Department of Human Services

Adopted Permanent Rules Relating to Inpatient Payment System

Rules as Adopted

9500.1090 PURPOSE AND SCOPE.

Parts 9500.1090 to 9500.1140 establish a prospective payment system for inpatient hospital services provided under the medical assistance and general assistance medical care programs.

Parts 9500.1090 to 9500.1140 are not applicable to inpatient hospital services provided by state owned hospitals.

If it is determined that any provision of parts 9500.1090 to 9500.1140 conflicts with requirements of the federal government with respect to federal financial participation in medical assistance, the federal requirements prevail.

9500.1095 STATUTORY AUTHORITY.

Parts 9500.1090 to 9500.1140 are authorized by Minnesota Statutes, sections 256.9685, 256.9686, 256.969, and 256.9695. Parts 9500.1090 to 9500.1140 must be read in conjunction with Titles XVIII and XIX of the Social Security Act, Code of Federal Regulations, title 42, Minnesota Statutes, chapters 256, 256B, and 256D, parts 9505.0170 to 9505.0475 which govern covered services, parts 9505.5000 to 9505.5030 which govern prior authorization, parts 9505.0545 and 9505.5035 to 9505.5105 which govern second surgical opinion, and parts 9505.0500 to 9505.0540 which govern admission certification.

9500.1100 DEFINITIONS.

Subpart 1. **Scope.** As used in parts 9500.1090 to 9500.1140, the terms in subparts ~~2~~ 1a to 51 are defined as follows.

Subp. 1a. **Accommodation service.** "Accommodation service" means those inpatient hospital services included by a hospital in a daily room charge. Accommodation services are composed of

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general routine services and special care units. These routine and special care units include the nursery, coronary, intensive, neonatal, rehabilitation, psychiatric, and chemical dependency care units.

Subp. 2. **Adjusted base year operating cost.** "Adjusted base year operating cost" means a hospital's allowable base year operating cost per admission or per day, adjusted by the hospital cost index.

Subp. 3. **Admission.** "Admission" means the time of birth at a hospital or the act that allows a patient to officially enter a hospital to receive inpatient hospital services under the supervision of a physician who is a member of the medical staff.

Subp. 4. [See repealer.]

Subp. 4a. [See repealer.]

Subp. 5. **Allowable base year operating cost.** "Allowable base year operating cost" means a hospital's base year inpatient hospital cost per admission or per day, that is adjusted for case mix and excludes property costs.

Subp. 6. **Ancillary service.** "Ancillary service" means inpatient hospital services that include laboratory and blood, radiology, anesthesiology, pharmacy, delivery and labor room, operating and recovery room, emergency room and outpatient clinic, therapy, medical supplies, renal dialysis, psychiatric, and chemical dependency services customarily charged in addition to an accommodation service charge.

Subp. 7. [See repealer.]

Subp. 8. [See repealer.]

Subp. 8a. [See repealer.]

Subp. 9. **Base year.** "Base year" means a hospital's fiscal year that is recognized by Medicare, or a hospital's fiscal year specified by the commissioner if a hospital is not required to file information with Medicare, from which cost and statistical data are used to establish medical assistance and general assistance medical care rates.

Subp. 10. [See repealer.]

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Subp. 11. **Case mix.** "Case mix" means a hospital's admissions distribution of relative values among the diagnostic categories.

Subp. 12. [See repealer.]

Subp. 12a. **Charges.** "Charges" means the usual and customary payment requested by the hospital of the general public.

Subp. 13. [See repealer.]

Subp. 14. **Commissioner.** "Commissioner" means the commissioner of the Department of Human Services or an authorized representative of the commissioner.

Subp. 15. ~~**Cost outlier.** "Cost outlier" means an admission whose operating cost exceeds the mean cost per admission for neonate and burn diagnostic categories by one standard deviation, and in the case of all other diagnostic categories by two standard deviations.~~ [See repealer.]

Subp. 16. **Cost to charge ratio.** "Cost to charge ratio" means a ratio of a hospital's inpatient hospital costs to its charges.

Subp. 17. [See repealer.]

Subp. 18. **Day outlier.** "Day outlier" means an admission whose length of stay exceeds the mean length of stay for neonate and burn diagnostic categories by one standard deviation, and in the case of all other diagnostic categories by two standard deviations.

Subp. 19. **Department.** "Department" means the Minnesota Department of Human Services.

Subp. 20. [See repealer.]

Subp. 20a. **Diagnostic categories.** "Diagnostic categories" means the diagnostic classifications ~~established according to~~ containing one or more diagnosis related groups (DRGs) used by the Medicare program and identified in parts 9500.1090 to 9500.1140. The DRG classifications must be assigned according to the base year program and specialty groups with modifications as specified in subparts 20b to 20g.

Subp. 20b. **Diagnostic categories eligible under the**

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medical assistance program. The following diagnostic categories are for persons eligible under the medical assistance program except as provided in subpart 20c, 20d, 20e, or 20f:

	~~NAME~~ DIAGNOSTIC CATEGORIES	DRG NUMBERS WITHIN DIAGNOSTIC CATEGORIES	INTERNATIONAL CLINICAL DIAGNOSIS CODES (9th Ed.)
A.	Nervous System Conditions		
	(1) Treated with Major Surgical Procedure	001-005, 007	
	(2) Other Nervous System Conditions	006, 008-035	
B.	Eye Diseases and Disorders	036-048	
C.	Ear, Nose, Mouth, And Throat Diseases	049-074, 168 169, 185-187	
D.	Respiratory System Conditions		
	(1) Treated with Surgical Procedure	075-077, 482, 483	
	(2) Treated with Ventilator Support	475	
	(3) Other Respiratory System Conditions	078-097, 099-102	
E.	Circulatory System		
	(1) Conditions Treated with Surgical Procedure	104-108, 110-120, 478, 479	
	(2) Other Circulatory System Conditions	121-145	
F.	Digestive System Diseases and Disorders	146-167, 170-183, 188-190	
G.	Hepatobiliary System		
	(1) Conditions Treated with Surgical Procedure	191-201	
	(2) Other Hepatobiliary System Conditions	202-208	
H.	Diseases and Disorders of the Musculoskeletal System and Connective Tissues	209-256, 471	
I.	Diseases and Disorders of the Skin, Subcutaneous Tissue, and Breast	257-284	
J.	Endocrine, Nutritional, and Metabolic Diseases and Disorders	285-301	
K.	Kidney and Urinary Tract Conditions	303-333	
L.	Male Reproductive System Conditions	334-352	
M.	Female Reproductive System Conditions	353-369	
N.	Pregnancy Related Conditions		
	(1) Postpartum Complications Treated with Surgical Procedure and Ectopic Pregnancy	377, 378	
	(2) Other Pregnancy Related Conditions	376, 379-384	
O.	[Reserved for future use]		
P.	Blood and Immunity Disorders		

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	(1) Treated with Surgical Procedure	392-394
	(2) Other Blood and Immunity Disorders	395-399
Q.	Myeloproliferative Diseases and Disorders, Poorly Differentiated Malignancy and other Neoplasms Not Elsewhere Classified	400-414, 473
R.	Infections and Parasitic Diseases	
	(1) Treated with Surgical Procedure	415
	(2) Other Infections and Parasitic Diseases	416-423
S.	Mental Diseases and Disorders	
	(1) Treated with Surgical Procedure (Ages 0+)	424
	(2) (Ages 0-17)	425, 427-429, 432
	(3) (Ages > 17)	425, 427-429, 432
T.	Substance Use and Substance Induced Organic Mental Disorder	
	(1) (Ages 0-20)	434, 435
	(2) (Ages > 20)	434, 435
U.	[Reserved for future use]	
V.	Toxic Effects of Drugs	
	(1) Treated with Surgical Procedure	439-443
	(2) Other Treatment of Toxic Effects of Drugs	444-455
W.	Burns	
	(1) Extensive Burns or Burns Treated with Surgical Procedure	457-459, 472
	(2) Nonextensive Burns Without Surgery	460
X.	Factors Influencing Health Status	461-467
Y.	Bronchitis and Asthma	
	(1) (Ages 0-1)	098
	(2) (Ages 2-17)	098
Z.	[Reserved for future use]	
AA.	Esophagitis, Gastroenteritis, Miscellaneous Digestive Disorders	
	(1) (Ages 0-1)	184
	(2) (Ages 2-17)	184
BB.	[Reserved for future use]	
CC.	Caesarean Sections	
	(1) with Complicating Diagnosis	370
	(2) without Complicating Diagnosis	371
DD.	Vaginal Delivery	
	(1) With Complicating Diagnosis or Operating Room Procedures	372, 374, 375
	(2) Without Complicating Diagnosis or Operating Room Procedures	373
EE.	[Reserved for future use]	
FF.	Depressive Neurosis	
	(1) (Ages 0-17)	426
	(2) (Ages > 17)	426
GG.	Psychosis	

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	(1) (Ages 0-17)	430	
	(2) (Ages > 17)	430	
HH.	Childhood Mental Disorders	431	
II.	Unrelated Operating Room Procedures		
	(1) Extensive	468	
	(2) Nonextensive	476, 477	
JJ.	[Reserved for future use]		
KK.	Extreme Immaturity		
	(1) (< 750 Grams)	386	76501, 76502
	(2) [Reserved for future use]		
	(3) [Reserved for future use]		
	(4) (750 to 1499 Grams)	386	76503, 76504, 76505
		387	76500
	(5) Neonate Respiratory Distress Syndrome	386	~~769-(Prior Codes-Take Precedence)~~ Codes for DRG 386 Except 76501 to 76505
LL.	Prematurity with Major Problems		
	(1) (< 1249 Grams)	387	76511, 76512, 76513, 76514
	(2) (1250 to 1749 Grams)	387	76506, 76510 76515, 76516
	(3) (> 1749 Grams)	387	~~All-Remaining~~ Codes for DRG 387 Except 76500, 76506, 76510 to 76516
MM.	Prematurity without Major Problems	388	
NN.	Full Term Neonates with		
	(1) Major Problems (Age 0)	389	
	(2) Other Problems	390	
OO.	Multiple Significant Trauma	484-487	
PP.	[Reserved for future use]		
QQ.	Normal Newborns	391	
RR.	[Reserved for future use]		
SS.	[Reserved for future use]		
TT.	[Reserved for future use]		
UU.	Organ Transplants	103, 302 480, 481	
VV.	Conditions Originating in Perinatal Period (Age > 0)	389	
WW.	Human Immunodeficiency Virus	488-490	

Subp. 20c. **Medical assistance covered diagnostic categories under the aid to families with dependent children program.** The following diagnostic categories are for persons eligible for medical assistance under the aid to families with dependent children program, except as provided in subpart 20d, 20e, or 20f:

~~NAME~~ DIAGNOSTIC CATEGORIES	DRG NUMBERS WITHIN DIAGNOSTIC CATEGORIES	INTERNATIONAL CLINICAL DIAGNOSIS

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		CODES (9th Ed.)
A.	Nervous System Conditions	
	(1) Treated with Major Surgical Procedure	001-005, 007
	(2) Other Nervous System Conditions	006, 008-035
B.	Eye Diseases and Disorders	036-048
C.	Ear, Nose, Mouth, And Throat Diseases	049-074, 168 169, 185-187
D.	Respiratory System Conditions	
	(1) Treated with Surgical Procedure	075-077, 482 483
	(2) Treated with Ventilator Support	475
	(3) Other Respiratory System Conditions	078-097, 099-102
E.	Circulatory System	
	(1) Conditions Treated with Surgical Procedure	104-108, 110-120, 478, 479
	(2) Other Circulatory System Conditions	121-145
F.	Digestive System Diseases and Disorders	146-167, 170-183, 188-190
G.	Hepatobiliary System	
	(1) Conditions Treated with Surgical Procedure	191-201
	(2) Other Hepatobiliary System Conditions	202-208
H.	Diseases and Disorders of the Musculoskeletal System and Connective Tissues	209-256, 471
I.	Diseases and Disorders of the Skin, Subcutaneous Tissue, and Breast	257-284
J.	Endocrine, Nutritional, and Metabolic Diseases and Disorders	285-301
K.	Kidney and Urinary Tract Conditions	303-333
L.	Male Reproductive System Conditions	334-352
M.	Female Reproductive System Conditions	353-369
N.	Pregnancy Related Conditions	
	(1) Postpartum Complications Treated with Surgical Procedure and Ectopic Pregnancy	377, 378
	(2) Other Pregnancy Related Conditions	376, 379-384
O.	[Reserved for future use]	
P.	Blood and Immunity Disorders	
	(1) Treated with Surgical Procedure	392-394
	(2) Other Blood and Immunity Disorders	395-399
Q.	Myeloproliferative Diseases and Disorders, Poorly Differentiated Malignancy and other Neoplasms Not Elsewhere	

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	Classified	400-414, 473
R.	Infections and Parasitic Diseases	
	(1) Treated with Surgical Procedure	415
	(2) Other Infections and Parasitic Diseases	416-423
S.	Mental Diseases and Disorders	
	(1) Treated with Surgical Procedure (Ages 0+)	424
	(2) (Ages 0-17)	425, 427-429, 432
	(3) (Ages > 17)	425, 427-429, 432
T.	Substance Use and Substance Induced Organic Mental Disorder	
	(1) (Ages 0-20)	434, 435
	(2) (Ages > 20)	434, 435
U.	[Reserved for future use]	
V.	Toxic Effects of Drugs	
	(1) Treated with Surgical Procedure	439-443
	(2) Other Treatment of Toxic Effects of Drugs	444-455
W.	Burns	
	(1) Extensive Burns or Burns Treated with Surgical Procedure	457-459, 472
	(2) Nonextensive Burns Without Surgery	460
X.	Factors Influencing Health Status	461-467
Y.	Bronchitis and Asthma	
	(1) (Ages 0-1)	098
	(2) (Ages 2-17)	098
Z.	[Reserved for future use]	
AA.	Esophagitis, Gastroenteritis, Miscellaneous Digestive Disorders	
	(1) (Ages 0-1)	184
	(2) (Ages 2-17)	184
BB.	[Reserved for future use]	
CC.	Caesarean Sections	
	(1) with Complicating Diagnosis	370
	(2) without Complicating Diagnosis	371
DD.	Vaginal Delivery	
	(1) With Complicating Diagnosis or Operating Room Procedures	372, 374, 375
	(2) Without Complicating Diagnosis or Operating Room Procedures	373
EE.	[Reserved for future use]	
FF.	Depressive Neurosis	
	(1) (Ages 0-17)	426
	(2) (Ages > 17)	426
GG.	Psychosis	
	(1) (Ages 0-17)	430
	(2) (Ages > 17)	430
HH.	Childhood Mental Disorders	431
II.	Unrelated Operating Room Procedure	
	(1) Extensive	468
	(2) Nonextensive	476, 477
JJ.	[Reserved for future use]	

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KK.	Extreme Immaturity		
	(1) (< 750 Grams)	386	76501, 76502
	(2) [Reserved for future use]		
	(3) [Reserved for future use]		
	(4) (750 to 1499 Grams)	386	76503, 76504, 76505
		387	76500
	(5) Neonate Respiratory Distress Syndrome	386	~~769~~ Codes for DRG 386 Except 76501 to 76505
LL.	Prematurity with Major Problems		
	(1) (< 1249 Grams)	387	76511, 76512, 76513, 76514
	(2) (1250 to 1749 Grams)	387	76506, 76510 76515, 76516
	(3) (> 1749 Grams)	387	~~ALL-REMAINING~~ Codes for DRG 387 Except 76500, 76506, 76510 to 76516
MM.	Prematurity without Major Problems	388	
NN.	Full Term Neonates with		
	(1) Major Problems	389	
	(2) Other Problems	390	
OO.	Multiple Significant Trauma	484-487	
PP.	[Reserved for future use]		
QQ.	Normal Newborns	391	
RR.	[Reserved for future use]		
SS.	[Reserved for future use]		
TT.	[Reserved for future use]		
UU.	Organ Transplants	103, 302, 480, 481	
VV.	[Reserved for future use]		
WW.	Human Immunodeficiency Virus	488-490	

Subp. 20d. **Diagnostic categories for persons eligible under the general assistance medical care program.** The following diagnostic categories are for persons eligible under the general assistance medical care program except as provided in subpart 20e or 20f:

	~~NAME~~ DIAGNOSTIC CATEGORIES	DRG NUMBERS WITHIN DIAGNOSTIC CATEGORIES	INTERNATIONAL CLINICAL DIAGNOSIS CODES (9th Ed.)
A.	Nervous System Conditions		
	(1) Treated with Major Surgical Procedure	001-005, 007	
	(2) Other Nervous System Conditions	006, 008-035	
B.	Eye Diseases and Disorders	036-048	
C.	Ear, Nose, Mouth, And Throat Diseases	049-074, 168 169, 185-187	
D.	Respiratory System Conditions		
	(1) Treated with Surgical		

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Procedure	075-077, 482, 483
(2) Treated with Ventilator Support	475
(3) Other Respiratory System Conditions	078-102,
E. Circulatory System	
(1) Conditions Treated with Surgical Procedure	103-108, 110-120, 478, 479
(2) Other Circulatory System Conditions	121-125 127-145
(3) Acute and Subacute Endocarditis	126
F. Digestive System Diseases and Disorders	146-167, 170-184, 188-190
G. Hepatobiliary System Conditions	
(1) Treated with Surgical Procedure	191-201, 480
(2) Other Hepatobiliary System Conditions	202-208
H. Diseases and Disorders of the Musculoskeletal System and Connective Tissues	209-256, 471
I. Diseases and Disorders of the Skin, Subcutaneous Tissue, and Breast	257-284
J. Endocrine, Nutritional, and Metabolic Diseases and Disorders	285-301
K. Kidney and Urinary Diseases and Disorders	302-333
L. Male Reproductive System Conditions	334-352
M. Female Reproductive System Conditions	353-369
N. Pregnancy Related Conditions	
(1) Postpartum Complications Treated with Surgical Procedure and Ectopic Pregnancy	377, 378
(2) Other Pregnancy Related Conditions	376, 379-384
O. Neonate - Premature or with Problems	386-390
P. Blood and Immunity Disorders	
(1) Treated with Surgical Procedure	392-394
(2) Other Blood and Immunity Disorders	395-399
Q. Myeloproliferative Diseases and Disorders, Poorly Differentiated Malignancy and other Neoplasms Not Elsewhere Classified	400-414, 473 481
R. Infections and Parasitic Diseases	
(1) Treated with Surgical Procedure	415
(2) Other Infections and Parasitic Diseases	416-423
S. Mental Diseases and Disorders	
(1) Treated with Surgical Procedure	424
(2) [Reserved for future use]	

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	(3) [Reserved for future use]	
	(4) Not Treated with Surgical Procedure	425, 427-429, 431-432
T.	Substance Use and Substance Induced Organic Mental Disorder	
	(1) [Reserved for future use]	
	(2) [Reserved for future use]	
	(3) (Ages 0+)	434, 435
U.	[Reserved for future use]	
V.	Toxic Effects of Drugs	
	(1) Treated with Surgical Procedure	439-443
	(2) Other Treatment of Toxic Effects of Drugs	444-455
W.	Burns	
	(1) Extensive Burns or Burns Treated with Surgical Procedure	457-459, 472
	(2) Nonextensive Burns Without Surgery	460
X.	Factors Influencing Health Status	461-467
Y.	[Reserved for future use]	
Z.	[Reserved for future use]	
AA.	[Reserved for future use]	
BB.	[Reserved for future use]	
CC.	Caesarean Sections	
	(1) with Complicating Diagnosis	370
	(2) without Complicating Diagnosis	371
DD.	Vaginal Delivery	
	(1) With Complicating Diagnosis or Operating Room Procedures	372, 374, 375
	(2) Without Complicating Diagnosis or Operating Room Procedures	373
EE.	[Reserved for future use]	
FF.	Depressive Neurosis	426
GG.	Psychosis	430
HH.	[Reserved for future use]	
II.	Unrelated Operating Room Procedure	
	(1) Extensive	468
	(2) Nonextensive	476, 477
JJ.	[Reserved for future use]	
KK.	[Reserved for future use]	
LL.	[Reserved for future use]	
MM.	[Reserved for future use]	
NN.	[Reserved for future use]	
OO.	Multiple Significant Trauma	484-487
PP.	[Reserved for future use]	
QQ.	Normal Newborns	391
RR.	[Reserved for future use]	
SS.	[Reserved for future use]	
TT.	[Reserved for future use]	
UU.	[Reserved for future use]	
VV.	[Reserved for future use]	
WW.	Human Immunodeficiency Virus	488-490

Subp. 20e. **Diagnostic categories relating to a rehabilitation hospital or a rehabilitation distinct part.** The following diagnostic categories are for services provided within

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a rehabilitation hospital or a rehabilitation distinct part regardless of program eligibility:

	NAME DIAGNOSTIC CATEGORIES	DRG NUMBERS WITHIN DIAGNOSTIC CATEGORIES	INTERNATIONAL CLINICAL DIAGNOSIS CODES (9th Ed.)
A.	Nervous System Diseases and Disorders	001-035	
B.	[Reserved for future use]		
C.	[Reserved for future use]		
D.	[Reserved for future use]		
E.	[Reserved for future use]		
F.	[Reserved for future use]		
G.	[Reserved for future use]		
H.	Diseases and Disorders of the Musculoskeletal System and Connective Tissues	209-256, 471	
I.	[Reserved for future use]		
J.	[Reserved for future use]		
K.	[Reserved for future use]		
L.	[Reserved for future use]		
M.	[Reserved for future use]		
N.	[Reserved for future use]		
O.	[Reserved for future use]		
P.	[Reserved for future use]		
Q.	[Reserved for future use]		
R.	[Reserved for future use]		
S.	[Reserved for future use]		
T.	[Reserved for future use]		
U.	[Reserved for future use]		
V.	[Reserved for future use]		
W.	[Reserved for future use]		
X.	[Reserved for future use]		
Y.	[Reserved for future use]		
Z.	[Reserved for future use]		
AA.	[Reserved for future use]		
BB.	[Reserved for future use]		
CC.	[Reserved for future use]		
DD.	[Reserved for future use]		
EE.	[Reserved for future use]		
FF.	[Reserved for future use]		
GG.	[Reserved for future use]		
HH.	[Reserved for future use]		
II.	[Reserved for future use]		
JJ.	[Reserved for future use]		
KK.	[Reserved for future use]		
LL.	[Reserved for future use]		
MM.	[Reserved for future use]		
NN.	[Reserved for future use]		
OO.	[Reserved for future use]		
PP.	Burns and Skin Diseases and Disorders	263-273, 277-284, 457-460, 472	
QQ.	[Reserved for future use]		
RR.	Mental Diseases and Disorders/Substance Use and Substance Induced Organic Mental Disorders	424-432, 434, 435	
SS.	Multiple Significant Trauma/Unrelated Operating Room Procedures	468, 476-477, 484-487	
TT.	Other Conditions Requiring Rehabilitation Services	036-108,	

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		110-208,	
		257-262,	
		274-276,	
		285-423,	
		439-455,	
		461-467,	
		473, 475	
		478-483,	
		488-490	

UU. [Reserved for future use]
VV. [Reserved for future use]
WW. [Reserved for future use]

Subp. 20f. **Diagnostic categories for neonatal transfers.** The following diagnostic categories are for services provided to neonatal transfers at receiving hospitals with neonatal intensive care units regardless of program eligibility:

NAME DIAGNOSTIC CATEGORIES	DRG NUMBERS WITHIN DIAGNOSTIC CATEGORIES	INTERNATIONAL CLINICAL DIAGNOSIS CODES (9th Ed.)
A. [Reserved for future use]		
B. [Reserved for future use]		
C. [Reserved for future use]		
D. [Reserved for future use]		
E. [Reserved for future use]		
F. [Reserved for future use]		
G. [Reserved for future use]		
H. [Reserved for future use]		
I. [Reserved for future use]		
J. [Reserved for future use]		
K. [Reserved for future use]		
L. [Reserved for future use]		
M. [Reserved for future use]		
N. [Reserved for future use]		
O. [Reserved for future use]		
P. [Reserved for future use]		
Q. [Reserved for future use]		
R. [Reserved for future use]		
S. [Reserved for future use]		
T. [Reserved for future use]		
U. [Reserved for future use]		
V. [Reserved for future use]		
W. [Reserved for future use]		
X. [Reserved for future use]		
Y. [Reserved for future use]		
Z. [Reserved for future use]		
AA. [Reserved for future use]		
BB. [Reserved for future use]		
CC. [Reserved for future use]		
DD. [Reserved for future use]		
EE. [Reserved for future use]		
FF. [Reserved for future use]		
GG. [Reserved for future use]		
HH. [Reserved for future use]		
II. [Reserved for future use]		
JJ. [Reserved for future use]		
KK. Extreme Immaturity		
(1) (< 750 Grams)	386	76501, 76502
(2) (750 to 999 Grams)	386	76503
(3) (1000 to 1499 Grams)	386	76504, 76505
	387	76500
(4) [Reserved for future use]		
(5) Neonate Respiratory		

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	Distress Syndrome	386	~~769-(PRIOR CODES-TAKE PRECEDENCE~~ Codes for DRG 386 Except 76501 to 76505
LL.	Prematurity with Major Problems		
	(1) (< 1249 Grams)	387	76511, 76512, 76513, 76514
	(2) (1250 to 1749 Grams)	387	76506, 76510, 76515, 76516
	(3) (1250 to 1749 Grams)	387	~~ALL-REMAINING~~ Codes for DRG 387 Except 76500, 76506, 76510 TO 76516
MM.	Prematurity without Major Problems (> 1749 Grams)	388	
NN.	Full Term Neonates		
	(1) with Major Problems (age 0)	389	
	(2) with Other Problems	390	
OO.	[Reserved for future use]		
PP.	[Reserved for future use]		
QQ.	[Reserved for future use]		
RR.	[Reserved for future use]		
SS.	[Reserved for future use]		
TT.	[Reserved for future use]		
UU.	[Reserved for future use]		
VV.	[Reserved for future use]		
WW.	[Reserved for future use]		

Subp. 20g. **Additional DRG requirements.**

A. The version of the Medicare grouper and DRG assignment ~~with modifications~~ to the diagnostic category must be used uniformly for all determinations of rates and payments.

B. The discharge status will be changed to "discharge to home" for DRG 385, 433, and 456.

C. A diagnosis with the prefix "v57" will be excluded when grouping under subpart 20e.

Subp. 21. [See repealer.]

Subp. 22. **General assistance medical care.** "General assistance medical care" means the program established by Minnesota Statutes, section 256D.03.

Subp. 23. [See repealer.]

Subp. 24. [See repealer.]

Subp. 24a. [See repealer.]

Subp. 25. **Hospital.** "Hospital" means a facility defined in Minnesota Statutes, section 144.696, subdivision 3, and licensed under Minnesota Statutes, sections 144.50 to 144.58, or

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an out-of-state facility licensed to provide acute care under the requirements of the state in which it is located, or an Indian health service facility designated by the federal government to provide acute care.

Subp. 26. **Hospital cost index.** "Hospital cost index" means the factor annually multiplied by the allowable base year operating cost to adjust for cost changes.

Subp. 26a. **Inpatient hospital costs.** "Inpatient hospital costs" means a hospital's base year inpatient hospital service costs determined allowable under the cost finding methods of Medicare without regard to adjustments in payments imposed by Medicare.

Subp. 27. **Inpatient hospital service.** "Inpatient hospital service" means a service provided by or under the supervision of a physician after admission to a hospital and furnished in the hospital, including outpatient services provided by the same hospital that directly precede the admission.

Subp. 28. [See repealer.]

Subp. 28a. **Local trade area hospital.** "Local trade area hospital" means a hospital that is located in a state other than Minnesota but in a county of the other state in which the county is contiguous to Minnesota.

Subp. 29. **Medical assistance.** "Medical assistance" means the program established under Title XIX of the Social Security Act and Minnesota Statutes, sections 256.9685 to 256.9695 and chapter 256B. For purposes of parts 9500.1090 to 9500.1140, "medical assistance" includes general assistance medical care unless otherwise specifically stated.

Subp. 30. [See repealer.]

Subp. 30a. [See repealer.]

Subp. 31. **Medicare.** "Medicare" means the federal health insurance program established under Title XVIII of the Social Security Act.

Subp. 32. **Medicare crossover.** "Medicare crossover" means a claim submitted by a hospital to request payment for Medicare Part A covered inpatient hospital services provided to a patient

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who is also eligible for medical assistance.

Subp. 33. **Metropolitan statistical area hospital.** "Metropolitan statistical area hospital" means a hospital located in a metropolitan statistical area as determined by Medicare for the October 1 prior to the most current rebased rate year.

Subp. 33a. [See repealer.]

Subp. 34. **Nonmetropolitan statistical area hospital.** "Nonmetropolitan statistical area hospital" means a hospital not located in a metropolitan statistical area as determined by Medicare for the October 1 prior to the most current rebased rate year.

Subp. 35. **Operating costs.** "Operating costs" means inpatient hospital costs excluding property costs.

[For text of subp 36, see M.R.]

Subp. 37. **Out-of-area hospital.** "Out-of-area hospital" means any hospital located outside of Minnesota excluding local trade area hospitals.

Subp. 38. **Property costs.** "Property costs" means inpatient hospital costs not subject to the hospital cost index, including depreciation, interest, rents and leases, property taxes, and property insurance.

Subp. 39. [See repealer.]

Subp. 40. [See repealer.]

Subp. 41. [See repealer.]

Subp. 41a. **Rate year.** "Rate year" means a calendar year from January 1 to December 31.

Subp. 42. [See repealer.]

Subp. 43. [See repealer.]

Subp. 43a. [See repealer.]

Subp. 44. [See repealer.]

Subp. 44a. **Rehabilitation distinct part.** "Rehabilitation distinct part" means inpatient hospital services that are provided by a hospital in a unit designated by Medicare as a rehabilitation distinct part.

Subp. 45. **Relative value.** "Relative value" means the mean

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operating cost within a diagnostic category divided by the mean operating cost in all diagnostic categories within a program at subpart 20b, 20c, or 20d or specialty group at subpart 20e or 20f.

Subp. 46. [See repealer.]

Subp. 47. [See repealer.]

Subp. 47a. [See repealer.]

Subp. 48. [See repealer.]

Subp. 49. [See repealer.]

Subp. 50. **Transfer.** "Transfer" means the movement of a patient after admission from one hospital directly to another hospital with a different provider number or to or from a rehabilitation distinct part.

Subp. 51. **Trim point.** "Trim point" means that number of inpatient days~~, or that amount of operating costs,~~ beyond which an admission is a day ~~or cost~~ outlier.

Subp. 52. [See repealer.]

9500.1105 BASIS OF PAYMENT FOR INPATIENT HOSPITAL SERVICES.

Subpart 1. **Reporting requirements.**

A. No later than October 1 preceding a rebased rate year or 60 days from the department's request, whichever is later, a Minnesota and local trade area hospital must provide to the department complete, true, and authorized information as outlined in subitems (1) to (7). Information called for in subitems (1) to (7) not provided in a timely manner will not be used in calculating the hospital's rates for that rate year and the following year if rebasing does not occur.

(1) The base year Medicare audited cost report of local trade area hospitals.

(2) The decision on whether certified registered nurse anesthetist services are to be paid separately from parts 9500.1090 to 9500.1140. Once elected, the decision to be paid separately is irrevocable.

(3) The identification of base year claims for admissions to a rehabilitation distinct part.

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(4) The elected outlier percentage for other than neonate and burn admissions to a minimum of 60 percent and a maximum of 80 percent. The chosen percentage shall apply to ~~cost-and-day-outliers-and-to~~ all program and specialty groups of the hospital.

(5) The most recent Medicare cost report submitted to Medicare by October 1 prior to a rebased rate year.

(6) The data on low income utilization necessary to implement the disproportionate population adjustment.

(7) The Medicare adjustments to prior base year data.

B. If Medicare does not require the hospital to file a complete cost report, that hospital must, no later than February 1 preceding a rebased rate year, provide true, complete, and authorized Medicare cost report data under the cost finding methods and allowable costs in effect during the base year.

Subp. 2. **Establishment of base years.**

A. Except as provided in items B and C, the base year for the 1993 rate year shall be each Minnesota and local trade area hospital's most recent Medicare cost reporting period ending prior to September 1, 1988. If that cost reporting period is less than 12 months, it must be supplemented by information from the prior cost reporting period so that the base year is 12 months except for hospitals that closed during the base year.

B. The base year for the 1993 rate year of a children's hospital shall be the hospital's most recent fiscal year ending prior to January 1, 1990. A children's hospital is one in which more than 50 percent of the admissions are individuals less than 18 years of age.

C. The base year for the 1993 rate year for a long-term hospital shall be that part of the most recent fiscal year ending prior to September 1, 1989, for which the hospital was designated a long-term hospital by Medicare.

D. The base year data will be moved forward three

years for hospitals subject to item A, one year for hospitals subject to item B, and two years for hospitals subject to item C beginning with the 1995 rate year. The base year data will be moved forward every two years after 1995 or every one year if notice is provided at least six months prior to the rate year.

9500.1110 DETERMINATION OF RELATIVE VALUES OF THE DIAGNOSTIC CATEGORIES.

Subpart 1. **Determination of relative values.** To determine the relative values of the diagnostic categories the department shall:

A. Select medical assistance claims for Minnesota and local trade area hospitals with admission dates from each hospital's base year.

B. Exclude the claims and charges in subitems (1) to (6):

(1) Medicare crossover claims;

(2) claims paid on a per day transfer rate basis for a period that is less than the average length of stay of the diagnostic category in effect on the admission date;

(3) inpatient hospital services for which medical assistance payment was not made;

(4) inpatient hospital claims that must be paid during the rate year on a per day basis without regard to relative values during the period for which rates are set;

(5) inpatient hospital services not covered by the medical assistance program on October 1 prior to a rebased rate year; and

(6) inpatient hospital charges for noncovered days calculated as the ratio of noncovered days to total days multiplied by charges.

C. Separate claims which combine the stay of both mother and newborn ~~shall be separated~~ into two or more claims according to subitems (1) to ~~(3)~~ (4).

(1) Accommodation service charges for each newborn claim are the sum of nursery and neonatal intensive care

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unit charges divided by the number of newborns. Accommodation service charges for the mother are all other accommodation service charges.

(2) Ancillary charges for each claim are calculated by multiplying each ancillary charge by each claim's ratio of accommodation service charges in subitem (1) to the total accommodation service charges in subitem (1).

(3) If the newborn's inpatient days continue beyond the discharge of the mother, the claim of the newborn shall be combined with any immediate subsequent claim of the newborn.

(4) If the newborn does not have charges under subitem (1), the ancillary charges of the mother and newborn shall be separated by the percentage of the total ancillary charges that are assigned to all other mothers and newborns.

D. Combine claims into the admission that generated the claim according to part 9500.1128, subpart 4.

E. Determine operating costs for each hospital admission in item D using each hospital's base year data according to subitems (1) to (6).

(1) Determine the operating cost of accommodation services by multiplying the number of accommodation service inpatient days by that accommodation service operating cost per diem and add the products of all accommodation services.

(2) Determine the operating cost of each ancillary service by multiplying the ancillary charges by that ancillary operating cost to charge ratio and add the products of all ancillary services.

(3) Determine the operating cost of services rendered by interns and residents not in an approved teaching program by multiplying the number of accommodation service inpatient days in subitem (1) by that teaching program accommodation service per diem and add the products of all teaching program accommodation services.

(4) Determine the cost of malpractice insurance, if that cost is not included in the accommodation and ancillary

cost, by multiplying the total hospital costs of malpractice insurance by the ratio of the claim charge to total hospital charges and then multiply that product by 0.915.

(5) Add subitems (1) to (4) to determine the operating cost for each admission.

(6) Multiply the result of subitem (5) by the hospital cost index that corresponds to the hospital's fiscal year end in part 9500.1120, subpart 2, item F.

F. Assign each admission and operating cost identified in item E, subitem (6), to the appropriate program or specialty group and diagnostic category according to part 9500.1100, subparts 20a to 20e and 20g.

G. Determine the mean cost per admission for all admissions identified in item F within each program and specialty group by dividing the sum of the operating costs by the total number of admissions.

H. Determine the mean cost per admission for each diagnostic category identified in item F within each program and specialty group by dividing the sum of the operating costs in each diagnostic category by the total number of admissions in each diagnostic category.

I. Determine the relative value for each diagnostic category by dividing item H by the corresponding result of item G within the program and specialty group and round the quotient to five decimal places.

J. Determine the mean length of stay for each diagnostic category identified in item F by dividing the total number of inpatient service days in each diagnostic category by the total number of admissions in that diagnostic category and round the quotient to two decimal places.

K. Determine the day outlier trim point for each diagnostic category and round to whole days.

~~L.--Determine-the-cost-outlier-trim-point-for-each diagnostic-category-and-round-to-whole-dollars.~~

Subp. 2. **Redetermination of relative values.** The department shall reassign the program, specialty group, and

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diagnostic category composition in part 9500.1100, subparts 20a to 20g, after notice of the change in the State Register and a 30-day comment period. The relative values in this part and adjusted base year operating costs in part 9500.1115 and 9500.1116 must be redetermined when changes are made to part 9500.1100, subparts 20a to 20g.

Subp. 3. [See repealer.]

9500.1115 DETERMINATION OF ADJUSTED BASE YEAR OPERATING COST PER ADMISSION AND PER DAY OUTLIER.

Subpart 1. **Minnesota and local trade area hospitals.** The department will determine the adjusted base year operating cost per admission for each Minnesota and local trade area hospital according to items A to D.

A. Determine and classify the operating cost for each admission according to part 9500.1110, subpart 1, items A to F, except that the ratios in item E, subitem (2), will be adjusted to exclude certified registered nurse anesthetist costs and charges if separate billing for these services is elected by the hospital.

B. Determine the operating costs for day ~~and cost~~ outliers for each admission in item A that is recognized in outlier payments ~~according to subitems (1) and (2).~~

~~(1) For each base year admission that is a cost outlier and is not partially denied under parts 9505.0500 to 9505.0540, multiply that cost outlier's operating costs in excess of the trim point at part 9500.1110, subpart 1, item K, by each hospital's elected outlier percentage or 70 percent if an election is not made. When neonate or burn diagnostic categories are used, the department shall substitute 90 percent for the 70 percent or elected percentage.~~

~~(2)~~ For each base year admission that is a day outlier, cut the operating cost of that admission at the trim point by multiplying the operating cost of that admission by the ratio of the admission's days of inpatient hospital services in excess of the trim point, divided by the admission's length of stay, and

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then multiply the cut operating cost by each hospital's elected outlier percentage or 70 percent if an election is not made. When neonate or burn diagnostic categories are used, the department shall substitute 90 percent for the 70 percent or elected percentage.

C. For each admission, subtract ~~the higher amount of~~ item B~~, subitem (1) or (2),~~ from item A, and for each hospital, add the results within each program and specialty group, and divide this amount by the number of admissions within each program and specialty group.

D. Adjust item C for case mix according to subitems (1) to (4).

(1) Multiply the hospital's number of admissions by program and specialty group within each diagnostic category by the relative value of that diagnostic category.

(2) Add together each of the products determined in subitem (1).

(3) Divide the total from subitem (2) by the number of hospital admissions and round that quotient to five decimal places.

(4) Divide the cost per admission as determined in item C by the quotient calculated in subitem (3) and round that amount to whole dollars.

Subp. 2. **Minnesota and local trade area hospitals.** The department will determine the adjusted base year operating cost per day outlier for each Minnesota and local trade area hospital according to items A and B.

A. To determine the allowable operating cost per day that is recognized in outlier payments, add the amounts calculated in subpart 1, item B~~, subitem (2),~~ and divide the total by the total number of days of inpatient hospital services in excess of the trim point.

B. Adjust item A for case mix according to subitems (1) to (4).

(1) Multiply the hospital's number of outlier days by program and specialty group within each diagnostic

category by the relative value of that diagnostic category.

(2) Add the products determined in subitem (1).

(3) Divide the total from subitem (2) by the number of hospital outlier days.

(4) Divide the cost per day outlier as determined in item A by the quotient calculated in subitem (3) and round that amount to whole dollars.

Subp. 3. **Out-of-area hospitals.** The department will determine the adjusted base year operating cost per admission and per day outlier by program and specialty group for out-of-area hospitals according to items A to C.

A. Multiply each adjusted base year operating cost per admission and per day outlier in effect on the first day of a rate year for each Minnesota and local trade area hospital by the number of corresponding admissions or outlier days in that hospital's base year.

B. Add the products calculated in item A.

C. Divide the total from item B by the total admissions or outlier days for all the hospitals and round that amount to whole dollars.

Subp. 4. **Minnesota and local trade area metropolitan statistical area hospitals that do not have medical assistance admissions or day outliers in the base year.** The department will determine the adjusted base year operating cost per admission or per day outlier by program and specialty group for Minnesota and local trade area metropolitan statistical area hospitals that do not have medical assistance admissions or day outliers in the base year according to items A to C.

A. Multiply each adjusted base year cost per admission and day outlier in effect on the first day of a rate year for each Minnesota and local trade area and metropolitan statistical area hospital by the number of corresponding admissions or outlier days in that hospital's base year.

B. Add the products calculated in item A.

C. Divide the total from item B by the total admissions or outlier days for all metropolitan statistical area

hospitals and round that amount to whole dollars.

Subp. 5. **Minnesota and local trade area nonmetropolitan statistical area hospitals that do not have medical assistance admissions or day outliers in the base year.** The department will determine the adjusted base year operating cost per admission or per day outlier by program and specialty group for Minnesota and local trade area nonmetropolitan statistical area hospitals by substituting nonmetropolitan statistical area hospitals terms and data for the metropolitan statistical area hospitals terms and data under subpart 4.

Subp. 6. **Limitation on separate payment and outlier percentage.** Hospitals that have rates established under subpart 3 may not have certified registered nurse anesthetists services paid separately from parts 9500.1090 to 9500.1140 and hospitals that have rates established under subpart 3, 4, or 5 may not elect an alternative outlier percentage.

9500.1116 DETERMINATION OF ADJUSTED BASE YEAR OPERATING COST PER DAY.

Subpart 1. **Neonatal transfers.**

A. For Minnesota and local trade area hospitals, the department will determine the neonatal transfer adjusted base year operating cost per day for Minnesota and local trade area hospital admissions that result from a transfer to a neonatal intensive care unit according to subitems (1) to (3).

(1) Determine the operating cost per day for each diagnostic category in part 9500.1100, subpart 20f, according to part 9500.1110, subpart 1, items A to F, except that the ratios in part 9500.1110, subpart 1, item E, subitem (2), will be adjusted to exclude certified registered nurse anesthetist costs and charges if separate billing for these services is elected by the hospital, and divide the total base year operating costs by the total corresponding inpatient hospital days for each admission.

(2) Determine relative values for each diagnostic category at part 9500.1100, subpart 20f, according to part

9500.1110, subpart 1, items G, H, and I, after substituting the term "day" for "admission."

(3) Adjust the result of subitem (2) according to part 9500.1115, subpart 1, item D, after substituting the term "day" for "admission."

B. For Minnesota and local trade area metropolitan statistical area hospitals that do not have medical assistance neonatal transfer admissions to a neonatal intensive care unit in the base year, the department will determine the neonatal transfer adjusted base year operating cost per day for admissions that result from a transfer to a neonatal intensive care unit according to subitems (1) to (3).

(1) Multiply each adjusted base year cost per day in effect on the first day of a rate year for each Minnesota and local trade area metropolitan statistical area hospital by the number of corresponding days in the hospital's base year.

(2) Add the products in subitem (1).

(3) Divide the total from subitem (2) by the total days for all metropolitan statistical area hospitals and round that amount to whole dollars.

C. For Minnesota and local trade area nonmetropolitan statistical area hospitals that do not have medical assistance neonatal transfer admissions to a neonatal intensive care unit in the base year, the department will determine the adjusted base year operating cost per day for admissions that result from a transfer to a neonatal intensive care unit by substituting nonmetropolitan statistical area hospitals terms and data for the metropolitan statistical area hospitals terms and data under item B.

Subp. 2. **Long-term hospital.** The department will determine the base year operating cost per day for Minnesota and local trade area hospital admissions to a long-term hospital as designated by Medicare for the rate year according to items A and B.

A. Determine the operating cost per day according to part 9500.1110, subpart 1, items A to E, except that claims

excluded in part 9500.1110, subpart 1, item B, subitems (2) and (4), will be included and the ratios in part 9500.1110, subpart 1, item E, subitem (2), will be adjusted to exclude certified registered nurse anesthetist costs and charges if separate billing for these services is elected by the hospital.

B. Divide the total base year operating costs for all admissions in item A by the total corresponding inpatient hospital days for all admissions and round that amount to whole dollars.

9500.1120 DETERMINATION OF HOSPITAL COST INDEX.

Subpart 1. **Adoption of Hospital Cost Index.** The hospital cost index will be derived from Health Care Costs as published by Data Resources Incorporated (DRI), 1200 G Street NW, Washington, D.C. 20005. This report is published quarterly. The health care costs report is available through the Minitex interlibrary loan system and this report is incorporated by reference.

Subp. 2. **Determination of hospital cost index.** For the period from the midpoint of each hospital's base year to the midpoint of the rate year, or, when the base year is not rebased, from the midpoint of the prior rate year to the midpoint of the current rate year, the department shall determine the hospital cost index according to items A to F.

A. The commissioner shall obtain from Data Resources, Inc., the average annual historical and projected cost change estimates in a decimal format for the operating costs in subitems (1) to (7):

(1) wages and salaries;

(2) employee benefits;

(3) medical and professional fees;

(4) raw food;

(5) utilities;

(6) insurance including malpractice; and

(7) other operating costs.

B. Obtain data for operating costs of hospitals in

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Minnesota which indicate the proportion of operating costs attributable to item A, subitems (1) to (7).

C. For each category in item A, multiply the amount determined in item B by the applicable amount determined in item A.

D. Add the products determined in item C and limit this amount to the statutory maximums on the rate of increase. Round the result to three decimal places.

E. For ~~each annual~~ the period beginning October 1, 1992, through June 30, 1993, add 0.01 to the medical assistance index, excluding general assistance medical care, in item D.

F. Add one to the amounts calculated in item E and multiply these amounts together. Round the result to three decimal places.

Subp. 3. [See repealer.]

9500.1121 DETERMINATION OF DISPROPORTIONATE POPULATION ADJUSTMENT.

Subpart 1. **Eligibility for disproportionate population adjustment.** To be eligible for a disproportionate population adjustment, the hospital must meet the requirements of item B under general assistance medical care and item A and item C, D, or E under medical assistance.

A. The hospital, at the time that an admission occurs, must have at least two obstetricians with staff privileges who provide obstetric services to medical assistance patients. For nonmetropolitan statistical area hospitals, an obstetrician may be any physician with staff privileges at the hospital to perform nonemergency obstetrics procedures. This requirement does not apply to hospitals where the majority of admissions are predominately individuals under 18 years of age or hospitals that did not offer nonemergency obstetric services as of December 21, 1987.

B. The hospital has a base year days utilization rate of medical assistance inpatient days, excluding general assistance medical care and Medicare crossovers, divided by

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total inpatient days that exceeds the arithmetic mean plus one standard deviation for Minnesota and local trade area hospitals. The difference is added to one and rounded to four decimal places.

C. The hospital has a base year days utilization rate of medical assistance inpatient days, excluding general assistance medical care and Medicare crossovers, divided by total inpatient days that exceeds the arithmetic mean for Minnesota and local trade area hospitals. The difference is added to one and rounded to four decimal places.

D. The hospital has a base year days utilization rate of medical assistance inpatient days, excluding general assistance medical care and Medicare crossovers, divided by total inpatient days that exceeds the arithmetic mean plus one standard deviation for Minnesota and local trade area hospitals. The difference is multiplied by 1.1 and added to one and rounded to four decimal places.

E. The hospital has a base year low-income utilization rate that exceeds 0.25. This rate is calculated by dividing medical assistance revenues, excluding general assistance medical care, plus any cash subsidies received by the hospital directly from state and local government by total revenues plus the cash subsidies amount. This rate is added to the quotient of inpatient "charity care" charges minus the cash subsidies divided by total inpatient charges. The result is added to one and rounded to four decimal places. For purposes of this part, "charity care" is care provided to individuals who have no source of payment from third-party or personal resources.

Subp. 2. **Days utilization rate used in cases where hospital qualifies under two rates.** If a hospital qualifies under both the days utilization rate at subpart 1, item C or D, and the low-income utilization rate at subpart 1, item E, the disproportionate population adjustment amount shall be the days utilization rate.

9500.1122 DETERMINATION OF PROPERTY COST PER ADMISSION.

Subpart 1. **Minnesota and local trade area hospitals.** The department will determine the property cost per admission for each Minnesota and local trade area hospital according to items A to D.

A. Determine the property cost for each hospital admission in part 9500.1110, subpart 1, item D, using each hospital's base year data according to subitems (1) to (4).

(1) Multiply the number of accommodation service inpatient days by that accommodation service property per diem and add the products.

(2) Multiply each ancillary charge by that ancillary property cost to charge ratio and add the products.

(3) Add subitems (1) and (2).

(4) Add the results of subitem (3) for all admissions for each hospital.

B. Determine the property cost for each hospital admission in part 9500.1110, subpart 1, item D, using each hospital's base year data and recent year data from part 9500.1105, subpart 1, item A, subitem (5), according to subitems (1) to (4).

(1) Multiply the base year number of accommodation service inpatient days by that same recent year accommodation service property per diem and add the products.

(2) Multiply each base year ancillary charge by that annualized recent year property cost to base year charge ratio and add the products.

(3) Add subitems (1) and (2).

(4) Add the totals of subitem (3) for all admissions for each hospital.

C. Determine the change in the property cost according to subitems (1) to (3).

(1) Subtract item A, subitem (4) from item B, subitem (4), and, if positive, divide the result by item A, subitem (4).

(2) Multiply the quotient of subitem (1) by 0.85.

(3) Add one to the result of subitem (2) and

round to two decimal places.

D. Determine the property cost per admission by program and specialty group according to subitems (1) to (3).

(1) Assign each admission and property cost in item A, subitem (3), to the appropriate program and specialty group according to part 9500.1100, subparts 20a to 20g.

(2) Multiply the cost of each admission in subitem (1) by the factor in item C, subitem (3).

(3) Add the products within each group in subitem (2), divide the total by the number of corresponding admissions, and round the resulting amount to whole dollars.

Subp. 2. **Out-of-area hospitals.** The department will determine the property cost per admission by program for out-of-area hospitals according to items A to C.

A. Multiply each property cost per admission in effect on the first day of a rate year for each Minnesota and local trade area hospital by the number of corresponding admissions in that hospital's base year.

B. Add the products in item A.

C. Divide the total from item B by the total admissions for all the hospitals and round the resulting amount to whole dollars.

Subp. 3. **Minnesota and local trade area metropolitan statistical area hospitals that do not have medical assistance admissions in the base year.** The department will determine the property cost per admission by program and specialty group for Minnesota and local trade area metropolitan statistical area hospitals that do not have medical assistance admissions in the base year according to items A to C.

A. Multiply each property cost per admission in effect on the first day of a rate year for each Minnesota and local trade area metropolitan statistical area hospital by the number of corresponding admissions in the hospital's base year.

B. Add the products in item A.

C. Divide the total from item B by the total admissions for all metropolitan statistical area hospitals and

round the resulting amount to whole dollars.

Subp. 4. **Minnesota and local trade area nonmetropolitan statistical area hospitals that do not have medical assistance admissions in the base year.** The department will determine the property cost per admission by program and specialty group for Minnesota and local trade area nonmetropolitan statistical area hospitals that do not have medical assistance admissions in the base year by substituting nonmetropolitan statistical area hospitals terms and data for the metropolitan statistical area hospitals terms and data under subpart 3.

9500.1124 DETERMINATION OF PROPERTY COST PER DAY.

Subpart 1. **Neonatal transfers.**

A. For Minnesota and local trade area hospitals, the department will determine the property cost per day for neonatal transfer admissions that result from a transfer to a neonatal intensive care unit according to part 9500.1122, subpart 1, item D, after substituting the term "day" for "admission."

B. For Minnesota and local trade area hospitals that do not have medical assistance neonatal transfer admissions in the base year, the department will determine the neonatal transfer property cost per day for admissions in the base year according to part 9500.1122, subpart 3, after substituting the term "day" for "admission."

Subp. 2. **Long-term hospitals.** For long-term hospitals, the department will determine the property cost per day for Minnesota and local trade area hospital admissions to a long-term hospital as designated by Medicare for the rate year according to subpart 1, item A, except that claims excluded in part 9500.1110, subpart 1, item B, subitems (2) and (4), will be included.

9500.1128 DETERMINATION OF PAYMENT RATES.

Subpart 1. **Notification.** Minnesota and local trade area hospitals will be provided a notice of rates and relative values that are to be effective for the rate year by the preceding December 1. The payment rates shall be based on the rates in

effect on the date of admission except when the inpatient admission includes both the first day of the rate year and the preceding July 1. In this case, the adjusted base year operating cost on the admission date shall be increased each rate year by the rate year hospital cost index.

Subp. 2. **Rate per admission.**

A. Each admission is classified to the appropriate program or specialty group and diagnostic category according to part 9500.1100, subparts 20a to 20g, and the rate per admission will be determined according to subitems (1) and (2):

(1) Medical Assistance Rate Per Admission	=	((Adjusted base year operating cost per admission multiplied by the relative value of the diagnostic category) plus the property cost per admission) and multiplied by the disproportionate population adjustment
(2) General Assistance Medical Care Rate per Admission	=	(Adjusted base year operating cost per admission multiplied by the relative value of the diagnostic category and multiplied by the disproportionate population adjustment) plus the property cost per admission

B. The metabolic testing fee for newborns that is paid to the Department of Health will be added to the rate per admission for each birth until the fee is included in the base year allowable operating costs of the hospital.

C. The day ~~and cost~~ outlier rates are in addition to the rate per admission and will be determined by program or specialty group as follows:

(1) The rate per day for day outliers, as classified in item A, is determined as follows:

Outlier Rate Per Day	=	Adjusted base year operating cost per day outlier multiplied by the relative value of the diagnostic category and multiplied by the disproportionate population adjustment

(2) The days of outlier status begin after the trim point for the appropriate diagnostic category and continue for the number of days a patient receives covered inpatient hospital services.

~~(3) Payment for cost outliers is determined~~

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according to units (a) to (g).

(a) Add the operating cost for each hospital's admissions in part 9500.1110, subpart 1, item E, subitem (5), and divide that total by the total charges on the corresponding claims to determine the overall operating cost to charge ratio for each hospital.

(b) For out of area hospitals and hospitals that do not have medical assistance admissions in the base year, add the operating cost for all admissions at part 9500.1110, subpart 1, item E, subitem (5), and divide that total by the total charges on the corresponding claims to determine the overall operating cost to charge ratio.

(c) Multiply the allowable charges of the admission by the applicable cost to charge ratio of either unit (a) or (b) and round the resulting amount to whole dollars.

(d) Subtract from the amount calculated in unit (c) the cost outlier trim point in part 9500.1110, subpart 1, item B.

(e) Multiply the amount calculated in unit (d) by 90 percent for neonate and burn diagnostic categories. For all other diagnostic categories, multiply the amount by 70 percent or the hospital elected percentage.

(f) For out of area hospitals and hospitals that do not have medical assistance admissions in the base year, multiply the amount calculated in unit (d) by the average outlier percent. The average outlier percent is calculated by multiplying each hospital's outlier percent by the number of admissions, excluding neonate and burn diagnostic category admissions. Add the products for all hospitals and divide this total by the total of all admissions.

(g) Multiply the final amount determined in unit (e) or (f) by the disproportionate population adjustment.

(4) If an admission is both a day and cost outlier, the payment will be determined at the higher amount except that a cost outlier shall not be applicable to admissions that are partially denied under parts 9505.0500 to 9505.0540.

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D. Except for admissions subject to subpart 3, a transfer rate per day for both the hospital that transfers a patient and the hospital that admits the patient who is transferred will be determined as follows:

Transfer Rate Per Day	=	The rate per admission in item A divided by the arithmetic mean length of stay of the diagnostic category

(1) A hospital will not receive a transfer payment that exceeds the hospital's applicable rate per admission specified in item A unless that admission is a day or cost outlier.

(2) Except as applicable under subpart 4, rehabilitation hospitals and rehabilitation distinct parts are exempt from a transfer payment.

Subp. 3. **Rate per day.**

A. Admissions resulting from a transfer to a neonatal intensive care unit and classified to a diagnostic category in part 9500.1100, subpart 20f, will have rates determined according to subpart 2, item A, after substituting the word "day" for "admission."

B. Admissions or transfers to a long-term hospital as designated by Medicare for the rate year will have rates determined according to subpart 2, item A, after substituting the word "day" for "admission," without regard to relative values.

Subp. 4. ~~**Rebasing adjustment.** The difference due to rebasing in part 9500.1131 will be added to each admission.~~

~~Subp. 5.~~ **Readmissions.** An admission and readmission of the same patient to the same or a different hospital within 15 days, excluding the days of discharge and readmission, is eligible for reimbursement according to the criteria in parts 9505.0500 to 9505.0540.

9500.1129 PAYMENT LIMITATIONS.

Subpart 1. **Charge limitation.**

A. The department will limit payment, including third party and recipient liability, for services provided by an

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out-of-area hospital to allowable charges for the admission.

B. Payments, in addition to third party and recipient liability, for discharges occurring during a rate year may not exceed, in aggregate, the allowable charges for the same period of time to the hospital. This limitation will exclude payments made under part 9500.1121 and Medicare crossover claims. The limitation will be calculated separately for general assistance medical care and medical assistance and separately from other services for a rehabilitation distinct part.

Subp. 2. **Transfers.** A discharging hospital is not eligible for a transfer payment for services provided to a discharged patient if the admission to the discharging hospital was not due to an emergency, as defined in part 9505.0500, subpart 11, and the discharging hospital knew or had reason to know at the time of admission that the inpatient hospital services were outside the scope of the hospital's available services and the transfer to another hospital resulted because of the patient's need for those services.

9500.1130 PAYMENT PROCEDURES.

Subpart 1. **Submittal of claims.** Claims may not be submitted to the department until after a patient is discharged or 30 days after admission and every subsequent 30 days, whichever occurs first. A hospital that submits a claim to the department after 30 days from admission, but before discharge, shall submit a final claim after discharge.

Subp. 1a. **Payor of last resort.** A hospital may not submit a claim to the department until a final determination of the patient's eligibility for potential third party payment has been made by a hospital. Any and all available third party benefits must be exhausted prior to billing medical assistance and the third party liability amounts must be entered on the claim.

Subp. 1b. **Third party liability.** Payment for patients that are simultaneously covered by medical assistance and a third party will be determined according to a hierarchy of application as set out in items A to E.

A. Medical assistance payment for a Medicare crossover will be determined by subtracting the third party liability from the Medicare deductible and coinsurance due from the patient. A negative difference will not be implemented.

B. Medical assistance payment for a Medicare crossover whose Medicare benefits either exhaust or begin during an admission will be determined by subtracting the Medicare payment and third party liability from the medical assistance rate. A negative difference will not be implemented.

C. Medical assistance payment will not be made for an admission when either charges are paid by a third party or the hospital has an agreement to accept payment for less than charges as payment in full.

D. Medical assistance payment for an admission under item C that requires a deductible or coinsurance will be made at a level equal to the deductible or coinsurance due from the patient.

E. Medical assistance payment for a patient with any third party benefits will be determined as the lesser of the covered charges minus the third party liability, or the medical assistance rate minus the third party liability. A negative difference will not be implemented.

Subp. 1c. **Reduction of recipient resources.** Recipient resources will also be reduced from the amounts in subpart 1b.

Subp. 2. [See repealer.]

Subp. 3. [See repealer.]

Subp. 4. [See repealer.]

Subp. 5. [See repealer.]

Subp. 6. [See repealer.]

Subp. 7. [See repealer.]

Subp. 8. [See repealer.]

Subp. 9. [See repealer.]

Subp. 10. [See repealer.]

Subp. 11. [See repealer.]

Subp. 12. [See repealer.]

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~~9500.1131 DETERMINATION OF DIFFERENCES DUE TO REBASING.~~

~~Subpart 1. Operating costs before and after rebasing. The department will determine the difference between the operating costs before rebasing and after rebasing for each Minnesota and local trade area hospital according to items A to D.~~

~~A. Determine the operating cost per admission for each hospital using data from the base year in effect on June 30, 1992, according to subitems (1) and (2).~~

~~(1) Assign each admission to the medical assistance, aid to families with dependent children, or general assistance medical care program and divide the total operating cost by the total corresponding admissions.~~

~~(2) Multiply the quotients of subitem (1) by the hospital cost index that corresponds to each hospital's fiscal year end to June 30, 1993.~~

~~B. Determine the operating cost per admission for each hospital using data from the base year in effect on July 1, 1993, according to subitems (1) to (5).~~

~~(1) Determine the operating cost for all admissions, including the cost of transfer admissions and part 9500.1116, according to part 9500.1110, subpart 1, items A to E.~~

~~(2) Assign each admission at subitem (1) to the medical assistance, aid to families with dependent children, or general assistance medical care program and add the results for each program for each hospital.~~

~~(3) Add the admissions and subtract from that total rehabilitation distinct part admissions and newborn admissions that have been separated from another admission.~~

~~(4) Divide the results of subitem (2) by subitem (3) for each program.~~

~~(5) Multiply the quotients of subitem (4) by the hospital cost index that corresponds to each hospital's fiscal year end to June 30, 1993.~~

~~C. Subtract item A, subitem (2), from item B, subitem (5), for each program.~~

~~D. Determine the operating cost per admission for~~

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~~hospitals that do not have admissions in a program in a base year by substituting metropolitan statistical area or nonmetropolitan statistical area hospital data in that base year for each hospital's program data under items A and B.~~

~~Subp. 2. Effect of rebasing property costs. The department will determine the effect of rebasing the property costs for each Minnesota and local trade area hospital according to items A to E.~~

~~A. Determine the property cost for all admissions, including the costs of transfer admissions and neonatal transfers at part 9500.1124, according to part 9500.1122, subpart 1, item A, subitems (1) to (3), and multiply the results by part 9500.1122, subpart 1, item C, subitem (3).~~

~~B. Assign each admission at item A to the medical assistance, aid to families with dependent children, or general assistance medical care program and add the results for each program.~~

~~C. Add the admissions and subtract from that total rehabilitation distinct part admissions and newborn admissions that have been separated from another admission.~~

~~D. Divide the results of item B by item C for each program.~~

~~E. Determine the property cost per admission for hospitals that do not have admissions in a program in a base year by substituting metropolitan statistical area or nonmetropolitan statistical area hospital data in that base year for each hospital's program data under items A to D.~~

~~Subp. 3. Cost differences before and after rebasing. The department will determine the difference between the costs, the disproportionate population adjustment, and small rural increase before rebasing and after rebasing for each Minnesota and local trade area hospital according to items A and B.~~

~~A. Adjust the medical assistance and aid to families with dependent children costs by the disproportionate population adjustment and the small rural increase according to subitems (1) to (13).~~

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~~(1) Multiply the result of subpart 1, item A, subitem (2), by the disproportionate population adjustment in effect on July 1, 1992, and add the property rate in effect on July 1, 1992.~~

~~(2) Add the results of subpart 1, item A, subitem (2), and the property rate in effect on October 1, 1992, and multiply the result by the disproportionate population adjustment in effect on October 1, 1992.~~

~~(3) Multiply the result of subitem (1) by .25 and the result of subitem (2) by .75 and add the two products.~~

~~(4) Multiply the result of subpart 1, item B, subitem (5), by the rebased disproportionate population adjustment under the laws in effect on July 1, 1992, and add this amount to the result of subpart 2, item D, for each program.~~

~~(5) Add the result of subpart 1, item B, subitem (5), and subpart 2, item D, for each program and multiply the result by the rebased disproportionate population adjustment under the laws in effect on October 1, 1992.~~

~~(6) Multiply the result of subitem (4) by .25 and the result of subitem (5) by .75 and add the two products.~~

~~(7) Subtract one from the disproportionate population adjustment in effect on October 1, 1992, and subtract the result from the applicable .15 or .20 small rural increase.~~

~~(8) Multiply the result of subitem (7), if positive, by .75 and add one.~~

~~(9) Multiply the result of subitem (3) by subitem (8).~~

~~(10) Subtract one from the rebased disproportionate population adjustment under the laws in effect on October 1, 1992, and subtract the result from the applicable .15 or .20 small rural increase.~~

~~(11) Multiply the result of subitem (10), if positive, by .75 and add one.~~

~~(12) Multiply the result of subitem (6) by subitem (11).~~

~~(13) Subtract subitem (9) from subitem (12).~~

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B.--Adjust the general assistance medical care costs by the disproportionate population adjustment according to subitems (1) to (7).

(1) Multiply the result of subpart 1, item A, subitem (2), by the disproportionate population adjustment in effect on July 1, 1992, and add the property rate in effect on July 1, 1992.

(2) Multiply the result of subpart 1, item A, subitem (2), by the disproportionate population adjustment in effect on October 1, 1992, and add the property rate in effect on October 1, 1992.

(3) Multiply the result of subitem (1) by .25 and the result of subitem (2) by .75 and add the two products.

(4) Multiply the result of subpart 1, item B, subitem (5), by the rebased disproportionate population adjustment under the laws in effect on July 1, 1992, and add the result of subpart 2, item B.

(5) Multiply the result of subpart 1, item B, subitem (5), by the rebased disproportionate population adjustment under the laws in effect on October 1, 1992, and add the result of subpart 2, item B.

(6) Multiply the result of subitem (4) by .25 and the result of subitem (5) by .75 and add the two products.

(7) Subtract subitem (3) from subitem (6).

Subp. 4. --Rebasing difference.--The department will determine the total difference that results from rebasing according to items A and B.

A.--Determine the medical assistance and aid to families with dependent children payment adjustment for each admission occurring from July 1, 1993 to June 30, 1994, according to subitems (1) to (4).

(1) Subtract the medical assistance cash flow add on in effect on July 1, 1992, from subpart 3, item A, subitem (13).

(2) Multiply the result of subitem (1) by the result of subpart 1, item B, subitem (3).

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~~(3) Divide the product of subitem (2) by the result of subpart 1, item B, subitem (2), and round to whole dollars.~~

~~(4) A change to the cash flow add on will result in a change to the subtraction at subitem (1) for the same length of time that it was in effect.~~

~~B. Determine the general assistance medical care payment adjustment for each admission occurring from July 1, 1993 to June 30, 1994, according to subitems (1) to (4).~~

~~(1) Subtract the general assistance medical care cash flow add on in effect on July 1, 1992, from subpart 3, item B, subitem (7).~~

~~(2) Multiply the result of subitem (1) by the result of subpart 1, item B, subitem (3).~~

~~(3) Divide the product of subitem (2) by the result of subpart 1, item B, subitem (2), and round to whole dollars.~~

~~(4) A change to the cash flow add on will result in a change to the subtraction at subitem (1) for the same length of time that it was in effect.~~

~~Subp. 5. Adjustments. The department will adjust the results of subparts 1 to 4 in circumstances occurring under items A and B.~~

~~A. If the implementation date of the Medicaid management information system is later than July 1, 1993, adjustments will be made according to subitems (1) to (3).~~

~~(1) Redetermine the hospital cost index in subpart 1 to the day prior to the implementation date of the Medicaid management information system.~~

~~(2) Redetermine the time weights calculated in subpart 3 by dividing three months by the number of months between July 1, 1992, and the implementation date of the Medicaid management information system. Subtract this amount from one.~~

~~(3) Redetermine the length of time that the adjustment in subpart 4 is in effect as the same length of time~~

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~~that the implementation date of the Medicaid management information system was delayed from July 1, 1993.~~

~~B. If changes are made to a hospital's disproportionate population adjustment or if appeal settlements are made after July 1, 1992, to the implementation date of the Medicaid management information system, adjustments will be made according to subitems (1) and (2).~~

~~(1) Redetermine the effect of the change by inserting the revisions and dates of change in subpart 3 after converting the payment to a per admission basis.~~

~~(2) Redetermine the time weights in subpart 3 as the number of months that the change was in effect divided by the number of months between July 1, 1992, and the implementation date of the Medicaid management information system.~~

9500.1140 APPEALS.

Subpart 1. **Scope of appeals.** A hospital may appeal a decision arising from the application of standards or methods under Minnesota Statutes, section 256.9685, 256.9686, or 256.969, if an appeal would result in a change to the hospital's payment rate or payments. The appeals procedure in subparts 2 to 6 shall apply to all appeals filed on or after August 1, 1989.

Subp. 2. **Filing of appeals.** An appeal must be received by the commissioner within the time period specified in subpart 3, 4, or 5. The appeal must include the information required in items A to D:

A. the disputed items;

B. the authority in federal or state statute or rule upon which the hospital relies for each disputed item;

C. the type of appeal in subpart 3, 4, or 5 that is applicable to each disputed item; and

D. the name and address of the person to contact regarding the appeal.

Subp. 3. **Case mix appeals.** A hospital may appeal a payment change that results from a difference in case mix

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between the base year and rate year. The appeal must be received by the commissioner or postmarked no later than 120 days after the end of the appealed rate year. A case mix appeal will apply to all medical assistance patients ~~that~~ who received inpatient hospital services from the hospital and the appeal is effective for the entire rate year. The results of case mix appeals do not automatically carry forward into later rate years. Separate case mix appeals must be submitted for each rate year based on the change in the mix of cases for that particular rate year. An adjustment will be made only to the extent that the need is attributable to circumstances that are separately identified by the hospital. The hospital must demonstrate that the average acuity or length of stay of patients in each rate year appealed has increased or services have been added or discontinued according to items A to C.

A. The change must be measured by use of case mix indices derived using all federal diagnostic related groups.

B. The percentage change, in whole numbers, between the recalculated case mix indices under item A will be reduced by the change in indices as measured using diagnostic groups in part 9500.1100, subparts 20b to 20g.

C. The resulting percentage change in item B, will be multiplied by payments made for admissions occurring during the appealed rate year under part 9500.1128 reduced by property payments made under parts 9500.1129 and 9500.1130.

Subp. 4. **Medicare adjustment appeals.** To appeal a payment rate or payment change that results from Medicare adjustments of base year information, the appeal must be received by the commissioner or postmarked not later than 60 days after the date the medical assistance determination was mailed to the hospital by the department or within 60 days of the date the Medicare determination was mailed to the hospital by Medicare, whichever is later.

Subp. 5. **Rate and payment appeals.** To appeal a payment rate or payment determination that is not a case mix or Medicare adjustment appeal, the appeal must be received by the

commissioner within 60 days of the date the determination was mailed to the hospital.

Subp. 6. **Resolution of appeals.** The appeal will be heard by an administrative law judge according to parts 1400.5100 to 1400.8401 and Minnesota Statutes, sections 14.57 to 14.62, and according to the requirements of items A to D.

A. The hospital must demonstrate by a preponderance of the evidence that the commissioner's determination is incorrect or not according to law.

B. Both overpayments and underpayments that result from the submission of appeals will be implemented.

C. Facts to be considered in any appeal of base year information are limited to those in existence at the time the payment rates of the first rate year were established from the base year information.

D. Relative values and rates that are based on averages will not be recalculated to reflect the appeal outcome.

REPEALER. Minnesota Rules, parts 9500.1100, subparts 4, 4a, 7, 8, 8a, 10, 12, 13, 15, 17, 20, 21, 23, 24, 24a, 28, 30, 30a, 33a, 39, 40, 41, 42, 43, 43a, 44, 46, 47, 47a, 48, 49, and 52; 9500.1110, subpart 3; 9500.1120, subpart 3; 9500.1125; 9500.1130, subparts 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, and 12; and 9500.1135, are repealed.

CHANGE IN TERMS. The reference to part 9500.1100, subpart 20, in Minnesota Rules, part 9505.0500, subpart 10a, shall be changed to part 9500.1100, subpart 20a. The references to part 9500.1130, subpart 7, in Minnesota Rules, part 9505.0540, subpart 5, items A to C, shall be changed to part 9500.1128, subpart 2, item D.

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