

1 Department of Human Services

2

3 Adopted Permanent Rules Relating to Inpatient Payment System

4

5 Rules as Adopted

6 9500.1090 PURPOSE AND SCOPE.

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

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

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

17 9500.1095 STATUTORY AUTHORITY.

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

28 9500.1100 DEFINITIONS.

29 Subpart 1. **Scope.** As used in parts 9500.1090 to
30 9500.1140, the terms in subparts 2 1a to 51 are defined as
31 follows.

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

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

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

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

14 Subp. 4. [See repealer.]

15 Subp. 4a. [See repealer.]

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

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

27 Subp. 7. [See repealer.]

28 Subp. 8. [See repealer.]

29 Subp. 8a. [See repealer.]

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

36 Subp. 10. [See repealer.]

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

4 Subp. 12. [See repealer.]

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

8 Subp. 13. [See repealer.]

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

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

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

20 Subp. 17. [See repealer.]

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

26 Subp. 19. Department. "Department" means the Minnesota
27 Department of Human Services.

28 Subp. 20. [See repealer.]

29 Subp. 20a. Diagnostic categories. "Diagnostic categories"
30 means the diagnostic classifications ~~established---according---to~~
31 containing one or more diagnosis related groups (DRGs) used by
32 the Medicare program and identified in parts 9500.1090 to
33 9500.1140. The DRG classifications must be assigned according
34 to the base year program and specialty groups with modifications
35 as specified in subparts 20b to 20g.

36 Subp. 20b. Diagnostic categories eligible under the

1	(1) Treated with Surgical	
2	Procedure	392-394
3	(2) Other Blood and Immunity	
4	Disorders	395-399
5	Q. Myeloproliferative	
6	Diseases and Disorders,	
7	Poorly Differentiated	
8	Malignancy and other	
9	Neoplasms Not Elsewhere	
10	Classified	400-414, 473
11	R. Infections and Parasitic	
12	Diseases	
13	(1) Treated with Surgical	
14	Procedure	415
15	(2) Other Infections and	
16	Parasitic Diseases	416-423
17	S. Mental Diseases and Disorders	
18	(1) Treated with Surgical	
19	Procedure (Ages 0+)	424
20	(2) (Ages 0-17)	425, 427-429,
21		432
22	(3) (Ages > 17)	425, 427-429,
23		432
24	T. Substance Use and Substance	
25	Induced Organic Mental	
26	Disorder	
27	(1) (Ages 0-20)	434, 435
28	(2) (Ages > 20)	434, 435
29	U. [Reserved for future use]	
30	V. Toxic Effects of Drugs	
31	(1) Treated with Surgical	
32	Procedure	439-443
33	(2) Other Treatment of	
34	Toxic Effects of Drugs	444-455
35	W. Burns	
36	(1) Extensive Burns or Burns	
37	Treated with Surgical	
38	Procedure	457-459, 472
39	(2) Nonextensive Burns	
40	Without Surgery	460
41	X. Factors Influencing	
42	Health Status	461-467
43	Y. Bronchitis and Asthma	
44	(1) (Ages 0-1)	098
45	(2) (Ages 2-17)	098
46	Z. [Reserved for future use]	
47	AA. Esophagitis,	
48	Gastroenteritis,	
49	Miscellaneous Digestive	
50	Disorders	
51	(1) (Ages 0-1)	184
52	(2) (Ages 2-17)	184
53	BB. [Reserved for future use]	
54	CC. Caesarean Sections	
55	(1) with Complicating	
56	Diagnosis	370
57	(2) without Complicating	
58	Diagnosis	371
59	DD. Vaginal Delivery	
60	(1) With Complicating	
61	Diagnosis or Operating	
62	Room Procedures	372, 374,
63		375
64	(2) Without Complicating	
65	Diagnosis or Operating	
66	Room Procedures	373
67	EE. [Reserved for future use]	
68	FF. Depressive Neurosis	
69	(1) (Ages 0-17)	426
70	(2) (Ages > 17)	426
71	GG. Psychosis	

1	(1) (Ages 0-17)	430	
2	(2) (Ages > 17)	430	
3	HH. Childhood Mental		
4	Disorders	431	
5	II. Unrelated Operating Room		
6	Procedures		
7	(1) Extensive	468	
8	(2) Nonextensive	476, 477	
9	JJ. [Reserved for future use]		
10	KK. Extreme Immaturity		
11	(1) (< 750 Grams)	386	76501, 76502
12	(2) [Reserved for future use]		
13	(3) [Reserved for future use]		
14	(4) (750 to 1499 Grams)	386	76503, 76504,
15			76505
16		387	76500
17	(5) Neonate Respiratory		
18	Distress Syndrome	386	769-(Prior
19			Codes-Take
20			Precedence)
21			Codes for DRG
22			<u>386 Except</u>
23			<u>76501 to 76505</u>
24	LL. Prematurity with Major		
25	Problems		
26	(1) (< 1249 Grams)	387	76511, 76512,
27			76513, 76514
28	(2) (1250 to 1749 Grams)	387	76506, 76510
29			76515, 76516
30	(3) (> 1749 Grams)	387	All-Remaining
31			Codes for DRG
32			<u>387 Except</u>
33			<u>76500, 76506,</u>
34			<u>76510 to</u>
35			<u>76516</u>
36	MM. Prematurity without		
37	Major Problems	388	
38	NN. Full Term Neonates with		
39	(1) Major Problems (Age 0)	389	
40	(2) Other Problems	390	
41	OO. Multiple Significant		
42	Trauma	484-487	
43	PP. [Reserved for future use]		
44	QQ. Normal Newborns	391	
45	RR. [Reserved for future use]		
46	SS. [Reserved for future use]		
47	TT. [Reserved for future use]		
48	UU. Organ Transplants	103, 302	
49		480, 481	
50	VV. Conditions Originating in		
51	Perinatal Period		
52	(Age > 0)	389	
53	WW. Human Immunodeficiency		
54	Virus	488-490	

55
 56 Subp. 20c. Medical assistance covered diagnostic
 57 categories under the aid to families with dependent children
 58 program. The following diagnostic categories are for persons
 59 eligible for medical assistance under the aid to families with
 60 dependent children program, except as provided in subpart 20d,
 61 20e, or 20f:

62	<u>NAME</u>	<u>DRG NUMBERS WITHIN</u>	<u>INTER-</u>
63	<u>DIAGNOSTIC</u>	<u>DIAGNOSTIC</u>	<u>NATIONAL</u>
64	<u>CATEGORIES</u>	<u>CATEGORIES</u>	<u>CLINICAL</u>
65			<u>DIAGNOSIS</u>

CODES
(9th Ed.)

1		
2		
3		
4		
5	A.	Nervous System Conditions
6		(1) Treated with Major
7		Surgical Procedure 001-005, 007
8		(2) Other Nervous
9		System Conditions 006, 008-035
10	B.	Eye Diseases and Disorders 036-048
11	C.	Ear, Nose, Mouth, And
12		Throat Diseases 049-074, 168
13		169, 185-187
14	D.	Respiratory System Conditions
15		(1) Treated with Surgical
16		Procedure 075-077, 482
17		483
18		(2) Treated with Ventilator
19		Support 475
20		(3) Other Respiratory
21		System Conditions 078-097,
22		099-102
23	E.	Circulatory System
24		(1) Conditions Treated with
25		Surgical Procedure 104-108,
26		110-120,
27		478, 479
28		(2) Other Circulatory
29		System Conditions 121-145
30	F.	Digestive System Diseases
31		and Disorders 146-167,
32		170-183,
33		188-190
34	G.	Hepatobiliary System
35		(1) Conditions Treated with
36		Surgical Procedure 191-201
37		(2) Other Hepatobiliary
38		System Conditions 202-208
39	H.	Diseases and Disorders of
40		the Musculoskeletal System
41		and Connective Tissues 209-256, 471
42	I.	Diseases and Disorders of
43		the Skin, Subcutaneous
44		Tissue, and Breast 257-284
45	J.	Endocrine, Nutritional,
46		and Metabolic Diseases
47		and Disorders 285-301
48	K.	Kidney and Urinary Tract
49		Conditions 303-333
50	L.	Male Reproductive System
51		Conditions 334-352
52	M.	Female Reproductive
53		System Conditions 353-369
54	N.	Pregnancy Related Conditions
55		(1) Postpartum Complications
56		Treated with Surgical
57		Procedure and Ectopic
58		Pregnancy 377, 378
59		(2) Other Pregnancy
60		Related Conditions 376, 379-384
61	O.	[Reserved for future use]
62	P.	Blood and Immunity Disorders
63		(1) Treated with Surgical
64		Procedure 392-394
65		(2) Other Blood and Immunity
66		Disorders 395-399
67	Q.	Myeloproliferative
68		Diseases and Disorders,
69		Poorly Differentiated
70		Malignancy and other
71		Neoplasms Not Elsewhere

1	Classified	400-414, 473
2	R. Infections and Parasitic	
3	Diseases	
4	(1) Treated with Surgical	
5	Procedure	415
6	(2) Other Infections and	
7	Parasitic Diseases	416-423
8	S. Mental Diseases and Disorders	
9	(1) Treated with Surgical	
10	Procedure (Ages 0+)	424
11	(2) (Ages 0-17)	425, 427-429,
12		432
13	(3) (Ages > 17)	425, 427-429,
14		432
15	T. Substance Use and Substance	
16	Induced Organic Mental	
17	Disorder	
18	(1) (Ages 0-20)	434, 435
19	(2) (Ages > 20)	434, 435
20	U. [Reserved for future use]	
21	V. Toxic Effects of Drugs	
22	(1) Treated with Surgical	
23	Procedure	439-443
24	(2) Other Treatment of	
25	Toxic Effects of Drugs	444-455
26	W. Burns	
27	(1) Extensive Burns or	
28	Burns Treated with	
29	Surgical Procedure	457-459, 472
30	(2) Nonextensive Burns	
31	Without Surgery	460
32	X. Factors Influencing	
33	Health Status	461-467
34	Y. Bronchitis and Asthma	
35	(1) (Ages 0-1)	098
36	(2) (Ages 2-17)	098
37	Z. [Reserved for future use]	
38	AA. Esophagitis,	
39	Gastroenteritis,	
40	Miscellaneous Digestive	
41	Disorders	
42	(1) (Ages 0-1)	184
43	(2) (Ages 2-17)	184
44	BB. [Reserved for future use]	
45	CC. Caesarean Sections	
46	(1) with Complicating	
47	Diagnosis	370
48	(2) without Complicating	
49	Diagnosis	371
50	DD. Vaginal Delivery	
51	(1) With Complicating	
52	Diagnosis or Operating	
53	Room Procedures	372, 374,
54		375
55	(2) Without Complicating	
56	Diagnosis or Operating	
57	Room Procedures	373
58	EE. [Reserved for future use]	
59	FF. Depressive Neurosis	
60	(1) (Ages 0-17)	426
61	(2) (Ages > 17)	426
62	GG. Psychosis	
63	(1) (Ages 0-17)	430
64	(2) (Ages > 17)	430
65	HH. Childhood Mental	
66	Disorders	431
67	II. Unrelated Operating Room	
68	Procedure	
69	(1) Extensive	468
70	(2) Nonextensive	476, 477
71	JJ. [Reserved for future use]	

1	KK. Extreme Immaturity		
2	(1) (< 750 Grams)	386	76501, 76502
3	(2) [Reserved for future use]		
4	(3) [Reserved for future use]		
5	(4) (750 to 1499 Grams)	386	76503, 76504,
6			76505
7		387	76500
8	(5) Neonate Respiratory		
9	Distress Syndrome	386	769
10			<u>Codes for DRG</u>
11			<u>386 Except</u>
12			<u>76501</u>
13			<u>to 76505</u>
14	LL. Prematurity with Major		
15	Problems		
16	(1) (< 1249 Grams)	387	76511, 76512,
17			76513, 76514
18	(2) (1250 to 1749 Grams)	387	76506, 76510
19			76515, 76516
20	(3) (> 1749 Grams)	387	ALL-REMAINING
21			<u>Codes for DRG</u>
22			<u>387 Except</u>
23			<u>76500, 76506,</u>
24			<u>76510 to</u>
25			<u>76516</u>
26	MM. Prematurity without		
27	Major Problems	388	
28	NN. Full Term Neonates with		
29	(1) Major Problems	389	
30	(2) Other Problems	390	
31	OO. Multiple Significant		
32	Trauma	484-487	
33	PP. [Reserved for future use]		
34	QQ. Normal Newborns	391	
35	RR. [Reserved for future use]		
36	SS. [Reserved for future use]		
37	TT. [Reserved for future use]		
38	UU. Organ Transplants	103, 302,	
39		480, 481	
40	VV. [Reserved for future use]		
41	WW. Human Immunodeficiency		
42	Virus	488-490	

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

49	<u>NAME</u>	<u>DRG NUMBERS WITHIN</u>	<u>INTER-</u>
50	<u>DIAGNOSTIC</u>	<u>DIAGNOSTIC</u>	<u>NATIONAL</u>
51	<u>CATEGORIES</u>	<u>CATEGORIES</u>	<u>CLINICAL</u>
52			<u>DIAGNOSIS</u>
53			<u>CODES</u>
54			<u>(9th Ed.)</u>
55			
56	A. Nervous System Conditions		
57	(1) Treated with Major		
58	Surgical Procedure	001-005, 007	
59	(2) Other Nervous		
60	System Conditions	006, 008-035	
61	B. Eye Diseases and Disorders	036-048	
62	C. Ear, Nose, Mouth, And		
63	Throat Diseases	049-074, 168	
64		169, 185-187	
65	D. Respiratory System Conditions		
66	(1) Treated with Surgical		

1	Procedure	075-077, 482,
2		483
3	(2) Treated with Ventilator	
4	Support	475
5	(3) Other Respiratory	
6	System Conditions	078-102,
7	E. Circulatory System	
8	(1) Conditions Treated with	
9	Surgical Procedure	103-108,
10		110-120,
11		478, 479
12	(2) Other Circulatory	
13	System Conditions	121-125
14		127-145
15	(3) Acute and Subacute	
16	Endocarditis	126
17	F. Digestive System Diseases	
18	and Disorders	146-167,
19		170-184,
20		188-190
21	G. Hepatobiliary System	
22	Conditions	
23	(1) Treated with Surgical	
24	Procedure	191-201, 480
25	(2) Other Hepatobiliary	
26	System Conditions	202-208
27	H. Diseases and Disorders of	
28	the Musculoskeletal System	
29	and Connective Tissues	209-256, 471
30	I. Diseases and Disorders of	
31	the Skin, Subcutaneous	
32	Tissue, and Breast	257-284
33	J. Endocrine, Nutritional,	
34	and Metabolic Diseases	
35	and Disorders	285-301
36	K. Kidney and Urinary Diseases	
37	and Disorders	302-333
38	L. Male Reproductive System	
39	Conditions	334-352
40	M. Female Reproductive	
41	System Conditions	353-369
42	N. Pregnancy Related Conditions	
43	(1) Postpartum Complications	
44	Treated with Surgical	
45	Procedure and Ectopic	
46	Pregnancy	377, 378
47	(2) Other Pregnancy	
48	Related Conditions	376, 379-384
49	O. Neonate - Premature or	
50	with Problems	386-390
51	P. Blood and Immunity Disorders	
52	(1) Treated with Surgical	
53	Procedure	392-394
54	(2) Other Blood and Immunity	
55	Disorders	395-399
56	Q. Myeloproliferative	
57	Diseases and Disorders,	
58	Poorly Differentiated	
59	Malignancy and other	
60	Neoplasms Not Elsewhere	400-414, 473
61	Classified	481
62	R. Infections and Parasitic	
63	Diseases	
64	(1) Treated with Surgical	
65	Procedure	415
66	(2) Other Infections and	
67	Parasitic Diseases	416-423
68	S. Mental Diseases and Disorders	
69	(1) Treated with Surgical	
70	Procedure	424
71	(2) [Reserved for future use]	

1	(3) [Reserved for future use]	
2	(4) Not Treated with	
3	Surgical Procedure	425, 427-429,
4		431-432
5	T. Substance Use and Substance	
6	Induced Organic Mental	
7	Disorder	
8	(1) [Reserved for future use]	
9	(2) [Reserved for future use]	
10	(3) (Ages 0+)	434, 435
11	U. [Reserved for future use]	
12	V. Toxic Effects of Drugs	
13	(1) Treated with Surgical	
14	Procedure	439-443
15	(2) Other Treatment of	
16	Toxic Effects of Drugs	444-455
17	W. Burns	
18	(1) Extensive Burns or Burns	
19	Treated with Surgical	
20	Procedure	457-459, 472
21	(2) Nonextensive Burns	
22	Without Surgery	460
23	X. Factors Influencing	
24	Health Status	461-467
25	Y. [Reserved for future use]	
26	Z. [Reserved for future use]	
27	AA. [Reserved for future use]	
28	BB. [Reserved for future use]	
29	CC. Caesarean Sections	
30	(1) with Complicating	
31	Diagnosis	370
32	(2) without Complicating	
33	Diagnosis	371
34	DD. Vaginal Delivery	
35	(1) With Complicating	
36	Diagnosis or Operating	
37	Room Procedures	372, 374,
38		375
39	(2) Without Complicating	
40	Diagnosis or Operating	
41	Room Procedures	373
42	EE. [Reserved for future use]	
43	FF. Depressive Neurosis	426
44	GG. Psychosis	430
45	HH. [Reserved for future use]	
46	II. Unrelated Operating Room	
47	Procedure	
48	(1) Extensive	468
49	(2) Nonextensive	476, 477
50	JJ. [Reserved for future use]	
51	KK. [Reserved for future use]	
52	LL. [Reserved for future use]	
53	MM. [Reserved for future use]	
54	NN. [Reserved for future use]	
55	OO. Multiple Significant	
56	Trauma	484-487
57	PP. [Reserved for future use]	
58	QQ. Normal Newborns	391
59	RR. [Reserved for future use]	
60	SS. [Reserved for future use]	
61	TT. [Reserved for future use]	
62	UU. [Reserved for future use]	
63	VV. [Reserved for future use]	
64	WW. Human Immunodeficiency	
65	Virus	488-490

66
67 Subp. 20e. Diagnostic categories relating to a
68 rehabilitation hospital or a rehabilitation distinct part. The
69 following diagnostic categories are for services provided within

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

3	4	5	6	7	8	9
	<u>NAME</u>		<u>DRG NUMBERS WITHIN</u>		<u>INTER-</u>	
	<u>DIAGNOSTIC</u>		<u>DIAGNOSTIC</u>		<u>NATIONAL</u>	
	<u>CATEGORIES</u>		<u>CATEGORIES</u>		<u>CLINICAL</u>	
					<u>DIAGNOSIS</u>	
					<u>CODES</u>	
					<u>(9th Ed.)</u>	
10	A. Nervous System Diseases					
11	and Disorders		001-035			
12	B. [Reserved for future use]					
13	C. [Reserved for future use]					
14	D. [Reserved for future use]					
15	E. [Reserved for future use]					
16	F. [Reserved for future use]					
17	G. [Reserved for future use]					
18	H. Diseases and Disorders of					
19	the Musculoskeletal System					
20	and Connective Tissues		209-256, 471			
21	I. [Reserved for future use]					
22	J. [Reserved for future use]					
23	K. [Reserved for future use]					
24	L. [Reserved for future use]					
25	M. [Reserved for future use]					
26	N. [Reserved for future use]					
27	O. [Reserved for future use]					
28	P. [Reserved for future use]					
29	Q. [Reserved for future use]					
30	R. [Reserved for future use]					
31	S. [Reserved for future use]					
32	T. [Reserved for future use]					
33	U. [Reserved for future use]					
34	V. [Reserved for future use]					
35	W. [Reserved for future use]					
36	X. [Reserved for future use]					
37	Y. [Reserved for future use]					
38	Z. [Reserved for future use]					
39	AA. [Reserved for future use]					
40	BB. [Reserved for future use]					
41	CC. [Reserved for future use]					
42	DD. [Reserved for future use]					
43	EE. [Reserved for future use]					
44	FF. [Reserved for future use]					
45	GG. [Reserved for future use]					
46	HH. [Reserved for future use]					
47	II. [Reserved for future use]					
48	JJ. [Reserved for future use]					
49	KK. [Reserved for future use]					
50	LL. [Reserved for future use]					
51	MM. [Reserved for future use]					
52	NN. [Reserved for future use]					
53	OO. [Reserved for future use]					
54	PP. Burns and Skin Diseases					
55	and Disorders		263-273,			
56			277-284,			
57			457-460, 472			
58	QQ. [Reserved for future use]					
59	RR. Mental Diseases and					
60	Disorders/Substance Use					
61	and Substance Induced					
62	Organic Mental Disorders		424-432, 434,			
63			435			
64	SS. Multiple Significant					
65	Trauma/Unrelated Operating					
66	Room Procedures		468, 476-477,			
67			484-487			
68	TT. Other Conditions Requiring					
69	Rehabilitation Services		036-108,			

1 110-208,
 2 257-262,
 3 274-276,
 4 285-423,
 5 439-455,
 6 461-467,
 7 473, 475
 8 478-483,
 9 488-490

10 UU. [Reserved for future use]
 11 VV. [Reserved for future use]
 12 WW. [Reserved for future use]

14 Subp. 20f. Diagnostic categories for neonatal transfers.

15 The following diagnostic categories are for services provided to
 16 neonatal transfers at receiving hospitals with neonatal
 17 intensive care units regardless of program eligibility:

18	19	20	21	22	23	24
	<u>NAME</u>		<u>DRG NUMBERS WITHIN</u>	<u>INTER-</u>		
	<u>DIAGNOSTIC</u>		<u>DIAGNOSTIC</u>	<u>NATIONAL</u>		
	<u>CATEGORIES</u>		<u>CATEGORIES</u>	<u>CLINICAL</u>		
				<u>DIAGNOSIS</u>		
				<u>CODES</u>		
				<u>(9th Ed.)</u>		
25	A.	[Reserved for future use]				
26	B.	[Reserved for future use]				
27	C.	[Reserved for future use]				
28	D.	[Reserved for future use]				
29	E.	[Reserved for future use]				
30	F.	[Reserved for future use]				
31	G.	[Reserved for future use]				
32	H.	[Reserved for future use]				
33	I.	[Reserved for future use]				
34	J.	[Reserved for future use]				
35	K.	[Reserved for future use]				
36	L.	[Reserved for future use]				
37	M.	[Reserved for future use]				
38	N.	[Reserved for future use]				
39	O.	[Reserved for future use]				
40	P.	[Reserved for future use]				
41	Q.	[Reserved for future use]				
42	R.	[Reserved for future use]				
43	S.	[Reserved for future use]				
44	T.	[Reserved for future use]				
45	U.	[Reserved for future use]				
46	V.	[Reserved for future use]				
47	W.	[Reserved for future use]				
48	X.	[Reserved for future use]				
49	Y.	[Reserved for future use]				
50	Z.	[Reserved for future use]				
51	AA.	[Reserved for future use]				
52	BB.	[Reserved for future use]				
53	CC.	[Reserved for future use]				
54	DD.	[Reserved for future use]				
55	EE.	[Reserved for future use]				
56	FF.	[Reserved for future use]				
57	GG.	[Reserved for future use]				
58	HH.	[Reserved for future use]				
59	II.	[Reserved for future use]				
60	JJ.	[Reserved for future use]				
61	KK.	Extreme Immaturity				
62		(1) (< 750 Grams)	386		76501, 76502	
63		(2) (750 to 999 Grams)	386		76503	
64		(3) (1000 to 1499 Grams)	386		76504, 76505	
65			387		76500	
66		(4) [Reserved for future use]				
67		(5) Neonate Respiratory				

1	Distress Syndrome	386	769-(PRIOR
2			CODES-TAKE
3			PRECEDENCE
4			Codes for DRG
5			<u>386 Except</u>
6			<u>76501</u>
7			<u>to 76505</u>
8	LL. Prematurity with Major		
9	Problems		
10	(1) (< 1249 Grams)	387	76511, 76512,
11			76513, 76514
12	(2) (1250 to 1749 Grams)	387	76506, 76510,
13			76515, 76516
14	(3) (1250 to 1749 Grams)	387	ALL-REMAINING
15			Codes for DRG
16			<u>387 Except</u>
17			<u>76500,</u>
18			<u>76506, 76510</u>
19			<u>TO 76516</u>
20	MM. Prematurity without		
21	Major Problems		
22	(> 1749 Grams)	388	
23	NN. Full Term Neonates		
24	(1) with Major Problems		
25	(age 0)	389	
26	(2) with Other Problems	390	
27	OO. [Reserved for future use]		
28	PP. [Reserved for future use]		
29	QQ. [Reserved for future use]		
30	RR. [Reserved for future use]		
31	SS. [Reserved for future use]		
32	TT. [Reserved for future use]		
33	UU. [Reserved for future use]		
34	VV. [Reserved for future use]		
35	WW. [Reserved for future use]		

36
37 Subp. 20g. Additional DRG requirements.

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

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

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

45 Subp. 21. [See repealer.]

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

49 Subp. 23. [See repealer.]

50 Subp. 24. [See repealer.]

51 Subp. 24a. [See repealer.]

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

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

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

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

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

18 Subp. 28. [See repealer.]

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

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

29 Subp. 30. [See repealer.]

30 Subp. 30a. [See repealer.]

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

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

1 who is also eligible for medical assistance.

2 Subp. 33. Metropolitan statistical area hospital.

3 "Metropolitan statistical area hospital" means a hospital
4 located in a metropolitan statistical area as determined by
5 Medicare for the October 1 prior to the most current rebased
6 rate year.

7 Subp. 33a. [See repealer.]

8 Subp. 34. Nonmetropolitan statistical area hospital.

9 "Nonmetropolitan statistical area hospital" means a hospital not
10 located in a metropolitan statistical area as determined by
11 Medicare for the October 1 prior to the most current rebased
12 rate year.

13 Subp. 35. Operating costs. "Operating costs" means
14 inpatient hospital costs excluding property costs.

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

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

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

23 Subp. 39. [See repealer.]

24 Subp. 40. [See repealer.]

25 Subp. 41. [See repealer.]

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

28 Subp. 42. [See repealer.]

29 Subp. 43. [See repealer.]

30 Subp. 43a. [See repealer.]

31 Subp. 44. [See repealer.]

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

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

1 operating cost within a diagnostic category divided by the mean
 2 operating cost in all diagnostic categories within a program at
 3 subpart 20b, 20c, or 20d or specialty group at subpart 20e or
 4 20f.

5 Subp. 46. [See repealer.]

6 Subp. 47. [See repealer.]

7 Subp. 47a. [See repealer.]

8 Subp. 48. [See repealer.]

9 Subp. 49. [See repealer.]

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

14 Subp. 51. **Trim point.** "Trim point" means that number of
 15 inpatient days~~7-or-that-amount-of-operating-costs7~~, beyond which
 16 an admission is a day ~~or-cost~~ outlier.

17 Subp. 52. [See repealer.]

18 9500.1105 BASIS OF PAYMENT FOR INPATIENT HOSPITAL SERVICES.

19 Subpart 1. **Reporting requirements.**

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

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

30 (2) The decision on whether certified registered
 31 nurse anesthetist services are to be paid separately from parts
 32 9500.1090 to 9500.1140. Once elected, the decision to be paid
 33 separately is irrevocable.

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

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

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

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

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

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

18 Subp. 2. Establishment of base years.

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

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

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

36 D. The base year data will be moved forward three

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

6 9500.1110 DETERMINATION OF RELATIVE VALUES OF THE DIAGNOSTIC
 7 CATEGORIES.

8 Subpart 1. Determination of relative values. To determine
 9 the relative values of the diagnostic categories the department
 10 shall:

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

14 B. Exclude the claims and charges in subitems (1) to
 15 (6):

16 (1) Medicare crossover claims;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9 F. Assign each admission and operating cost
 10 identified in item E, subitem (6), to the appropriate program or
 11 specialty group and diagnostic category according to part
 12 9500.1100, subparts 20a to 20e and 20g.

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

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

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

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

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

33 ~~E. Determine the cost outlier trim point for each~~
 34 ~~diagnostic category and round to whole dollars.~~

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

1 diagnostic category composition in part 9500.1100, subparts 20a
 2 to 20g, after notice of the change in the State Register and a
 3 30-day comment period. The relative values in this part and
 4 adjusted base year operating costs in part 9500.1115 and
 5 9500.1116 must be redetermined when changes are made to part
 6 9500.1100, subparts 20a to 20g.

7 Subp. 3. [See repealer.]

8 9500.1115 DETERMINATION OF ADJUSTED BASE YEAR OPERATING COST PER
 9 ADMISSION AND PER DAY OUTLIER.

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

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

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

23 ~~(1) For each base year admission that is a cost~~
 24 ~~outlier and is not partially denied under parts 9505.0500 to~~
 25 ~~9505.0540, multiply that cost outlier's operating costs in~~
 26 ~~excess of the trim point at part 9500.1110, subpart 1, item K,~~
 27 ~~by each hospital's elected outlier percentage or 70 percent if~~
 28 ~~an election is not made. When neonate or burn diagnostic~~
 29 ~~categories are used, the department shall substitute 90 percent~~
 30 ~~for the 70 percent or elected percentage.~~

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

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

6 C. For each admission, subtract ~~the higher amount of~~
7 ~~item B₇ subitem (1) or (2)~~ from item A, and for each hospital,
8 add the results within each program and specialty group, and
9 divide this amount by the number of admissions within each
10 program and specialty group.

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

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

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

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

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

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

28 A. To determine the allowable operating cost per day
29 that is recognized in outlier payments, add the amounts
30 calculated in subpart 1, item B₇ ~~subitem (2)~~ and divide the
31 total by the total number of days of inpatient hospital services
32 in excess of the trim point.

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

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

1 category by the relative value of that diagnostic category.

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

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

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

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

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

17 B. Add the products calculated in item A.

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

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

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

34 B. Add the products calculated in item A.

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

1 hospitals and round that amount to whole dollars.

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

11 Subp. 6. Limitation on separate payment and outlier
12 percentage. Hospitals that have rates established under subpart
13 3 may not have certified registered nurse anesthetists services
14 paid separately from parts 9500.1090 to 9500.1140 and hospitals
15 that have rates established under subpart 3, 4, or 5 may not
16 elect an alternative outlier percentage.

17 9500.1116 DETERMINATION OF ADJUSTED BASE YEAR OPERATING COST PER
18 DAY.

19 Subpart 1. Neonatal transfers.

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

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

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

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

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

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

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

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

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

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

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

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

1 excluded in part 9500.1110, subpart 1, item B, subitems (2) and
 2 (4), will be included and the ratios in part 9500.1110, subpart
 3 1, item E, subitem (2), will be adjusted to exclude certified
 4 registered nurse anesthetist costs and charges if separate
 5 billing for these services is elected by the hospital.

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

10 9500.1120 DETERMINATION OF HOSPITAL COST INDEX.

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

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

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

- 28 (1) wages and salaries;
- 29 (2) employee benefits;
- 30 (3) medical and professional fees;
- 31 (4) raw food;
- 32 (5) utilities;
- 33 (6) insurance including malpractice; and
- 34 (7) other operating costs.

35 B. Obtain data for operating costs of hospitals in

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

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

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

9 E. For ~~each-annual~~ the period beginning October 1,
10 1992, through June 30, 1993, add 0.01 to the medical assistance
11 index, excluding general assistance medical care, in item D.

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

15 Subp. 3. [See repealer.]

16 9500.1121 DETERMINATION OF DISPROPORTIONATE POPULATION
17 ADJUSTMENT.

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

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

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

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

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

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

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

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

35 9500.1122 DETERMINATION OF PROPERTY COST PER ADMISSION.

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

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

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

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

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

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

16 B. Determine the property cost for each hospital
 17 admission in part 9500.1110, subpart 1, item D, using each
 18 hospital's base year data and recent year data from part
 19 9500.1105, subpart 1, item A, subitem (5), according to subitems
 20 (1) to (4).

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

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

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

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

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

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

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

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

1 round to two decimal places.

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

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

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

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

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

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

19 B. Add the products in item A.

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

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

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

34 B. Add the products in item A.

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

1 round the resulting amount to whole dollars.

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

11 9500.1124 DETERMINATION OF PROPERTY COST PER DAY.

12 Subpart 1. Neonatal transfers.

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

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

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

31 9500.1128 DETERMINATION OF PAYMENT RATES.

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

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

6 Subp. 2. Rate per admission.

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

- 11 ((Adjusted base year operating
- 12 (1) Medical cost per admission multiplied by
- 13 Assistance the relative value of the diagnostic
- 14 Rate Per = category) plus the property
- 15 Admission = cost per admission) and
- 16 multiplied by the disproportionate
- 17 population adjustment
- 18
- 19 (Adjusted base year operating
- 20 (2) General cost per admission multiplied by
- 21 Assistance the relative value of the diagnostic
- 22 Medical = category and multiplied by the
- 23 Care = disproportionate population
- 24 Rate per adjustment) plus the property
- 25 Admission cost per admission
- 26
- 27

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

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

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

37 Adjusted base year operating

38 Outlier Rate = cost per day outlier multiplied

39 Per Day = by the relative value of the

40 diagnostic category and

41 multiplied by the disproportionate

42 population adjustment

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

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

1 according-to-units-(a)-to-(g).
 2 (a)-Add-the-operating-cost-for-each
 3 hospital's-admissions-in-part-9500.11107-subpart-17-item-E7
 4 subitem-(5)7-and-divide-that-total-by-the-total-charges-on-the
 5 corresponding-claims-to-determine-the-overall-operating-cost-to
 6 charge-ratio-for-each-hospital.

7 (b)-For-out-of-area-hospitals-and-hospitals
 8 that-do-not-have-medical-assistance-admissions-in-the-base-year7
 9 add-the-operating-cost-for-all-admissions-at-part-9500.11107
 10 subpart-17-item-E7-subitem-(5)7-and-divide-that-total-by-the
 11 total-charges-on-the-corresponding-claims-to-determine-the
 12 overall-operating-cost-to-charge-ratio.

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

16 (d)-Subtract-from-the-amount-calculated-in
 17 unit-(c)-the-cost-outlier-trim-point-in-part-9500.11107-subpart
 18 17-item-E7.

19 (e)-Multiply-the-amount-calculated-in-unit
 20 (d)-by-90-percent-for-neonate-and-burn-diagnostic-categories.
 21 For-all-other-diagnostic-categories7-multiply-the-amount-by-70
 22 percent-or-the-hospital-elected-percentage.

23 (f)-For-out-of-area-hospitals-and-hospitals
 24 that-do-not-have-medical-assistance-admissions-in-the-base-year7
 25 multiply-the-amount-calculated-in-unit-(d)-by-the-average
 26 outlier-percent.--The-average-outlier-percent-is-calculated-by
 27 multiplying-each-hospital's-outlier-percent-by-the-number-of
 28 admissions7-excluding-neonate-and-burn-diagnostic-category
 29 admissions.--Add-the-products-for-all-hospitals-and-divide-this
 30 total-by-the-total-of-all-admissions.

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

33 (4)-If-an-admission-is-both-a-day-and-cost
 34 outlier7-the-payment-will-be-determined-at-the-higher-amount
 35 except-that-a-cost-outlier-shall-not-be-applicable-to-admissions
 36 that-are-partially-denied-under-parts-9505.0500-to-9505.0540.

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

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

9
 10 (1) A hospital will not receive a transfer
 11 payment that exceeds the hospital's applicable rate per
 12 admission specified in item A unless that admission is a day or
 13 cost outlier.

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

17 Subp. 3. Rate per day.

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

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

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

30 Subp. 5. Readmissions. An admission and readmission of
 31 the same patient to the same or a different hospital within 15
 32 days, excluding the days of discharge and readmission, is
 33 eligible for reimbursement according to the criteria in parts
 34 9505.0500 to 9505.0540.

35 9500.1129 PAYMENT LIMITATIONS.

36 Subpart 1. Charge limitation.

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

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

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

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

19 9500.1130 PAYMENT PROCEDURES.

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

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

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

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

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

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

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

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

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

25 Subp. 2. [See repealer.]

26 Subp. 3. [See repealer.]

27 Subp. 4. [See repealer.]

28 Subp. 5. [See repealer.]

29 Subp. 6. [See repealer.]

30 Subp. 7. [See repealer.]

31 Subp. 8. [See repealer.]

32 Subp. 9. [See repealer.]

33 Subp. 10. [See repealer.]

34 Subp. 11. [See repealer.]

35 Subp. 12. [See repealer.]

1 ~~9500.1131-DETERMINATION-OF-DIFFERENCES-DUE-TO-REBASING-~~

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

6 ~~A.--Determine-the-operating-cost-per-admission-for~~
 7 ~~each-hospital-using-data-from-the-base-year-in-effect-on-June~~
 8 ~~30,1992-according-to-subitems-(1)-and-(2)-~~

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

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

16 ~~B.--Determine-the-operating-cost-per-admission-for~~
 17 ~~each-hospital-using-data-from-the-base-year-in-effect-on-July-1,~~
 18 ~~1993-according-to-subitems-(1)-to-(5)-~~

19 ~~(1)-Determine-the-operating-cost-for-all~~
 20 ~~admissions,including-the-cost-of-transfer-admissions-and-part~~
 21 ~~9500.1116,according-to-part-9500.1110,subpart-1,items-A-to-E-~~

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

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

29 ~~(4)-Divide-the-results-of-subitem-(2)-by-subitem~~
 30 ~~(3)-for-each-program-~~

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

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

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

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

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

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

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

18 C.--Add-the-admissions-and-subtract-from-that-total
 19 rehabilitation-distinct-part-admissions-and-newborn-admissions
 20 that-have-been-separated-from-another-admission.

21 D.--Divide-the-results-of-item-B-by-item-C-for-each
 22 program.

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

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

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

1 (1)-Multiply-the-result-of-subpart-17-item-A7
2 subitem-(2)-by-the-disproportionate-population-adjustment-in
3 effect-on-July-17-1992-and-add-the-property-rate-in-effect-on
4 July-17-1992.

5 (2)-Add-the-results-of-subpart-17-item-A7-subitem
6 (2)-and-the-property-rate-in-effect-on-October-17-1992-and
7 multiply-the-result-by-the-disproportionate-population
8 adjustment-in-effect-on-October-17-1992.

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

11 (4)-Multiply-the-result-of-subpart-17-item-B7
12 subitem-(5)-by-the-rebased-disproportionate-population
13 adjustment-under-the-laws-in-effect-on-July-17-1992-and-add
14 this-amount-to-the-result-of-subpart-27-item-D7-for-each-program.

15 (5)-Add-the-result-of-subpart-17-item-B7-subitem
16 (5)-and-subpart-27-item-D7-for-each-program-and-multiply-the
17 result-by-the-rebased-disproportionate-population-adjustment
18 under-the-laws-in-effect-on-October-17-1992.

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

21 (7)-Subtract-one-from-the-disproportionate
22 population-adjustment-in-effect-on-October-17-1992-and-subtract
23 the-result-from-the-applicable-.15-or-.20-small-rural-increase.

24 (8)-Multiply-the-result-of-subitem-(7)-if
25 positive-by-.75-and-add-one.

26 (9)-Multiply-the-result-of-subitem-(3)-by-subitem
27 (8).

28 (10)-Subtract-one-from-the-rebased
29 disproportionate-population-adjustment-under-the-laws-in-effect
30 on-October-17-1992-and-subtract-the-result-from-the-applicable
31 .15-or-.20-small-rural-increase.

32 (11)-Multiply-the-result-of-subitem-(10)-if
33 positive-by-.75-and-add-one.

34 (12)-Multiply-the-result-of-subitem-(6)-by
35 subitem-(11).

36 (13)-Subtract-subitem-(9)-from-subitem-(12).

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

4 (1)-Multiply-the-result-of-subpart-17-item-A7
 5 subitem-(2),-by-the-disproportionate-population-adjustment-in
 6 effect-on-July-17-1992,-and-add-the-property-rate-in-effect-on
 7 July-17-1992.

8 (2)-Multiply-the-result-of-subpart-17-item-A7
 9 subitem-(2),-by-the-disproportionate-population-adjustment-in
 10 effect-on-October-17-1992,-and-add-the-property-rate-in-effect
 11 on-October-17-1992.

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

14 (4)-Multiply-the-result-of-subpart-17-item-B7
 15 subitem-(5),-by-the-rebased-disproportionate-population
 16 adjustment-under-the-laws-in-effect-on-July-17-1992,-and-add-the
 17 result-of-subpart-27-item-D.

18 (5)-Multiply-the-result-of-subpart-17-item-B7
 19 subitem-(5),-by-the-rebased-disproportionate-population
 20 adjustment-under-the-laws-in-effect-on-October-17-1992,-and-add
 21 the-result-of-subpart-27-item-D.

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

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

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

28 A.--Determine-the-medical-assistance-and-aid-to
 29 families-with-dependent-children-payment-adjustment-for-each
 30 admission-occurring-from-July-17-1993-to-June-30-1994,
 31 according-to-subitems-(1)-to-(4).

32 (1)-Subtract-the-medical-assistance-cash-flow
 33 add-on-in-effect-on-July-17-1992,-from-subpart-37-item-A7
 34 subitem-(13).

35 (2)-Multiply-the-result-of-subitem-(1)-by-the
 36 result-of-subpart-17-item-B7-subitem-(3).

1 (3)-Divide-the-product-of-subitem-(2)-by-the
2 result-of-subpart-17-item-B7-subitem-(2)7-and-round-to-whole
3 dollars7

4 (4)-A-change-to-the-cash-flow-add-on-will-result
5 in-a-change-to-the-subtraction-at-subitem-(1)-for-the-same
6 length-of-time-that-it-was-in-effect7

7 B7--Determine-the-general-assistance-medical-care
8 payment-adjustment-for-each-admission-occurring-from-July-17
9 1993-to-June-307-19947-according-to-subitems-(1)-to-(4)7

10 (1)-Subtract-the-general-assistance-medical-care
11 cash-flow-add-on-in-effect-on-July-17-19927-from-subpart-37-item
12 B7-subitem-(7)7

13 (2)-Multiply-the-result-of-subitem-(1)-by-the
14 result-of-subpart-17-item-B7-subitem-(3)7

15 (3)-Divide-the-product-of-subitem-(2)-by-the
16 result-of-subpart-17-item-B7-subitem-(2)7-and-round-to-whole
17 dollars7

18 (4)-A-change-to-the-cash-flow-add-on-will-result
19 in-a-change-to-the-subtraction-at-subitem-(1)-for-the-same
20 length-of-time-that-it-was-in-effect7

21 Subp7-57--Adjustments7--The-department-will-adjust-the
22 results-of-subparts-1-to-4-in-circumstances-occurring-under
23 items-A-and-B7

24 A7--If-the-implementation-date-of-the-Medicaid
25 management-information-system-is-later-than-July-17-19937
26 adjustments-will-be-made-according-to-subitems-(1)-to-(3)7

27 (1)-Redetermine-the-hospital-cost-index-in
28 subpart-1-to-the-day-prior-to-the-implementation-date-of-the
29 Medicaid-management-information-system7

30 (2)-Redetermine-the-time-weights-calculated-in
31 subpart-3-by-dividing-three-months-by-the-number-of-months
32 between-July-17-19927-and-the-implementation-date-of-the
33 Medicaid-management-information-system7--Subtract-this-amount
34 from-one7

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

1 ~~that the implementation date of the Medicaid management~~
 2 ~~information system was delayed from July 17, 1993.~~

3 ~~B. If changes are made to a hospital's~~
 4 ~~disproportionate population adjustment or if appeal settlements~~
 5 ~~are made after July 17, 1992, to the implementation date of the~~
 6 ~~Medicaid management information system, adjustments will be made~~
 7 ~~according to subitems (1) and (2):~~

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

11 ~~(2) Redetermine the time weights in subpart 3 as~~
 12 ~~the number of months that the change was in effect divided by~~
 13 ~~the number of months between July 17, 1992, and the~~
 14 ~~implementation date of the Medicaid management information~~
 15 ~~system.~~

16 9500.1140 APPEALS.

17 Subpart 1. Scope of appeals. A hospital may appeal a
 18 decision arising from the application of standards or methods
 19 under Minnesota Statutes, section 256.9685, 256.9686, or
 20 256.969, if an appeal would result in a change to the hospital's
 21 payment rate or payments. The appeals procedure in subparts 2
 22 to 6 shall apply to all appeals filed on or after August 1, 1989.

23 Subp. 2. Filing of appeals. An appeal must be received by
 24 the commissioner within the time period specified in subpart 3,
 25 4, or 5. The appeal must include the information required in
 26 items A to D:

27 A. the disputed items;

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

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

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

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

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

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

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

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

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

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

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

3 Subp. 6. Resolution of appeals. The appeal will be heard
4 by an administrative law judge according to parts 1400.5100 to
5 1400.8401 and Minnesota Statutes, sections 14.57 to 14.62, and
6 according to the requirements of items A to D.

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

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

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

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

18 REPEALER. Minnesota Rules, parts 9500.1100, subparts 4, 4a, 7,
19 8, 8a, 10, 12, 13, 15, 17, 20, 21, 23, 24, 24a, 28, 30, 30a,
20 33a, 39, 40, 41, 42, 43, 43a, 44, 46, 47, 47a, 48, 49, and 52;
21 9500.1110, subpart 3; 9500.1120, subpart 3; 9500.1125;
22 9500.1130, subparts 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, and 12; and
23 9500.1135, are repealed.

24
25 CHANGE IN TERMS. The reference to part 9500.1100, subpart 20,
26 in Minnesota Rules, part 9505.0500, subpart 10a, shall be
27 changed to part 9500.1100, subpart 20a. The references to part
28 9500.1130, subpart 7, in Minnesota Rules, part 9505.0540,
29 subpart 5, items A to C, shall be changed to part 9500.1128,
30 subpart 2, item D.