

- (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 rule 5122-14-10 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 5101:3-2-0713 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) AND (D) OF RULE 5101:3-2-01 OF THE ADMINISTRATIVE CODE.
- (1) COVERAGE OF INPATIENT SERVICES PROVIDED IN HOSPITALS TO ELIGIBLE RECIPIENTS SHALL BE PROVIDED IN ACCORDANCE WITH RULE 5122-14-10 OF THE ADMINISTRATIVE CODE OR SECTION 5119.01 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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SUPERSEDES

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Certification: *Donald R. Trough*
MAY 22 1995
Date

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Rule Amplifies RC Section 5111.01 and 5111.02

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5101:3-2-071
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5101:3-2-071 Hospital services subject to and excluded from DRG prospective payment.

All inpatient services associated with admissions occurring on and after October 1, 1984, and furnished by hospitals defined as eligible providers of hospital services in rule 5101:3-2-01 of the Administrative Code, are subject to the DRG prospective payment system described in this chapter except for services described in paragraphs (A)1 and (B)1 AND (C) of this rule.

(A) Services provided by the following institutions:

- (1) "Freestanding rehabilitation hospitals" which the department of health and human services has determined to be excluded from medicare prospective payment in accordance with 42 CFR 412.23(b);
- (2) "Freestanding long-term hospitals" which the department of health and human services has determined to be excluded from medicare prospective payment in accordance with 42 CFR 412.23(e);
- (3) Hospitals that are excluded from medicare prospective payment due to providing services, in total, which are excluded due to a combination of the provisions of paragraphs (A)(1) and (A)(2) of this rule;
- (4) Ohio hospitals which are owned and operated by health maintenance organizations licensed by the Ohio department of insurance and which limit services to medicaid recipients (either to recipients enrolled in a health maintenance organization or to short-term services provided on an emergency basis).
- (5) CANCER HOSPITALS AS DEFINED IN RULE 5101:3-2-072 OF THE ADMINISTRATIVE CODE FOR DISCHARGES DURING JULY 1, 1992 TO JUNE 30, 1993.

(B) Transplant services that are excluded from the DRG prospective payment system are listed in paragraphs (B)(1) to (B)(4) of this rule.

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SUPERSEDES

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- (1) Heart/lung and pancreas transplantation services provided by eligible medicaid providers to eligible medicaid recipients who are discharged on or after October 1, 1986;
- (2) Heart and liver transplantation services provided by eligible medicaid providers to eligible medicaid recipients who are discharged on or after October 1, 1986 and prior to SEPTEMBER 3, 1991; ~~the effective date of this rule;~~
- (3) Bone marrow transplantation services provided by eligible medicaid providers to eligible medicaid recipients who are discharged on or after October 19, 1987 and prior to SEPTEMBER 3, 1991; ~~the effective date of this rule;~~
- (4) Single/double lung transplantation services by eligible medicaid providers to eligible medicaid recipients who are discharged on or after January 1, 1991.
- (5) Reimbursement for all organ transplant services is contingent upon review and approval by the "Ohio Solid Organ Transplant Consortium" and authorization from the department's prior authorization unit. Bone marrow TRANSPLANT REIMBURSEMENT IS CONTINGENT UPON REVIEW AND APPROVAL ~~transplants are not reviewed~~ by the "Ohio BONE MARROW TRANSPLANTATION ~~Solid Organ Transplant Consortium,~~" ~~but do~~ AND require prior authorization.

(C) NORPLANT CONTRACEPTIVE DEVICES INSERTED POST DELIVERY PRIOR TO DISCHARGE FROM THE HOSPITAL. REIMBURSEMENT IS CONTINGENT UPON THE INCLUSION IN THE MEDICAL RECORD OF A PAPER SIGNED BY THE RECIPIENT AT LEAST FOURTEEN DAYS PRIOR TO DISCHARGE STATING THAT THE RECIPIENT HAS BEEN COUNSELED CONCERNING THE VARIOUS METHODS OF BIRTH CONTROL AVAILABLE AND THE RECIPIENT UNDERSTANDS THE COMPLICATIONS AND SIDE EFFECTS THAT CAN OCCUR WITH NORPLANT AND THAT NORPLANT IS THE BIRTH CONTROL METHOD OF CHOICE.

PAYMENT FOR NORPLANT WILL BE MADE IN ACCORDANCE WITH APPENDIX F OF RULE 5101:3-2-21 OF THE ADMINISTRATIVE CODE. RETROSPECTIVE REVIEW OF THESE MEDICAL RECORDS WILL OCCUR IN ACCORDANCE WITH RULE 5101:3-2-0713 OF THE ADMINISTRATIVE CODE.

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Rule Amplifies RC Sections 5111.01 and 5111.02

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5101:3-2-04 Coverage of hospital provided pharmaceutical, dental, vision care, medical supply and equipment, and ambulance or ambulette services.

(A) Drugs.

- (1) Drugs are classified as: administered, inpatient (drugs administered to a patient while an inpatient); administered, outpatient (drugs administered to a patient at the hospital in connection with outpatient services); take home (drugs dispensed on an outpatient basis for use away from the hospital).
- (2) Administered inpatient drugs are considered inpatient services and are reimbursed as an inpatient service. Administered outpatient drugs are considered outpatient services and are reimbursed as an outpatient hospital service IN ACCORDANCE WITH RULE 5101:3-2-21 OF THE ADMINISTRATIVE CODE. Take-home drugs must be billed in accordance with provisions in Chapter 5101:3-9 of the Administrative Code. Payment to hospitals for take-home drugs will be reimbursed according to the provisions of Chapter 5101:3-9 of the Administrative Code. ODHS may periodically require hospitals to produce evidence of invoice costs supporting amounts billed for take-home drugs.

(B) Medical supplies and equipment.

- (1) Inpatient: Supplies and equipment ~~ordinarily furnished by the hospital~~ for the care and treatment of the recipient ~~solely~~ during his inpatient stay, including ~~surgical~~ implants AND DEVICES THAT ARE PART OF A SURGICAL, IMMEDIATE POST SURGICAL, OR EARLY FITTING PROCEDURE (e.g., pacemakers, HALOS, AND PROSTHETIC DEVICES), APPLIANCES THAT ARE GENERALLY APPLIED PRIOR TO DISCHARGE (E.G., INITIAL PROSTHESES), AND OTHER ITEMS THAT ARE MEDICALLY NECESSARY AS DESCRIBED IN RULE 5101:3-2-02 OF THE ADMINISTRATIVE CODE TO PERMIT OR FACILITATE THE PATIENT'S DISCHARGE FROM THE HOSPITAL UNTIL SUCH TIME AS THE RECIPIENT CAN OBTAIN A PERMANENT ITEM OR SUPPLY are covered inpatient hospital services and, as such, must be included in the hospital's inpatient billing. In order to be reimbursed for supplies and equipment furnished to an inpatient for use

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solely outside the hospital, the hospital must be approved under the medicaid program as a medical supplies provider. See Chapter 5101:3-10 of the Administrative Code for coverage, limitation, billing, and reimbursement provisions relative to medical supplies providers.

- (2) **Outpatient:** In order to be reimbursed for medical supplies and equipment on an outpatient basis, a hospital must be approved under the medicaid program as a medical supplies provider. Hospital outpatient departments that so desire may make application to provider enrollment. See Chapter 5101:3-10 of the Administrative Code for coverage, limitation, billing, and reimbursement provisions relative to medical supplies providers.
- (C) **Dental services:** Except for dental services described in rule 5101:3-2-03 of the Administrative Code and emergency dental services provided in the emergency room, all outpatient dental services are covered and reimbursed as dental services under the provisions set forth in Chapter 5101:3-5 of the Administrative Code. All inpatient services for dental services are covered and reimbursed as inpatient services, subject to the requirement that all inpatient admissions for dental services must be **PREADMISSION CERTIFIED prior authorized** (see rule 5101:3-2-03 of the Administrative Code).
- (D) **Vision care services:** All **VISION professional** services are covered and reimbursed as inpatient or outpatient hospital services. All vision care materials are covered and reimbursed in accordance with the provisions of Chapter 5101:3-6 of the Administrative Code.
- (E) **Ambulance and ambulette services:** The services of hospital staff as attendants during transportation are covered and reimbursed as an inpatient or outpatient hospital service. Services related to the use and operation of the transport vehicle, including standard equipment and driver, are reimbursed as an ambulance or ambulette service. The provisions of this paragraph apply to ambulance and ambulette services provided to or from the hospital, including interhospital ambulance or ambulette services. See Chapter 5101:3-15 of the Administrative Code for coverage, limitation, billing, and reimbursement provisions relative to ambulance and ambulette services providers.

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~~(F) Dialysis related services, supplies, and equipment provided to home dialysis patients are covered as an outpatient hospital service.~~

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5101:3-2-071 Hospital services subject to and excluded from DRG prospective payment.

All inpatient services associated with admissions occurring on and after October 1, 1984, and furnished by hospitals defined as eligible providers of hospital services in rule 5101:3-2-01 of the Administrative Code, are subject to the DRG prospective payment system described in this chapter except for services described in paragraphs (A), (B), and (C) of this rule.

(A) Services provided by the following institutions:

- (1) "Freestanding rehabilitation hospitals" which the department of health and human services has determined to be excluded from medicare prospective payment in accordance with 42 CFR 412.23(b);
- (2) "Freestanding long-term hospitals" which the department of health and human services has determined to be excluded from medicare prospective payment in accordance with 42 CFR 412.23(e);
- (3) Hospitals that are excluded from medicare prospective payment due to providing services, in total, which are excluded due to a combination of the provisions of paragraphs (A)(1) and (A)(2) of this rule;
- (4) Ohio hospitals which are owned and operated by health maintenance organizations licensed by the Ohio department of insurance and which limit services to medicaid recipients (either to recipients enrolled in a health maintenance organization or to short-term services provided on an emergency basis).
- (5) Cancer hospitals as defined in rule 5101:3-2-072 of the Administrative Code for discharges on and after July 1, 1992.

(B) Transplant services ARE SUBJECT TO ~~that are excluded from~~ the DRG prospective payment system WITH THE FOLLOWING EXCEPTIONS, AS ~~are~~ listed in paragraphs (B)(1) to (B)(~~3~~)(~~4~~) of this rule.

- (1) Heart/lung and pancreas transplantation services provided by eligible medicaid providers to eligible medicaid recipients ~~who are discharged on or after October 1, 1986;~~
- (2) ~~Heart and liver transplantation services provided by eligible medicaid providers to eligible medicaid recipients who are discharged on or after October 1, 1986 and prior to September 3, 1991;~~
- (3) ~~Bone marrow transplantation services provided by eligible medicaid providers to eligible medicaid recipients who are discharged on or after October 19, 1987 and prior to September 3, 1991;~~

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- (2)(4) Single/double lung transplantation services by eligible medicaid providers to eligible medicaid recipients who are discharged on or after January 1, 1991 AND PRIOR TO FEBRUARY 1, 2000.
- (3) LIVER/SMALL BOWEL TRANSPLANTATION SERVICES FOR ELIGIBLE MEDICAID PROVIDERS TO ELIGIBLE MEDICAID RECIPIENTS.
- (4)(5) Reimbursement for all organ transplant services is contingent upon review and recommendation by the "Ohio Solid Organ Transplant Consortium" based on criteria established by Ohio organ transplant surgeons and authorization from the department's prior authorization unit.
- (5)(6) Reimbursement for bone marrow transplant, as defined in rule 3701-12-32 of the Administrative Code, is contingent upon review and the recommendation by the "Ohio Bone Marrow Transplantation Consortium," based on criteria established by Ohio experts in the field of bone marrow transplant and authorization from the department's prior authorization unit. Authorization is contingent upon the transplant program's approval by the Ohio department of health or a letter of nonreview ability from the Ohio department of health, or having had a bone marrow transplant program in operation prior to April 2, 1992. Reimbursement is further contingent upon:
- (a) Membership in the "Ohio Bone Marrow Transplantation Consortium"; or
 - (b) Compliance with the performance standards described in rule 3701-12-32 of the Administrative Code, and the performance of ten autologous or ten allogeneic bone marrow transplants, dependent on which volume criteria is appropriate for the transplant requested.
- (C) NORPLANT contraceptive devices inserted post delivery prior to discharge from the hospital. Reimbursement is contingent upon the inclusion in the medical record of a paper signed by the recipient at least fourteen days prior to discharge stating that the recipient has been counseled concerning the various methods of birth control available and the recipient understands the complications and side effects that can occur with NORPLANT and that NORPLANT is the birth control method of choice.

Reimbursement for a NORPLANT contraceptive device is available in the case of a premature delivery, if the recipient has signed the paper at least seventy-two hours prior to the delivery.

Payment for NORPLANT will be made in accordance with appendix F of rule 5101:3-2-21 of the Administrative Code. Retrospective review of these medical records will occur in

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