



Ohio Administrative Code Rule 5160-2-03 Conditions and limitations.

Effective: [March 1, 2022](#)

(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 medicare, part A, except as provided in rule 5160-4-01 of the Administrative Code.

(2) The following inpatient or outpatient services related to the provision of the services described in this rule are not covered:

(a) Abortions other than those that meet the criteria for coverage set forth in rule 5160-17-01 of the Administrative Code.

(b) Sterilizations and hysterectomies other than those that meet the criteria for coverage set forth in Chapter 5160-21 of the Administrative Code.

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

(d) 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, faciaplasty, osteoplasty (prognathism and micrognathism), dermabrasion, skin grafts, and lipectomy.

(e) Gender transformation.

(f) Acupuncture, with the exception of conditions described in rule 5160-8-51 of the Administrative Code.

(g) Services of a research nature or services that are experimental and not in accordance with



customary standards of medical practice or are not commonly used.

(h) Dental procedures unless:

(i) The nature of the surgery or the condition of the patient precludes performing the procedure in the dentist's office or other non hospital 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.

(i) Patient convenience items.

(j) Pregnancy related services pertaining to a pregnancy that is a result of a contract for surrogacy services. For the purposes of this rule, "surrogacy services" means a woman agrees to become pregnant for the purpose of gestating and giving birth to a child she will not raise, but hand over to a contracted party.

(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 rooms are covered only when the patient's condition necessitates isolation to protect the patient's health or the health of others.

(b) When no semiprivate rooms are available, the private room will be reimbursed as semiprivate



rooms.

(c) For hospitals paid on a DRG prospective payment basis as identified in rule 5160-2-65 of the Administrative Code, private rooms will be excluded for purposes of determining outliers.

(d) For hospitals paid on a non-DRG prospective payment basis as identified in rule 5160-2-05 of the Administrative Code, private rooms are not covered and, accordingly, will not be reimbursed.

(2) Covered days --In general, medicaid covers only those days of care that are medically necessary or otherwise within certain limits as follows.

(a) The number of days of care charged by a hospital are to be reported in units of full days.

(i) The day of admission counts as a full day.

(ii) 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 0100-0219 are covered for the days on which the services were rendered, not for the days the charges were posted.

(b) 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 or because of physician negligence.

(c) 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.

(d) Days waiting for placement and custodial care--Coverage is not available for hospital inpatients for whom acute short-term hospital care is no longer necessary. 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.

(e) Reimbursement for medicaid inpatient hospital services for the treatment of persons whose principal diagnosis is a mental health disorder, will only be made to facilities that are licensed by the department of mental health and addiction services in accordance with Chapter 5122-14 of the Administrative Code.

(f) For hospitals paid on a DRG prospective payment basis as identified in rule 5160-2-65 of the Administrative Code, the non covered days of inpatient stay described in paragraphs (B)(2)(a) to (B)(2)(e) of this rule will be excluded for purposes of determining outliers in accordance with rule 5160-2-65 of the Administrative Code.

(g) For hospitals paid on a non-DRG prospective payment basis as identified in rule 5160-2-05 of the Administrative Code, the non covered days of inpatient stay described in paragraphs (B)(2)(a) to (B)(2)(e) of this rule, including associated inpatient services, are not covered and, accordingly, are not reimbursable.

(3) Surgical treatment for obesity is covered when prior authorized.

(C) Coverage conditions and limitations applicable to hospitals eligible to provide services pursuant to paragraphs (B) and (D) of rule 5160-2-01 of the Administrative Code.

(1) Coverage of inpatient services provided in hospitals to eligible recipients will be provided in accordance with Chapter 5122-14 of the Administrative Code or section 5119.33 of the Revised Code.

(2) Outpatient services provided in hospitals to eligible recipients will be provided in accordance with rule 5160-2-76 of the Administrative Code.