METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

VI. PER DISCHARGE PROSPECTIVE PAYMENT METHODOLOGY FOR HOSPITALS (*continued*)

A. Services Included in or Excluded from the Prospective Rate *(continued)*

1. Services which may be billed separately include:
   a. Ambulance service when the patient is transferred from one hospital to another and is admitted as an inpatient in the second hospital
   b. Physician services furnished to individual patients
   c. Long Acting Reversible Contraception (LARC)
   d. High-investment drugs
      i. High-investment drugs are reimbursed under the methodology described in Attachment 4.19-B, Page 7a. A list of high-investment drugs is found on www.okhca.org.
   e. Opioid antagonists
   d. Rapid Whole Genome Sequencing

   The agency's fee schedule rate is updated annually in July. All rates are published on the agency's website at www.okhca.org. A uniform rate is paid to governmental and non-governmental providers.

B. Computation of DRG Relative Weights

1. Relative weights used for determining rates for cases paid by DRG under the State Plan shall be derived, to the greatest extent possible, from Oklahoma hospital claim data. All such claims are included in the relative weight computation, except as described below.

2. Hospital fee-for-service (FFS) claims and adjusted managed care encounter data for discharges occurring from July 1, 2000, through June 30, 2003, are included in the computation and prepared as follows:
   a. All interim and final claims for single inpatient stay were combined into a single record per discharge.
   b. All Medicaid inpatient discharges were classified using the Diagnostic Related Group (DRG) methodology, a patient classification system that reflects clinically cohesive groupings of inpatient resources. Input files were created for the Medicare Version 22 grouper software. Lines containing detail ICD-9 procedure codes were transposed and attached to the claim header record to produce a single claim record per line. Historical diagnosis and procedure codes that are no longer valid and not recognized by the CMS Medicare Version 22 grouper were updated to reflect their placement codes.
   c. Claims that were grouped into Major Diagnostic Category 15 "Newborns and other Neonates with Conditions Originating in the Perinatal Period" were further grouped using enhanced neonate logic. The enhanced neonate logic creates 20 groupings. The groupings are hierarchical based on discharge state, transfer status, neonate weight, major operating room procedure performed, and the existence of a major or minor diagnosis.