5101:3-2-07.11 **Payment methodology.**

(A) Payments under the prospective payment system.

For inpatient hospitals subject to prospective payment as described in rule 5101:3-2-07.1 of the Administrative Code, payments are made on the basis of a prospectively determined rate as provided in rule 5101:3-2-07.4 of the Administrative Code. Additional payments for cases which qualify as outliers are described in rule 5101:3-2-07.9 of the Administrative Code. ~~Additional payments may be made for services described in accordance with paragraph (C) of rule 5101:3-2-07.1 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 5101:3-2-07.8 and 5101:3-2-24 of the Administrative Code. Except as provided in rules 5101:3-2-24, 5101:3-2-07.13, 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 5101:3-2-07.9 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, the department uses the "grouper" distributed by "Health Services, Incorporated," a software package used by medicare during federal fiscal year 1998. A listing of DRG classifications is shown in appendix A of this rule. The relative weights assigned are those described in rule 5101:3-2-07.3 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 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 listed as a diagnosis. In

accordance with rule 5101:3-2-07.3 of the 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 5101:3-2-07.3 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 . 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 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 5101:3-2-07.13 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 5101:3-2-07.4 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 5101:3-2-07.4 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 5101:3-2-07.4 of the Administrative Code by the statewide geometric mean length of stay calculated excluding outliers for the specific DRG as described in rule 5101:3-2-07.3 of the Administrative Code into which the case falls.

(2) Payment to the discharging hospital.

A hospital which receives a transfer and subsequently discharges that individual (as defined in 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 5101:3-2-07.4 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 5101:3-2-07.4 of the Administrative Code by the geometric mean length of stay calculated excluding outliers for the specific DRG as described in rule 5101:3-2-07.3 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 5101:3-2-07.9 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 469, and 470 will be denied due to ungroupable coding.

(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 5101:3-2-07.4 of the Administrative Code and outlier payments as described in rule 5101:3-2-07.9 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 5101:3-1-19.3 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 5101:3-2-07.4 of the Administrative Code by the statewide geometric mean length of stay calculated excluding outliers for that DRG as described in rule 5101:3-2-07.3 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 5101:3-2-07.4 of the Administrative Code.

Effective:

R.C. 119.032 review dates: 03/12/2004

Certification

Date

Promulgated Under:	119.03
Statutory Authority:	5111.02
Rule Amplifies:	5111.01, 5111.02
Prior Effective Dates:	10/1/84, 7/1/85, 7/3/86, 10/19/87, 6/30/89 (Emer.), 7/21/89, 7/1/90, 9/3/91 (Emer.), 11/10/91, 7/1/92, 1/20/95, 2/1/00, 8/1/02