4, total. Round to six decimal places.
 - (2) Determination of one standard deviation above the statewide mean ratio of medicaid, general assistance, and Title V inpatient days to total inpatient days.
 - (a) Sum the ratios derived from paragraph (F)(1)(b) of this rule across all Ohio hospitals. Divide the resulting sum by the number of hospitals to determine the statewide mean ratio.

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- (b) Determine the value of one standard deviation above the statewide mean ratio. Round the ratio to six decimal places.
 - (c) Sum the values calculated as described in paragraphs (F)(2)(a) and (F)(2)(b) of this rule to determine the value of one standard deviation above the statewide mean ratio of medicaid, general assistance, and Title V inpatient days to total inpatient days.
- (G) Hospitals whose total number of cases in the claim files used for setting relative weights in accordance with rule 5101:3-2-073 of the Administrative Code that group into DRG 488, DRG 489, or DRG 490 is greater than two standard deviations above the statewide mean for all cases that fall into these DRGs, as described in paragraphs (G)(1)(a) to (G)(1)(c) of this rule, are subject to the special outlier payment policies described in paragraphs (A)(6), (B)(5), and (C)(6) of this rule for discharges on or after the effective date of this rule.
- (1) Determination of two standard deviations above the statewide mean total cases that group into DRG 488, DRG 489, or DRG 490.
 - (a) Sum the number of cases that group into DRG 488, DRG 489, and DRG 490 using the claim base described in paragraphs (C) to (C)(2)(b) of rule 5101:3-2-073 of the Administrative Code. Divide the resulting sum by the number of hospitals which had any claim group into DRG 488, DRG 489, or DRG 490.
 - (b) Determine the value of two standard deviations above the statewide mean number of cases.
 - (c) Sum the values calculated as described in paragraphs (G)(1)(a) and (G)(1)(b) of this rule to determine the value of two standard deviations above the statewide mean total number of cases in DRG 488, DRG 489, DRG 490.

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EFFECTIVE DATE: ~~JAN 20 1995~~
CERTIFICATION: Donald R. Touff
JAN 10 1995
DATE

Promulgated Under RC Chapter 119.
Statutory Authority RC Section 5111.02
Rule Amplifies RC Sections 5111.01 and 5111.02

Prior Effective Dates: 10/1/84, 7/3/86, 10/19/87, 2/1/88
(Emer.), 4/18/88, 7/1/89, 6/29/90
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5101:3-2-0710 Definitions of readmissions, transfers, and discharges.

(A) Transfers.

A hospital inpatient is "transferred" when the patient has been moved from a hospital which receives payment under the department's prospective payment system to any other hospital, including state psychiatric facilities.

(B) Readmissions.

For hospitals paid under the prospective system, a "readmission" is an admission to the same institution within thirty days of discharge.

(C) Discharges.

A patient is said to be "discharged" when he or she:

- (1) Is formally released from a hospital;
- (2) Dies while hospitalized;
- (3) IS DISCHARGED, WITHIN THE SAME HOSPITAL, FROM AN ACUTE CARE BED AND ADMITTED TO A BED IN A PSYCHIATRIC UNIT DISTINCT PART AS DESCRIBED IN PARAGRAPH (B)(8) OF RULE 5101:3-2-02 OF THE ADMINISTRATIVE CODE OR IS DISCHARGED WITHIN THE SAME HOSPITAL, FROM A BED IN A PSYCHIATRIC UNIT DISTINCT PART TO AN ACUTE CARE BED. ~~Is transferred from an acute care hospital unit to a psychiatric distinct part unit recognized by medicare as excluded from medicare prospective payment system when both units are within the same hospital.~~ Rule 5101:3-2-0711 of the Administrative Code explains the payment methodology for this type of a discharge; or
- (4) Signs self out against medical advice (AMA).

JUL 01 1990

EFFECTIVE DATE:

Roland F. Hairston

CERTIFICATION:

JUN 21 1990

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5101:3-2-0711

Payment methodology.

(A) Payments under the prospective payment system.

For inpatient hospitals subject to prospective payment as described in rule 5101:3-2-071 of the Administrative Code, payments are made on the basis of a prospectively determined rate as provided in rule 5101:3-2-074 of the Administrative Code. Additional payments for cases which qualify as outliers are described in rule 5101:3-2-079 of the Administrative Code. Additional payments may be made for services described in accordance with paragraph (C) of rule 5101:3-2-071 of the Administrative Code. The amount paid represents final payment based on a submission of a discharge bill. No year-end retrospective adjustment is made for prospective payment except as provided in rules 5101:3-2-078 and 5101:3-2-24 of the Administrative Code. Except as provided in rules 5101:3-2-24, 5101:3-2-0713, and 5101:3-2-42 of the Administrative Code, a hospital may keep the difference between its prospective payment rate and costs incurred in furnishing inpatient services and is at risk for costs which exceed the prospective payment amounts.

(B) Amounts of payment, including all components of the prospective payment rate, DRG categories and relative weights associated with such categories, identification of outlier cases and payment methods for outliers, transfers and readmissions, and other provisions affecting amounts of payment are based on applying the provisions of this chapter to claims associated with dates of discharge on or after the effective dates of the rules in this chapter, unless otherwise specified.

(C) Hospitals must submit a claim for payment only upon a recipient's final discharge as defined in rule 5101:3-2-02 of the Administrative Code including those discharges which meet the criteria for outlier payments defined in rule 5101:3-2-079 of the Administrative Code unless the claim qualifies for interim billing as described in paragraph (C)(3) of this rule. Transfers and readmissions are defined and paid in accordance with the provisions of this rule. The department shall assign a DRG by using the DRG "grouper," modified as described in this paragraph. For discharges on or after FEBRUARY 1, 2000 ~~January 1, 1995~~, the department uses the "grouper" distributed by "Health Services, Incorporated," a software package used by medicare during federal fiscal year 1998-1999 ~~1998-1999~~. A listing of DRG classifications is shown in appendix A of this rule. The relative weights assigned are those described in rule 5101:3-2-073 of the Administrative Code.

Cases which would be classified in DRG 385 or DRG 456 because of a transfer or death, but which involve a length of stay greater than fifteen days, are classified in the DRG which is otherwise appropriate if the transfer or death is not considered. For cases classified into DRG 386, two subgroups are created based upon the ICD-9-CM code. One subgroup is determined by cases which have ICD-9-CM code 765.0 ~~7650~~ listed as one of its diagnoses. The second subgroup is comprised of those cases that are grouped into DRG 386, but do not have 765.0 ~~7650~~ listed as a diagnosis. In accordance with rule 5101:3-2-073 of the

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Administrative Code, different relative weights are assigned to the second DRG 386 subgroup depending on whether one, the hospital operates a level I or level II nursery, or two, a level III nursery. For cases classified into DRG 387, two subgroups are created based upon birthweight. Infants with weights of zero to one thousand seven hundred fifty grams are grouped into one subgroup and infants with weights of one thousand seven hundred fifty-one grams and above are grouped into another subgroup. In accordance with rule 5101:3-2-073 of the Administrative Code, different relative weights are assigned to each DRG 387 subgroup depending on whether one, the hospital operates a level I or II nursery, or two, a level III nursery.

Prior to submitting a claim to the DRG "Grouper," each claim will be submitted to the medicare clinical editor to ensure that the information on the claim is complete and consistent (~~see rule 5101:3-2-073 of the Administrative Code for a description of the medicare "Clinical Editor"~~). Each discharge will be assigned to only one DRG regardless of the number of conditions treated or services furnished by a hospital, except as provided in paragraph (C)(1) of this rule.

- (1) For inpatient services provided to patients who are discharged, within the same hospital, from an acute care bed and admitted to a bed in a psychiatric unit distinct part, payment will be made based on the DRG representing services provided in the acute care section and the services provided in the psychiatric unit distinct part if the services are assigned to DRGs 425 to 435. If the services provided in both the acute care section and the psychiatric unit distinct part are assigned to any combination of DRGs 425 to 435, payment will be made only for that DRG assigned as a result of the information on a claim submitted by the hospital for services provided from the date of admission to the hospital through the date of discharge or transfer from the hospital. If separate claims are submitted for any combination of DRGs 425 to 435, only the first claim processed will be paid. In order to receive payment for the entire period of hospitalization, the hospital will need to submit an adjustment claim reflecting services and charges for the entire hospitalization.

In accordance with rule 5101:3-2-03 of the Administrative Code, no coverage is available for days of inpatient care which occur solely for the provision of rehabilitation services related to a chemical dependency. Therefore, ICD-9-CM procedure codes which must be present for a claim to group to either DRG 436 or 437, will not be submitted to the DRG "grouper."

- (2) For claims with discharge dates after September 3, 1991 which are rejected by the clinical editor as a result of an age, diagnosis code conflict, and the accuracy of the information contained on the claim is confirmed by the hospital, the prospective payment amount will be eighty-five per cent of the product of allowed claim

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charges times the hospital-specific, medicaid inpatient cost-to-charge ratio as described in paragraph (B)(2) of rule 5101:3-2-22 of the Administrative Code.

(3) A claim for inpatient services qualifies for interim payment on the thirtieth day of a consecutive inpatient stay and at thirty-day intervals thereafter. Under interim payment, hospitals will be paid on a percentage basis of charges. The percentage will represent the hospital-specific cost-to-charge ratio as described in paragraph (B)(2) of rule 5101:3-2-22 of the Administrative Code. For those hospitals which are not required to file a cost report under the provisions of rule 5101:3-2-23 of the Administrative Code, the statewide average inpatient cost-to-charge ratio as described in paragraph (B)(2) of rule 5101:3-2-22 of the Administrative Code will be used. Interim payments are made as a credit against final payment of the final discharge bill. Amounts of difference between interim payment made and the prospective payment described in paragraph (A) of this rule for the final discharge will be reconciled when the final discharge bill is processed.

(D) Payments for transfers as defined in rule 5101:3-2-02 of the Administrative Code are subject to the provisions of paragraphs (D)(1) and (D)(2) of this rule.

(1) Payment to the transferring hospital.

If a hospital paid under the prospective payment system transfers an inpatient to another hospital and that transfer is appropriate as defined in rule 5101:3-2-0713 of the Administrative Code, then the transferring hospital is paid a per diem rate for each day of the patient's stay in that hospital, plus capital and teaching allowances, as applicable, not to exceed, for nonoutlier cases, the final prospective payment rate that would have been paid for the appropriate DRG as described in paragraph (I) of rule 5101:3-2-074 of the Administrative Code, except when that case is grouped into DRG 385 or DRG 456. Cases which are grouped into DRG 385 or DRG 456 are paid the full DRG payment in accordance with rule 5101:3-2-074 of the Administrative Code. Except for DRG 385 and DRG 456, when a patient is transferred, the department's payment is based on the DRG under which the patient was treated at each hospital.

The per diem rate is determined by dividing the product of the hospital's adjusted inflated average cost per discharge multiplied by the DRG relative weight as described in paragraph (I) of rule 5101:3-2-074 of the Administrative Code by the statewide geometric mean length of stay calculated excluding outliers for the specific DRG as described in rule 5101:3-2-073 of the Administrative Code into which the case falls.

(2) Payment to the discharging hospital.

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A hospital which receives a transfer and subsequently discharges that individual (as defined in paragraphs (B)(14) and (B)(16) of rule 5101:3-2-02 of the Administrative Code) is paid a per diem rate for each day of the patient's stay in that hospital, plus capital and teaching allowances, as applicable, not to exceed, for nonoutlier cases, the final prospective payment rate amount that would have been paid for the appropriate DRG as described in paragraph (I) of rule 5101:3-2-074 of the Administrative Code. When a patient is transferred, the department's payment is based on the DRG under which the patient was treated at each hospital.

The per diem rate is determined by dividing the product of the hospital's adjusted inflated average cost per discharge multiplied by the DRG relative weight as described in paragraph (I) of rule 5101:3-2-074 of the Administrative Code by the geometric mean length of stay calculated excluding outliers for the specific DRG as described in rule 5101:3-2-073 of the Administrative Code into which the case falls.

(E) Outlier payments.

In addition to the payment provisions described in this rule, any hospital that is involved in discharging or transferring a patient as defined in rule 5101:3-2-02 of the Administrative Code or that provides services to a medicaid patient who is partially eligible as described in paragraph (K) of this rule may qualify for additional payments in the form of outlier payments as described in rule 5101:3-2-079 of the Administrative Code.

(F) Readmissions are defined in rule 5101:3-2-02 of the Administrative Code. A readmission within one calendar day of discharge, to the same institution, is considered to be one discharge for payment purposes so that one DRG payment is made. If two claims are submitted, the second claim processed will be rejected. In order to receive payment for the entire period of hospitalization, the hospital will need to submit an adjustment claim reflecting services and charges for the entire hospitalization.

(G) Claims for payment for inpatient hospital services must be submitted on the UB-92 as provided in rule 5101:3-2-02 of the Administrative Code and include the data essential to assignment of a DRG. Claims assigned to DRGs 468, 469, and 470 (~~as described in rule 5101:3-2-073 of the Administrative Code~~) will be DENIED DUE TO UNGROUPABLE CODING returned to the hospital to request additional information.

(H) Claims for payment for discharges that may qualify for outlier payment may be billed only after discharge unless the claim qualifies for interim billing as described in paragraph (C)(3) of this rule. The claim will be processed for payment of the appropriate DRG prospective discharge payment rate as described in paragraph (I) of rule 5101:3-2-074 of

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the Administrative Code and outlier payments as described in rule 5101:3-2-079 of the Administrative Code.

- (I) Providers must submit a new claim with a copy of the remittance statement and a completed adjustment request form as described in rule ~~5101:3-1-193~~ ~~5101:3-2-193~~ of the Administrative Code in order to adjust any claim which results in an improper assignment of a DRG or to correct any information provided.
- (J) In the case of deliveries, the department requires hospitals to submit separate UB-92 invoices based respectively on the mother's individual eligibility and the child's individual eligibility.
- (K) In instances when a recipient's eligibility begins after the date of admission to the hospital or is terminated during the course of a hospitalization, payment will be made on a per diem basis plus the allowance for capital and teaching, as applicable. The per diem payment will be determined by dividing the product of the hospital's adjusted inflated average cost per discharge multiplied by the DRG relative weight for the DRG as described in paragraph (I) of rule 5101:3-2-074 of the Administrative Code by the statewide geometric mean length of stay calculated excluding outliers for that DRG as described in rule 5101:3-2-073 of the Administrative Code. The per diem amount will be multiplied times the number of covered days for which the patient was medicaid-eligible during the hospitalization. Payment for a nonoutlier case cannot exceed the final prospective payment rate for the DRG as described in paragraph (I) of rule 5101:3-2-074 of the Administrative Code.

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