

(A) As used in this rule:

- (1) "ADRG" means the adjacent diagnosis-related groups as defined by the DRG refinement system.
- (2) "DRG" or "DRGs" means the diagnosis-related group or groups that a hospital assigns based upon the clinical record of the patient for the purpose of classifying inpatient hospital services and determining reimbursement for services performed .
- (3) "Charge outlier case" means a patient discharged from the hospital whose total charges are equal to or greater than the charge trim point for that patient's DRG.
- (4) "Charge trim point" means two standard deviations above the arithmetic - mean of charges for all cases in a DRG.
- (5) "Day outlier case" means a patient discharged from the hospital whose total number of inpatient days are equal to or greater than the length of stay trim point for that patient's DRG.
- (6) "DRG refinement system" means the severity of illness classification system developed by the "Health Systems Management Group, School of Management, Yale University," as updated by the director of health.
- (7) "HSMG refinement grouper" means the software which implements the DRG refinement system as updated by the director of health for discharges on or after October first of each year.
- (8) "Hospital" means an institution classified and registered as a hospital under section 3701.07 of the Revised Code.
- (9) "ICD-9-CM procedure code" means an identifier assigned to describe the medical procedure used for the treatment of illness and injury.
- (10) "Length of stay trim point" means two standard deviations above the arithmetic mean of the length of stay for all cases in a DRG.
- (11) "LOS" or "length of stay" means the number of days a patient is in the hospital per admission as calculated by counting the number of days from and including the day of admission up to but not including the day of discharge.
- (12) "Mean" means the arithmetic average that is calculated by adding the values and dividing by the number of cases.
- (13) "Median" means the middle case where fifty per cent of the cases have lower values and fifty per cent of the cases have higher values.

- (14) "Outpatient procedure" means a non-urgent medical procedure performed on an outpatient basis in a hospital under the supervision of a physician for the diagnosis or treatment of a disease or other disorder. "Outpatient procedure" does not include procedures performed in clinics or other settings where only ancillary services are provided or where physician services are not typically provided, such as radiology, laboratory services, physical rehabilitation, renal dialysis, or pharmacy.
- (15) "Range" means the lowest and the highest values.
- (16) "Refinement class" means the severity level within each ADRG, as defined by the DRG refinement system and HSMG refinement grouper, in which a patient may be classified based on the extent that a patient's illness involves multiple complications and comorbid conditions requiring a certain degree of complexity in treatment and diagnosis.
- (17) "Refinement group number" or "RGN" means the complete four-digit number assigned by the HSMG refinement grouper which consists of the ADRG code number in character positions one through three and the refinement class code number in character position four.
- (18) "Trim points" mean charge trim point and length of stay trim point.
- (19) "Primary procedure code" means the code that identifies the principal procedure performed during the period covered by a bill and the date on which the principal procedure described on the bill was performed.
- (B) On or before the first day of May each year, every hospital shall disclose to the director of health the following inpatient data:
- (1) The total number of patients in each of the sixty DRGs most frequently treated on an inpatient basis in the hospital as represented by discharges during the previous calendar year and based upon the DRG grouper in effect on the first day of October of the calendar year preceding the calendar year which the patient was discharged. If DRG 468, 469, or 470 appears on the list of most frequently treated DRGs, the DRG or DRGs shall be removed from the list and the next most frequently treated DRG or DRGs shall be substituted in its place:
- (a) The total number of patients discharged;
- (b) The mean, median, and range of total hospital charges;
- (c) The mean, median, and range of length of stay;
- (d) The number of admissions from each of the following:
- (i) Emergency room: For the purposes of this provision, "admissions from emergency room" means the number of patients admitted to the hospital through the emergency room upon the recommendation of a physician;
- (ii) Transfer from another hospital;

(iii) Other sources of admission including, but not limited to, skilled nursing facilities or health care facilities other than an acute care hospital; referrals from a personal physician, clinic physician, health maintenance organization, a court of law; a newborn if the patient was born in the facility; and those admissions for which information is not available;

(e) The number of cases, mean charges, and mean length of stay in each refinement class or refinement group number excluding all charge outlier cases and day outlier cases based on the trim points provided and published by the director at least one hundred twenty days prior to May first each year; and

(2) The number of patients falling within DRG numbers 468, 469, and 470.

Paragraphs (B)(1)(a) to (B)(1)(d) of this rule do not require the disclosure of data for any DRG for which the hospital treated fewer than ten patients during the year. Paragraph (B)(1)(e) of this rule does not require the disclosure of data for any refinement group number for which the hospital treated less than three patients during the year.

(C) On or before the first day of May each year, every hospital shall disclose to the director of health the following outpatient data:

(1) The total number of patients in each of the sixty most frequently performed outpatient primary procedures in the hospital as reported by ICD-9-CM primary procedure codes for patients treated during the previous calendar year.

(2) The mean and median of the total hospital charges for those sixty most frequently performed outpatient procedures identified in paragraph (C)(1) of this rule.

(3) The hospital is not required to disclose data for any procedure for which the hospital treated fewer than ten patients during the year.

(D) Each hospital shall:

(1) Submit the hospital identification and certification form, prescribed in appendix A of this rule, signed by the chief executive officer of the hospital;

(2) Submit the inpatient data required to be reported under this rule to the director in an electronic format as provided in appendix B of this rule, or in a paper format as provided in appendix C to this rule, and report the DRG data required by paragraph (B)(1) of this rule in descending order according to the frequency of admissions with the DRG having the most frequent number of admissions reported first;

(3) Submit the outpatient data required to be reported under this rule to the director in an electronic format as provided in appendix D to this rule and

report the procedure data required by paragraph (C) of this rule in descending order according to the frequency of patients with the procedure having the most frequent number of patients reported first.

- (E) Each hospital may include with the data disclosed under this rule commentary concerning reasons for major deviations in the range of data for any DRG. The hospital shall submit the commentary in the format prescribed by appendix C to this rule. Any release of the data disclosed under this rule identifying a hospital shall include the commentary, if any, submitted by the hospital pursuant to this paragraph.
- (F) Any releases by the department of information collected pursuant to section 3727.34 of the Revised Code that list charge data by hospital shall include conspicuous language explaining that the data in the report either has been reported by severity of illness or adjusted with respect to the severity of illness of the patients and that an individual hospital's average charges may differ significantly from the average charges of a group of hospitals because of a variety of reasons including, but not limited to:
 - (1) Indigent care and bad debt loads;
 - (2) Medical education costs;
 - (3) Physician practice patterns;
 - (4) Capital requirements;
 - (5) Hospital location;
 - (6) Local labor market conditions; and
 - (7) Other operating requirements.
- (G) Under no circumstances shall the name or social security number of a patient, dentist or physician be submitted under this rule.

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CERTIFIED ELECTRONICALLY

Certification

09/17/2014

Date

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