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Conditions and limitations.

(A) Conditions and limitations applicable to both inpatient and outpatient hospital services.

(1) Coverage of provider-based physician services reimbursable as an inpatient or outpatient hospital service is limited to those services reimbursable under ~~Title XVIII (medicare), part A, as provided in 42 CFR Part 415, Subpart B medicare, part A,~~ except as provided in rule 5101:3-4-04 of the Administrative Code. For information concerning coverage of direct-care physician services provided in a hospital setting, see Chapter 5101:3-4-01 of the Administrative Code.

(2) Inpatient or outpatient services related to the provision of the services described in paragraphs (A)(2)(a) to (A)(2)(i) of this rule are not covered:

(a) Abortions other than those which meet the criteria for coverage set forth in rule 5101:3-17-01 of the Administrative Code.

(b) Sterilizations and hysterectomies other than those which meet the criteria for coverage set forth in rule 5101:3-21-01 of the Administrative Code.

(c) Artificial insemination, treatment of infertility, including procedures for reversal of voluntary sterilization.

(d) Treatment of obesity, including gastroplasty, gastric stapling, or ileo-jejunal shunt.

(e) Plastic or cosmetic surgery when the surgery is performed for aesthetic purposes; for example, rhinoplasty, ear piercing, mammary augmentation or reduction, tattoo removal, excision of keloids, facio-plasty, osteoplasty (prognathism and micrognathism), dermabrasion, skin grafts, and lipectomy.

(f) Acupuncture.

(g) Services of a research nature or services which are experimental and not in accordance with customary standards of medical practice or are not commonly used.

(h) Dental procedures unless:

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- (i) The nature of the surgery or the condition of the patient precludes performing the procedure in the dentist's office or other nonhospital outpatient setting and the inpatient or outpatient service is a medicaid covered service.
 - (ii) The service was an emergency dental procedure performed in the emergency room, or precertified as an inpatient admission as described in rule 5101:3-2-40 of the Administrative Code.
- (i) Patient convenience items, including television service.
- (3) Blood and blood components--The department encourages the use of replacement blood donated on behalf of the recipient. However, the medicaid program will cover the cost of all blood administered, equivalent quantities of packed red blood cells or plasma when not available to the recipient from other sources, and the administering of replacement blood.
- (4) Services related to covered organ donations are reimbursable when the recipient of a transplant is medicaid eligible.
- (B) Conditions and limitations applicable to inpatient services only.

- (1) Accommodations--The medicaid program covers semiprivate accommodations. A private room will be covered only when such accommodations are medically necessary and the patient's condition requires him to be isolated for his own health or the health of others.
- (2) Covered days: In general, medicaid covers only those days of care which are medically necessary or otherwise within certain limits. The provisions set forth in this paragraph operate as limitations in one of two ways. The number of days of care charged by a hospital must be in units of full days. The day of admission counts as a full day. The day of discharge is not counted as a covered day, but charges for any covered services other than those described in revenue center codes ~~100 to 179~~ 0100 to 0179 (see rule 5101:3-2-02 of the Administrative Code for identification of revenue center codes) are covered. Charges for the services described in the foregoing sentence are covered on the days the services were rendered; not the day the charges were posted. For hospitals identified in rule 5101:3-2-07.1 of the Administrative Code which are paid on a prospective basis, the noncovered days of inpatient stay described in paragraphs (B)(2)(a) to (B)(2)(f) of this rule will be excluded for purposes of determining outliers in accordance with rule 5101:3-2-07.9 of the Administrative Code. For hospitals excluded from the prospective payment

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system as identified in rule 5101:3-2-07.1 of the Administrative Code, the noncovered days of inpatient stay described in paragraphs (B)(2)(a) to (B)(2)(f) of this rule, including associated inpatient services, are not covered and, accordingly, are not reimbursable.

- (a) Rehabilitation services related to chemical dependencies: Coverage of inpatient days for treatment of a chemical dependency is limited to coverage of services for detoxification. No coverage is available for days of inpatient care which occur solely for the provision of rehabilitation services related to a chemical dependency.
- (b) Benefit period--The number of days of inpatient care covered under the medicaid program shall not exceed thirty days during a period beginning on the day of the recipient's admission to a hospital and ending sixty days after the termination of that hospital stay, whether or not completed in the same hospital. However, the department will make exceptions to this limitation, when:
- (i) The recipient is jointly eligible under the medicaid program and the program for medically handicapped children as described in section 3701.023 of the Revised Code.
- (ii) Additional hospitalization is medically necessary before sixty days have passed since the most recent discharge date.
- (iii) A determination is made by the hospital that the care was medically necessary in accordance with rule 5101:3-2-07.13 of the Administrative Code.
- (iv) The hospital is paid on a prospective DRG basis.
- (v) The hospital is recognized as a long-term care hospital as described in 42 CFR Part 412, Subpart B under medicare.
- (c) Late discharge--The medicaid program will not pay for a patient's continued stay beyond the checkout time because of personal reasons on the part of the patient and/or physician's negligence.
- (d) Leave of absence--The day on which a patient begins a leave of absence cannot be counted as a covered day unless the patient returns to the hospital prior to midnight of the same day.

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(e) Days waiting for placement and custodial care--Coverage is not available for hospital inpatient services for patients who no longer require acute short-term hospital care. This includes days waiting for transfer to a long-term care facility, days of inpatient care due to unnecessary delays in applying for court-ordered commitment, grace periods, administrative days, and custodial care. For purposes of this rule, "custodial care" is defined as maintenance, rather than curative care, on an indefinite basis, while grace periods and administrative days relate to days of care while waiting for placement elsewhere. This exclusion also applies to days spent as an inpatient at a transferring hospital on or after the effective date of a court commitment to another facility and inpatient days resulting from a hospital's failure to timely request or perform necessary diagnostic studies, medical-surgical procedures, or consultations.

(f) Psychiatric admissions to hospitals not licensed by the department of mental health--Admissions of persons whose principal diagnosis is a mental disorder ~~according to the latest edition of the "American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders"~~ as described in Chapter 5122-14 of the Administrative Code into hospitals not licensed by the department of mental health will not be reimbursed by the medicaid program.

(C) Coverage conditions and limitations applicable to outpatient services only.

(1) When recipients use greater than forty-eight outpatient visits per year, information from paid claims will be reviewed by the department to determine whether the recipient should be referred to a managed care program. As a result of this review, the department or its contractual designee may also review hospital medical records in accordance with rule 5101:3-2-07.13 of the Administrative Code to determine whether services were medically necessary and appropriate to the recipient's illness or injury as described in rule 5101:3-2-02 of the Administrative Code.

(2) For purposes of paragraph (C)(1) of this rule, a visit is defined as services provided on one date of service to one recipient.

(D) Coverage conditions and limitations applicable to hospitals eligible to provide services pursuant to paragraphs (C) , (D) and (F) of rule 5101:3-2-01 of the Administrative Code.

(1) Coverage of inpatient services provided in hospitals to eligible recipients shall

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be provided in accordance with Chapter 5122-14 of the Administrative Code or section 5119.20 of the Revised Code.

- (2) Outpatient services provided in hospitals to eligible recipients are not coverable under the provisions set forth in Chapter 5101:3-2 of the Administrative Code.

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Effective: 10/01/2003

R.C. 119.032 review dates: 07/10/2003 and 10/01/2008

CERTIFIED ELECTRONICALLY

Certification

09/17/2003

Date

Promulgated Under: 119.03
Statutory Authority: 5111.02
Rule Amplifies: 5111.01, 5111.02
Prior Effective Dates: 4/7/77, 12/21/77, 12/30/77,
1/8/79, 2/1/80, 7/1/82,
10/1/83 (Emer.), 12/29/83,
10/1/84, 7/3/86, 11/1/86,
4/6/88 (Emer.), 6/24/88,
7/1/90, 7/1/92, 6/1/95,
8/1/2002

TN No. 04-006 APPROVAL DATE MAR 25 2003
SUPERSEDES
TN No. 03-005 EFFECTIVE DATE 01-01-05