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 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 who received inpatient hospital services from the hospital for which the hospital received medical assistance payment excluding Medicare crossovers and the appeal is effective for the entire rate year. A case mix appeal excludes medical assistance admissions whose payments have been made according to part 9500.1130, subpart 1b, item E. A case mix appeal excludes medical assistance admissions that have a relative value of zero for its DRG. 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 J.

A. The change must be measured by use of case mix indices derived using all DRG's. Relative values for each DRG will be determined according to part 9500.1110, subpart 1, by substituting DRG terms and data for diagnostic category terms and data. DRG relative values will be determined based on all programs and the rehabilitation distinct part specialty group. Separate DRG relative values will be determined for transfers to the

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neonatal intensive care unit specialty group. For each program and specialty group, make the determinations in subitems (1) to (6).

(1) Multiply the hospital's number of rate year admissions within each DRG by the relative value of that DRG.

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

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

(4) Complete the functions in subitems (1) to (3) for the hospital's base year admissions determined in part 9500.1110, subpart 1, item C.

(5) Divide the quotient determined in subitem (3) by the quotient determined in subitem (4).

(6) Multiply subitem (5) by 100 and round the percentage to five decimal places.

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 categories in part 9500.1100, subparts 20b to 20g. For each program and specialty group, make the determinations in subitems (1) to (8).

(1) Multiply the hospital's number of rate year admissions within each diagnostic category by the relative value of that diagnostic category as determined in part 9500.1100.

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

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

(4) Complete the functions in subitems (1) to (3) for the hospital's base year admissions determined in part 9500.1110, subpart 1, item C.

(5) Divide the quotient determined in subitem (3) by the quotient determined in subitem (4).

(6) Multiply subitem (5) by 100 and round the percentage to five decimal places.

(7) Divide item A, subitem (6), by subitem (6).

(8) Multiply subitem (7) by 100 and round the percentage change to whole numbers.

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C. Determine the payments made for admissions occurring during the appealed rate year under part 9500.1128 reduced by property payments made under parts 9500.1121, 9500.1122, 9500.1123, 9500.1124, and 9500.1126 for each program and specialty group.

D. Multiply item B, subitem (8), by item C for each program and specialty group.

E. Subtract item C from item D for each program and specialty group.

F. Add the differences in item E.

G. Add the differences in item C.

H. Divide item F by item G. If the quotient is less than positive 0.05 and more than negative 0.05, there can be no payment adjustment for a change in case mix.

I. Subtract 0.05 from the quotient in item H if the quotient is positive or add 0.05 if the quotient is negative.

J. Multiply item G by item I. If the product is positive, there is an underpayment with that amount due the hospital. If the product is negative, there is an overpayment with that amount due the department.

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.

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

Statutory Authority: *MS s 256.9685; 256.969; 256.9695*

History: *10 SR 227; 18 SR 1115; 26 SR 976*

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