Hospital Handbook Table of Contents

John R. Kasich, Governor

John B. McCarthy, Director

Ohio Department of Medicaid

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Hospital Handbook Transmittal Letters (HHTLs)

HHTL 3352-15-07 (2015 Hospital Franchise Fee Program)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-15-07

April 27, 2015

TO: Eligible Hospital Providers

Directors, County Departments of Job and Family Services

FROM: John B. McCarthy, Director

SUBJECT: 2015 Hospital Franchise Fee Program

Summary

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to payment data policies and the assessment for hospitals, for the 2014 Hospital Franchise Fee Program.

Rule 5160-2-30 entitled Hospital Franchise Fee Program sets forth the policies to administer this program. This rule modifies the rate at which total facility cost will be assessed and the payment schedule of the franchise fee for the 2015 program year.

Access to Rules and Related Material

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HHTL 3352-15-06 (Outpatient Hospital Services)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-15-06

April 27, 2015

TO: All Hospital Providers

Directors, County Departments of Job and Family Services

FROM: John B. McCarthy, Director

SUBJECT: Outpatient Hospital Services

Summary

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to the revisions to payment policies for outpatient hospital services.

Ohio Administrative Code (OAC) rule 5160-2-21, "Policies for outpatient hospital services," has been amended to update appendices to reflect the annual Healthcare Common Procedure Coding System (HCPCS) update. Paragraph (B)(4) updates the referral of revenue center codes from Appendix A in rule 5160-2-02 to Appendix I of the Department's Hospital Billing Guidelines. Effective for dates of service on or after January 1, 2016, the initial maximum payment amount for new HCPCS codes is set at seventy-six percent of the Medicare allowed amount but is not to exceed the Medicaid allowed amount of similar procedure codes. The effective date of this rule is April 30, 2015.

Rule Changes

Rule 5160-2-21, "Policies for outpatient hospital services," describes the outpatient payment rates and policies for outpatient services delivered by hospitals that are subject to prospective payment based on diagnosis related groups (DRG).

Changes:

- The title to the rule has been amended to more accurately reflect the content of the rule.
- Appendices C, D, F, G, and H have been amended to add new codes and to delete obsolete codes to be consistent with the 2015 (Current Procedural Terminology) CPT and HCPCS manuals.
- Hyperbaric oxygen CPT code C1300 was discontinued and replaced with CPT code G0277.
- HLA I Typing CPT codes (81379-81382) added to Appendix H.
- Preventative services codes 99385 and 99395 are now reimbursable for years 18-39.
- Preventative services codes 99386-99387 and 99396-99397 added to Appendix D.
- Coverage of CPT code 90644 added to Vaccine for Children program.
- Language in paragraph (B)(4) of the rule updates the referral of revenue center codes from Appendix A in OAC rule 5160-2-02 to Appendix I of the Department's Hospital Billing Guidelines.
- New paragraph (B)(3)(b) contains language regarding setting the initial maximum payment amount for new HCPCS codes at seventy-six percent of the Medicare allowed amount but is not to exceed the Medicaid allowed amount of similar procedure codes; this is effective for dates of service on or after January 1, 2016.
- Appendix A to this HHTL provides a list of procedure codes that were removed from Appendix C as they were deemed inpatient only by the Centers for Medicare and Medicaid Services (CMS).
- Grammatical and spelling errors were corrected, outdated information was removed, clarifying language was added and a paragraph regarding comprehensive vision exams was moved for improved readability.

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Appendix A

The following CPT codes were deleted from Appendix C to 5160-2-21 as they were deemed inpatient only by the Centers for Medicare and Medicaid Services (CMS).						
11004	21366	27303	38747	47015	54417	61210
11005	21422	27470	39010	47100	55605	61316
11006	21423	27495	41130	47380	55650	62223
11008	21510	27506	42953	47381	56630	62256
15756	21620	27507	43460	47570	57110	62258
16036	21750	27511	43496	48100	57311	63044

19361	21825	27513	43500	49000	57531	64755
19364	22010	27514	43605	49002	57540	64760
20661	22015	27535	44187	49010	57545	64809
20664	22318	27536	44188	49020	58140	64818
20955	22319	27540	44202	49040	58146	64866
20956	22325	27556	44203	49060	58267	64868
20962	22326	27557	44204	49062	58275	69554
20969	22327	27558	44205	49255	58280	
20970	22328	27712	44227	49425	58293	
21141	26551	27715	44345	49428	58400	
21142	26553	27724	44346	49900	58700	
21143	26554	31290	44800	49904	58720	
21145	26556	31291	44820	50010	58740	
21146	26992	31584	44850	50040	58822	
21147	27005	31587	44900	50205	58825	
21151	27025	31800	44960	50391	58940	
21154	27030	31805	45400	50520	58950	
21155	27036	32650	45402	50546	59120	
21159	27054	32653	45562	51840	59121	
21160	27070	32655	45563	51841	59130	
21194	27071	32997	45800	51865	59140	
21196	27090	33886	45820	51900	59325	
21247	27187	34803	46705	51920	59830	
21343	27215	35697	46710	53415	59855	
21344	27216	37215	46712	53448	59856	
21347	27232	37618	46751	54125	59857	
21348	27240	38746	47010	54411	60650	

HHTL 3352-15-05 (Updates to Appeals and Utilization Reviews for Hospital Services)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-15-05

April 27, 2015

To: All Hospital Providers

Directors, County Departments of Job and Family Services

From: John B. McCarthy, Director

Subject: Updates to Appeals and Utilization Reviews for Hospital Services

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to appeals and utilization reviews for hospital services. The updates pertaining to these rules are effective 4/30/2015.

Rule 5160-2-07.12 (formerly 5101:3-2-07.12), entitled Appeals and reconsideration of departmental determinations regarding hospital inpatient and outpatient services, sets forth the process for requesting reconsideration after a utilization review of inpatient or outpatient hospital services by the department or its medical review entity. This rule has been amended to comply with five-year rule review as specified within section 119.032 of the Ohio Revised Code. The changes include updates of references to Ohio Administrative Code (OAC), the addition of clarifying language, and the removal of the allowance of reconsideration based upon disagreement with assignment of a diagnostic related group.

Rule 5160-2-07.13 (formerly 5101:3-2-07.13), entitled Utilization control, sets forth the nature and timelines of utilization reviews conducted on inpatient and outpatient hospital services by the department or its contracted medical review entity. This rule has been amended to comply with five-year rule review as specified within section 119.032 of the Ohio Revised Code. The changes include the addition of language formerly located in OAC 5160-2-04 around utilization review expectations regarding the justification of amounts billed by hospitals for take-home drugs, updates to OAC rule and agency references, adding date references to Code of Federal Regulations references, and updating the rule structure to improve readability.

Rule 5160-2-40 (formerly 5101:3-2-40), entitled Precertification review, describes the pre-certification review program for inpatient services. This rule has been amended to comply with five-year rule review as specified within section 119.032 of the Ohio Revised Code. The changes include updates to OAC rule and agency references, the addition of clarifying language and updating the rule structure to improve readability. Additionally, the psychiatric precertification request period was increased to two business days from the date of admission.

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HHTL 3352-15-04 (Inpatient and Outpatient Hospital Coverage and Reimbursement Changes)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-15-04

April 27, 2015

To: All Hospital Providers

Directors, County Departments of Job and Family Services

From: John B. McCarthy, Director

Subject: Inpatient and Outpatient Hospital Coverage and Reimbursement Changes

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to payment for inpatient and outpatient hospital services. The updates pertaining to these rules are effective 4/30/2015.

Rule 5160-2-01 entitled Eligible providers, has been amended to comply with five-year rule review as specified within section 119.032 of the Ohio Revised Code. This rule sets forth the eligible providers of inpatient and outpatient hospital services. The changes to the rule include updates to agency references, adding date references to Code of Federal Regulations references, and correcting grammatical errors. There were no policy changes to this rule.

Rule 5160-2-02 entitled General provisions: hospital services, has been amended to comply with five-year rule review as specified within section 119.032 of the Ohio Revised Code. This rule sets forth definitions used in Chapter 2 of the Ohio Administrative Code. The changes to the rule include updates to references to the Ohio Administrative Code (OAC), removal of irrelevant definitions, and updating definitions to reflect current terminology, which includes redirecting the definition of "medical necessity" to OAC rule 5160-1-01. Appendix A to 5160-2-02 was also updated to include new revenue codes and descriptions, and was relocated to the Department's **Hospital Billing Guidelines**. There were no policy changes to this rule.

Rule 5160-2-03 entitled Conditions and limitations sets forth coverage conditions and limitations applicable to inpatient and outpatient hospital services. The rule has been amended to comply with five-year rule review as specified within section 119.032 of the Ohio Revised Code. The changes to the rule include updates to Ohio Administrative Code references, Ohio Revised Code references and agency references. The changes also include the addition of language regarding explicit non-coverage of gender transformation, explicit coverage of surgical treatment of obesity through the prior authorization process, and clarification that private rooms are only reimbursed when the patient's medical condition requires isolation. In addition, the changes include removal of language regarding television service as a patient convenience item, removal of the pre-certification requirement for dental procedures, removal of the benefit period provision, and removal of coverage conditions and limitations applicable to outpatient services only. Language regarding reimbursement of covered days was restructured to improve readability.

Rule 5160-2-04 entitled Coverage of hospital provided pharmaceutical, dental, vision care, medical supply and equipment, and medically-related transportation services sets forth coverage of pharmaceutical, dental, vision care, medical supply and equipment and transportation services provided by hospitals. The rule has been amended to comply with five-year rule review as specified within section 119.032 of the Ohio Revised Code. The changes to the rule include updates to Ohio Administrative Code (OAC) references and correcting grammatical errors. Language regarding inpatient coverage of medical supplies and equipment was restructured to improve readability, while language regarding outpatient coverage of medical supplies and equipment was directed to Chapter 5160-10 of the OAC. The changes also include the addition of language regarding medically-related transportation services, and the removal of language around utilization review expectations regarding the justification of amounts billed by hospitals for take-home drugs, which is now located in OAC rule 5160-2-07.13. There were no policy changes to this rule.

Access to Rules and Related Material

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HHTL 3352-15-03 (Hospital Billing Guidelines)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-15-03

April 27, 2015

TO: All Hospital Providers

Directors, County Departments of Job and Family Services

FROM: John B. McCarthy, Director

SUBJECT: Hospital Billing Guidelines

Summary

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to the relocation of Appendix A to 5160-2-02 to the Office of Benefits **Hospital Billing Guidelines**. This update is effective 4/30/2015.

Rule 5160-2-02, entitled "General provisions: hospital services," describes and defines general provisions for medically necessary inpatient and outpatient hospital services.

Changes: Appendix A to the rule has been updated to include new revenue codes and descriptions. Appendix A to the rule is also being relocated to the Hospital Billing Guidelines (Appendix I).

Access to Rules and Related Material

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HHTL 3352-15-02 (Inpatient Hospital Reimbursement Changes)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-15-02

March 26, 2015

To: All Hospital Providers

Directors, County Departments of Job and Family Services

From: John B. McCarthy, Director

Subject: Inpatient Hospital Reimbursement Changes

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to payment for inpatient hospital services.

Rule 5160-2-21.1 entitled Consumer co-payments for non-emergency emergency department services sets forth policy around consumer copayments when emergency department services are not for an emergency medical condition. The rule has been amended for five-year rule review. The changes to the rule are: updates to the Ohio Administrative Code references, and removal of language regarding copay exclusion for participants in Medicaid managed care, as the copay requirements for participants in Medicaid Managed care are contained in OAC rule 5160-26-12. There are no policy changes to this rule.

Access to Rules and Related Material

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HHTL 3352-15-01 (Hospital Updates Effective January 1, 2015)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-15-01

January 13, 2015

TO: All Hospital Providers

Directors, County Departments of Job and Family Services

FROM: John B. McCarthy, Director

SUBJECT: Hospital updates effective January 1, 2015

Summary

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding changes effective January 1, 2015.

Hospital Inpatient Services

Rule 5160-2-65 entitled Inpatient hospital reimbursement, sets forth the methodology for determining the relative weights and hospital average cost per discharge that is used to reimburse hospitals for inpatient services under prospective payment. In accordance with the provisions of this rule, the hospital specific DRG base rates that were in effect on December 31, 2014 remain unchanged.

Rule 5160-2-07.6 entitled Capital costs, sets forth the methodology for inpatient hospital capital reimbursement for those hospitals paid under prospective payment. Capital costs are reimbursed on a prospective basis at eighty-five percent of historical costs. A separate letter dated December 19, 2014 was sent to all hospitals operating within Ohio, with the hospital specific capital rates effective January 1, 2015.

Relative Weights

The relative weight tables may be accessed by selecting Hospital Provider Information from the Provider Types - Hospital - More Information link located under the Providers tab on Medicaid.ohio.gov. The current weights are those that were in effect for discharges on or after July 1, 2013. There are no changes for January 1, 2015.

Hospital Outpatient Services

Rule 5160-2-21 entitled Policies for outpatient hospital services, describes the outpatient payment rates and policies for hospitals that are subject to DRG prospective payment. Effective January 1, 2015, the rule was amended, on an emergency basis, to implement the 2015 Healthcare Common Procedure Coding System (HCPCS) codes, which includes the 2015 Current Procedural Terminology (CPT) codes. The revision consisted of adding new codes, deleting obsolete codes and updating the fee schedules in appendices C, F, G and H. A separate HHTL will be published to inform hospitals of these changes.

Other Updates

Medicare Coinsurance and Deductible

The coinsurance and deductible amounts for Medicare's hospital insurance program (Part A) have been updated effective January 1, 2015. The Medicare Part A inpatient hospital deductible amount is $1,260.00. The daily coinsurance amounts are updated as follows: (a) $315.00 coinsurance for the 61st through 90th day of hospitalization in a benefit period; (b) $630.00 for lifetime reserve days; and (c) $157.50 for the 21st through 100th day of extended care services in a skilled nursing facility in a benefit period. The Medicare Part B deductible has not been updated. The deductible amount will continue to be $147.

Access to Rules and Related Material

The Ohio Department of Job and Family Services' (ODJFS) website located at **http://www.jfs.ohio.gov** includes links to valuable information about its services and programs. The Ohio Department of Medicaid's (ODM) website may be accessed through the ODJFS website's home page or directly at **http://www.medicaid.ohio.gov**.

Information about hospital payment policies may be accessed through the 'Provider Payment Policies & Relative Weight Tables' link on the Hospital Provider Information web page, **http://medicaid.ohio.gov/PROVIDERS/ProviderTypes/HospitalProviderInformation/HospitalPaymentPolicy.aspx**.

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HHTL 3352-14-05 (Non-DRG Prospective Payment for Hospital Services)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-14-05

August 14, 2014

TO: Eligible Hospital Providers

Directors, County Departments of Job and Family Services

FROM: John B. McCarthy, Director

SUBJECT: Non-DRG Prospective Payment For Hospital Services

Summary

Rule 5160-2-22 of the Ohio Administrative Code, "Non-DRG prospective payment for hospital services," has been amended. This rule sets forth the reimbursement policies for hospitals which are not paid under the All Patient Refined - Diagnosis Related Groups prospective payment system and applies to inpatient discharges and outpatient services occurring on or after October 1, 2014. Hospitals that are exempt from DRG based prospective payment will be reimbursed at a rate of 90% of historical costs with no settlement to actual costs. Cancer hospitals, as defined in rule 5160-2-07.2 of the Administrative Code will be reimbursed using a three-year step-down of historical costs.

Access to Rules and Related Material

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Information about hospital payment policies may be accessed through the 'Provider Payment Policies & Relative Weight Tables' link on the Hospital Provider Information web page, **http://medicaid.ohio.gov/PROVIDERS/ProviderTypes/HospitalProviderInformation.aspx**.

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Additional Information

Questions pertaining to this letter should be addressed to:

hospital_policy@medicaid.ohio.gov

or

Ohio Department of Medicaid

Bureau of Health Plan Policy

Hospital Services

P.O. Box 182709
Columbus, OH 43218-2709
Telephone (800) 686-1516

HHTL 3352-14-04 (HCPCS Updates to Administrative Rules 5160-1-60, 5160-2-21, 5160-4-22, 5160-21-02.3, and 5160-35-04)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-14-04

Medicaid Handbook Transmittal Letter (MHTL) No. 3334-14-01

Long Term Care Services and Supports Transmittal Letter (LTCSSTL) No. 14-04

March 28, 2014

TO: Eligible Non-Institutional Providers
Eligible Hospital Providers
Eligible Medicaid School Program Providers
Chief Executive Officers, Managed Care Plans
Directors, County Departments of Job and Family Services
Other Interested Parties

FROM: John B. McCarthy, Director of Medicaid

SUBJECT: HCPCS Updates to Administrative Rules 5160-1-60, 5160-2-21, 5160-4-22, 5160-21-02.3, and 5160-35-04

The federal Centers for Medicare and Medicaid Services, in conjunction with the American Medical Association and other professional groups, updates the Healthcare Common Procedure Coding System (HCPCS) annually. To the extent that HCPCS codes or descriptions are incorporated into the Ohio Administrative Code (OAC) governing the Medicaid program, changes made to HCPCS necessitate corresponding changes in OAC rules. Codes must be added, deleted, or revised, and maximum payment amounts and coverage policies must be established for new codes.

Changes are being made to the following rules, effective for dates of service January 1, 2014, or thereafter:

Rule **5160-1-60**, "Medicaid reimbursement," sets forth payment policies for services furnished by professional providers.

> *Changes:* In the appendix to this rule, new HCPCS codes are added, obsolete HCPCS codes are marked as discontinued, definitions are revised, and maximum payment amounts are established for new codes. No change is being made to the rule body itself.

Rule **5160-2-21**, "Policies for outpatient hospital services," sets forth polices and payment rates for outpatient services delivered by hospitals that are subject to prospective payment based on diagnosis related groups (DRG).

> *Changes:* In the appendices to this rule, new covered HCPCS codes are added, obsolete HCPCS codes are removed, and the fee schedules associated with the codes are updated. No change is being made to the rule body itself.

Rule **5160-4-22**, "Surgical services," sets forth coverage and payment policies for surgical services delivered by physician providers.

> *Changes:* In the appendix to this rule, new HCPCS codes are added, obsolete HCPCS codes are struck, definitions are revised, and updates are made to the schedule of surgical procedures that are subject to multiple-procedure, bilateral-procedure, or assistant-at-surgery fee adjustments. Within the body of this rule, references to the Ohio Department of Medicaid or to other Medicaid rules are modified to comport with the new agency name and designation in the Ohio Administrative Code.

Rule **5160-21-02.3**, "Limited family planning benefit," sets forth payment policies for services that are covered under this benefit.

Changes: In the appendix to this rule, one new HCPCS code is added. Within the body of this rule, references to other Medicaid rules are modified to comport with the new agency designation in the Ohio Administrative Code.

Rule **5160-35-04**, "Reimbursement for services provided by medicaid school program (MSP) providers," sets forth payment policies for services that are covered under this program.

Changes: In the appendix to this rule, four new HCPCS codes are added to replace one obsolete HCPCS code that is struck, and maximum payment amounts are established for the new codes. Within the body of this rule, references to the Ohio Department of Medicaid or to other Medicaid rules are modified to comport with the new agency name and designation in the Ohio Administrative Code, and citations of federal law are updated.

Access to Rules and Related Material

Information about the services and programs of the Ohio Department of Medicaid (ODM) may be accessed through the main ODM web page, **http://www.medicaid.ohio.gov/**.

Some information about provider payment is listed by provider type on the 'Fee Schedule and Rates' web page, which may be accessed through the main ODM web page (Providers > Fee Schedule and Rates).

The Ohio Department of Job and Family Services (ODJFS) maintains an "electronic manuals" web page of ODJFS and Medicaid rules, manuals, transmittal letters, forms, and handbooks. This "eManuals" web page may be accessed through the main ODM web page (Resources > Publications > eManuals) or directly at http://emanuals.odjfs.state.oh.us/emanuals/.

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(1) Select the 'Medicaid - Provider' collection.

(2) Select the appropriate service provider type or handbook.

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(4) Select the desired item from the 'Table of Contents' pull-down menu.

Current Medicaid maximum payment amounts for many professional services are listed in rule 5160-1-60 (formerly 5101:3-1-60) or in Appendix DD to that rule. Providers may view this information by following these steps:

(1) Select the 'Medicaid - Provider' collection.

(2) Select 'General Information for Medicaid Providers'.

(3) Select 'General Information for Medicaid Providers (Rules)'.

(4) Select the rule number and title from the 'Table of Contents' pull-down menu.

(5) Scroll down and select the link to Appendix DD.

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Additional Information

Questions pertaining to this letter should be addressed to the Ohio Department of Medicaid.

Hospital services policy:

Bureau of Health Plan Policy, Hospital Services

P.O. Box 182709

Columbus, OH 43218-2709

(800) 686-1516

hospital_policy@medicaid.ohio.gov

Medicaid School Program policy:

Bureau of Long-Term Care Services and Support

P.O. Box 182709

Columbus, OH 43218-2709

bltcss@medicaid.ohio.gov

Other provider policy:

Bureau of Provider Services

P.O. Box 1461

Columbus, OH 43216-1461

(800) 686-1516

HHTL 3352-14-03 (Inpatient Hospital Reimbursement Changes)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-14-03

March 28, 2014

To: All Hospital Providers

Directors, County Departments of Job and Family Services

From: John B. McCarthy, Director

Subject: Inpatient Hospital Reimbursement Changes

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to payment for inpatient hospital services.

Rule 5160-2-65 (formerly 5101:3-2-65) entitled Inpatient hospital reimbursement sets forth the methodology for determining the relative weights and hospital average cost per discharge that is used to reimburse hospitals for services provided to Medicaid recipients enrolled in both traditional Medicaid and Medicaid Managed Care under prospective payment. The methodology is in effect for inpatient hospital discharges occurring on or after July 1, 2013. The proposed change to the rule is to: terminate a temporary five percent inpatient rate increase that was built into the hospital base payments and medical education payments for all hospitals except children's hospitals; and reduce the percent of outlier eligible costs from ninety-five to ninety percent for all hospitals.

Rule 5160-2-07.6 (formerly 5101:3-2-07.6) entitled Capital costs sets forth the methodology for inpatient hospital capital reimbursement for those hospitals paid under prospective payment. The proposed change to the rule is to reduce interim capital payments to eighty five percent of cost and to eliminate cost settlement of capital-related costs to all hospitals paid by Medicaid under prospective payment.

Access to Rules and Related Material

Information about the services and programs of the Ohio Department of Medicaid (ODM) may be accessed through the main ODM web page, **http://www.medicaid.ohio.gov/**.

Information about hospital payment policies is available on the "Fee Schedule and Rates' web page, which may be accessed through the main ODM web page (Proviers > Fee Schedule and Rates).

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Questions

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Columbus, OH 43218-2709
Telephone (800) 686-1516
Or
hospital_policy@medicaid.ohio.gov

HHTL 3352-14-02 (2014 Hospital Franchise Fee Program)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-14-02

February 19, 2014

TO: Eligible Hospital Providers

Directors, County Departments of Job and Family Services

FROM: John B. McCarthy, Director

SUBJECT: 2014 Hospital Franchise Fee Program

Summary

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to payment data policies and the assessment for hospitals, for the 2014 Hospital Franchise Fee Program.

Rule 5160-2-30 (formerly 5101:3-2-30) entitled Hospital Franchise Fee Program sets forth the policies to administer this program. This rule modifies the rate at which total facility cost will be assessed and the payment schedule of the franchise fee for the 2014 program year.

Access to Rules and Related Material

The main web page of the Ohio Department of Medicaid (ODM) includes links to valuable information about its services and programs; the address is **http://medicaid.ohio.gov/**.

Information about hospital payment policies may be accessed through the 'Provider Payment Policies & Relative Weight Tables' link on the Hospital Provider Information web page,

http://medicaid.ohio.gov/PROVIDERS/ProviderTypes/HospitalProviderInformation.aspx

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or

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Bureau of Health Plan Policy

Hospital Services

P.O. Box 182709

Columbus, OH 43218-2709
Telephone (800) 686-151

HHTL 3352-14-01 (Hospital updates effective January 1, 2014)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-14-01

February 12, 2014

TO: All Hospital Providers

Directors, County Departments of Job and Family Services

FROM: John B. McCarthy, Director

SUBJECT: Hospital updates effective January 1, 2014

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding changes effective January 1, 2014.

Hospital Inpatient Services

Rule 5160-2-65 (formerly 5101:3-2-65), entitled Inpatient hospital reimbursement, sets forth the methodology for determining the relative weights and hospital average cost per discharge that is used to reimburse hospitals for inpatient services under prospective payment. Effective January 1, 2014, the rule was amended on an emergency basis to terminate the temporary five percent inpatient rate increase that was built into the hospital base payments and medical education payments for all hospitals except children's hospitals. In addition, the outlier eligible costs were reduced from ninety-five to ninety percent for all hospitals. A separate letter dated December 20, 2013 was sent to all hospitals operating within Ohio, with the hospital specific rates effective January 1, 2014.

Rule 5160-2-07.6 (formerly 5101:3-2-07.6), entitled Capital costs, sets forth the methodology for inpatient hospital capital reimbursement for those hospitals paid under prospective payment. Effective January, 1, 2014, the rule was amended on an emergency basis to reduce interim capital payments to eighty-five percent of prospective capital costs and to eliminate cost settlement of capital-related costs to all hospitals paid by Medicaid under prospective payment. A separate letter dated December 20, 2013 was sent to all hospitals operating within Ohio, with the hospital specific capital rates effective January 1, 2014.

Relative Weights

The relative weight table may be accessed by selecting Hospital Provider Information from the Providers Types on the Providers page of Medicaid.ohio.gov. The current weights are those that were in effect for discharges on or after July 1, 2013. There are no changes for January 1, 2014.

Hospital Outpatient Services

Rule 5160-2-21 (formerly 5101:3-2-21), entitled Policies for outpatient hospital services, describes the outpatient payment rates and policies for hospitals that are subject to DRG prospective payment. Effective January 1, 2014, the rule was amended, on an emergency basis, to implement the 2014 Healthcare Common Procedure Coding System (HCPCS) codes, which includes the 2014 Current Procedural Terminology (CPT) codes. The revision consisted of adding new codes, deleting obsolete codes and updating the fee schedules in appendices C, F, G, and H. A separate HHTL will be published to inform hospitals of these changes.

The rule was also amended to implement provisions of Am. Sub. H.B. 59 of the 130th General Assembly and to add certain HCPCS codes to the laboratory fee schedule. Specifically, the changes set fixed prices for most outpatient services currently reimbursed at cost. A separate transmittal 'HHTL 3352-13-07' was published to inform hospitals of these changes.

Other Updates

Medicare Coinsurance and Deductible

The coinsurance and deductible amounts for Medicare's hospital insurance program (Part A) have been updated effective January 1, 2014. The Medicare Part A inpatient hospital deductible amount is $1,216.00. The daily coinsurance amounts are updated as follows: (a) $304.00 coinsurance for the 61st through 90th day of hospitalization in a benefit period; (b) $608.00 for lifetime reserve days; and (c) $152.00 for the 21st

through 100th day of extended care services in a skilled nursing facility in a benefit period. The Medicare Part B deductible has not been updated. The deductible amount will continue to be $147.

Access to Rules and Related Material

The main ODJFS web page includes links to valuable information about its services and programs; the address is **http://www.jfs.ohio.gov**. The web page of the Department of Medicaid is **http://www.medicaid.ohio.gov**.
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Bureau of Health Plan Policy

Hospital Services

P.O. Box 182709

Columbus, OH 43218-2709

Telephone (800) 686-1516

Or

hospital_policy@medicaid.ohio.gov

HHTL 3352-13-07A(Outpatient Hospital Services)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-13-07A

February 3, 2014

To: All Hospital Providers

Directors, County Departments of Job and Family Services

From: John B. McCarthy, Director

Subject: Outpatient Hospital Services

This Hospital Handbook Transmittal Letter (HHTL) provides clarification pertaining to the revisions to payment policies for outpatient hospital services specified in HHTL 3352-13-07.

Summary

HHTL 3352-13-07 provided information regarding several changes to Ohio Administrative Code rule 5160-2-21, Policies for outpatient hospital services, that were effective January 1, 2014, including the implementation of provisions of Am. Sub. H.B. 59 of the 130th General Assembly and the addition of certain HCPCS codes to the laboratory fee schedule.

The version of Appendix H to this rule that was posted to eManuals on December 26, 2013 is incorrect, as it did not reflect these changes. Therefore, this transmittal is being provided to include the correct version of Appendix H.

Transmittal Changes

Rule **5160-2-21**, "Policies for outpatient hospital services," describes the outpatient payment rates and policies for hospitals that are subject to diagnosis related groups (DRG) prospective payment.

Changes:

- **Appendix H** is being updated to correctly reflect the changes specified in HHTL 3352-13-07. There are no policy changes included in this transmittal.
- Appendix A of this transmittal provides an updated list of codes impacted by HHTL 3352-13-07.

Access to Rules and Related Material

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Information about hospital payment policies may be accessed through the 'Provider Payment Policies & Relative Weight Tables' link on the Hospital Provider Information web page, **http://www.jfs.ohio.gov/ohp/bhpp/hbfm.stm**.

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Hospital Services

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Columbus, OH 43218-2709

Telephone (800) 686-1516

Or

hospital_policy@medicaid.ohio.gov

Appendix A

Appendix C	Appendix F	Appendix G	Appendix H
15999, 17999	90296	76496	81200, 81201, 81202,
19499, 20999	90393	76497	81203, 81205, 81206,
21299, 21499	90940	76498	81207, 81208, 81209,
21899, 22899	90999	76499	81210, 81211, 81212,
22999, 23929	91132	76999	81213, 81214, 81215,
24999, 25999	91133	77299	81216, 81217, 81220,
26989, 27299	93318	77371	81221, 81222, 81223,
27599, 27899	93998	77372	81224, 81225, 81226,
28899, 29799	95990	77373	81227, 81228, 81229,
29999, 30999		77399	81235, 81240, 81241,
31299, 31599		77424	81242, 81243, 81244,
31899, 32999		77425	81245, 81250, 81251,
36299, 37501		77435	81252, 81253, 81254,
37799, 38589		77469	81255, 81256, 81257,
38999, 39499		77499	81260, 81261, 81262,
39599, 40799		77522	81263, 81264, 81265,
40899, 41599		77525	81266, 81267, 81268,
41899, 42299		78099	81270, 81275, 81280,
42699, 42999		78199	81281, 81282, 81290,
43289, 43499		78299	81291, 81292, 81293,
43659, 43999		78399	81294, 81295, 81296,
44238, 44799		78499	81297, 81298, 81299,
44899, 44979		78599	81300, 81301, 81302,
45499, 45999		78608	81303, 81304, 81310,
46999, 47379		78609	81315, 81316, 81317,
47399, 47579		78699	81318, 81319, 81321,
47999, 48999		78799	81322, 81323, 81324,
49329, 49659		78999	81325, 81326, 81330,
49999, 50549		79999	81331, 81332, 81340,
50949, 51999			81341, 81342, 81350,
53899, 54699			81355, 81370, 81371,
55559, 55899			81372, 81373, 81374,
58578, 58579			81375, 81376, 81377,
58679, 58999			81378, 81379, 81380,
59897, 59898			81381, 81382, 81383,
59899, 60659			81400, 81401, 81402,
60699, 64999			81403, 81404, 81405,
66999, 67299			81406, 81407, 81408,
67399, 67599			81479, 81500, 81503,

HHTL 3352-13-07 (Outpatient Hospital Services)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-13-07

December 26, 2013

To: All Hospital Providers

Directors, County Departments of Job and Family Services

From: John B. McCarthy, Director

Subject: Outpatient Hospital Services

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to the revisions to payment policies for outpatient hospital services.

Summary

Ohio Administrative Code rule 5160-2-21, Policies for outpatient hospital services, is being amended to implement provisions of Am. Sub. H.B. 59 of the 130th General Assembly and to add certain HCPCS codes to the laboratory fee schedule. Specifically, the changes set fixed prices for most outpatient services currently reimbursed at cost. Unlisted surgeries, radiology services, and ancillary procedures will now have published fees. Reimbursement for drugs administered with IV therapy, independently billed drugs and medical supplies will be set at 60 percent of cost. Additionally, the hospital laboratory fee schedule will be recalibrated to align payment rates to prescribed Medicare ceilings. Finally, the rule adds codes and reimbursement rates for molecular pathology services. The reimbursement changes in this rule will be effective January 1, 2014.

Rule Changes

Rule **5160-2-21**, "Policies for outpatient hospital services," describes the outpatient payment rates and policies for hospitals that are subject to diagnosis related groups (DRG) prospective payment.

Changes:

- Language is added to paragraph (B)(3) to clarify the use of the UB modifier.
- The language in paragraph (F) for the pricing methodology for unlisted procedure codes is being changed to pay unlisted surgeries at the surgical group rates, and to subject these codes to the existing surgery bundling methodology, including the methodology for cancelled surgeries.
- Appendix C is being updated to reflect unlisted procedure codes being reimbursed at the surgical group rates.
- Appendix F is updated to set fee schedule prices for ancillary service codes previously paid at cost.
- The language in paragraph (G) for the pricing methodology for revenue center codes 025X present with an IV therapy code is being changed to pay 60% of the hospital specific outpatient cost-to-charge ratio.
- The language in paragraph (H) for the pricing methodology for revenue center codes 025X present with an IV therapy code is being changed to pay 60% of the hospital specific outpatient cost-to-charge ratio.
- Appendix H is updated to set fee schedule prices for lab codes previously paid at cost, to recalibrate and align payment rates to prescribed Medicare ceilings, and to add codes and reimbursement rates for molecular pathology services.
- Appendix G is updated to set fee schedule prices for radiology codes previously paid at cost.
- The language in paragraph (J) clarifies existing policy regarding the pricing methodology for revenue center codes 025X present with an IV therapy code, is paid at cost for claims between 1/1/2012 and 12/31/2012, and it also changes this methodology for claims on or after 1/1/2014 so that revenue center codes 025X present with an IV therapy code will pay 60% of the hospital specific outpatient cost-to-charge ratio for claims on or after 1/1/2014.

- The language in paragraph (L) for the pricing methodology for independently billed revenue center codes 025X, 636, and 027X is being changed to pay 60% of the hospital specific outpatient cost-to-charge ratio.

Appendix A of this transmittal provides a listing of impacted codes.

Access to Rules and Related Material

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Telephone (800) 686-1516

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hospital_policy@medicaid.ohio.gov

Appendix A

Appendix C	Appendix F	Appendix G	Appendix H
15999, 17999	90296	76496	81200, 81201, 81202,
19499, 20999	90393	76497	81203, 81205, 81206,
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21899, 22899	90999	76499	81210, 81211, 81212,
22999, 23929	91132	76999	81213, 81214, 81215,
24999, 25999	91133	77299	81216, 81217, 81220,
26989, 27299	93318	77371	81221, 81222, 81223,
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28899, 29799	95990	77373	81227, 81228, 81229,
29999, 30999	96401	77399	81235, 81240, 81241,
31299, 31599	96402	77424	81242, 81243, 81244,
31899, 32999	96405	77425	81245, 81250, 81251,
36299, 37501	96406	77435	81252, 81253, 81254,
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38999, 39499	96411	77499	81260, 81261, 81262,
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42699, 42999	96417	78199	81281, 81282, 81290,
43289, 43499	96420	78299	81291, 81292, 81293,
43659, 43999	96422	78399	81294, 81295, 81296,
44238, 44799	96423	78499	81297, 81298, 81299,
44899, 44979	96425	78599	81300, 81301, 81302,
45499, 45999	96440	78608	81303, 81304, 81310,
46999, 47379	96446	78609	81315, 81316, 81317,
47399, 47579	96450	78699	81318, 81319, 81321,
47999, 48999	96542	78799	81322, 81323, 81324,
49329, 49659	96549	78999	81325, 81326, 81330,
49999, 50549		79999	81331, 81332, 81340,
50949, 51999			81341, 81342, 81350,
53899, 54699			81355, 81370, 81371,
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HHTL 3352-13-06 (Assessment Rates - Hospital Care Assurance Program)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-13-06

December 26, 2013

To: All Hospital Providers

Directors, County Departments of Job and Family Services

From: John B. McCarthy, Director

Subject: Assessment Rates - Hospital Care Assurance Program

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to the assessment for general hospitals as it relates to the Hospital Care Assurance Program (HCAP).

Rule 5160-2-08.1 (formerly 5101:3-2-08.1) entitled Assessment rates sets forth the assessment rate for HCAP. This rule has been amended to establish the assessment rates and the cost levels to which those rates apply to fund HCAP for the 2013 program year. Hospitals will be assessed 0.83584% of a hospital's adjusted total facility costs up to $216,372,500 and 0.665% for any amount in excess of $216,372,500. In addition, this rule updates the assessment rates applicable to the 2012 program year and allows Ohio to access additional Federal funds.

Access to Rules and Related Material

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Information about hospital payment policies may be accessed through the 'Provider Payment Policies & Relative Weight Tables' link on the Hospital Provider Information web page, **http://medicaid.ohio.gov/PROVIDERS/ProviderTypes/HospitalProviderInformation.aspx**.

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Bureau of Health Plan Policy

Hospital Services

P.O. Box 182709

Columbus, OH 43218-2709

Telephone (800) 686-1516

or

hospital_policy@medicaid.ohio.gov

HHTL 3352-13-05 (Inpatient Hospital Reimbursement On Or After July 1, 2013)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-13-05

September 24, 2013

TO: Eligible Hospital Providers

Directors, County Departments of Job and Family Services

FROM: John B. McCarthy, Director

SUBJECT: Inpatient Hospital Reimbursement on or after July 1, 2013

Summary

Rule **5101:3-2-65** titled Inpatient Hospital Reimbursement of the Ohio Administrative Code is being newly adopted. The rule was adopted on an emergency basis effective July 1, 2013 and is now being adopted as a permanent rule. This rule sets forth the payment policies for inpatient hospital reimbursement using 3M Health Information System's All Patient Refined - Diagnostic Related Groups (APR-DRG). The APR-DRG will be used to reimburse hospitals paid on a prospective basis, for inpatient discharges occurring on or after July 1, 2013. The rule describes how an inpatient claim will be reimbursed including adjustments/add-ons for Capital Cost, Medical Education and Outliers. A summary of the policy changes is provided below. All hospitals currently subject to the prospective payment system will continue to be paid on a prospective basis.

Diagnostic Related Groups

The APR-DRG was developed and is maintained by 3M Health Information Systems. The software is currently based on Version 30 of the International Classification of Disease 9 - Clinical Modification (ICD9) diagnosis and procedure codes. Therefore, the software is commonly referred to as APR-DRG Version 30 (APR-DRGv30). Hospitals are expected to always bill using the most current version of the ICD9 code sets. The APR-DRG consists of 314 individual DRGs. Each DRG is categorized into one of four Severity of Illness (SOI) categories; 1. Minor, 2. Moderate, 3. Major and 4. Extreme, for a total of 1,256 DRGs. Each DRG/SOI combination is assigned a relative weight and average length of stay.

Payment Calculation

The relative weight for a DRG/SOI is multiplied by the hospital base rate to determine the DRG Base Payment for a claim. For hospitals that have a Medical Education rate, the Medical Education Add-on is calculated by multiplying the Medical Education Rate by the relative weight for the DRG/SOI. Each hospital is paid a hospital-specific Capital Add-on for each claim that is paid. A claim may also be eligible to receive an additional payment for high cost cases and/or an additional payment related to organ acquisition for transplant cases.

The final payment to a hospital is the sum of;

a. DRG Base Payment

b. Medical Education Payment

c. Capital Add-on

d. Applicable Outlier Add-on.

e. Applicable Organ Acquisition Add-on

f. The final payment is rounded to the nearest whole penny.

Medical Education Payment

Those hospitals which were eligible to receive a Medical Education Payment under the previous prospective payment system shall continue to receive such payment. The methodology for determining the Medical Education base payment did not change. However, due to changes in the case mix for those hospitals, current Medical Education rates were adjusted to insure that a hospital would receive, in the aggregate, the same dollar payment for Medical Education as previously received.

Capital Add-on

The calculation of the Capital Add-on remains the same as described in rule **5101:3-2-07.6** of the Administrative Code. However, rule **5101:3-2-65** does implement a separate capital add-on for recipients that are enrolled in Medicaid Managed Care.

Outlier Add-on

A claim is eligible for an Outlier Add-on if the claim costs are greater than the Outlier Threshold for that claim. Claim costs are determined by multiplying allowable claim charges by the hospital-specific cost-to-charge ratio. The Outlier Threshold is the sum of the DRG Base Payment and the Fixed Outlier Threshold shown in the table below. Any costs above the Outlier Threshold will be paid as an add-on at 95% of costs.

Threshold Applies To:	Fixed Outlier Threshold
DRGs 004 & 005 or Neonate DRGs (580 - 639)	$42,900
Children's or Major Teaching Hospitals	$54,400
All Other DRGs/Peer Groups	$68,000

Continued Policies with Modification

Claims that include a transfer into or out of a hospital and claims where the recipient is eligible for Medicaid for only a portion of the inpatient stay will be paid on a per diem basis except that the Average Length of Stay will be used instead of the Geometric Mean Length of Stay to calculate the per diem.

The Centers for Medicare and Medicaid Services (CMS) has required states to not pay for Hospital Acquired Conditions (HAC) since July 1, 2011. Ohio's previous grouper was not capable of the required editing to enforce this requirement. As a result, Ohio has been enforcing HACs on a retrospective basis through our claims review vendor. The APR-DRG grouper includes a component that is specifically designed to analyze and enforce HAC editing. Therefore, all claims for inpatient discharges on or after July 1, 2013 will be compared to the CMS Medicaid Hospital Acquired Conditions to determine if any service provided should not be included in the payment calculation. The department expects that removal of a HAC from a claim would result in a DRG/SOI that is less intense than if the HAC were not removed from the claim.

Discontinued Policies

- Claims will no longer be eligible for a Day Outlier.
- Claims will no longer be eligible for the Exceptional Cost Outlier.
- Relative weights for Neonate DRGs will no longer differentiate within DRGs based on the highest nursery level at a hospital.
- Relative weights for Psychiatric DRGs will no longer differentiate within DRGs based on status as a free-standing psychiatric hospital or distinct psychiatric unit within a hospital.

Access to Rules and Related Material

The main ODJFS web page includes links to valuable information about its services and programs; the address is **http://www.jfs.ohio.gov**. The web page of the Department of Medicaid may be accessed through the ODJFS main page or directly at **http://www.jfs.ohio.gov/ohp/**.

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Bureau of Health Plan Policy

Hospital Services

P.O. Box 182709

Columbus, OH 43218-2709

Telephone (800) 686-1516

or

hospital_policy@medicaid.ohio.gov

HHTL 3352-13-04 (2013 Hospital Franchise Fee)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-13-04

July 24, 2013

To: All Hospital Providers

Directors, County Departments of Job and Family Services

From: John B. McCarthy, Director

Subject: 2013 Hospital Franchise Fee Program

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to payment data policies and the assessment for hospitals, for the 2013 Hospital Franchise Fee Program.

Rule 5101:3-2-30 entitled Hospital Franchise Fee Program sets forth the policies to administer this program. This rule was adopted on an emergency basis, effective May 9, 2013 and has now been adopted on a permanent basis. This rule modifies the rate at which total facility cost will be assessed and the payment schedule of the franchise fee for the 2013 program year.

Access to Rules and Related Material

The main ODJFS web page includes links to valuable information about its services and programs; the address is **http://www.jfs.ohio.gov**. The web page of the Department of Medicaid may be accessed through the ODJFS main page or directly at **http://www.jfs.ohio.gov/ohp/**.

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Columbus, OH 43218-2709

Telephone (800) 686-1516

Or

hospital_policy@medicaid.ohio.gov

HHTL 3352-13-03 (Outpatient Hospital Services)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-13-03

March 20, 2013

TO: Eligible Hospital Providers

Directors, County Departments of Job and Family Services

FROM: John B. McCarthy, Director

SUBJECT: Outpatient Hospital Services

Summary

Ohio Administrative Code rule 5101:3-2-21, Policies for outpatient hospital services, is being amended to update the appendices in order to implement the new January 2013 Current Procedural Terminology (CPT) and the 2013 Healthcare Common Procedural Coding System (HCPCS) coding changes. The appendices to this rule are being updated to add new HCPCS codes, delete obsolete HCPCS codes, and update the fee schedules associated with the codes. No changes are being made to the rule body. The effective date of this rule is March 28, 2013.

Rule Changes

Rule 5101:3-2-21, "Policies for outpatient hospital services," describes the outpatient payment rates and policies for hospitals that are subject to diagnostic related groups (DRG) prospective payment.

Changes:

- Appendices C, F, G, and H have been amended to add new codes and to delete obsolete codes to be consistent with the 2013 CPT and HCPCS manuals. Appendix A of this document contains a list of the new codes added in this update.

Access to Rules and Related Material

The main ODJFS web page includes links to valuable information about its services and programs; the address is **http://www.jfs.ohio.gov**. The web page of the Office of Medical Assistance (Medicaid) may be accessed through the ODJFS main page or directly at **http://www.jfs.ohio.gov/ohp/**.

Information about hospital payment policies may be accessed through the 'Provider Payment Policies & Relative Weight Tables' link on the Hospital Provider Information web page, **http://www.jfs.ohio.gov/ohp/bhpp/hbfm.stm**.

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P.O. Box 182709

Columbus, OH 43218-2709

Telephone (614) 466-6420

or

hospital_policy@jfs.ohio.gov

Appendix A - 2013 HCPCS Codes added to Ohio Administrative Code Rule 5101:3-2-21, "Policies for outpatient hospital services."

Appendix A: New 2013 HCPCS Codes added to Ohio Administrative Code Rule 5101:3-2-21, "Policies for outpatient hospital services."				
Appendix C	**Appendix F**		**Appendix G**	**Appendix H**
23473	90672	93656	78012	82777
24370	90785	93657	78013	86711
24371	90791	95017	78014	86828
31647	90792	95018	78071	86829
31648	90832	95076	78072	86830
31649	90833	95079		86831
31651	90834	95782		86832
31660	90836	95783		86833
31661	90837	95907		86834
32554	90838	95908		86835
32555	90839	95909		87631
32556	90840	95910		87632
32557	91112	95911		87633
36221	92920	95912		87910

36222	92921	95913		87912
36223	92924	95924		
36224	92925	95940		
36225	92928	95941		
36226	92929	95943		
37197	92933			
37211	92934			
37212	92937			
37213	92938			
37214	92941			
38243	92943			
43206	92944			
43252	93653			
52287	93654			
64615	93655			

HHTL 3352-13-02 (Assessment Rates - Hospital Care Assurance Program)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-13-02

February 19, 2013

To: All Hospital Providers

Directors, County Departments of Job and Family Services

From: John B. McCarthy, Director

Subject: Assessment Rates - Hospital Care Assurance Program

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to payment and data policies for disproportionate share and indigent care rules for general hospitals, as well as the assessment for general hospitals.

Rule 5101:3-2-08.1 entitled Assessment rates sets forth the assessment rate for the Hospital Care Assurance Program (HCAP). This rule was filed on an emergency basis, effective November 28, 2012. This rule has been amended to establish the assessment rates and the cost levels to which those rates apply to fund HCAP for the 2012 program year.

Access to Rules and Related Material

The main ODJFS web page includes links to valuable information about its services and programs; the address is **http://www.jfs.ohio.gov**. The web page of the Office of Medical Assistance (Medicaid) may be accessed through the ODJFS main page or directly at **http://www.jfs.ohio.gov/ohp/**.

Information about hospital payment policies may be accessed through the 'Provider Payment Policies & Relative Weight Tables' link on the Hospital Provider Information web page, **http://www.jfs.ohio.gov/ohp/bhpp/hbfm.stm**.

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HHTL 3352-13-01 (Hospital Updates Effective January 1, 2013)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-13-01

February 8, 2013

TO: All Hospital Providers

Directors, County Departments of Job and Family Services

FROM: John B. McCarthy, Director

SUBJECT: Hospital updates effective January 1, 2013

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding changes effective January 1, 2013.

Hospital Inpatient Services

Inpatient Rates

Ohio Administrative Code (OAC) rule 5101:3-2-07.4, entitled "Basic methodology for determining prospective payment rates", became effective on September 29, 2011. In accordance with this rule, there will be no adjustment to Inpatient Hospital base or Medical Education rates. A separate letter has been sent to all hospitals operating within Ohio, with the hospital specific rates effective January 1, 2013.

Outliers

In accordance with **OAC rule 5101:3-2-07.9**, entitled "Payment for outliers", the exceptional outlier threshold effective January 1, 2013 has been inflated by 1.9 percent to $642,176. All inpatient discharges on or after January 1, 2013 will be subject to the new threshold. The threshold for calendar year 2012 discharges was $630,202.

Relative Weights

The calendar year 2013 relative weight table may be accessed from the 'Bureau of Health Plan Policy' web page by going to **http://jfs.ohio.gov/ohp/bhpp/hbfm.stm** and selecting the option for provider payment policies. For CY 2013 there is no change to the relative weights, day high trim, charge high trim, or geometric mean length of stay. Please reference the relative weight table for discharges on or after 1/1/2012.

Hospital Outpatient Services

OAC rule 5101:3-2-21, entitled "Policies for outpatient hospital services", describes the outpatient payment rates and policies for hospitals that are subject to DRG prospective payment. Effective January 1, 2013, the rule was amended, on an emergency basis, to implement the 2013 Healthcare Common Procedural Coding System (HCPCS) and the 2013 Current Procedural Terminology (CPT) manual. The revision consisted of adding new codes, deleting obsolete codes, and updating the fee schedules in appendices C, F, G, and H. The rule will be effective, on a permanent basis, on March 28, 2013.

Other Updates

Medicare Coinsurance and Deductible

The coinsurance and deductible amounts for Medicare's hospital insurance program (Part A) have been updated effective January 1, 2013. The Medicare Part A inpatient hospital deductible amount is $1,184. The daily coinsurance amounts are updated as follows: (a) $296 coinsurance for the 61st through 90th day of hospitalization in a benefit period; (b) $592 for lifetime reserve days; and (c) $148 for the 21st through 100th day of extended care services in a skilled nursing facility in a benefit period.

The Medicare Part B deductibles have also been updated. Effective January 1, 2013 the deductible amount will reflect $147.

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Bureau of Health Plan Policy

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hospital_policy@jfs.ohio.gov

HHTL 3352-12-03 (Updates to Upper Payment Limit Reimbursement Rates for Hospital Services)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-12-03

August 21, 2012

TO: Eligible Providers of Hospital Services
Chief Executive Officers, Managed Care Plans (MCPs)
Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: Updates to Upper Payment Limit Reimbursement Rates for Hospital Services

Summary

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding the recission and adoption of the following Ohio Administrative Code (OAC) rules:

- **5101:3-2-50**, "Supplemental Inpatient Hospital Upper Limit Payments for Public Hospitals,"
- **5101:3-2-51**, "Supplemental Inpatient Hospital Upper Limit Payments for State Hospitals,"
- **5101:3-2-52**, "Supplemental Inpatient Hospital Upper Limit Payments for Private Hospitals,"
- **5101:3-2-53**, "Supplemental Inpatient Hospital Upper Limit Payments for Children's Hospitals," and
- **5101:3-2-54**, "Supplemental Outpatient Hospital Upper Limit Payments for Private, Public Non State-Owned, and Public State-Owned Hospitals."

In accordance with Am. Sub. H.B. 153 of the 129th General Assembly, these rules are being updated to reflect changes in the calculation methodology and reimbursement of upper payment limits for inpatient and outpatient hospital services.

Rule Changes

Rule 5101:3-2-50, "Supplemental Inpatient Hospital Upper Limit Payments for Public Hospitals," describes the upper payment limit (UPL) reimbursement policies for inpatient hospital services provided in a public hospital. This rule replaces old rule 5101:3-2-50.

> Changes: The rule was updated to provide additional payment distribution details and provide additional clarity for inpatient hospital services provided in a public hospital.

Rule 5101:3-2-51, "Supplemental Inpatient Hospital Upper Payment Limit Payments for State Hospitals," describes the UPL reimbursement policies for inpatient hospital services provided in state hospitals. This rule replaces old rule 5101:3-2-51.

> Changes: The payment methodology for supplemental inpatient hospital services provided in state hospitals was changed from utilizing a payment-to-charge ratio for UPL calculations to a cost-to-charge ratio methodology. The rule was also updated to provide additional payment details and provide additional clarity to providers of hospital services.

Rule 5101:3-2-52, "Supplemental Inpatient Hospital Upper Payment Limit Payments for Private Hospitals," describes the UPL reimbursement policies for inpatient hospital services provided in a private hospital. This rule replaces old rule 5101:3-2-52.

> Changes: The payment methodology for inpatient hospital services provided in private hospitals was changed from utilizing a payment-to-charge ratio for UPL calculations to a cost-to-charge ratio methodology. The rule was also updated to provide additional payment distribution details and provide additional clarity to providers of hospital services.

Rule 5101:3-2-53, "Supplemental Inpatient Hospital Payments for Children's Hospitals," describes the UPL reimbursement policies for inpatient services provided in a children's hospital. This rule replaces old rule 5101:3-2-53.

Changes: The payment methodology for inpatient hospital services provided in children's hospitals was changed from utilizing a payment-to-charge ratio for UPL calculations to a cost-to-charge ratio methodology. The rule was also updated to provide additional payment distribution details and provide additional clarity to providers of hospital services.

Rule 5101:3-2-54, "Supplemental Outpatient Hospital Upper Limit Payments for Private, Public Non State-Owned, and Public State-Owned Hospitals. This rule replaces old rule 5101:3-2-54.

Changes: The payment methodology for outpatient hospital services was changed from utilizing a payment-to-charge ratio for UPL calculations to a cost-to-charge ratio methodology. The rule was also updated to provide additional payment distribution details and provide additional clarity to providers of hospital services.

Access to Rules and Related Material

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Information about hospital payment policies may be accessed through the 'Provider Payment Policies & Relative Weight Tables' link on the Hospital Provider Information web page, **http://www.jfs.ohio.gov/ohp/bhpp/hbfm.stm**.

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Additional Information

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Office of Ohio Health Plans, Bureau of Policy and Health Plan Services

Hospital Services

P.O. Box 182709

Columbus, OH 43218-2709

or

hospital_policy@jfs.ohio.gov

or

Telephone (800)-686-1516

HHTL 3352-12-02 (Outpatient Hospital Services)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-12-02

March 30, 2012

TO: Eligible Hospital Providers

Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: Outpatient Hospital Services

Summary

Ohio Administrative Code rule **5101:3-2-21**, Policies for outpatient hospital services, is being amended for three reasons: (1) to update appendices implementing the new January 2012 Current Procedural Terminology (CPT) and the 2012 Healthcare Common Procedural Coding System (HCPCS) coding changes, (2) to also make coding changes that were not included in the January 1, 2012 updates and (3) to add language to update the radiology code range. The effective date of this rule is March 29, 2012.

Rule Changes

Rule 5101:3-2-21, "Policies for outpatient hospital services," describes the outpatient payment rates and policies for hospitals that are subject to diagnostic related groups (DRG) prospective payment.

Changes:

- Rule language has been changed to add which codes are considered radiology services for pricing purposes.
- Appendices C, F, G, and H have been amended to add new codes and to delete obsolete codes to be consistent with the 2012 CPT and HCPCS manuals.
- Appendix C has been updated to remove CPT codes 61796, 61797, 61798, and 61799 because they are defined as professional services.

Access to Rules and Related Material

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Office of Ohio Health Plans, Bureau of Policy and Health Plan Services

Hospital Services

P.O. Box 182709

Columbus, OH 43218-2709

Telephone (614) 466-6420

or

hospital_policy@jfs.ohio.gov

HHTL 3352-12-01 (Hospital Updates Effective January 1, 2012)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-12-01

January 5, 2012

TO: All Hospital Providers

Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: Hospital updates effective January 1, 2012

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding changes effective January 1, 2012.

Hospital Inpatient Services

Inpatient Rates

Ohio Administrative Code (OAC) rule 5101:3-2-07.4, entitled "Basic methodology for determining prospective payment rates," became effective on September 29, 2011. In accordance with this rule, there will be no adjustment to Inpatient Hospital base or Medical Education rates. A separate letter has been sent to all hospitals operating within Ohio, with the hospital specific rates effective January 1, 2012.

Outliers

In accordance with **OAC rule 5101:3-2-07.9**, entitled "Payment for outliers," the exceptional outlier threshold effective January 1, 2012 has been inflated by 3.6 percent to $630,202. All inpatient discharges on or after January 1, 2012 will be subject to the new threshold. The threshold for calendar year 2011 discharges was $608,303. Also in accordance with this rule, the statewide charge threshold for each Diagnostic Related Group (DRG) will be inflated by 9.72 percent and will be effective for discharges on or after January 1, 2012.

Relative Weights

The calendar year 2012 relative weight table may be accessed from the Bureau of Policy and Health Plan Services' web page by going to **http://jfs.ohio.gov/ohp/bhpp/hbfm.stm** and selecting the option for provider payment policies. For CY 2012 there is no change to the relative weights, day high trim, or geometric mean length of stay.

Hospital Outpatient Services

OAC rule 5101:3-2-21, entitled "Policies for outpatient hospital services," describes the outpatient payment rates and policies for hospitals that are subject to DRG prospective payment. The rule was filed on an emergency basis to become effective on January 1, 2012, in order to comply with the Health Insurance Portability and Accountability Act (HIPAA), and to be consistent with industry coding standards. A permanent version of this rule will be filed in January 2012 and will follow the regular public process for accepting comments.

Effective January 1, 2012, the rule was amended to add new codes and update fee schedules, and to delete obsolete codes listed in appendices C, F, G, and H, to be consistent with the 2012 Current Procedural Terminology (CPT) manual and the 2012 Healthcare Common Procedural Coding System (HCPCS).

The changes included in the December 22, 2011 filing of OAC rule 5101:3-2-21 are also effective January 1, 2012. The rule was amended to clarify reimbursement language for independently billed services along with laboratory and pregnancy related services, and to change the reimbursement methodology for certain Current Procedural Terminology (CPT) codes and Revenue Center Codes that are priced using a percentage of charges. Effective January 1, 2012, these codes will be reimbursed using the Medicaid hospital specific outpatient cost-to-charge ratio described in paragraph (B)(2) of Ohio Administrative Code **5101:3-2-22**, Reasonable Cost and Cost-Related Reimbursement for Hospital Services.

Other Updates

Medicare Coinsurance and Deductible

The coinsurance and deductible amounts for Medicare's hospital insurance program (Part A) have been updated effective January 1,2012. The Medicare Part A inpatient hospital deductible amount is $1,156. The daily coinsurance amounts are updated as follows: (a) $289 coinsurance for the 61st through 90th day of hospitalization in a benefit period; (b) $578 for lifetime reserve days; and (c) $144.50 for the 21st through 100th day of extended care services in a skilled nursing facility in a benefit period.

The Medicare Part B deductibles have also been updated. Effective January 1, 2012the deductible amount will reflect $140.

Part B Cost-Sharing for Hospital Providers

OAC Rule 5101:3-2-25, entitled "Third-Party Liability," describes Medicaid reimbursement policies for hospital services subject to reimbursement from other payers, including Medicare. The Medicaid reimbursement methodology for hospital services covered by Medicare Part B has been changed. Effective January 1, 2012, Medicaid reimbursement for hospital services covered by Medicare Part B will be equal to the lesser of:

- The sum of the deductible, coinsurance and co-payment amount as provided by Medicare Part B; or
- The Medicaid maximum allowed amount, minus the total prior payment, not to equal less than zero.

Additionally, the rule title has been changed from "Third Party Liability" to "Coordination of Benefits: Hospital Services" and a paragraph reference number was corrected.

Web Page

The Ohio Department of Job and Family Services has a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is **www.jfs.ohio.gov**. The web address for the Office of Ohio Health Plans front page is **www.jfs.ohio.gov/ohp/**. Information regarding hospital payment policies may be accessed from the department's web page by going to **www.jfs.ohio.gov/ohp/bhpp/hbfm.stm** and selecting the option for provider payment policies and relative weight tables.

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, and handbooks. The URL is http://emanuals.odjfs.state.oh.us/emanuals/

Providers may view documents online by:

(1) Select "Ohio Health Plans - Provider."

(2) Select "Provider Type"; and

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The Legal/Policy Central Calendar (**http://www.odjfs.state.oh.us/lpc/calendar**) site is a quick reference of documents recently published. The Legal/Policy Center Calendar site also provides a link to a listing of ODJFS Letters (**http://www.odjfs.state.oh.us/lpc/mtl**). The listing is categorized by letter number and subject and a link is provided to the easy print (PDF) document.

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Questions:

Questions pertaining to this letter may be emailed to hospital_policy@jfs.ohio.gov or addressed to:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Policy & Health Plan Services

Hospital Benefit Unit

P.O. Box 182709

Columbus, OH 43218-2709
614-466-6420

HHTL 3352-11-10 (Assessment Rates - Hospital Care Assurance and Hospital Franchise Fee Programs)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-11-10

December 22, 2011

To: All Hospital Providers

Directors, County Departments of Job and Family Services

From: Michael B. Colbert, Director

Subject: Assessment Rates - Hospital Care Assurance and Hospital Franchise Fee programs

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to payment and data policies for disproportionate share and indigent care rules for general hospitals, as well as the assessment for general hospitals. This transmittal also provides information on the hospital franchise fee program for the 2012 program year.

Rule 5101:3-2-08.1 entitled Assessment rates sets forth the assessment rate for the Hospital Care Assurance Program (HCAP). This rule has been amended to establish the assessment rates and the cost levels to which those rates apply to fund HCAP for the 2011 program year. This rule was filed on an emergency basis, effective September 29, 2011, to allow for the immediate operation of HCAP.

Rule 5101:3-2-30 entitled Hospital Franchise Fee Program sets forth the assessment rate and payment schedule for hospital franchise fees for the 2012 program year. This rule was filed on an emergency basis effective September 29, 2011. This rule has been amended to establish the assessment rate, payment schedule and to require hospitals not enrolled as Medicaid providers to submit the required information to make an assessment.

Web Page:

The Ohio Department of Job and Family Services maintains a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is www.jfs.ohio.gov. The web address for the Office of Ohio Health Plans front page is **http://www.jfs.ohio.gov/ohp/**. Information regarding hospital payment policies may be accessed from the department's web page by browsing to **http://www.jfs.ohio.gov/ohp/bhpp/hbfm.stm** and selecting the option for provider payment policies and relative weight tables.

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Providers may view documents online by:

(1) Selecting the "Ohio Health Plans - Provider" folder;

(2) Selecting the appropriate topic from the document list; and

(3) Selecting the desired item from the "Table of Contents" pull-down menu.

Most current Medicaid maximum reimbursement rates are listed in rule 5101:3-1-60 or in Appendix DD to that rule. Providers may view these rates by:

(1) Selecting the "Ohio Health Plans - Provider" folder;

(2) Selecting "General Information for Medicaid Providers"; and

(3) Selecting "5101:3-1-60 Medicaid Reimbursement" from the "Table of Contents" pull-down menu.

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Questions:

Questions pertaining to this letter should be addressed to hospital_policy@jfs.ohio.gov or to:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Policy and Health Plan Services

Hospital Section

P.O. Box 182709

Columbus, OH 43218-2709

Telephone 614-466-6420

HHTL 3352-11-09 (Outpatient Hospital Services)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-11-09

December 29, 2011

TO: Eligible Hospital Providers

Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: Outpatient Hospital Services

Summary

Ohio Administrative Code rule **5101:3-2-21**, Policies for outpatient hospital services, is being amended to clarify reimbursement language for independently billed services along with laboratory and pregnancy related services, and to change the reimbursement methodology for certain Current Procedural Terminology (CPT) codes and Revenue Center Codes that are priced using a percent of charges. Effective January 1, 2012, these codes will be reimbursed using the Medicaid hospital specific outpatient cost-to-charge ratio described in paragraph (B)(2) of Ohio Administrative Code rule 5101:3-2-22, Reasonable Cost and Cost-Related Reimbursement for Hospital Services. The reimbursement changes in this rule will be effective January 1, 2012.

Rule Changes

Rule 5101:3-2-21, "Policies for outpatient hospital services," describes the outpatient payment rates and policies for hospitals that are subject to diagnosis related groups (DRG) prospective payment.

Changes:

- The language in paragraph (F) for the pricing methodology for unlisted procedure codes is being changed to pay at the hospital specific outpatient cost-to-charge ratio.
- The language in paragraph (G) for the pricing methodology for revenue center codes 25X present with an IV therapy code is being changed to pay at the hospital specific outpatient cost-to-charge ratio.
- The language in paragraph (H) for the pricing methodology for revenue center codes 25X present with an IV therapy code is being changed to pay at the hospital specific outpatient cost-to-charge ratio.
- Add paragraph (K) to describe reimbursement for laboratory and pregnancy related services.
- The language in paragraph (L) for the pricing methodology for revenue center codes 25X, 636, and 27X is being changed to pay at the hospital specific outpatient cost-to-charge ratio, and to strike language for laboratory and pregnancy related services reimbursement.
- Appendix C is being updated to reflect unlisted procedure codes being reimbursed at the hospital specific outpatient cost-to-charge ratio.
- Appendix F is being updated to include the following codes to be covered for pregnant women and for persons age 20 and under: 99406, 99407, S9453.
- Appendices F and G are being updated to reflect procedure codes previously reimbursed at a set percentage will now be reimbursed at the hospital specific outpatient cost-to-charge ratio.

Access to Rules and Related Material

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Hospital Services

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Columbus, OH 43218-2709

Telephone (614) 466-6420

or

hospital_policy@jfs.ohio.gov

HHTL 3352-11-08 (Update to Medicare Part B Cost Sharing for Hospital Providers)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-11-08

December 22, 2011

TO: Eligible Hospital Providers

Chief Executive Officers, Managed Care Plans (MCPs)

Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: Update to Medicare Part B Cost Sharing for Hospital Providers

Summary

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding the amendment of Ohio Administrative Code (OAC) rule **5101:3-2-25**, now titled "Coordination of Benefits: Hospital Services." In accordance with Am. Sub. H.B. 153, this rule is being updated to reflect a change in reimbursement for hospital services covered by Medicare Part B for Qualified Medicare Beneficiaries (QMBs) and dually-eligible consumers, effective January 1, 2012.

Rule Changes

Rule 5101:3-2-25, "Coordination of Benefits: Hospital Services," describes Medicaid reimbursement policies for hospital services subject to reimbursement from other payers, including Medicare.

Changes: The Medicaid reimbursement methodology for hospital services covered by Medicare Part B has been changed. Effective January 1, 2012, Medicaid reimbursement for hospital services covered by Medicare Part B will be equal to the lesser of:

- The sum of the deductible, coinsurance and co-payment amount as provided by Medicare Part B; or
- The Medicaid maximum allowed amount, minus the total prior payment, not to equal less than zero.

Additionally, the rule title has been changed from "Third Party Liability" to "Coordination of Benefits: Hospital Services" and a paragraph reference number was corrected.

Access to Rules and Related Material

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Most current Medicaid maximum reimbursement amounts are listed in rule 5101:3-1-60 or in Appendix DD to that rule. Providers may view this information by following these steps:

(1) Select the 'Ohio Health Plans - Provider' folder.

(2) Select 'General Information for Medicaid Providers'.

(3) Select 'General Information for Medicaid Providers (Rules)'.

(4) Select '5101:3-1-60 Medicaid Reimbursement' from the 'Table of Contents' pull-down menu and then scroll down to the link to Appendix DD.

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Hospital Services

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Columbus, OH 43218-2709

Telephone (614) 466-6420

or

hospital_policy@jfs.ohio.gov

HHTL 3352-11-07 (2011 Hospital Cost Reports)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-11-07

November 14, 2011

To: All Hospital Providers

Directors, County Departments of Job and Family Services

From: Michael B. Colbert, Director

Subject: 2011 Hospital Cost Reports

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to data collection and cost reporting for general hospitals.

Rule 5101:3-2-23 entitled Cost Reports sets forth the requirements and specific forms for hospital cost reporting. This rule was updated to reflect changes to dates and filing requirements relevant to hospital reporting periods ending during state fiscal year 2011. The rule applies to hospital reporting periods ending between July 1, 2010 and June 30, 2011.

The cost report forms have been updated to match the Centers for Medicare and Medicaid Services (CMS) 2552-10 Hospital Cost Report. The cost report instructions in the appendix will guide those hospitals that are using the CMS 2552-96. Instructions will be made available at a later date for those hospitals using the CMS 2552-10.

Additionally, in order to comply with the Disproportionate Share Audit requirements published in the Federal Register on December 19, 2008, the Department has added three new schedules to the cost report. Schedules F1, F2, and F3 provide for cost center level detail reporting of charges for each of the Uncompensated Care categories currently reported on Schedule F. Please thoroughly review the instructions for the completion and filing of these new schedules.

Access to Rules and Related Material

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Information about hospital payment policies may be accessed through the 'Provider Payment Policies & Relative Weight Tables' link on the Hospital Provider Information web page, **http://www.jfs.ohio.gov/ohp/bhpp/hbfm.stm**.

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Additional Information

Questions pertaining to this letter should be addressed to:

Ohio Department of Job and Family Services
Office of Ohio Health Plans, Bureau of Policy and Health Plan Services
Hospital Services
P.O. Box 182709
Columbus, OH 43218-2709
Telephone (614) 466-6420

or

hospital_policy@jfs.ohio.gov

HHTL 3352-11-06 (Hospital Payment for Outliers)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-11-06

October 4, 2011

To: All Hospital Providers

Directors, County Departments of Job and Family Services

From: Michael B. Colbert, Director

Subject: Hospital Payment for Outliers

Summary

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to payment policy for inpatient hospital stays that qualify for an outlier payment.

Rule **5101:3-2-07.9** entitled, Payment for outliers, has been amended to modify the inflation factor for the inpatient hospital outlier payment methodology. Pursuant to Am. Sub. H.B. 153 of the 129th General Assembly, the rule increases the threshold amount in effect for each DRG on September 30, 2011 by 13.6% for discharges on or after October 1, 2011 through December 31, 2011. The rule also increases the threshold amount in effect for each DRG on December 31, 2011 by 9.72% for discharges on or after January 1, 2012 through the implementation of the new diagnosis-related groups established by section 309.30.30 of Am. Sub. H.B. 153 of the 129th General Assembly.

Access to Rules and Related Material

The main ODJFS web page includes links to valuable information about its services and programs; the address is **http://www.jfs.ohio.gov**. The web page of the Office of Ohio Health Plans (Medicaid) may be accessed through the ODJFS main page or directly at **http://www.jfs.ohio.gov/ohp/**.

Information about hospital payment policies may be accessed through the 'Provider Payment Policies & Relative Weight Tables' link on the Hospital Provider Information web page, **http://www.jfs.ohio.gov/ohp/bhpp/hbfm.stm**.

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(1) Select "Ohio Health Plans - Provider"

(2) Select "Hospital Handbook"

(3) From the drop down menu at the top of the page entitled "Table of Contents," scroll to and select the desired HHTL number.

(4) Scroll through the HHTL to the desired rule number highlighted in blue and select the rule number.

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Office of Ohio Health Plans, Bureau of Policy and Health Plan Services
Hospital Services
P.O. Box 182709
Columbus, OH 43218-2709
Telephone (614) 466-6420

HHTL 3352-11-05 (Inpatient Hospital Base and Medical Education Rates)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-11-05

September 22, 2011

TO: All Hospital Providers

Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: Inpatient Hospital Base and Medical Education Rates

Summary

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to the hospital base and medical education rates for calendar years 2012 and 2013.

Inpatient Hospital Base and Medical Education Rates

The Ohio Administrative Code rule **5101:3-2-07.4** entitled "Basic methodology for determining prospective payment rates" describes the methodology for determining prospective payment rates for inpatient hospital services and sets the annual inflationary update. This rule has been amended to not provide for inpatient hospital rate changes for calendar years 2012 and 2013. Instead, pursuant to Am. Sub. H. B. 153 of the 129th General Assembly, the rule continues a fixed 5.0 percent increase to the inpatient hospital adjusted average cost per discharge (base rate) and the hospital-specific medical education allowance in effect on September 30, 2009. The continuation of the increase will be applied to discharges occurring during the period October, 1, 2009 through June 30, 2013. The rule is also being amended to address the period after the expiration of the Am. Sub. H.B. 153 increase, to revert to a zero percent composite inflation factor.

Access to Rules and Related Material

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Hospital Services
P.O. Box 182709
Columbus, OH 43218-2709
Telephone (614) 466-6420

or

hospital_policy@jfs.ohio.gov

HHTL 3352-11-04 (Outpatient Hospital Services)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-11-04

March 29, 2011

TO: Eligible Hospital Providers

Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: Outpatient Hospital Services

Summary

The rule addressed in this transmittal letter has been amended for four reasons: (1) to update appendices implementing the new January 2011 Current Procedural Terminology (CPT) and the 2011 Healthcare Common Procedural Coding System (HCPCS) coding changes, (2) to also make coding changes that were not included in the January 1, 2011 updates, (3) to add language to the rule to clarify coding requirements, and (4) to delete rule language and update appendices for previous date specific references. The effective date of this rule is March 30, 2011.

Rule Changes

Rule 5101:3-2-21, "Policies for outpatient hospital services," describes the outpatient payment rates and policies for hospitals that are subject to diagnostic related groups (DRG) prospective payment.

Changes:

- Rule language has been changed to add which codes are considered laboratory service for pricing purposes, to clarify only valid HCPCS J codes will be accepted with revenue center code 0636, and to delete previous date specific references.
- Appendices C and E have been reformatted to delete previous effective dates.
- Appendices C, F, G, and H have been amended to add new codes and to delete obsolete codes to be consistent with the 2011 CPT and HCPCS manuals.
- Appendix B has been updated to reference only valid J codes will be accepted with revenue center code 0636, and to delete obsolete revenue center codes.
- Appendix C has been updated to include prior authorization requirement for CPT codes 14020 and 19300. These procedures have been reviewed and are considered cosmetic.
- Appendix F has been updated to include the Vaccine for Children (VFC) program coding changes. Also, CPT code 99183 has been removed and replaced by a more appropriate HCPCS code, C1300, and requires prior authorization.
- Appendix H has been updated to include CPT codes 36415 and 36416. These codes have been deleted from the ancillary fee schedule, Appendix F. For pricing purposes, these two CPT codes will now be considered a laboratory service.

Access to Rules and Related Material

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Information about hospital payment policies may be accessed through the 'Provider Payment Policies & Relative Weight Tables' link on the Hospital Provider Information web page, **http://www.jfs.ohio.gov/ohp/bhpp/hbfm.stm**.

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Hospital Services

P.O. Box 182709

Columbus, OH 43218-2709

Telephone (614) 466-6420

or

hospital_policy@jfs.ohio.gov

HHTL 3352-11-03 (Hospital Care Assurance Program: Eligibility and Requirements)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-11-03

April 21, 2011

TO: All Hospital Providers

Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: Hospital Care Assurance Program: Eligibility and Requirements

Summary

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to the Hospital Care Assurance Program (HCAP).

Rule 5101:3-2-07.17 entitled Provision of basic, medically necessary hospital-level services sets forth eligibility policy and requirements for the Hospital Care Assurance Program (HCAP). In accordance with Ohio Revised Code 119.032, the department has reviewed this rule for any necessary changes and determined that no changes were necessary.

Access to Rules and Related Material

The main ODJFS web page includes links to valuable information about its services and programs; the address is **http://www.jfs.ohio.gov**. The web page of the Office of Ohio Health Plans (Medicaid) may be accessed through the ODJFS main page or directly at **http://www.jfs.ohio.gov/ohp/**.

Information about hospital payment policies may be accessed through the 'Provider Payment Policies & Relative Weight Tables' link on the Hospital Provider Information web page, **http://www.jfs.ohio.gov/ohp/bhpp/hbfm.stm**.

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(2) Select the appropriate service provider type or handbook.

(3) Select the desired document type.

(4) Select the desired item from the 'Table of Contents' pull-down menu.

Most current Medicaid maximum reimbursement amounts are listed in rule 5101:3-1-60 or in Appendix DD to that rule. Providers may view this information by following these steps:

(1) Select the 'Ohio Health Plans - Provider' folder.

(2) Select 'General Information for Medicaid Providers'.

(3) Select 'General Information for Medicaid Providers (Rules)'.

(4) Select '5101:3-1-60 Medicaid Reimbursement' from the 'Table of Contents' pull-down menu and then scroll down to the link to Appendix DD.

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hospital_policy@jfs.ohio.gov

HHTL 3352-11-02 (2011 Hospital Franchise Fee Program)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-11-02

January 7, 2011

To: All Hospital Providers

Directors, County Departments of Job and Family Services

From: Douglas E. Lumpkin, Director

Subject: 2011 Hospital Franchise Fee Program

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to data collection and cost reporting for general hospitals.

Rule 5101:3-2-30 entitled Hospital Franchise Fee Program sets forth the policies to administer this program. This rule modifies the rate at which total facility cost will be assessed, removes from total facility costs the cost of providing services to Medicare recipients and delays the first installment of the franchise fee to November 30, 2010. This rule was originally filed on an emergency basis with an effective date of October 14, 2010.

Web Page:

The Ohio Department of Job and Family Services maintains a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is www.jfs.ohio.gov. The web address for the Office of Ohio Health Plans front page is www.jfs.ohio.gov/ohp/. Information regarding hospital payment policies may be accessed from the department's web page by browsing to **http://jfs.ohio.gov/ohp/bhpp/hbfm.stm** and selecting the option for provider payment policies and relative weight tables.

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Providers may view documents online by:

(1) Selecting the "Ohio Health Plans - Provider" folder;

(2) Selecting the appropriate topic from the document list; and

(3) Selecting the desired item from the "Table of Contents" pull-down menu.

Most current Medicaid maximum reimbursement rates are listed in rule **5101:3-1-60** or in **Appendix DD** to that rule. Providers may view these rates by:

(1) Selecting the "Ohio Health Plans - Provider" folder;

(2) Selecting "General Information for Medicaid Providers"; and

(3) Selecting "**5101:3-1-60** Medicaid Reimbursement" from the "Table of Contents" pull-down menu.

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Columbus, OH 43218-2709
Telephone 614-466-6420

HHTL 3352-11-01 (Hospital Updates Effective January 1, 2011)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-11-01

January 4, 2011

TO: All Hospital Providers

Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Hospital updates effective January 1, 2011

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding changes effective January 1, 2011.

Hospital Inpatient Services

Inpatient Rates

Ohio Administrative Code (OAC) rule 5101:3-2-07.4, entitled "Basic methodology for determining prospective payment rates," became effective on October 15, 2009 for dates of service on or after October 1, 2009. In accordance with this rule, there will be no adjustment to Inpatient Hospital base or Medical Education rates. A separate letter will be sent to all hospitals operating within Ohio, with the hospital specific rates effective January 1, 2011.

Outliers

In accordance with **OAC rule 5101:3-2-07.9**, entitled "Payment for outliers," the exceptional outlier threshold effective January 1, 2011 has been inflated by 3.1 percent to $608,303. All inpatient discharges on or after January 1, 2011 will be subject to the new threshold. The threshold for calendar year 2010 discharges was $590,013. Also in accordance with this rule, the statewide charge threshold for each Diagnostic Related Group (DRG) will be inflated by 3.1 percent and will be effective for discharges on or after January 1, 2011.

Relative Weights

The calendar year 2011 relative weight table may be accessed from the Bureau of Policy and Health Plan Services' web page by going to **http://jfs.ohio.gov/ohp/bhpp/hbfm.stm** and selecting the option for provider payment policies. For CY 2011 there is no change to the relative weights, day high trim, or geometric mean length of stay.

Hospital Outpatient Services

OAC rule 5101:3-2-21, entitled "Policies for outpatient hospital services," describes the outpatient payment rates and policies for hospitals that are subject to DRG prospective payment. The rule was filed on an emergency basis to become effective on January 1, 2011, in order to comply with the Health Insurance Portability and Accountability Act (HIPAA), and to be consistent with industry coding standards. A permanent version of this rule will be filed in January 2011 and will follow the regular public process for accepting comments.

Effective January 1, 2011, the rule was amended to add new codes and update fee schedules, and to delete obsolete codes listed in appendices C, F, G, and H, to be consistent with the 2011 Current Procedural Terminology (CPT) manual and the 2011 Healthcare Common Procedural Coding System (HCPCS).

Other Updates

Medicare Coinsurance and Deductible

The coinsurance and deductible amounts for Medicare's hospital insurance program (Part A) have been updated effective January 1, 2011. The Medicare Part A inpatient hospital deductible amount is $1,132. The daily coinsurance amounts are updated as follows: (a) $283 coinsurance for the 61st through 90th day of hospitalization in a benefit period; (b) $566 for lifetime reserve days; and (c) $141.50 for the 21st through 100th day of extended care services in a skilled nursing facility in a benefit period.

The Medicare Part B deductibles have also been updated. Effective January 1, 2011 the deductible amount will reflect $162.

Web Page

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Questions:

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Bureau of Policy & Health Plan Services

Hospital Benefit Unit

P.O. Box 182709

Columbus, OH 43218-2709

614-466-6420

HHTL 3352-10-07 (MITS-Related Changes to Rule in OAC Chapter 5101:3-2)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-10-07

December 6, 2010

TO: Eligible Hospital Providers

Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: MITS-Related Changes to Rule in OAC Chapter 5101:3-2

The rule addressed in this transmittal letter is being amended for three reasons: (1) to comply with requirements of the five-year review process, (2) to update existing rule language, and (3) to support implementation of the Medicaid Information Technology System (MITS). MITS is Ohio Medicaid's new electronic claims submission interface and is scheduled to become operational in the near future. The effective date of this rule is December 6, 2010.

Rule Changes

Rule 5101:3-2-02, "General provisions: hospital services," describes and defines general provisions for medically necessary inpatient and outpatient hospital services.

Changes: The meaning of "inpatient" has been clarified. Appendix A to the rule has been updated to reflect outpatient coverage of revenue code 0636 (drugs requiring detailed coding). Obsolete revenue codes have been removed.

Access to Rules and Related Material

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Information about hospital payment policies may be accessed through the 'Provider Payment Policies & Relative Weight Tables' link on the Hospital Provider Information web page, **http://www.jfs.ohio.gov/ohp/bhpp/hbfm.stm**.

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Telephone (614) 466-6420

or

hospital_policy@jfs.ohio.gov

HHTL 3352-10-06 (Payment/Data Policies for Disproportionate Share and Indigent Care Adjustments)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-10-06

December 21, 2010

To: All Hospital Providers

Directors, County Departments of Job and Family Services

From: Douglas E. Lumpkin, Director

Subject: Payment/Data Policies for Disproportionate Share and Indigent Care Adjustments

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to payment and data policies for disproportionate share and indigent care rules for general hospitals, as well as the assessment for general hospitals.

Rule 5101:3-07.5 entitled Disproportionate share adjustment sets forth the methodology for determining the hospital-specific disproportionate share limit. This rule has been amended to include in the calculation any payments received by a hospital under Section 1011 - Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens.

Rule 5101:3-2-08 entitled Data policies for disproportionate share and indigent care adjustments for hospital services sets forth the data set used to calculate disproportionate share and indigent care adjustments. This rule has been amended to clarify the treatment of data for hospitals which experience a change of ownership and to clarify the policy regarding data corrections.

Rule 5101:3-2-08.1 entitled Assessment rates sets forth the assessment rate for the Hospital Care Assurance Program (HCAP). This rule has been amended to establish the assessment rates and the cost levels to which those rates apply to fund HCAP for the 2010 program year and to allow the department to make assessments for a prior year's HCAP when the department is notified by CMS that an additional disproportionate share allotment is available, for that prior program year.

Rule 5101:3-2-09 entitled Payment policies for disproportionate share and indigent care adjustments for hospital services sets forth the conditions, requirements, and operation of HCAP as well as the distribution formula. This rule has been amended to update the distribution formula for payment policies for disproportionate share hospitals (DSH) for use in program year 2010.

Web Page:

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(1) Selecting the "Ohio Health Plans - Provider" folder;

(2) Selecting the appropriate topic from the document list; and

(3) Selecting the desired item from the "Table of Contents" pull-down menu.

Most current Medicaid maximum reimbursement rates are listed in rule **5101:3-1-60** or in **Appendix DD** to that rule. Providers may view these rates by:

(1) Selecting the "Ohio Health Plans - Provider" folder;

(2) Selecting "General Information for Medicaid Providers"; and

(3) Selecting "5101:3-1-60 Medicaid Reimbursement" from the "Table of Contents" pull-down menu.

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Questions:

Questions pertaining to this letter should be addressed to hospital_policy@jfs.ohio.gov or to:

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Office of Ohio Health Plans

Bureau of Policy and Health Plan Services

Hospital Section

P.O. Box 182709

Columbus, OH 43218-2709

Telephone 614-466-6420

HHTL 3352-10-05 (SFY 2010 Hospital Cost Report)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-10-05

September 30, 2010

To: All Hospital Providers

Directors, County Departments of Job and Family Services

From: Douglas E. Lumpkin, Director

Subject: 2010 Hospital Cost Reports

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to data collection and cost reporting for general hospitals.

Rule 5101:3-2-23 entitled Cost Reports sets forth the requirements and specific forms for hospital cost reporting. This rule was updated to reflect changes to dates and filing requirements relevant to hospital reporting periods ending during state fiscal year 2010. The rule applies to hospital reporting periods ending between July 1, 2009 and June 30, 2010.

Additionally, the amendments to this rule are intended to provide guidance and clarification on the charges and payments that should be reported for services provided to Ohio Medicaid recipients. The department expects hospitals to use their own accounting/patient information systems to compile the data necessary for completing the cost report.

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(3) Selecting "5101:3-1-60 Medicaid Reimbursement" from the "Table of Contents" pull-down menu.

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HHTL 3352-10-04 (Payment Policies for Supplemental Upper Limit programs for Hospitals)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-10-04

April 12, 2010

To: All Eligible Hospital Providers

Directors, County Departments of Job and Family Services

From: Douglas E. Lumpkin, Director

Subject: Payment Policies for Supplemental Upper Limit programs for Hospitals.

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to rules for payment policies for Supplemental Upper Limit programs for Hospitals. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Rule 5101:3-2-50 entitled Supplemental inpatient hospital upper limit payments for public hospitals is being proposed for amendment to delete references to the sources of state share, pursuant to a Centers for Medicare and Medicaid Services requirement and to provide for the funding of the state match for the upper payment limit program as appropriated by section 309.30.17 of Am. Sub. H.B. 1 of the 128th General Assembly.

Rule 5101:3-2-51 entitled Supplemental inpatient hospital upper limit payments for state hospitals is being proposed for amendment to delete references to the sources of state share, pursuant to a Centers for Medicare and Medicaid Services requirement and to provide for the funding of the state match for the upper payment limit program as appropriated by section 309.30.17 of Am. Sub. H.B. 1 of the 128th General Assembly.

Rule 5101:3-2-52 entitled Supplemental inpatient hospital payments for private hospitals, is being proposed for adoption, pursuant to section 309.30.17 of Am. Sub. H.B. 1 of the 128th General Assembly which creates a supplemental inpatient upper limit payment program for private hospitals. This rule implements a supplemental inpatient hospital upper limit payment program for all non children's private hospitals, that provides for increased reimbursements to all private non children's hospitals paid under the prospective payment system for inpatient hospital services, using available funding appropriated by Am. Sub. H.B. 1 of the 128th Ohio General Assembly, and based on the federal upper payment limits for inpatient hospital services rendered by private hospitals in Ohio in accordance with 42 CFR 447.272.

Rule 5101:3-2-53 entitled Supplemental inpatient hospital payments for children's hospitals, sets forth the methodology used to determine the supplemental inpatient hospital upper limit payments for children's hospitals. This rule is being proposed for amendment to implement section 309.30.15 of Am. Sub. H.B. 1 of the 128th General Assembly, which re-authorizes the supplemental inpatient hospital payments for children's hospitals program for two more years, and also increases the appropriations for the program and makes technical corrections that demonstrates how gap calculations are made for private psychiatric hospitals.

Rule 5101:3-2-54 entitled Supplemental outpatient hospital upper limit payments for private, public non state-owned, and public state-owned hospitals, is being proposed for adoption, pursuant to section 309.30.17 of Am. Sub. H.B. 1 of the 128th General Assembly which creates a supplemental outpatient upper limit payment program for Ohio private, public non state-owned, and public state-owned hospitals. This rule implements a supplemental outpatient hospital upper limit payment program for all non children's private, public and public state hospitals, that provides for increased reimbursements to all non children's hospitals paid under the prospective payment system for inpatient hospital services, using available funding appropriated by Am. Sub. H.B. 1 of the 128th Ohio General Assembly, and based on the federal upper payment limits for outpatient hospital services rendered by in state private, public and public state hospitals, in accordance with 42 CFR 447.321.

Web Page:

The Ohio Department of Job and Family Services maintains a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is **www.jfs.ohio.gov**. The web address for the Office of Ohio Health Plans front page is **www.jfs.ohio.gov/ohp/**. Information regarding hospital payment policies may be accessed from the department's web page by browsing to **www.jfs.ohio.gov/ohp/bhpp/hbfm.stm** and selecting the option for provider payment policies and relative weight tables.

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Providers may view documents online by:

(1) Selecting the "Ohio Health Plans - Provider" folder;

(2) Selecting the appropriate topic from the document list; and

(3) Selecting the desired item from the "Table of Contents" pull-down menu.

Most current Medicaid maximum reimbursement rates are listed in rule **5101:3-1-60** or in Appendix DD to that rule. Providers may view these rates by:

(1) Selecting the "Ohio Health Plans - Provider" folder;

(2) Selecting "General Information for Medicaid Providers"; and

(3) Selecting "5101:3-1-60 Medicaid Reimbursement" from the "Table of Contents" pull-down menu.

The Legal/Policy Central - Calendar site (**http://www.odjfs.state.oh.us/lpc/calendar/**) is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of ODJFS manual transmittal letters (**http://www.odjfs.state.oh.us/lpc/mtl/**). The listing is categorized by letter number and subject, and a link is provided to each easy-print (PDF) document.

Questions:

Questions pertaining to this letter should be addressed to hospital_policy@jfs.ohio.gov or to:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Policy and Program Support

Hospital Section

P.O. Box 182709

Columbus, OH 43218-2709

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HHTL 3352-10-03 (Outpatient Hospital Services)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-10-03

April 1, 2010

TO: All Eligible Hospital Providers

Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Outpatient Hospital Services

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding changes to Ohio Administrative code (OAC) rule **5101:3-2-21**, Policies for outpatient hospital services.

Policies for outpatient hospital services:

The rule entitled "Policies for outpatient hospital services," OAC 5101:3-2-21, describes the outpatient payment rates and policies for hospitals that are subject to diagnostic related groups (DRG) prospective payment. The rule is being amended to add new codes and to delete obsolete codes listed in appendices C, F, G, and H, to be consistent with the 2010 Current Procedural Terminology (CPT) and the 2010 Healthcare Common Procedural Coding System (HCPCS) manuals. Additional changes to the rule include the following:

- To update language to be date specific to the ability of hospitals to bill with revenue center code 0636, and to update language describing how it will be reimbursed for IV therapy (described in paragraphs (G)(2)(e) and (H)(2)(d)), and independently billed pharmacy services (described in paragraph (K)(1))
- To update Appendix C (Ambulatory Surgery Fee Schedule), Appendix F (Ancillary Fee Schedule), Appendix G (Radiology Fee Schedule), to include CPT codes that were previously inpatient only

The rule was filed on an emergency basis in order to incorporate the HCPCS updates effective for dates of service on and after January 1, 2010. This change is necessary in order to comply with the Health Insurance Portability and Accountability Act (HIPAA), and to be consistent with industry coding standards. A permanent version was subsequently filed and will be effective March 31, 2010.

Web Page:

The Ohio Department of Job and Family Services maintains a web page that provides valuable information about Ohio Medicaid. The web address for the Ohio Department of Job and Family Services is **www.jfs.ohio.gov**. The web address for the Office of Ohio Health Plans front page is **www.jfs.ohio.gov/ohp/**. Information regarding hospital payment policies may be accessed from the department's web page by browsing to **www.jfs.ohio.gov/ohp/bhpp/hbfm.stm** and selecting the option for provider payment policies and relative weight tables.

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Providers may view documents online by:

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Questions:

Questions pertaining to this letter should be addressed to hospital_policy@jfs.ohio.gov or to:

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Hospital Section

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HHTL 3352-10-02 (2009 Hospital Cost Reports)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-10-02

February 25, 2010

To: All Hospital Providers

Directors, County Departments of Job and Family Services

From: Douglas E. Lumpkin, Director

Subject: 2009 Hospital Cost Reports

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to data collection and cost reporting for general hospitals.

Rule 5101:3-2-23 entitled Cost Reports sets forth the requirements and specific forms for hospital cost reporting. This rule was updated to reflect changes to dates and filing requirements relevant to hospital reporting periods ending during state fiscal year 2009. The rule applies to hospital reporting periods ending between July 1, 2008 and June 30, 2009.

This rule establishes new policies or procedures related to the reporting of inpatient days and discharges for services provided to recipients enrolled in Medicaid Managed Care Plans and for services provided to undocumented aliens under Section 1011 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub. L. 108-173) (MMA). This rule also establishes the necessary columns to calculate an estimate of the capital cost associated with providing services to Medicaid Managed Care recipients.

Web Page:

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(1) Selecting the "Ohio Health Plans - Provider" folder;

(2) Selecting the appropriate topic from the document list; and

(3) Selecting the desired item from the "Table of Contents" pull-down menu.

Most current Medicaid maximum reimbursement rates are listed in rule **5101:3-1-60** or in Appendix DD to that rule. Providers may view these rates by:

(1) Selecting the "Ohio Health Plans - Provider" folder;

(2) Selecting "General Information for Medicaid Providers"; and

(3) Selecting "5101:3-1-60 Medicaid Reimbursement" from the "Table of Contents" pull-down menu.

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HHTL 3352-10-01 (Hospital updates effective January 1, 2010)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-10-01

January 22, 2010

TO: All Hospital Providers

Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Hospital updates effective January 1, 2010

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding changes effective January 1, 2010.

Hospital Inpatient Services

Inpatient Rates

Ohio Administrative Code (OAC) rule 5101:3-2-07.4, entitled "Basic methodology for determining prospective payment rates," became effective on October 15, 2009 for dates of service on or after October 1, 2009. This rule provides for a 5 percent increase to the inpatient hospital rates. A separate letter will be sent to all hospitals with the hospital specific rates effective January 1, 2010.

Outliers

In accordance with **OAC rule 5101:3-2-07.9**, the exceptional outlier threshold effective January 1, 2010 has been inflated by 1.8 percent to $590,013. All inpatient discharges on or after January 1, 2010 will be subject to the new threshold. The threshold for calendar year 2009 discharges was $579,580. Also in accordance with this rule, the statewide charge threshold for each Diagnostic Related Group (DRG) will be inflated by 1.8 percent and will be effective for discharges on or after January 1, 2010.

Relative Weights

The calendar year 2010 relative weight table may be accessed from the Bureau of Policy and Benefit Management's web page by going to **http://jfs.ohio.gov/ohp/bhpp/hbfm.stm** and selecting the option for provider payment policies. For CY 2010 there is no change to the relative weights, day high trim, or geometric mean length of stay.

Hospital Outpatient Services

As described in Medicaid Handbook Transmittal Letter 3340-09-01, effective August 1, 2009, rule 5101:3-34-01.3, entitled Physical Therapy, Occupational Therapy and Speech-language Pathology/Audiology Services: Provider Claims, Billing, Payment and Reimbursement, has been amended to set forth that the provision of therapy services to residents of a nursing facility (NF) is the responsibility of the NF and reimbursable through the nursing facility per diem.

Am. Sub. H.B. 1 of the 128th General Assembly, changed how Medicaid will reimburse some services provided to nursing facility (NF) residents. These services, which include transportation, physical, occupational and speech language pathology/audiology therapy, were previously provided by, and reimbursed to, fee-for-service providers. Am. Sub. H.B. 1 of the 128th General Assembly, changed this arrangement by making NFs responsible for providing these services to Medicaid NF residents and by reimbursing NFs for the services through the nursing facility per diem.

Hospitals providing certain services in an outpatient setting, such as therapy or transportation, to a consumer who's primary residence is a nursing facility will be required to submit an invoice to that nursing facility for reimbursement. This would also include any cost sharing obligations from Medicare.

OAC rule 5101:3-2-21, entitled "Policies for outpatient hospital services," describes the outpatient payment rates and policies for hospitals that are subject to DRG prospective payment. The rule was filed on a emergency basis to become effective on January 1, 2010, in order to comply with the Health Insurance Portability and Accountability Act (HIPAA), and to be consistent with industry coding standards. A permanent

version of this rule will be filed in January 2010 and will follow the regular public process for accepting comments.

Effective January 1, 2010, the rule was amended to add new codes and update fee schedules, and to delete obsolete codes listed in appendices C, F, G, and H, to be consistent with the 2010 Current Procedural Terminology (CPT) manual and the 2010 Healthcare Common Procedural Coding System (HCPCS). The changes also include the addition of CPT code 90663, influenza virus vaccine, pandemic formulation, to be used when billing for the administration of the H1N1 vaccine; (The H1N1 pandemic influenza vaccine is federally-funded for both children and adults.)

Other Updates

Medicare Coinsurance and Deductible

The coinsurance and deductible amounts for Medicare's hospital insurance program (Part A) have been updated effective January 1, 2010. The Medicare Part A inpatient hospital deductible amount is $1,100. The daily coinsurance amounts are updated as follows: (a) $275 coinsurance for the 61st through 90th day of hospitalization in a benefit period; (b) $550 for lifetime reserve days; and (c) $137.50 for the 21st through 100th day of extended care services in a skilled nursing facility in a benefit period.

The Medicare Part B deductibles have also been updated. Effective January 1, 2010 the deductible amount will reflect $155.

Web Page

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Questions:

Questions pertaining to this letter may be emailed to hospital_policy@jfs.ohio.gov or addressed to:

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Hospital Benefit Unit

P.O. Box 182709

Columbus, OH 43218-2709

614-466-6420

HHTL 3352-09-08 (Methodology for Determining Relative Weights)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-09-08

December 29, 2009

TO: All Eligible Hospital Providers

Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Methodology for Determining Relative Weights

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding the amendment of Ohio Administrative Code (OAC) rule **5101:3-2-07.3**, Methodology for determining relative weights.

Methodology for Determining Relative Weights:

Ohio Administrative Code (OAC) rule **5101:3-2-07.3** entitled "Methodology for Determining Relative Weights" applies to hospitals subject to prospective payment for inpatient services. The rule describes the method for determining the relative weight of each DRG, which represents the average resources required to care for cases in that particular DRG. The existing rule requires the relative weights to be updated January 1, 2010, and annually thereafter. The change delays the requirement for updating the relative weights until January 1, 2012, and continues to require annual updates thereafter.

Web Page:

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Questions:

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HHTL 3352-09-07 (Outpatient Hospital Services)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-09-07

December 7, 2009

TO: All Eligible Hospital Providers

Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Outpatient Hospital Services

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding changes to Ohio Administrative code (OAC) rule **5101:3-2-21**, Policies for outpatient hospital services.

Policies for outpatient hospital services:

The rule entitled "Policies for outpatient hospital services," **5101:3-2-21**, describes the outpatient payment rates and policies for hospitals that are subject to DRG prospective payment. The rule was filed on an emergency basis to be effective for dates of service on or after October 1, 2009 in order to comply with Am. Sub. H.B. 1 of the 128th General Assembly. The permanent amendment of the rule was effective December 3, 2009. The following changes of the permanent rule will be effective January 1, 2010:

- To update text within the rule to define the National Drug Code (NDC)
- To update text within the rule to delete language pertaining to prior service dates
- To update Appendix B, revenue center codes requiring current procedural terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) coding, to include revenue center code 0636
- To update Appendix C, ambulatory surgery groups, with the new fee schedules effective 10/1/2009 and 1/1/2010
- To update Appendix D, clinic facility visits, with the new fee schedule effective 1/1/2010
- To update Appendix E, emergency room facility services, with the new fee schedules effective 10/1/2009 and 1/1/2010
- To update Appendix F, ancillary services , with the new fee schedule effective 1/1/2010
- To update Appendix G, radiology services , with the new fee schedule effective 1/1/2010
- Change the text within the rule to use Appendix H for reimbursement of laboratory services
- To implement Appendix H, laboratory services, with the new fee schedule effective 1/1/2010
- To increase reimbursement for all immunizations covered under the Vaccines for Children (VFC) program to ten dollars for individuals eighteen years of age or younger

Web Page:

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Questions:

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Hospital Section

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Telephone 614-466-6420

HHTL 3352-09-06 (Inpatient Hospital Base and Medical Education Rates)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-09-06

October 14, 2009

To: All Hospital Providers

Directors, County Departments of Job and Family Services

From: Douglas E. Lumpkin, Director

Subject: Inpatient Hospital Base and Medical Education Rates

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to the hospital base and medical education rates for calendar years 2010 and 2011. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Inpatient Hospital Base and Medical Education Rates

The Ohio Administrative Code rule 5101:3-2-07.4 entitled "Basic methodology for determining prospective payment rates" describes the methodology for determining prospective payment rates for inpatient hospital services and sets the annual inflationary update. This rule was updated to reflect changes to the annual inflationary updates to inpatient hospital base and medical education rates. This rule has been amended to not provide for inpatient hospital rate changes for calendar year (CY) 2010 and CY 2011. Instead, pursuant to Am. Sub. H. B. 1 of the 128th General Assembly, the rule provides a fixed 5.0 percent increase to the inpatient hospital adjusted average cost per discharge (base rate) and the hospital-specific education allowance in effect on September 30, 2009. The increase will be applied to discharges occurring during the period October, 1, 2009 to June 30, 2011. The rule is also being amended to address the period after the expiration of the Am. Sub. H.B. 1 increase, to revert to a zero percent composite inflation factor. A separate letter has been sent to all hospitals with the hospital specific rates effective October 1, 2009.

Web Page:

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At the "electronic manuals" web page, this HHTL, and any attachments, may be viewed as follows:

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(2) Then select "Hospital Handbook."

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(4) Scroll through the HHTL to the desired rule number highlighted in blue and select the rule number.

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Questions:

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Bureau of Policy & Benefit Management

Hospital Section

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Columbus, OH 43218-2709

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HHTL 3352-09-05 (Payment/Data Policies for Disproportionate Share and Indigent Care Adjustments)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-09-05

August 10, 2009

To: All Hospital Providers

Directors, County Departments of Job and Family Services

From: Douglas E. Lumpkin, Director

Subject: Payment/Data Policies for Disproportionate Share and Indigent Care Adjustments

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to payment and data policies for disproportionate share and indigent care rules for general hospitals, as well as the assessment for general hospitals. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Rule 5101:3-2-08.1 entitled Assessment rates sets forth the assessment rate for the Hospital Care Assurance Program (HCAP). This rule has been amended to establish the assessment rates and the cost levels to which those rates apply to fund HCAP for the 2009 program year.

Rule 5101:3-2-09 entitled Payment policies for disproportionate share and indigent care adjustments for hospital services sets forth the conditions, requirements, and operation of HCAP as well as the distribution formula. This rule has been amended to update the distribution formula for payment policies for disproportionate share hospitals (DSH) for use in program year 2009.

Web Page:

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Providers may view documents online by:

(1) Selecting the "Ohio Health Plans - Provider" folder;

(2) Selecting the appropriate topic from the document list; and

(3) Selecting the desired item from the "Table of Contents" pull-down menu.

Most current Medicaid maximum reimbursement rates are listed in rule 5101:3-1-60 or in Appendix DD to that rule. Providers may view these rates by:

(1) Selecting the "Ohio Health Plans - Provider" folder;

(2) Selecting "General Information for Medicaid Providers"; and

(3) Selecting "5101:3-1-60 Medicaid Reimbursement" from the "Table of Contents" pull-down menu.

The Legal/Policy Central - Calendar site (**http://www.odjfs.state.oh.us/lpc/calendar/**) is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of ODJFS manual transmittal letters (**http://www.odjfs.state.oh.us/lpc/mtl/**). The listing is categorized by letter number and subject, and a link is provided to each easy-print (PDF) document.

Questions:

Questions pertaining to this letter should be addressed to hospital_policy@jfs.ohio.gov or to:

Ohio Department of Job and Family Services
Office of Ohio Health Plans
Bureau of Policy and Benefit Management
Hospital Section
P.O. Box 182709
Columbus, OH 43218-2709
Telephone 614-466-6420

HHTL 3352-09-04 (Supplemental inpatient hospital upper limit payments for state and public hospitals and Administrative fees on supplemental upper limit payments)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-09-04

March 25, 2009

To: All Eligible Hospital Providers

Directors, County Departments of Job and Family Services

From: Douglas E. Lumpkin, Director

SUBJECT: Supplemental inpatient hospital upper limit payments for state and public hospitals and Administrative fees on supplemental upper limit payments

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding changes to Ohio Administrative code (OAC) rule 5101:3-2-50 Supplemental inpatient hospital upper limit payments for public hospitals, Ohio Administrative Code (OAC) rule 5101:3-2-51 Supplemental inpatient hospital upper limit payments for state hospitals and Ohio Administrative Code (OAC) rule 5101:3-2-52 Administrative fees on supplemental upper limit payments. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Ohio Administrative Code (OAC) rule 5101:3-2-50 is titled Supplemental inpatient hospital upper limit payments for public hospitals. This rule explains the process of calculating supplemental inpatient payments for public hospitals owned and operated by a governmental entity other than the state. The rule was filed in compliance with the five year rule review requirement. Changes include clarification that the inpatient payment gap for specified cost based hospitals is zero and other minor technical corrections. This rule becomes effective on April 1, 2009.

Ohio Administrative Code (OAC) rule 5101:3-2-51 is titled Supplemental inpatient hospital upper limit payments for state hospitals. This rule explains the process of calculating supplemental inpatient payments for hospitals owned and operated by the state. The rule was filed in compliance with the five year rule review requirement. Changes include clarification that the inpatient payment gap for specified cost based hospitals is zero and other minor technical corrections. This rule is also being amended to include a regulatory cite with regards to state psychiatric hospitals being excluded from the Medicare prospective payment system. This rule becomes effective on April 1, 2009.

Ohio Administrative Code (OAC) rule 5101:3-2-52 is titled Administrative fees on supplemental upper limit payments. This rule is to be rescinded.

Web Page :

The Ohio Department of Job and Family Services maintains a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is http://jfs.ohio.gov/. The web address for the Office of Ohio Health Plans is **http://jfs.ohio.gov/ohp/**. Information regarding hospital payment policies may be accessed from the department's web page by browsing to **www.jfs.ohio.gov/ohp/bhpp/hbfm.stm** and selecting the option for provider payment policies and relative weight tables.

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Questions:

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Office of Ohio Health Plans

Bureau of Policy and Benefit Management

Hospital Section

P.O. Box 182709

Columbus, OH 43218-2709

Telephone 614-466-6420

HHTL 3352-09-03(Outpatient Hospital Services)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-09-03

March 25, 2009

TO: All Hospital Providers

Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Outpatient Hospital Services

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding changes to Ohio Administrative code (OAC) rule 5101:3-2-21, Policies for outpatient hospital services. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Policies for outpatient hospital services:

The rule entitled "Policies for outpatient hospital services," OAC 5101:3-2-21, describes the outpatient payment rates and policies for hospitals that are subject to DRG prospective payment. The rule is being amended to add new codes and to delete obsolete codes listed in appendices C, D, F, and G, to be consistent with the 2009 Current Procedural Terminology (CPT) manual and the 2009 Healthcare Common Procedural Coding System (HCPCS). Additional changes to the rule include the following:

- Update to the vaccine for children (VFC) procedure codes in Appendix F to be consistent with Appendix DD in OAC rule 5101:3-1-60.

The rule became effective on an emergency basis for dates of service on or after January 1, 2009. It was filed on an emergency basis in order to comply with the Health Insurance Portability and Accountability Act (HIPAA), and to be consistent with industry coding standards. A permanent version was subsequently filed and will be effective March 31, 2009.

Web Page:

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Paper Distribution:

Providers will receive one printed copy of this letter and an accompanying JFS 03400, "Ohio Department of Job and Family Services, Service Provider Update Request Form." Providers may request a second printed copy of this letter with all attachments by completing the JFS 03400 and returning it to the Ohio Department of Job and Family Services in accordance with the instructions at the top of the form.

Questions pertaining to this letter should be addressed to hospital_policy@jfs.ohio.gov or to:

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Office of Ohio Health Plans

Bureau of Policy and Benefit Management

Hospital Section

P.O. Box 182709

Columbus, OH 43218-2709

Telephone 614-466-6420

HHTL 3352-09-02 (Conditions and Limitations)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-09-02

March 25, 2009

TO: All Eligible Hospital Providers

Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Conditions and Limitations

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding the amendment of Ohio Administrative Code (OAC) rule 5101:3-2-03, Conditions and limitations. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Conditions and Limitations:

Ohio Administrative Code (OAC) rule 5101:3-2-03 entitled "Conditions and Limitations" describes the coverage of inpatient and outpatient hospital services and has been filed in compliance with five year rule review requirements. This rule has been updated to reflect current references, add surrogacy services to the non-covered list, and include minor clarification changes, such as the removal of redundant language.

Web Page:

The Ohio Department of Job and Family Services maintains a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is **www.jfs.ohio.gov**. The web address for the Office of Ohio Health Plans is **www.jfs.ohio.gov/ohp/**. Information regarding hospital payment policies may be accessed from the department's web page by browsing to **www.jfs.ohio.gov/ohp/bhpp/hbfm.stm** and selecting the option for provider payment policies and relative weight tables.

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(1) Selecting the "Ohio Health Plans - Provider" folder;

(2) Selecting the appropriate topic from the document list; and

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Bureau of Policy and Benefit Management

Hospital Section
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HHTL 3352-08-08 (Payment/Data Policies for Disproportionate Share and Indigent Care Adjustments)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-08-08

July 31, 2008

To: All Hospital Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Helen E. Jones-Kelley, Director

Subject: Payment/Data Policies for Disproportionate Share and Indigent Care Adjustments

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to payment and data policies for disproportionate share and indigent care rules for general hospitals, as well as the assessment for general hospitals. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Rule 5101:3-2-08.1 entitled Assessment rates sets forth the assessment rate for the Hospital Care Assurance Program (HCAP). This rule has been amended to establish the assessment rates and the cost levels to which those rates apply to fund HCAP for the 2008 program year.

Rule 5101:3-2-09 entitled Payment policies for disproportionate share and indigent care adjustments for hospital services sets forth the conditions, requirements, and operation of HCAP as well as the distribution formula. This rule has been amended to update the distribution formula for payment policies for disproportionate share hospitals (DSH) for use in program year 2008.

Department Web Page

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Web Page and Paper Distribution:

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http://emanuals.odjfs.state.oh.us/emanuals/

At the "electronic manuals" web page, this HHTL, and any attachments, may be viewed as follows:

(1) From the left column, select "Ohio Health Plans - Provider."

(2) From the left column, select "Hospital Handbook."

(3) From the drop-down menu "Table of Contents" at the top of the page, scroll to and select the desired HHTL number.

(4) Scroll through the HHTL to the desired rule number highlighted in blue and select the rule number.

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Providers will receive one hard copy of this transmittal letter and, if there are attachments, one hard copy of the JFS 03400 "Ohio Department of Job and Family Services, Service Provider Update Request Form." If a provider does not have access to the Internet and wishes to request a paper copy of this transmittal letter with

all attachments, the Provider should complete the attached JFS 03400 and return it to the Ohio Department of Job and Family according to the instructions at the top of the form.

Questions:

Questions pertaining to this letter should be addressed to the address below or emailed to hospital_policy@jfs.ohio.gov.

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Health Plan Policy

Financial Management and Hospital Benefit Section

P.O. Box 182709

Columbus, OH 43218-2709

614-466-6420

HHTL 3352-08-07 (Methodology for Determining Relative Weights)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-08-07

July 17, 2008

TO: All Hospital Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Methodology for determining relative weights

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to the methodology for determining relative weights. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Ohio Administrative Code (OAC) rule 5101:3-2-07.3, entitled "Methodology for determining relative weights," applies to hospitals subject to prospective payment for inpatient services. The rule describes the method for determining the relative weight of each DRG, which represents the average resources required to care for cases in that particular DRG. The existing rule requires the relative weights to be updated July 1, 2008, and annually thereafter. The change delays the requirement for updating the relative weights until January 1, 2010, and continues to require annual updates thereafter.

Web Page and Paper Distribution:

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(1) Select "Ohio Health Plans - Provider."

(2) Select "Provider Type"; and

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Questions:

Questions pertaining to this letter should be addressed to:

Ohio Department of Job and Family Services
Office of Ohio Health Plans
Bureau of Health Plan Policy

Financial Management and Hospital Benefit Section
P.O. Box 182709
Columbus, OH 43218-2709
614-466-6420

HHTL 3352-08-06 (Cost Reports SFY 2008)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-08-06

July 10, 2008

To: All Hospital Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Helen E. Jones-Kelley, Director

Subject: Cost Reports

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to the hospital cost report instructions and filing requirements for reporting periods ending in state fiscal year 2008. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Cost Reports

The Ohio Administrative Code rule 5101:3-2-23 entitled "Cost Reports" is effective. This rule was updated to reflect changes to dates and filing requirements relevant to hospital reporting periods ending during state fiscal year 2008. This rule does not establish any new policies or procedures for cost reports. The rule applies to hospital reporting periods ending between July 1, 2007 and June 30, 2008

Department Web Page

The Ohio Department of Job and Family Services has a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is **http://jfs.ohio.gov/**. The web address for the Office of Ohio Health Plans is **http://jfs.ohio.gov/ohp/**. Information regarding **hospital payment policies** may be accessed from the department's web page by going to **www.jfs.ohio.gov/ohp/bhpp/hbfm.stm** and selecting the option for provider payment policies and relative weight tables.

Web Page and Paper Distribution:

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Questions:

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Columbus, OH 43218-2709

614-466-6420

HHTL 3352-08-05 (Hospital billing update effective April 1, 2008)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-08-05

April 24, 2008

TO: All Hospital Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Hospital billing update effective April 1, 2008

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding changes being made to the billing instruction to be compliant with the National Uniform Billing Committee (NUBC) guidelines. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Point of Origin for Admission or Visit

Point of Origin for Admission or Visit codes used on inpatient billing are being updated to reflect the NUBC changes. Effective April 1, 2008, the following changes will be implemented in the Medicaid payment system.

The following codes will no longer be valid codes:

- Code 3 - HMO referral
- Code A - transfer from a critical access hospital
- Code 1 - normal delivery (used with Priority (Type) of Visit code 4)
- Code 2 - premature deliver (used with Priority (Type) of Visit code 4)
- Code 3 - sick baby (used with Priority (Type) of Visit code 4)
- Code 4 - extramural birth (used with Priority (Type) of Visit code 4)

The following codes will be added as acceptable codes:

- Code E - transfer from ambulatory surgery center
- Code F - transfer from hospice and is under a hospice plan of care or enrolled in a hospice program
- Code 5 - born inside this hospital (used with Priority (Type) of Visit code 4)
- Code 6 - born outside of this hospital (used with Priority (Type) of Visit code 4)

(Please note: Point of Origin for Admission or Visit codes were previously referred to as Source of Referral for Admission or Visit codes)

Web Page and Paper Distribution:

The Ohio Department of Job and Family Services has a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is **www.jfs.ohio.gov**. The web address for the Office of Ohio Health Plans front page is **www.jfs.ohio.gov/ohp/**. Information regarding hospital payment policies may be accessed from the department's web page by going to **www.jfs.ohio.gov/ohp/bhpp/hbfm.stm** and selecting the option for provider payment policies and relative weight tables.

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Questions:

Questions pertaining to this letter should be addressed to:

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Office of Ohio Health Plans

Bureau of Health Plan Policy

Financial Management and Hospital Benefit Section

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Columbus, OH 43218-2709

614-466-6420

HHTL 3352-08-04 (Hospital Inpatient Prospective Rate Update 2008)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-08-04

March 31, 2008

To: All Hospital Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Helen E. Jones-Kelley, Director

Subject: Inpatient Hospital Base and Medical Education Rates

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to the hospital base and medical education rates for calendar years 2008 and 2009. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Inpatient Hospital Base and Medical Education Rates

The Ohio Administrative Code rule 5101:3-2-07.4 entitled "Basic methodology for determining prospective payment rates" is effective. This rule was updated to reflect changes to the annual inflationary updates to inpatient hospital base and medical education rates. This rule has been amended to not provide for inpatient hospital rate changes for calendar year (CY) 2008 or CY 2009. The amended rule will apply to payments for discharges on or after January 1, 2008.

The rule will provide for a 0.0 percent inflationary adjustment for inpatient hospital adjusted average cost per discharge (base rate) and for the hospital-specific education allowance effective January 1, 2008 through December 31, 2009. This change holds the base rate and the education allowance constant at the CY 2007 levels for the CY 2008 and CY 2009 rate years. A separate letter has been sent to all hospitals with the hospital specific rates effective January 1, 2008.

Department Web Page

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(2) From the left column, select "Hospital Handbook."

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Questions:

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Office of Ohio Health Plans

Bureau of Health Plan Policy

Financial Management and Hospital Benefit Section

P.O. Box 182709

Columbus, OH 43218-2709

614-466-6420

HHTL 3352-08-03 (Outpatient Hospital Services)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-08-03

March 28, 2008

TO: All Hospital Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Outpatient hospital services

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding changes to Ohio Administrative code (OAC) rule 5101:3-2-21, Policies for outpatient hospital services. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Policies for outpatient hospital services

The rule entitled "Policies for outpatient hospital services," OAC 5101:3-2-21, describes the outpatient payment rates and policies for hospitals that are subject to DRG prospective payment. The rule is being amended to add new codes and to delete obsolete codes listed in appendices C, F, and G, to be consistent with the 2008 Current Procedural Terminology (CPT) manual and the 2008 Healthcare Common Procedural Coding System (HCPCS). Additional changes to the rule include the following:

- Addition of existing CPT codes that are now appropriate for outpatient use.
- Update to the vaccine for children (VFC) procedure codes in Appendix F to be consistent with Appendix DD in OAC rule 5101:3-1-60.
- Update to text within the rule for clarification.

The rule became effective on an emergency basis for dates of service on or after January 1, 2008. It was filed on an emergency basis in order to comply with the Health Insurance Portability and Accountability Act (HIPAA), and to be consistent with industry coding standards. A permanent version was subsequently filed and will be effective March 30, 2008.

Web Page and Paper Distribution:

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Providers may view documents online by:

(1) Select "Ohio Health Plans - Provider."

(2) Select " Provider Type"; and

(3) Selecting the desired item from the "Table of Contents" pull-down menu

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Questions:

Questions pertaining to this letter should be addressed to:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Health Plan Policy

Financial Management and Hospital Benefit Section

P.O. Box 182709

Columbus, OH 43218-2709

614-466-6420

HHTL 3352-08-02 (Supplemental Inpatient Hospital Payments for Children's Hospitals)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-08-02

April 16, 2008

TO: To Ohio's Children's Hospital Providers

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Supplemental inpatient hospital payments for children's hospitals

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding changes to Ohio Administrative Code rule 5101:3-2-53, Supplemental Inpatient Hospital Payments for Children's Hospitals. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Ohio Administrative Code (OAC) rule 5101:3-2-53 entitled Supplemental inpatient hospital payments for children's hospitals, implements supplemental payments for children's hospitals that provide for increased reimbursements to children's hospitals paid under the prospective payment system for inpatient hospital services. The rule was amended to implement Section 309.30.13 of Am. Sub. H. B. No. 119 of the 127th General Assembly. The rule is effective April 18, 2008.

Web Page and Paper Distribution:

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Columbus, OH 43218-2709
614-466-6420

HHTL 3352-08-01 (Hospital Updates Effective January 1, 2008)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-08-01

February 21, 2008

TO: All Hospital Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Hospital updates effective January 1, 2008

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding changes effective January 1, 2008. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Hospital Inpatient Services

Inpatient Rates

Ohio Administrative Code (OAC) rule 5101:3-2-07.4, entitled "Basic methodology for determining prospective payment rates," became effective on an emergency basis for dates of service on or after January 1, 2008. It was emergency filed to hold inpatient hospital rates constant at the CY 2007 levels for the CY 2008 rate year. The change to the rule is in paragraph (G)(2), with the following clause added: "and the rate year beginning January 1, 2008 and ending December 31, 2008, when the composite inflation factor will be adjusted to 0.00 percent for the period January 1, 2008 through March 30, 2008." The emergency amendment will be effective for ninety days during which period the department intends to seek to make it permanent through the regular rule filing process. A separate letter will be sent to all hospitals with the hospital specific rates effective January 1, 2008.

Outliers

In accordance with OAC rule 5101:3-2-07.9, the exceptional outlier threshold effective January 1, 2008 has been inflated by 3.8 percent to $551,456. All inpatient discharges on or after January 1, 2008 will be subject to the new threshold. The threshold for calendar year 2007 discharges was $531,268. Also in accordance with this rule, the statewide charge threshold for each Diagnostic Related Group (DRG) will be inflated by 3.8 percent and will be effective for discharges on or after January 1, 2008.

Relative Weights

The calendar year 2008 relative weight table may be accessed from the Bureau of Health Plan Policy's web page by going to **http://jfs.ohio.gov/ohp/bhpp/hbfm.stm** and selecting the option for provider payment policies. These rates will remain in effect through June 30, 2008.

Hospital Outpatient Services

OAC rule 5101:3-2-21, entitled "Policies for outpatient hospital services," describes the outpatient payment rates and policies for hospitals that are subject to DRG prospective payment. The rule was amended to add new codes and update fee schedules, and to delete obsolete codes listed in appendices C, F, and G, to be consistent with the 2008 Current Procedural Terminology (CPT) manual and the 2008 Healthcare Common Procedural Coding System (HCPCS).

The rule became effective on an emergency basis for dates of service on or after January 1, 2008. It was filed on an emergency basis in order to comply with the Health Insurance Portability and Accountability Act (HIPAA), and to be consistent with industry coding standards. A permanent version of this rule was filed in January 2008 and will follow the regular public process for accepting comments.

Other Updates

Medicare Coinsurance and Deductible

The coinsurance and deductible amounts for Medicare's hospital insurance program (Part A) have been updated effective January 1, 2008. The Medicare Part A inpatient hospital deductible amount is $1,024. The daily coinsurance amounts are updated as follows: (a) $256 coinsurance for the 61st through 90th day of hospitalization in a benefit period; (b) $512 for lifetime reserve days; and (c) $128 for the 21st through 100th day of extended care services in a skilled nursing facility in a benefit period.

The Medicare Part B deductibles have also been updated. Effective January 1, 2008 the deductible amount will reflect $135.

National Provider Identifier (NPI)

ODJFS is extending its NPI dual identifier period until May 23, 2008. During this extended period, ODFJS requires both the Medicaid Legacy Provider Identifier and the NPI. Failure to continue to send the Medicaid Legacy Provider Identifier during the dual identifier period could result in non payment or rejection of claims. After May 23, 2008, it will no longer be necessary to submit a Medicaid Legacy Provider Identifier.

Web Page and Paper Distribution:

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Questions:

Questions pertaining to this letter should be addressed to:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Health Plan Policy

Financial Management and Hospital Benefit Section

P.O. Box 182709

Columbus, OH 43218-2709

614-466-6420

HHTL 3352-07-09 (Classification of Hospitals and Redetermination of Prospective Payment Rates)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-07-09

December 21, 2007

TO: All Hospital Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Classification of Hospitals and Redetermination of Prospective Payment Rates

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding changes to Ohio Administrative code (OAC) rule 5101:3-2-07.2, Classification of Hospitals and Ohio Administrative Code (OAC) rule 5101:3-2-07.8, Redetermination of Prospective Payment Rates.

Ohio Administrative Code (OAC) rule 5101:3-2-07.2 is entitled **Classification of Hospitals**. This rule explains the process of classification of most hospitals into mutually exclusive peer groups. The rule was filed in compliance with the five year rule review requirement. The only changes are minor technical corrections.

Ohio Administrative Code (OAC) rule 5101:3-2-07.8 is entitled **Redetermination of Prospective Payment Rates**. The rule explains describes how prospective payment rates may change. The rule was filed in compliance with five year rule review requirement. The only changes are minor technical corrections.

Web Page:

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At the "electronic manuals" web page, this HHTL may be viewed as follows:

(1) Select "Ohio Health Plans - Provider."

(2) Select "Hospital Handbook."

(3) From the drop-down menu "Table of Contents" at the top of the page, scroll to and select the desired HHTL number.

Questions:

Questions regarding this transmittal letter should be directed to the following:

Ohio Department of Job and Family Services
Office of Ohio Health Plans
Bureau of Health Plan Policy
Financial Management and Hospital Benefit Section
P.O. Box 182709
Columbus, OH 43218-2709

614-466-6420

HHTL 3352-07-07 (Coverage of Hospital-Provided Pharmaceutical, Dental, Vision Care, Medical Supply and Equipment, and Ambulance or Ambulette Services)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-07-07

October 25, 2007

TO: All Hospital Providers

Directors, County Departments of Job and Family Services

Medical Assistance Coordinators

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Coverage of hospital-provided pharmaceutical, dental, vision care, medical supply and equipment, and ambulance or ambulette services

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding changes to Ohio Administrative Code (OAC) rule 5101:3-2-04, Coverage of hospital-provided pharmaceutical, dental, vision care, medical supply and equipment, and ambulance or ambulette services. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Ohio Administrative Code (OAC) rule 5101:3-2-04 is entitled Coverage of hospital- provided pharmaceutical, dental, vision care, medical supply and equipment, and ambulance or ambulette services. This rule explains the reimbursement policy for drugs administered to patients during an inpatient stay or as part of an outpatient service. It also explains the coverage of medical supplies and equipment when billed as part of an inpatient and outpatient visit. The rule further explains how dental, vision care, and ambulance and ambulette services will be reimbursed in the hospital inpatient and outpatient setting. This rule has been filed in compliance with five year rule review requirements and has been updated to reflect current policies in associated rules, including grammatical changes.

Web Page and Paper Distribution:

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(2) Select "Hospital Handbook."

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Providers will receive one hard copy of this transmittal letter and one hard copy of the JFS 03400 "Ohio Department of Job and Family Services, Service Provider Update Request Form." If a provider does not have access to the Internet and wishes to request a paper copy of this transmittal letter with all attachments, the provider should complete the attached JFS 03400 and return it to the Ohio Department of Job and Family according to the instructions at the top of the form.

Questions:

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Office of Ohio Health Plans
Bureau of Health Plan Policy
Financial Management and Hospital Benefit Section
P.O. Box 182709
Columbus, OH 43218-2709
614-466-6420

HHTL 3352-07-06 (HCAP 2007 Assessment Rates)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-07-06

September 13, 2007

To: All Hospital Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Helen E. Jones-Kelley, Director

Subject: Assessment Rates

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to the HCAP Assessment Rates rule. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Assessment Rates

The Ohio Administrative Code rule 5101:3-2-08.1 entitled "Assessment Rates" sets forth the assessment rate for the Hospital Care Assurance Program (HCAP). This rule has been amended to establish the assessment rates and cost levels to which those rates apply to fund HCAP for the 2007 program year.

Department Web Page

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(2) From the left column, select "Hospital Handbook."

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(4) Scroll through the HHTL to the desired rule number highlighted in blue and select the rule number.

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Bureau of Health Plan Policy
Financial Management and Hospital Benefit Section
P.O. Box 182709
Columbus, OH 43218-2709
614-466-6420

HHTL 3352-07-05 (Cost Reports SFY 2007)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-07-05

September 13, 2007

To: All Hospital Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Helen E. Jones-Kelley, Director

Subject: Cost Reports

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to the SFY 2007 Cost Report rule. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Cost Reports

The Ohio Administrative Code rule 5101:3-2-23 entitled "Cost Reports" is effective. The cost report rule was reviewed and updated to reflect enhancements to data collection related to reporting uncompensated care. Changes to the cost report rule or to the Appendix, the cost report instructions and forms are as follows:

- A Title Page and Table of Contents have been added as pages 1 and 2 of the Appendix.
- The mailing address for submission of the cost report has changed. See page 3 of the General Instructions. It should be noted that the new address is very similar to the address used for submitting payments due the department. Please use the correct address for each mailing.
- The procedures for the independent third party validation of the uncompensated care data on Schedule F have been updated.
    - In step two, verification that each log entry has a unique (unduplicated) identifier for each patient has been added.
    - For each category listed in step three, charges and receipts must be verified between the provider's logs and entries on Schedule F.
    - In addition to the sample thresholds and sizes in step five, any account which shows receipts and is in the Uncompensated Care < 100% FPL with no insurance categories must be reviewed.
    - In step six, verification of receipts for each account selected for review has been added.
- The instructions for Medical Education costs on Schedule E have been revised to indicate that all sub-columns should be included.

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Financial Management and Hospital Benefit Section

P.O. Box 182709

Columbus, OH 43218-2709

614-466-6420

HHTL 3352-07-04 (Outpatient Hospital Services)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-07-04

April 12, 2007

TO: All Hospital Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Outpatient hospital services

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding changes to Ohio Administrative code (OAC) rule 5101:3-2-21, Policies for outpatient hospital services. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Policies for outpatient hospital services

The rule entitled "Policies for outpatient hospital services," OAC 5101:3-2-21, describes the outpatient payment rates and policies for hospitals that are subject to DRG prospective payment. The rule is being amended to add new codes and to delete obsolete codes listed in appendices C, F, and G, to be consistent with the 2007 Current Procedural Terminology (CPT) manual and the 2007 Healthcare Common Procedural Coding System (HCPCS). Special attention should be paid to the following changes that will directly impact billing for chemotherapy, drug administration, and outpatient surgeries:

- For chemotherapy services, HCPCS Level II codes C8953, C8954, C8955 have been eliminated. CPT codes 96400 through 96549 should be used instead. Paragraph (E) of OAC rule 5101:3-2-21 describes the reimbursement methodology for these chemotherapy services.
- For drug administration services, HCPCS Level II codes C8950, C8951, and C8952 have been eliminated. The department will add CPT codes 90760, 90761, 90765, 90766, 90767, 90768, 90774, and 90775 to existing codes 90772, 90773, and 90779. Codes 90765 through 90768 will be recognized as IV therapy procedures subject to the pricing methodology described in paragraphs (G)(2)(e) and (H)(2)(d) of OAC rule 5101:3-2-21.
- For surgical services, the department will adopt HCPCS Level II codes G0392 and G0393. These codes will be reimbursed in accordance with the methodology described in paragraph (F) of OAC rule 5101:3-2-21.

The rule became effective on an emergency basis for dates of service on or after January 1, 2007. It was filed on an emergency basis in order to comply with the Health Insurance Portability and Accountability Act (HIPAA), and to be consistent with industry coding standards. A permanent version was subsequently filed and was effective March 29, 2007. The permanent version of the rule included the following additional changes that were not included in the emergency version:

- The list of revenue center codes requiring HCPCS coding will be updated in Appendix B.
- Some procedures that were previously covered as inpatient only will now be covered as outpatient.
- The vaccine procedure codes that are covered under the federal "Vaccines for Children" (VFC) program were updated.

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Questions:

Questions regarding this transmittal letter should be directed to the following:

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Office of Ohio Health Plans

Bureau of Health Plan Policy

Financial Management and Hospital Benefit Section

30 East Broad Street, 27th floor

Columbus, OH 43215-3414

614-466-6420

HHTL 3352-07-03 (Appeals and Reconsideration Process for Hospital Inpatient and Outpatient Services and Hospital Utilization Control)

Hospital Handbook Transmittal Letter (HHTL) 3352-07-03

April 26, 2007

TO: All Hospital Providers

Directors, County Departments of Job and Family Services

Medical Assistance Coordinators

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Appeals and Reconsideration Process for Hospital Inpatient and Outpatient Services and Hospital Utilization Control

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to utilization reviews of hospital services and the appeals and reconsideration process regarding hospital inpatient and outpatient services. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Ohio Administrative Code (OAC) rule 5101:3-2-07.12 is entitled Appeals and reconsideration of departmental determinations regarding hospital inpatient and outpatient services. The rule provides information about the process for appeals, including the timeline for submitting an appeal, the documentation which must accompany an appeal, and identifies items not subject to reconsideration. The rule has been filed in compliance with five year rule review requirements and amended to update references and to make minor grammatical changes.

OAC rule 5101:3-2-07.13 entitled Utilization control describes examples of the various types of reviews which may be completed by ODJFS in order to assure appropriateness of hospital services and billing practices. Currently, ODJFS has a contract with Permedion to perform utilization reviews. ODJFS has delegated to the Ohio Department of Mental Health (ODMH) the authority to make determinations regarding utilization reviews for inpatient psychiatric services. Currently, ODMH has a contract with Health Care Excel to conduct utilization reviews. This rule has been filed in compliance with five year rule review requirements and amended to update references and to make minor grammatical changes.

Instructions:

To update your handbook, add this transmittal letter to your handbook and replace the previous version of OAC rules 5101:3-2-07.12 and 5101:3-2-07.13 with the updated version of these rules.

Web Page:

The Ohio Department of Job and Family Services has a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is **http://www.jfs.ohio.gov/**. The web address for the Office of Ohio Health Plans front page is **http://www.jfs.ohio.gov/ohp/**. Information regarding hospital payment policies may be accessed from the department's web page by going to **http://www.jfs.ohio.gov/ohp/bhpp/hbfm.stm** and selecting the option for provider payment policies and relative weight tables.

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, and handbooks. The URL is as follows: http://emanuals.odjfs.state.oh.us/emanuals/

At the "electronic manuals" web page, this HHTL may be viewed as follows:

(1) Select "Ohio Health Plans - Provider."

(2) Select "Hospital Handbook."

(3) From the drop-down menu "Table of Contents" at the top of the page, scroll to and select the desired HHTL number.

Providers will receive one hard copy of this transmittal letter and one hard copy of the JFS 03400 "Ohio Department of Job and Family Services, Service Provider Update Request Form." If a provider does not have access to the Internet and wishes to request a paper copy of this transmittal letter with all attachments, the Provider should complete the attached JFS 03400 and return it to the Ohio Department of Job and Family according to the instructions at the top of the form.

Questions:

Questions regarding this transmittal letter should be directed to the following:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Health Plan Policy

Financial Management and Hospital Benefit Section

P.O. Box 182709

Columbus, OH 43218-2709

614-466-6420

HHTL 3352-07-02 (Methodology for Determining Relative Weights)

Hospital Handbook Transmittal Letter (HHTL) 3352-07-02

March 23, 2007

TO: All Hospital Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Helen E. Jones-Kelley, Director

Subject: Methodology for determining relative weights

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to the methodology for determining relative weights. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Rule 5101:3-2-07.3 entitled, Methodology for determining relative weights, applies to hospitals subject to prospective payment for inpatient services. The rule describes the method for determining the relative weight of each DRG, which represents the average resources required to care for cases in that particular DRG. The rule is being amended to revise the date of the next recalibration of relative weights to state fiscal year 2009. The relative weights set on January 1, 2006 will remain effective until SFY 2009.

Department Web Page

The Ohio Department of Job and Family Services has a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is **www.jfs.ohio.gov**, the web address for the Office of Ohio Health Plans is **www.jfs.ohio.gov/ohp/**. Relative weight tables and information regarding payment policies may be accessed from the Bureau of Health Plan Policy's web page by going to **www.jfs.ohio.gov/ohp/bhpp/hbfm.stm** and selecting the option for provider payment policies.

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(1) Select "Ohio Health Plans - Provider."

(2) Select "Hospital Handbook."

(3) From the drop-down menu "Table of Contents" at the top of the page, scroll to and select the desired HHTL number.

(4) Scroll through the HHTL to the desired rule number highlighted in blue and select the rule number.

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HHTL 3352-07-01 (Change of Mailing Address for Permedion Appeals and Claim Resubmissions)

Hospital Handbook Transmittal Letter (HHTL) 3352-07-01

March 23, 2007

TO: All Hospital Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Change of Mailing Address for Permedion Appeals and Claim Resubmissions

This Hospital Handbook Transmittal Letter (HHTL) is being sent to hospitals as notification of a change in address for mailing appeals and claim resubmissions as a result of Permedion's utilization review process. These new addresses are effective immediately.

Appeals as a result of Retrospective Review

Effective immediately all appeals of denials resulting from a retrospective review finding by Permedion should be submitted to the following address:

ORAA - Bureau of Audit

Surveillance and Utilization Review

P.O. Box 182582

Columbus, Ohio 43218-2582

Please use this address for appeals only. DO NOT send claims or resubmissions of claims to this address. Questions or inquiries related to appeals of Permedion denials should be directed to the Surveillance and Utilization Review Section (SURS) at (614) 466-7936. The fax number for SURS is (614) 728-3334.

Claim Resubmissions as a result of Retrospective Review

Per Ohio Administrative Code rule 5101:3-2-40, a retrospective review by Permedion may determine that the location of service was not medically necessary, but the services rendered were medically necessary. In this instance, the hospital may bill the department on an outpatient basis for those medically necessary services rendered on the date of admission. In addition, only laboratory and diagnostic radiology services rendered during the remainder of the medically unnecessary admission may be billed on the outpatient claim. The outpatient claim must be submitted with the accompanying documents:

- A copy of the reconsideration and/or the administrative decision affirming the original decision
- A copy of the remittance advice recouping payment for the medically unnecessary admission
- A copy of the original decision (Case Summary Sheet)
- Condition Code C3 recorded on the outpatient claim in one of the Form Locators 24-30

Effective immediately, claims resubmitted as a result of a retrospective review decision, must be sent with the above documents to the following address:

Ohio Department of Job and Family Services

Provider Services Section

P. O. Box 1461

Columbus, Ohio 43216-1461

PLEASE PLACE PERMEDION'S DENIAL LETTER ON TOP OF THE RESUBMISSION.

Do not send retrospective review resubmissions on the Adjustment Request Form 06766. To ensure that your resubmission is accurate, refer to page two of the Permedion denial letter for detailed information about the reason for the original denial.

Please use this address for claim resubmissions only. DO NOT send appeals to this address. If you need to speak with someone regarding a claim resubmission, please contact the Provider Services Section at 1-800-686-1516.

Reminder about procedures requiring Precertification

HHTL 3352-06-02 was published with an updated list of procedures (Effective October 1, 2006) that require precertification. A complete list can also be located at **www.permedion.com**. Claims for procedures appearing on this list must have a valid precertification number entered in the Treatment Authorization field; otherwise, they will be denied. Precertification must be obtained prior to the delivery of service and will not be issued retroactively. Additionally, all inpatient psychiatric stays (both elective and emergency) also require precertification.

Ohio Administrative Code (OAC) rule 5101:3-2-40 explains the precertification requirements, including situations excluded from the precertification process. Excluded from the precertification process are:

(a) Emergency admissions, with the exception of emergency psychiatric admissions.

(b) Substance abuse admissions.

(c) Maternity admissions.

(d) Recipients enrolled in health insuring corporations under contract with the department for provision of health services to recipients.

(e) Services provided in hospitals which are located in noncontiguous states.

(f) Elective care that is performed in a hospital inpatient setting on a patient who is already hospitalized for a medically necessary condition unrelated to the elective care or when an unrelated procedure which does not require precertification is being performed simultaneously.

(g) Persons whose eligibility is pending at the time of admission or who make application for Medicaid subsequent to admission.

(h) Patients who are jointly eligible for Medicare and Medicaid and who are being admitted under the Medicare Part A benefit.

(i) Patients who are eligible for benefits through a third party insurance as the primary payer for the services subject to precertification.

(j) Transfers from one hospital to another hospital with the exception of those hospitals identified for intensified review in accordance with paragraph (C)(1) of rule 5101:3-2-07.13 of the Administrative Code.

(k) Admissions for those elective surgical procedures or diagnoses which are not included in the department's precertification list.

(l) If the patient is not identified as a Medicaid recipient at the time of an elective admission or procedure. However, every effort should be made by both the attending and/or admitting physicians and hospital providers to identify Medicaid recipients before an admission or procedure that requires precertification.

If a procedure is excluded from precertification requirements based upon a condition listed above, use Condition Code 'AN' on the claim. Failure to identify an exempted procedure with Condition Code 'AN' will result in a denial of the claim.

Precertification Contact Information:

To obtain precertification for all services and procedures requiring precertification, except for psychiatric stays, please contact:

Permedion

Telephone line: 1-800-772-2179

Fax line: 1-800-591-1819

http://www.permedion.com/OhioMedicaid.htm

To obtain precertification for all inpatient psychiatric stays, please contact:

Health Care Excel

Telephone line: 1-800-580-1937

Fax line: 1-800-281-9386

https://ohiourip.hce.org

Instructions:

Add this transmittal letter to your handbook for future reference. Also, please update your billing instructions to note change of addresses for Permedion appeals and resubmissions resulting from Permedion reviews.

Web Page:

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(2) Select "Hospital Handbook."

(3) From the drop-down menu "Table of Contents" at the top of the page, scroll to and select the desired HHTL number.

Questions:

Questions regarding this transmittal letter should be directed to the following:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Health Plan Policy

Financial Management and Hospital Benefit Section

30 East Broad Street, 27th floor

Columbus, OH 43215-3414

(614) 466-6420

HHTL 3352-06-09 (Hospital Updates Effective January 1, 2007)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-06-09

December 22, 2006

TO: All Hospital Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: Hospital updates effective January 1, 2007

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding upcoming Ohio Administrative Code (OAC) rule changes effective January 1, 2007. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Hospital Inpatient Services

Inpatient Rates

Ohio Administrative Code (OAC) Rule 5101:3-2-07.4, entitled "Basic Methodology for determining prospective payment rates," became effective on December 8, 2005. This rule holds inpatient hospital rates constant at the CY 2005 levels for the CY 2006 and CY 2007 rate years. A separate letter has been sent to all hospitals with the hospital specific rates effective January 1, 2007.

CY 2007 Relative Weight Table

The charge high trims listed in the relative weight table were inflated 3.2% effective January 1, 2007. The relative weight table may be accessed from the Bureau of Health Plan Policy's web page by going to **http://jfs.ohio.gov/ohp/bhpp/hbfm.stm** and selecting the option for provider payment policies.

Exceptional Outlier

OAC Rule 5101:3-2-07.9 (A)(6) defines a base exceptional outlier threshold and provides that the threshold amount will be inflated on an annual basis on January 1st of each year. According to this rule, the exceptional outlier threshold effective January 1, 2007 has been inflated by 3.2 percent to $531,268. All inpatient discharges on or after January 1, 2007 will be subject to the new threshold. The threshold for calendar year 2006 discharges was $514,794.

Medicare Coinsurance and Deductible

The coinsurance and deductible amounts for Medicare's hospital insurance program (Part A) have been updated effective January 1, 2007. The Medicare Part A inpatient hospital deductible amount is $992. The daily coinsurance amounts are updated as follows: (a) $248 coinsurance for the 61st through 90th day of hospitalization in a benefit period; (b) $496 for lifetime reserve days; and (c) $124 for the 21st through 100th day of extended care services in a skilled nursing facility in a benefit period.

The Medicare Part B deductibles have also been updated. Effective January 1, 2007 the deductible amount will reflect $131.

Hospital Outpatient Services

OAC Rule 5101:3-2-21, entitled "Policies for outpatient hospital services," describes the outpatient payment rates and policies for hospitals that are subject to DRG prospective payment. The rule is being amended to add new codes and update fee schedules, and to delete obsolete codes listed in appendices C, F, and G, to be consistent with the 2007 Current Procedural Terminology (CPT) manual and the 2007 Healthcare Common Procedural Coding System (HCPCS). Special attention should be paid to the following changes that will directly impact billing for chemotherapy, drug administration, and outpatient surgeries:

- For chemotherapy services, HCPCS Level II codes C8953, C8954, C8955 have been eliminated. CPT codes 96400 through 96549 should be used instead. Paragraph (E) of OAC rule 5101:3-2-21 describes the reimbursement methodology for these chemotherapy services.
- For drug administration services, HCPCS Level II codes C8950, C8951, and C8952 have been eliminated. The department will add CPT codes 90760, 90761, 90765, 90766, 90767, 90768, 90774, and 90775 to existing codes 90772, 90773, and 90779. Codes 90765 through 90768 will be recognized as IV therapy procedures subject to the pricing methodology described in paragraphs (G)(2)(e) and (H)(2)(d) of OAC rule 5101:3-2-21.
- For surgical services, the department will adopt HCPCS Level II codes G0392 and G0393. These codes will be reimbursed in accordance with the methodology described in paragraph (F) of OAC rule 5101:3-2-21.

The rule will become effective on an emergency basis for dates of service on or after January 1, 2007. It is being filed on an emergency bases in order to comply with the Health Insurance Portability and Accountability Act (HIPAA), and to be consistent with industry coding standards. A permanent version of this rule will be filed in January 2007 and will follow the regular public process for accepting comments.

Web Page and Paper Distribution:

The Ohio Department of Job and Family Services has a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is **www.jfs.ohio.gov**. The web address for the Office of Ohio Health Plans front page is **www.jfs.ohio.gov/ohp/**. Information regarding hospital payment policies may be accessed from the department's web page by going to **www.jfs.ohio.gov/ohp/bhpp/hbfm.stm** and selecting the option for provider payment policies and relative weight tables.

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(1) Select "Ohio Health Plans Provider."

(2) Select "Hospital Handbook."

(3) From the drop-down menu "Table of Contents" at the top of the page, scroll to and select the desired HHTL number.

Providers will receive one hard copy of this transmittal letter and one hard copy of the JFS 03400 "Ohio Department of Job and Family Services, Service Provider Update Request Form." If a provider does not have access to the Internet and wishes to request a paper copy of this transmittal letter with all attachments, the Provider should complete the attached JFS 03400 and return it to the Ohio Department of Job and Family according to the instructions at the top of the form.

Questions:

Questions regarding this transmittal letter should be directed to the following:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Health Plan Policy

Financial Management and Hospital Benefit Section

30 East Broad Street, 27th floor

Columbus, OH 43215-3414

614-466-6420

HHTL 3352-06-08 (Cost Reports)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-06-08

November 13, 2006

To: All Hospital Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Barbara E. Riley, Director

Subject: Cost Reports

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to the SFY 2006 Cost Report rule. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Cost Reports

The Ohio Administrative Code rule 5101:3-2-23 entitled "Cost Reports" is effective on November 9, 2006. The cost report rule was reviewed and updated to reflect additional data collection related to uncompensated care. Changes to the cost report rule or to Appendix A, the cost report instructions and forms are as follows:

- Clarification of the Filing Requirements on page 1 of the General Instructions.
- Clarification on the proper handling of drugs related to Renal Dialysis or Home Program Dialysis on page 4 of the General Instructions.
- Clarification on the proper handling of Observation Bed Days related to a subprovider and Employee Discount Days on page 6 of the General Instructions.
- Modification of the Uncompensated Care data collected and how it is reported on pages 12 through 20 of the General Instructions.
    - Lines 8 - 15, columns 1 and 2 are now for reporting GROSS charges, previously these columns were for net charges.
    - Lines 8 - 15, columns 6 and 7 are new columns and are for reporting RECEIPTS.
    - Lines 8 - 15, columns 4 and 5, the formula for calculating uncompensated care costs has been modified to calculate the actual cost of uncompensated care.
    - Lines 16 - 23, columns 6 and 7, these are new columns and are for reporting UNDUPLICATED Discharges or Visits.
- Added lines to report payments received from HMOs for Title XIX patients on Schedule I on page 25 of the General Instructions.

Modification of Supporting Documentation Required by OAC Rule 5101:3-2-07.17

The changes made to Schedule F of the Cost Report will require that your hospital modify the Hospital Care Assurance (HCAP) (1) Application, and (2) Patient Account Logs. The HCAP application must now include a unique patient identifier (Example: Social Security Number). The HCAP logs must include a unique patient identifier (Example: Social Security Number) and receipts (payments) for each account. The sum of the receipts for each patient account classification must match the amounts reported in columns 6 and 7 of Schedule F of the cost report.

It is not required that you collect a patient's Social Security Number for the purposes of HCAP. It will be necessary for your hospital to establish some form of a unique identifier in order to properly determine your unduplicated discharges and visits. The identifier must be unique to each patient and not to each discharge or visit of a particular patient.

Department Web Page

The Ohio Department of Job and Family Services has a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is **http://www.jfs.ohio.gov/**. The web address for the Office of Ohio Health Plans is **http://www.jfs.ohio.gov/ohp/**.

Web Page and Paper Distribution:

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(1) From the left column, select "Ohio Health Plans - Provider."

(2) From the left column, select "Hospital Handbook."

(3) From the drop-down menu "Table of Contents" at the top of the page, scroll to and select the desired HHTL number.

(4) Scroll through the HHTL to the desired rule number highlighted in blue and select the rule number.

Providers will receive one hard copy of this transmittal letter and, if there are attachments, one hard copy of the JFS 03400 "Ohio Department of Job and Family Services, Service Provider Update Request Form." If a provider does not have access to the Internet and wishes to request a paper copy of this transmittal letter with all attachments, the Provider should complete the attached JFS 03400 and return it to the Ohio Department of Job and Family according to the instructions at the top of the form.

HHTL 3352-06-07 (Eligible Providers)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-06-07

October 20, 2006

TO: All Hospital Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: Eligible Providers

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding Ohio Administrative Code (OAC) rule 5101:3-2-01. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Eligible providers

OAC rule 5101:3-2-01, entitled "Eligible providers," describes providers eligible to participate in the Medicaid program as hospital providers and defines the provider agreement. The rule is being amended to clarify language and correct references to other rules by including appropriate decimal points.

Instructions:

To update your handbook, replace the previous version of OAC rule 5101:3-2-01 with the updated version of OAC rule 5101:3-2-01 effective 10/16/2006.

Web Page and Paper Distribution:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, and handbooks. The URL is as follows:

http://emanuals.odjfs.state.oh.us/emanuals/

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(1) Select "Ohio Health Plans - Provider."

(2) Select "Hospital Handbook."

(3) From the drop-down menu "Table of Contents" at the top of the page, scroll to and select the desired HHTL number.

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Questions:

Questions regarding this transmittal letter should be directed to the following:

Ohio Department of Job and Family Services
Office of Ohio Health Plans
Bureau of Health Plan Policy
Financial Management and Hospital Benefit Section
30 East Broad Street, 27th Floor
Columbus, OH 43215-3414

614-466-6420

For pre-certification, call 1-800-772-2179.

HHTL 3352-06-06 (Consumer Co-Payments for Non-Emergency Emergency Department Services)

Hospital Handbook Transmittal Letter (HHTL) 3352-06-06

September 13, 2006

To: All Hospital Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Barbara E. Riley, Director

Subject: Consumer co-payments for non-emergency emergency department services

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to consumer co-payments for non-emergency emergency department services. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Rule 5101:3-2-21.1 entitled Consumer co-payments for non-emergency emergency department services sets forth the conditions, requirements and limitations of the co-payment requirement for non-emergency, emergency department services. The rule has been amended to clarify situations in which hospitals would not have to pursue collection efforts in the co-payment program.

Hospitals are also still required to notify ODJFS of any non-emergency, emergency department encounter through claims submission in accordance with hospital billing instructions, including the supplemental billing instructions, as described in Hospital Handbook Transmittal Letter **(HHTL) 3352-05-12**.

Department Web Page

The Ohio Department of Job and Family Services has a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is **http://www.jfs.ohio.gov/**, the web address for the Office of Ohio Health Plans is **http://www.jfs.ohio.gov/ohp/**. Relative weight tables and information regarding payment policies may be accessed from the Bureau of Health Plan Policy's web page by going to **http://www.jfs.ohio.gov/ohp/bhpp/hbfm.stm** and selecting the option for provider payment policies.

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HHTL 3352-06-05 (Payment/Data Policies for Disproportionate Share and Indigent Care Adjustments)

Hospital Handbook Transmittal Letter (HHTL) 3352-06-05

November 20, 2006

To: All Hospital Providers

Directors, County Departments of Job and Family Services

Medical Assistance Coordinators

From: Barbara E. Riley, Director

Subject: Payment/Data Policies for Disproportionate Share and Indigent Care Adjustments

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to payment and data policies for disproportionate share and indigent care rules for general hospitals, as well as the assessment for general hospitals. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Rule 5101:3-2-08.1 entitled Assessment rates sets forth the assessment rate for the Hospital Care Assurance Program (HCAP). This rule has been amended to establish the assessment rates and the cost levels to which those rates apply to fund HCAP for the 2006 program year.

Rule 5101:3-2-09 entitled Payment policies for disproportionate share and indigent care adjustments for hospital services sets forth the conditions, requirements, and operation of HCAP as well as the distribution formula. This rule has been amended to update the distribution formula for payment policies for disproportionate share hospitals (DSH) for use in Program Year 2006. In addition, the rule was updated to require hospitals to submit their assessment amount via electronic funds transfer beginning in the program year that ends in the calendar year 2006.

Department Web Page

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information about Ohio Medicaid with topics ranging from payment policies to forms for

ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is http://jfs.ohio.gov/, the web address for the Office of Ohio Health Plans is http://jfs.ohio.gov/ohp/. Relative weight tables and information regarding payment policies may be accessed from the Bureau of Health Plan Policy's web page by going to http://jfs.ohio.gov/ohp/bhpp/ and selecting the option for provider payment policies.

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HHTL 3352-06-04 (Assessment, Payment and Data Policies forDSH and Indigent Care Adjustments)

HOSPITAL HANDBOOK TRANSMITTAL LETTER (HHTL) 3352-06-04

September 25, 2006

To: All Hospital Providers

Directors, County Departments of Job and Family Services

Medical Assistance Coordinators

From: Barbara E. Riley, Director

Subject: Assessment, Payment and Data Policies for Disproportionate Share (DSH) and Indigent Care Adjustments

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to payment and data policies for the disproportionate share program and indigent care adjustments for freestanding psychiatric hospitals. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

5101:3-2-07.5 entitled Disproportionate share adjustment describes the disproportionate share definition and limitations on payment methods. The rule has been filed in compliance with five year rule review requirements and amended to strike language now contained in another rule and to make other minor technical changes.

5101:3-2-10 entitled Payment policies for disproportionate share and indigent care adjustments for psychiatric hospitals sets forth the conditions, requirements, and operation of the Institutions for Mental Diseases Disproportionate Share (IMD DSH) program, as well as the distribution formula. This rule has been amended because of the five-year rule review requirements and to update the distribution formula for payment policies for IMD hospitals for use in Program Year 2006.

Department Web Page

The Ohio Department of Job and Family Services has a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is **http://jfs.ohio.gov/**, the web address for the Office of Ohio Health Plans is **http://jfs.ohio.gov/ohp/**. Relative weight tables and information regarding payment policies may be accessed from the Bureau of Health Plan Policy's web page by going to **http://jfs.ohio.gov/ohp/bhpp/**and selecting the option for provider payment policies.

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, and handbooks. The URL is as follows: http://emanuals.odjfs.state.oh.us/emanuals/

At the "electronic manuals" web page, this HHTL, and any attachments, may be viewed as follows:

(1) Select "Ohio Health Plans - Provider."

(2) Select "Hospital Handbook."

(3) From the drop-down menu "Table of Contents" at the top of the page, scroll to and select the desired HHTL number.

(4) Scroll through the HHTL to the desired rule number highlighted in blue and select the rule number.

Providers will receive one hard copy of this transmittal letter and, if there are attachments, one hard copy of the JFS 03400 "Ohio Department of Job and Family Services, Service Provider Update Request Form." If a provider does not have access to the Internet and wishes to request a paper copy of this transmittal letter with all attachments, the provider should complete the attached JFS 03400 and return it to the Ohio Department of Job and Family according to the instructions at the top of the form.

HHTL 3352-06-03 (Hospital Payment for Outliers)

HOSPITAL HANDBOOK TRANSMITTAL LETTER (HHTL) 3352-06-03

September 22, 2006

To: All Hospital Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Barbara E. Riley, Director

Subject: Hospital Payment for Outliers

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to payment policy for inpatient hospital stays that qualify for an outlier payment. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Rule 5101:3-2-07.9 entitled, Payment for outliers, has been amended to modify the inpatient hospital outlier payment methodology. This modification is necessary to maintain compliance with Center for Medicare and Medicaid Services (CMS) conditions for State Plan approval. Under the proposed amendment, payment for day outliers will be reinstituted, but payment for cost outliers will take precedent when a claim qualifies for both a day and cost outlier. The payment policies contained in the rule will be effective for claims with dates of discharge on or after January 1, 2006.

Department Web Page

The Ohio Department of Job and Family Services has a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is **http://jfs.ohio.gov/**, the web address for the Office of Ohio Health Plans is **http://jfs.ohio.gov/ohp/**. Relative weight tables and information regarding payment policies may be accessed from the Bureau of Health Plan Policy's web page by going to **http://jfs.ohio.gov/ohp/bhpp/** and selecting the option for provider payment policies.

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows: http://emanuals.odjfs.state.oh.us/emanuals/

At the "electronic manuals" web page, this HHTL, and any attachments, may be viewed as follows:

(1) Select "Ohio Health Plans - Provider"

(2) Select "Hospital Handbook"

(3) From the drop down menu at the top of the page entitled "Table of Contents," scroll to and select the desired HHTL number.

(4) Scroll through the HHTL to the desired rule number highlighted in blue and select the rule number.

Hospital providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If a hospital provider does not have access to the Electronic Manuals Internet Site referenced above, the JFS 03400 form may be used to request hard-copies of the rules referenced in the HHTL. The JFS 03400 form, completed in full, may be faxed or mailed to ODJFS as directed on the form at no cost to the hospital provider.

HHTL 3352-06-02 (Precertification List Update)

Hospital Handbook Transmittal Letter (HHTL) 3352-06-02

August 11, 2006

TO: All Hospital Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: Precertification List Update

This Hospital Handbook Transmittal Letter (HHTL) is being sent to hospitals as notification that the list of hospital services that require precertification is being revised and to provide hospitals with the revised list. The revised list will be effective October 1, 2006 and is being published in accordance with Ohio Administrative Code 5101:3-2-40.

Procedures Requiring Precertification

The revision adds additional CPT codes that correlate to two ICD-9 billing categories (99.25 and 45.16). Please note that there have been some CPT codes eliminated from the previous precertification list. These include TMJ surgery, arthroscopy of the knee and shoulder, peripheral vascular shunt or bypass, total hip replacement, total knee replacement, and transurethral resection of the prostate. Not every CPT code that falls within the ICD-9 billing category will require precertification. Only those CPT codes listed will require a precertification number. Claims for procedures requiring precertification must have a valid precertification number entered in the Treatment Authorization field; otherwise, they will be denied.

A complete updated list of procedures that require precertification is contained within this HHTL. A complete list can also be located at www.permedion.com. In addition to the attached precertification list, all inpatient psychiatric stays (elective and emergency) also require precertification. Please note that precertification must be obtained prior to the delivery of service and is not issued retroactively.

Procedures Excluded from Precertification

Ohio Administrative Code (OAC) rule 5101:3-2-40 outlines precertification requirements, including situations excluded from the precertification process. If a procedure is excluded from precertification requirements based upon a condition outlined in OAC rule **5101:3-2-40**, use Condition Code 'AN' on the claim. Failure to identify an exempted procedure with Condition Code 'AN' will result in a denial of the claim.

Type of Admission

Effective for claims with first dates of service on or after October 1, 2005, claims should be submitted to ODJFS using Type of Admission codes in accordance with National Uniform Billing Committee (NUBC) guidelines. Specifically, Type of Admission '2' and '3' should be used to indicate Urgent and Elective admissions, respectively. Historically, ODJFS required Type of Admission '2' to identify claims excluded from precertification and Type of Admission '3' for services requiring precertification. Per **HHTL 3352-05-11**, this practice is no longer appropriate and Type of Admission codes should only be used in accordance with NUBC guidelines.

Contact Information:

To obtain precertification for all services and procedures requiring precertification, except for psychiatric stays, please contact:

Permedion

Telephone line: 1-800-772-2179

Fax line: 1-800-591-1819

http://www.permedion.com/OhioMedicaid.htm

To obtain precertification for all inpatient psychiatric stays, please contact:

Health Care Excel

Telephone line: 1-800-580-1937

Fax line: 1-800-281-9386

https://ohiourip.hce.org

Instructions:

Add this transmittal letter to your handbook for future reference.

Web Page:

The Ohio Department of Job and Family Services has a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is **http://www.jfs.ohio.gov/**. The web address for the Office of Ohio Health Plans front page is **http://www.jfs.ohio.gov/ohp/**. Information regarding hospital payment policies may be accessed from the department's web page by going to **http://www.jfs.ohio.gov/ohp/bhpp/hbfm.stm** and selecting the option for provider payment policies and relative weight tables.

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, and handbooks. The URL is as follows:

http://emanuals.odjfs.state.oh.us/emanuals/

At the "electronic manuals" web page, this HHTL may be viewed as follows:

(1) Select "Ohio Health Plans - Provider."

(2) Select "Hospital Handbook."

(3) From the drop-down menu "Table of Contents" at the top of the page, scroll to and select the desired HHTL number.

Questions:

Questions regarding this transmittal letter should be directed to the following:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Health Plan Policy

Financial Management and Hospital Benefit Section

30 East Broad Street, 27th floor

Columbus, OH 43215-3414

614-466-6420

Updated List:

The following is a complete updated list of procedures that require precertification.

OHIO DEPARTMENT OF JOB AND FAMILY SERVICES

HOSPITAL PRE-CERTIFICATION LIST

Effective October 1, 2006, the following procedures require pre-certification when performed electively in an inpatient setting only:

- **Cervical laminectomy**

  ICD9 codes 81.02 - 81.03

CPT codes 22554, 22556, 22558, 22585, 22808, 22810, 22812, 22590, 22600, 22610, 22612, 22614, 22800, 22802, 22804, 22840, 22851, 63075, and 63076

- **Esophagogastroduodenoscopy (EGD) with closed biopsy**

  ICD9 code 45.16

  CPT codes 43235, 43238, 43239, 43242, 44360, 44361, 44376, and 44377

- **Injection or infusion of cancer chemotherapeutic substance**

  ICD9 code 99.25

  CPT codes 36823, 51720, 96401, 96402, 96405, 96406, 96409, 96411, 96413, 96415, 96416, 96417, 96420, 96422, 96423, 96425, 96521, and 96522

- **Laparoscopic cholecystectomy**

  ICD9 codes 51.23, 51.24

  CPT codes 47562 - 47564

- **Laparoscopic- diagnostic**

  ICD9 code 54.21

  CPT codes 49320 - 49323, 49329

- **Lumbar laminectomy - posterior**

  ICD9 codes 80.51 and 81.08

  CPT CODES 22600, 22610, 22612, 22614, 22630, 22632, 22800, 22802, 22804, 22842, 22843, 22844, 22851, 63030, 63035, 63042, 63044, and 63047

- **Percutaneous angioplasty - non coronary vessel**

  ICD9 code 39.50

  CPT codes 35470 - 35476

- **PTCA- coronary angioplasty**

  ICD9 code 00.66

  CPT codes 92982, 92984, 92995, and 92996

The following procedures will continue to require pre-certification in both **inpatient and outpatient settings:**

- **Hysterectomy**

  ICD9 codes 68.31, 68.39, 68.4, 68.51, and 68.59

  CPT codes 51925, 58150, 58152, 58180, 58200, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58550, 58552, and 58951

As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

HHTL 3352-06-01 (Outpatient Hospital Services Updated)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-06-01

March 22, 2006

TO: All Hospital Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: Outpatient hospital services updated

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding rule OAC 5101:3-2-21, Policies for outpatient hospital services. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Policies for outpatient hospital services

The rule entitled "Policies for outpatient hospital services," Ohio Administrative Code (OAC) 5101:3-2-21, describes the outpatient policies and payment rates for hospitals that are subject to DRG prospective payment. The rule was filed on an emergency basis effective December 30, 2005. The permanent amendment of the rule is effective March 27, 2006. The rule was amended to make the following changes:

- Addition of new 2006 HCPCS codes and deletion of obsolete HCPCS codes, which were part of the emergency rule and are effective 1/1/2006.
- Addition of existing CPT codes that are now appropriate for outpatient use.
- Deletion of existing CPT codes that are no longer appropriate for outpatient use.
- Update the revenue codes in Appendix B to be consistent with Appendix A in OAC rule 5101:3-2-02.
- Update the vaccine procedure codes in Appendix F to be consistent with Appendix DD in OAC rule 5101:3-1-60.
- Update text within the rule and its appendices to delete language pertaining to prior service dates.
- Implement the following Healthcare Common Procedural Coding System (HCPCS) level II intravenous therapy codes C8950, C8951, C8952 in place of the following new 2006 CPT codes 90760, 90761, 90765, 90766, 90767, 90768, 90774, and 90775.

Corrections to prior HHTL:

Please note the following corrections to HHTL 3352-05-14, dated January 19, 2006:

- CPT code C5952 was listed incorrectly, the correct code is C8952.
- CPT codes 90760 and 90761 should have been included in the list of codes being replaced by C8950, C8951, or C8952.

Instructions:

To update your handbook, replace the previous version of OAC rule 5101:3-2-21 and all appendices with the updated version of OAC 5101:3-2-21 and all appendices effective 3/27/2006.

Web Page and Paper Distribution:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, and handbooks. The URL is as follows:

http://emanuals.odjfs.state.oh.us/emanuals/

This transmittal letter, and its attachments, may be viewed as follows:

(1) Select "Ohio Health Plans - Provider" (left column).

(2) Select "Hospital Services" (right column).

(3) Select "Hospital Handbook Transmittal Letters" and "Hospital Services - Ohio Administrative Code" (left column).

Providers will receive one hard copy of this transmittal letter and one hard copy of the JFS 03400 "Ohio Department of Job and Family Services, Service Provider Update Request Form." If a provider does not have access to the Internet and wishes to request a paper copy of this transmittal letter with all attachments, the Provider should complete the attached JFS 03400 and return it to the Ohio Department of Job and Family according to the instructions at the top of the form.

Questions:

Questions regarding this transmittal letter should be directed to the following:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Health Plan Policy

Financial Management and Hospital Benefit Section

30 East Broad Street, 27th floor

Columbus, OH 43215-3414

614-466-6420

For pre-certification, call 1-800-772-2179.

HHTL 3352-05-15 (Capital Costs and Medical Education)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-05-15

February 6, 2006

To: All Hospital Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Barbara E. Riley, Director

Subject: Capital Costs and Medical Education

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to the Capital Costs and Medical Education rules. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Capital Costs

The Ohio Administrative Code rule 5101:3-2-07.6 entitled "Capital Costs" will become effective on January 27, 2006. The rule was reviewed due to the five year rule review requirement of ORC 119 and to update references and terminology for consistency. Also, language regarding cost reporting periods was adjusted for purposes of clarification as to the cost report used for rate setting and grammatical changes were completed. There were no policy changes made to the capital costs rule.

Medical Education

The Ohio Administrative Code rule 5101:3-2-07.7 entitled "Medical Education" will become effective on January 27, 2006. The rule was reviewed due to the five year rule review requirement of ORC 119 and to update references within the rule and grammatical changes. There were no policy changes made to the medical education rule.

Department Web Page

The Ohio Department of Job and Family Services has a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is **http://jfs.ohio.gov/**. The web address for the Office of Ohio Health Plans is **http://jfs.ohio.gov/ohp/**.

OAC rules 5101:3-2-07.6 and 5101:3-2-07.7 may be accessed from the following web address: http://emanuals.odjfs.state.oh.us/emanuals. Select "Ohio Health Plans-Provider" (left column), "Hospital Services"(right column), and then select the appropriate rules from the menu on the left side of the screen under "Hospital Services Ohio Administrative Code." If you do not have access to the Internet and wish to request a copy of this HHTL with attachments, please complete the attached JFS 03400 and submit it via the fax number or address shown on the form.

HHTL 3352-05-14 (Hospital Updates Effective January 1, 2006)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-05-14

January 19, 2006

TO: All Hospital Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: Hospital updates effective January 1, 2006

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding upcoming Ohio Administrative Code (OAC) rule changes effective January 1, 2006. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Hospital Inpatient Services:

Inpatient Rates:

Ohio Administrative Code (OAC) Rule 5101:3-2-07.4 entitled "Basic Methodology for determining prospective payment rates", became effective on December 8, 2005. This, rule holds inpatient hospital rates constant at the CY 2005 levels for the CY 2006 and CY 2007 rate years. A separate letter has been sent to all hospitals with the hospital specific rates effective January 1, 2006.

CY 2006 Relative Weight Table:

OAC Rules 5101:3-2-07.3 and 5101:3-2-07.9 effective October 13, 2005 set new relative weights and charge high trims effective for discharges occurring on or after 01/01/06. The relative weight table may be accessed from the Bureau of Health Plan Policy's web page by going to **http://jfs.ohio.gov/ohp/bhpp/** and selecting the option for provider payment policies.

Exceptional Outlier:

Rule 5101:3-2-07.9 (A)(3) defines a base exceptional outlier threshold and provides that the threshold amount will be inflated on an annual basis on January 1 of each year. According to this rule, the exceptional outlier threshold effective January 1, 2006 has been inflated by 4.4 percent to $514,794. All inpatient discharges on or after 01/01/2006 will be subject to the new threshold (the threshold for calendar year 2005 was $493,098).

Medicare Coinsurance and Deductible:

The coinsurance and deductible amounts for Medicare's hospital insurance program (Part A) have been updated effective January 1, 2006. The Medicare **Part A** inpatient hospital deductible amount is $952. The daily coinsurance amounts are updated as follows: (a) $238 coinsurance for the 61st through 90th day of hospitalization in a benefit period; (b) $476 for lifetime reserve days; and (c) $119 for the 21st through 100th days of extended care services in a skilled nursing facility in a benefit period.

The Medicare **Part B** deductibles have also been updated. Effective January 1, 2006 the deductible amount will reflect $124.

Hospital Outpatient Services:

The rule entitled "Policies for outpatient hospital services," (OAC) rule 5101:3-2-21, describes the outpatient payment rates and policies for hospitals that are subject to DRG prospective payment. The rule is being amended to add new codes and update fee schedules along with deleting obsolete codes listed in appendices C, F, and G of the rule to be consistent with the 2006 Current Procedural Terminology (CPT) manual. The rule will also implement the following Healthcare Common Procedural Coding System (HCPCS) level II intravenous therapy codes C8950, C8951, C5952 in place of the following new 2006 CPT codes 90765, 90766, 90767, 90768, 90774, and 90775.

The rule will become effective on an emergency basis for dates of service on or after January 1, 2006. It is being emergency filed in order to comply with the requirements of the Centers for Medicare and Medicaid Services (CMS) and Health Insurance Portability and Accountability Act (HIPAA). A permanent version of this rule will be filed in January, 2006 and will follow normal clearance and hearing procedures.

Non-emergency, Emergency department co-payments:

OAC rule 5101:3-2-21.1 entitled "Consumer co-payments for non-emergency, emergency department services" describes a new policy for those who seek treatment in a hospital emergency department that is of a non-emergent nature. This rule was enacted in accordance with Am. Sub. to H.B. 66 and requires hospitals to charge patients a $3.00 co-pay for non-emergency use of the hospital's emergency department for dates of service on or after January 1, 2006. The administration of this co-pay is subject to exclusions for those under the age of 21, or pregnant, or seeking family planning services, or are receiving hospice care, or who are institutionalized (skilled nursing facility, etc). For information on particular exclusions please refer to (OAC) 5101:3-1-09 or HHTL 3352-05-12 which can be found at our e-manuals website listed below.

Web Page and Paper Distribution:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, and handbooks. The URL is as follows:

http://emanuals.odjfs.state.oh.us/emanuals/

This transmittal letter, and its attachments, may be viewed as follows:

(1) Select "Ohio Health Plans - Provider" (left column).

(2) Select "Hospital Services" (right column).

(3) Select "Hospital Handbook Transmittal Letters" and "Hospital Services - Ohio Administrative Code" (left column).

Providers will receive one hard copy of this transmittal letter and one hard copy of the JFS 03400 "Ohio Department of Job and Family Services, Service Provider Update Request Form." If a provider does not have access to the Internet and wishes to request a paper copy of this transmittal letter with all attachments, the Provider should complete the attached JFS 03400 and return it to the Ohio Department of Job and Family according to the instructions at the top of the form.

Questions:

Questions regarding this transmittal letter should be directed to the following:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Health Plan Policy

Financial Management and Hospital Benefit Section

30 East Broad Street, 27th floor

Columbus, OH 43215-3414

614-466-6420

For pre-certification, call 1-800-772-2179.

HHTL 3352-05-13 (Payment for Outliers: Technical Correction)

Hospital Handbook Transmittal Letter (HHTL) 3352-05-13

January 19, 2006

To: All Hospital Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Barbara E. Riley, Director

Subject: Payment for Outliers: Technical Correction

This Hospital Handbook Transmittal Letter (HHTL) provides information on a technical correction made to OAC rule 5101:3-2-07.9. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Rule 5101:3-2-07.9 entitled, Payment for outliers, describes the reimbursement methodology for all outliers for inpatient hospitals subject to the prospective payment system. The rule is being amended to make one minor technical correction that was overlooked in the last filing. In paragraph (A)(3), "described in paragraph (D)" was changed to "described in paragraph (C)."The amendment is effective on January 1, 2006.

Department Web Page

The Ohio Department of Job and Family Services has a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is **http://jfs.ohio.gov/**, the web address for the Office of Ohio Health Plans is **http://jfs.ohio.gov/ohp/**. **Relative weight tables and information regarding payment policies may be accessed from the Bureau of Health Plan Policy's web page by going to http://jfs.ohio.gov/ohp/bhpp/ and selecting the option for provider payment policies.**

OAC rules referenced above can all be accessed from the following web address: http://emanuals.odjfs.state.oh.us/emanuals/medicaid/Hospital/.

Select the appropriate Rule from the menu on the left side of the screen.

Hospital providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form". If a hospital provider does not have access to the Electronic Manuals Internet Site referenced above, the JFS 03400 form may be used to request hard-copies of the rules referenced in the HHTL. The JFS 03400 form, completed in full, may be faxed or mailed to ODJFS as directed on the form at no cost to the hospital provider.

HHTL 3352-05-12 (Non Emergency Use of the Emergency Room Co-Payment Requirement)

Hospital Handbook Transmittal Letter (HHTL) 3352-05-12

February 6, 2006

To: All Hospital Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Barbara E. Riley, Director

Subject: Non Emergency Use of the Emergency Room Co-payment Requirement.

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding the OAC rule 5101:3-2-21.1 pertaining to Consumer co-payments for non-emergency emergency department services. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

5101:3-2-21.1

Effective for dates of service on or after January 1, 2006, Medicaid consumers shall pay a co-payment equal to three dollars for non-emergency emergency department services except as excluded in OAC rule 5101:3-1-09, listed below:

Co-payments **must not be charged** if the consumer is:

- under age 21, or
- in a nursing home or intermediate care facility for the mentally retarded, or
- a female who is pregnant, or
- a person seeking family planning services, or
- receiving hospice care.

Note: Exclusions listed above are listed to assist in determination of a co-pay. Hospitals are required to only indicate in the remarks field when a co-pay is taken.

The ODJFS claims payment system will edit each claim for exclusions, in the event that one of the exclusions above is determined to apply to the submitted claim, the system will override the co-pay assessment notation on the claim and will not take the co-pay.

Hospital providers shall report, through claim submission, the applicable co-payment to the department in accordance with hospital billing instructions.

Supplemental Billing Instructions-

For non-emergency services sought in the emergency department (codes 99281-99285) please indicate a $3.00 co-pay assessed by adding the following in the remarks field on the UB92 **COPAY_NEMR** (_indicates space).

INSTITUTIONAL CLAIMS

Click here to view the Institutional Claims table.

The department shall reimburse the emergency department claim the allowable Medicaid payment minus the applicable co-payment and any third party resources available to the patient.

This HHTL and referenced rule pertain to the fee-for-service (FFS) Medicaid program. For instructions and information regarding Medicaid recipients who are members of a managed care plan, please consult your managed care contract or contact your managed care plan.

Web Page and Paper Distribution:

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http://emanuals.odjfs.state.oh.us/emanuals/

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(1) Select "Ohio Health Plans - Provider" (left column).

(2) Select "Hospital Services" (right column).

(3) Select "Hospital Handbook Transmittal Letters" and "Hospital Services - Ohio Administrative Code" (left column).

Providers will receive one hard copy of this transmittal letter and one hard copy of the JFS 03400 "Ohio Department of Job and Family Services, Service Provider Update Request Form." If a provider does not have access to the Internet and wishes to request a paper copy of this transmittal letter with all attachments, the Provider should complete the attached JFS 03400 and return it to the Ohio Department of Job and Family according to the instructions at the top of the form.

Questions:

Questions regarding this transmittal letter should be directed to the following:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Health Plan Policy

Financial Management and Hospital Benefit Section

30 East Broad Street, 27th floor

Columbus, OH 43215-3414

614-466-6420

For pre-certification, call 1-800-772-2179.

HHTL 3352-05-11 (Hospital Billing Instructions Update)

Hospital Handbook Transmittal Letter (HHTL) 3352-05-11

Ohio Medicaid Billing Instructions

December 12, 2005

TO: All Hospital Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Barbara Riley, Director

SUBJECT: Hospital Billing Instructions Update

This Hospital Handbook Transmittal Letter (HHTL) notifies hospital providers of important changes to the Ohio Medicaid Hospital Billing Instructions. The following is a summary of the important changes found in the attached instructions:

HIPAA Related Changes

Effective for claims with first dates of service on or after October 1, 2005. Please note the following billing instruction changes made in accordance with HIPAA standardization requirements.

Type of Admission

Type of Admission codes should be used in accordance with National Uniform Billing Instruction (NUBC) guidelines. Valid values for Ohio Medicaid hospital claims are '1' through '5'. Values '6' through '8' will no longer be valid. Ohio Medicaid will no longer require Type of Admission '3' to be used on claims for services requiring precertification, or Type of Admission '2' on claims excluded from precertification. Type of Admission '2' and '3' should be used in accordance with NUBC guidelines to indicate Urgent and Elective admissions, respectively.

For claims for services requiring precertification (see **HHTL 3352-04-10**) providers must continue to enter the precertification number in the Treatment Authorization field. In addition to the procedures listed in HHTL 3352-04-10, please note that all inpatient psychiatric stays (elective and emergency) require precertification and must include the Treatment Authorization number. Ohio Administrative Code (OAC) rule 5101:3-2-40 contains additional precertification information, including situations excluded from precertification. Condition Code 'AN' should be used to report claims excluded from precertification when the services would otherwise require precertification.

Source of Admission

Source of Admission codes should be used in accordance with National Uniform Billing Instruction (NUBC) guidelines. Valid values for Ohio Medicaid hospital claims are '1' through '8', and 'A'. Source of Admission '4' should be used to indicate a transfer from a hospital (both DRG and DRG exempt). Source of Admission '6' should be used to indicate a transfer from another health care facility (other than a hospital or SNF). Source of Admission 'A' may be used to indicate a transfer from a Critical Access Hospital.

Patient Status Codes

Patient Status codes should be used in accordance with National Uniform Billing Instruction (NUBC) guidelines. Valid values for Ohio Medicaid hospital claims are '01'-'09', '20', '30', '43', '50', '51', and '61'-'66'. Patient Status code '09' is valid only for outpatient claims. Patient Status code '62' should only be used when transferring to a free-standing rehabilitation hospital. Ohio Medicaid does not recognize distinct part rehabilitation units of a hospital as separate providers and does not consider this a transfer, therefore, one admit through discharge claim should be submitted to include the stay in both the medical unit and rehabilitation unit of the hospital in these situations.

Type of Bill

Type of Bill codes have been updated in Ohio Medicaid's payment system to reflect NUBC guidelines. There are no billing changes related to Type of Bill required for claims submitted directly to Medicaid. However, the changes are expected to improve the processing of automatic crossovers received by Ohio Medicaid directly from the Medicare fiscal intermediary. Specifically, Critical Access Hospital bill type '851' for outpatient services will no longer deny.

Medicare Part A Changes

Effective for discharges on or after October 1, 2005, reimbursement for Medicare cost sharing for inpatient services will be limited to the lesser of (1) the sum of the coinsurance, deductible, and co-payment, or (2) the amount Medicaid would reimburse for the services (Medicaid maximum allowed amount) minus all prior payments. Additional details pertaining to this policy change were described in a HHTL 3352-05-06 and in OAC rule 5101:3-2-25, effective October 1, 2005.

Medicare Paid Amount / Prior Payments

Due to the policy change for inpatient Medicare crossovers, hospitals will now be required to report all prior payments, including Medicare payments, on all inpatient crossover claims submitted directly to Ohio Medicaid. Inpatient crossover claims with missing Medicare payment amounts will be denied. Providers should use payer code '500' in the Payer ID field to report Medicare payments on the UB-92, and the appropriate SBR09 and AMT01 code qualifiers for Medicare in EDI.

Instructions:

For billing claims with dates of service on or after October 1, 2005, use the attached version of the Hospital Billing Instructions (revised 10/1/2005). Updates to the billing instructions are notes in bold blue font.

Web Page and Paper Distribution:

The Ohio Department of Job and Family Services has a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is **http://jfs.ohio.gov/**. The web address for the Office of Ohio Health Plans front page is **http://jfs.ohio.gov/ohp/**. Information regarding hospital payment policies may be accessed from the department's web page by going to **http://jfs.ohio.gov/ohp/bhpp/** and selecting the option for provider payment policies and relative weight tables.

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, and handbooks. The URL is as follows:

http://emanuals.odjfs.state.oh.us/emanuals/

This transmittal letter, and its attachments, may be viewed as follows:

(1) Select "Ohio Health Plans - Provider" (left column)

(2) Select "Hospital Services" (right column)

(3) Select "Hospital Handbook Transmittal Letters" and "Hospital Billing Instructions" (left column)

Providers will receive one hard copy of this transmittal letter and one hard copy of the JFS 03400 "Ohio Department of Job and Family Services, Service Provider Update Request Form." If a provider does not have access to the Internet and wishes to request a paper copy of this transmittal letter with all attachments, the Provider should complete the attached JFS 03400 and return it to the Ohio Department of Job and Family Services according to the instructions at the top of the form.

Questions:

Questions regarding this transmittal letter should be directed to the following:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Health Plan Policy

Financial Management and Hospital Benefit Section

30 East Broad Street, 27th floor
Columbus, OH 43215-3414
614-466-6420

HHTL 3352-05-10 (Basic Methodology for Determining Prospective Payment Rates)

Hospital Handbook Transmittal Letter (HHTL) 3352-05-10

November 23, 2005

To: All Hospital Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Barbara E. Riley, Director

Subject: Basic Methodology for Determining Prospective Payment Rates

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding the rule pertaining to inpatient hospital payments. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Inpatient Hospital Payments

Ohio Administrative Code (OAC) Rule 5101:3-2-07.4, entitled "Basic Methodology for Determining Prospective Payment Rates," describes the methodology for determining prospective payment rates for inpatient hospital services and sets the annual inflationary update. This rule has been amended to not provide for inpatient hospital rate changes for the calendar year (CY) 2006 and the CY 2007 rate years. In addition, the rule was amended in compliance with the five year rule review requirement of the RC 119.032. The amended rule becomes effective December 8, 2005 and will apply to payments for discharges on or after January 1, 2006.

The rule will provide for a 0.0 percent inflationary adjustment for the inpatient hospital adjusted average cost per discharge (base rate) and for the hospital-specific education allowance effective January 1, 2006 through December 31, 2007. That proposed change holds the base rate and the education allowance constant at the CY 2005 levels for the CY 2006 and CY 2007 rate years. Hospitals will receive the base rate and the education allowance they received for inpatient services as of December 31, 2005. A separate letter has been sent to all hospitals with the hospital specific rates effective January 1, 2006.

Department Web Page

The Ohio Department of Job and Family Services has a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is **http://jfs.ohio.gov/**, the web address for the Office of Ohio Health Plans is **http://jfs.ohio.gov/ohp/**. Relative weight tables and information regarding payment policies may be accessed from the Bureau of Health Plan Policy's web page by going to **http://jfs.ohio.gov/ohp/bhpp/** and selecting the option for provider payment policies.

The OAC rule referenced above can be accessed from the following web address: http://emanuals.odjfs.state.oh.us/emanuals/medicaid/Hospital/.

Select the appropriate Rule from the menu on the left side of the screen.

Hospital providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If a hospital provider does not have access to the Electronic Manuals Internet Site referenced above, the JFS 03400 form may be used to request hard-copies of the rules referenced in the HHTL. The JFS 03400 form, completed in full, may be faxed or mailed to ODJFS as directed on the form at no cost to the hospital provider.

HHTL 3352-05-09 (Supplemental Inpatient Upper Limit Payments for Children's Hospitals)

Hospital Handbook Transmittal Letter (HHTL) 3352-05-09

November 23, 2005

To: All Children's Hospital Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Barbara E. Riley, Director

Subject: Supplemental Inpatient Upper Limit Payments for Children's Hospitals

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to the Supplemental Inpatient Upper Limit Payments Program for Children's Hospitals. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Rule 5101:3-2-53,entitled Supplemental inpatient hospital upper limit payment program for children's hospitals, implements a supplemental inpatient hospital upper limit payment program for children's hospitals that provides for increased reimbursements to children's hospitals paid under the prospective payment system for inpatient hospital services. The rule was proposed to implement Section 206.66.79 of Am. Sub. H.B. 66 of the 126th General Assembly. The rule is effective November 24, 2005.

Department Web Page

The Ohio Department of Job and Family Services has a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is **http://jfs.ohio.gov/**, the web address for the Office of Ohio Health Plans is **http://jfs.ohio.gov/ohp/**. Relative weight tables and information regarding payment policies may be accessed from the Bureau of Health Plan Policy's web page by going to **http://jfs.ohio.gov/ohp/bhpp/** and selecting the option for provider payment policies.

OAC rules referenced above can all be accessed from the following web address: http://emanuals.odjfs.state.oh.us/emanuals/medicaid/Hospital/.

Select the appropriate Rule from the menu on the left side of the screen.

Hospital providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form". If a hospital provider does not have access to the Electronic Manuals Internet Site referenced above, the JFS 03400 form may be used to request hard-copies of the rules referenced in the HHTL. The JFS 03400 form, completed in full, may be faxed or mailed to ODJFS as directed on the form at no cost to the hospital provider.

HHTL 3352-05-08 (HCAP: Eligibility and Requirements)

Hospital Handbook Transmittal Letter (HHTL) 3352-05-08

November 23, 2005

To: All Hospital Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Barbara E. Riley, Director

Subject: Hospital Care Assurance Program (HCAP): Eligibility and Requirements

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to HCAP eligibility and requirements. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Rule 5101:3-2-7.17 entitled Provisions of basic, medically necessary hospital-level services sets forth the eligibility policy and requirements for the Hospital Care Assurance Program (HCAP). The rule was amended in compliance with the five year rule review requirement and also in order to make minor changes that clarify polices and extend record retention requirements. Changes are summarized below. The amended rule is effective January 1, 2006

Summary of Policy Changes Effective January 1, 2006

- For the purpose of determining eligibility, language was added to clarify that the patient's spouse or parent shall be included in the family regardless of whether they live in the home.
- A completed, signed application is required for HCAP prior to determination of eligibility. At a minimum, the application must document income, family size and eligibility for the Medicaid program.
- Each hospital shall establish and maintain a written policy outlining its internal policy for administration of HCAP including the hospital's procedure for taking applications, a current copy of the application in use and the hospital's procedure for eligibility determination.
- With regard to reporting requirements, language was added to prohibit the use of estimation methods to determine amounts for charges related to non-hospital level services or to determine the health insurance status of patient charge on patient accounts.
- Record retention requirements were amended to require hospitals to retain records for a period of six years from the date of receipt of payment based upon those records or until any audit initiated within the six year period is completed.

Department Web Page

The Ohio Department of Job and Family Services has a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is **http://jfs.ohio.gov/**, the web address for the Office of Ohio Health Plans is **http://jfs.ohio.gov/ohp/**. Relative weight tables and information regarding payment policies may be accessed from the Bureau of Health Plan Policy's web page by going to **http://jfs.ohio.gov/ohp/bhpp/** and selecting the option for provider payment policies.

OAC rules referenced above can all be accessed from the following web address: http://emanuals.odjfs.state.oh.us/emanuals/medicaid/Hospital/.

Select the appropriate Rule from the menu on the left side of the screen.

Hospital providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form". If a hospital provider does not have access to the Electronic Manuals Internet Site referenced above, the JFS 03400 form may be used to request hard-copies of the rules referenced in the HHTL. The JFS 03400 form, completed in full, may be faxed or mailed to ODJFS as directed on the form at no cost to the hospital provider.

HHTL 3352-05-07 (Recalibration of DRG Relative Weights and Outlier Payment Changes)

Hospital Handbook Transmittal Letter (HHTL) 3352-05-07

October 4, 2005

To: All Hospital Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Barbara E. Riley, Director

Subject: Recalibration of DRG Relative Weights and Outlier Payment Changes

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to payment for inpatient hospital stays. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Rule 5101:3-2-07.3 entitled, Methodology for determining relative weights, applies to hospitals subject to prospective payment for inpatient services that the department reimburses based on a case mixed amount per discharge that varies according to the diagnostic related group (DRG) to which the service is assigned. The rule describes the method for determining the relative weight of each DRG, which represents the average resources required to care for cases in that particular DRG. The rule has been amended to provide a more current, true weighting. The claims base of September 1, 1993 to June 30, 1995, that was previously used to determine relative weights in 1999, will be updated to a claims base of July 1, 2001 to June 30, 2003 effective for discharges on January 1, 2006 through December 31, 2006. Thereafter, relative weights will be recalibrated annually based on claims data from the state fiscal year ending in the calendar year preceding the immediate past calendar year. Relative weights are recalibrated to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources.

Rule 5101:3-2-07.9 entitled, Payment for outliers, describes the reimbursement methodology for all outliers for inpatient hospitals subject to the prospective payment system. The rule has been amended to modify outlier payment methodology, effective January 1, 2006. The changes include the elimination of day outlier payments for inpatient hospital stays, cases for which the patient stays longer than the predetermined day threshold for each DRG. Inpatient stays with total allowable charges that exceed the predetermined charge threshold for each DRG will continue to qualify for a cost outlier. Currently, if a claim qualifies for both day and cost outlier payment, day outlier payment takes precedent for the majority of hospitals. However, after the amended methodology is in effect, claims that previously would have paid as day outliers, may qualify for cost outlier payment (many of the day outlier claims also qualify as cost outliers). To qualify as a cost outlier, the total allowed claim charges must exceed the applicable charge high trim for the DRG assigned to the claim.

The outlier changes also include revising the methodology for determining the cost outlier payment for those hospitals that do not have a high outlier experience, so that all hospitals, including those that have a high outlier experience use the hospital specific cost to charge ratio instead of the fixed percentages currently in use. Hospitals may determine the new cost outlier payment, by multiplying outlier charges (total allowed claim charges minus applicable charge high trim assigned to the DRG) by their hospital specific cost to charge ratio instead of the current rates of either 60% or 80% depending on the DRG assigned to the claim.

Department Web Page

The Ohio Department of Job and Family Services has a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is **http://jfs.ohio.gov/**, the web address for the Office of Ohio Health Plans is **http://jfs.ohio.gov/ohp/**. **Relative weight tables and information regarding payment policies may be accessed from the Bureau of Health Plan Policy's web page by going to http://jfs.ohio.gov/ohp/bhpp/ and selecting the option for provider payment policies.**

OAC rules referenced above can all be accessed from the following web address: http://emanuals.odjfs.state.oh.us/emanuals/medicaid/Hospital.

Select the appropriate Rule from the menu on the left side of the screen.

Hospital providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form". If a hospital provider does not have access to the Electronic Manuals Internet Site referenced above, the JFS 03400 form may be used to request hard-copies of the rules referenced in the HHTL. The JFS 03400 form, completed in full, may be faxed or mailed to ODJFS as directed on the form at no cost to the hospital provider.

HHTL 3352-05-06 (Hospital Third Party Liability Rule)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-05-06

September 29, 2005

TO: All Hospital Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: Hospital Third Party Liability Rule

This Hospital Handbook Transmittal Letter (HHTL) notifies hospital providers that the Hospital Third Party Liability Rule, Ohio Administrative Code 5101:3-2-25, has been updated. Effective October 1, 2005, the update revises the methodology for payment of Medicare Part A deductible, co-payment and/or coinsurance (hereafter referred to as "cost sharing") for services rendered to Medicaid consumers enrolled in Medicare Part A and Qualified Medicare Beneficiaries, including Qualified Medicare Beneficiaries Plus (hereafter referred to as QMBs).

In accordance with Section 4714 of the Balanced Budget Act of 1997, the Department of Job and Family Services has revised the methodology for payment of Medicare Part A cost sharing for QMBs and Medicaid consumers enrolled in Medicare Part A (hospital insurance benefit) such that:

The department will pay the lesser of: (1) the sum of the deductible, coinsurance and co-payment amount as provided by Medicare Part A; or (2) the Medicaid maximum allowed amount minus the sum of Medicare and third party payments. The Medicaid maximum allowed amount is the amount Medicaid would have paid for the same claim if the patient had no insurance coverage other than Medicaid.

A subsequent HHTL will be released with updated hospital billing instructions for the purpose of assisting Ohio Medicaid hospital providers to correctly file inpatient Claims for the deductible, coinsurance and/or co-payment amount where Medicare is also a payer.

Instructions:

Remove and file as obsolete the previous version of rule 5101:3-2-25, and replace with rule 5101:3-2-25, effective 10/1/2005.

Web Page and Paper Distribution:

The Ohio Department of Job and Family Services has a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is **www.jfs.ohio.gov.**. The web address for the Office of Ohio Health Plans front page is **www.jfs.ohio.gov/ohp/**. Information regarding hospital payment policies may be accessed from the department's web page by going to **www.jfs.ohio.gov/ohp/bhpp/hbfm.stm** and selecting the option for provider payment policies and relative weight tables.

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, and handbooks. The URL is as follows:

http://emanuals.odjfs.state.oh.us/emanuals/

This transmittal letter, and its attachments, may be viewed as follows:

(1) Select "Ohio Health Plans - Provider" (left column)

(2) Select "Hospital Services" (right column)

(3) Select "Hospital Handbook Transmittal Letters" and "Hospital - Ohio Administrative Code" (left column)

Providers will receive one hard copy of this transmittal letter and one hard copy of the JFS 03400 "Ohio Department of Job and Family Services, Service Provider Update Request Form." If a provider does not have

access to the Internet and wishes to request a paper copy of this transmittal letter with all attachments, the Provider should complete the attached JFS 03400 and return it to the Ohio Department of Job and Family Services according to the instructions at the top of the form.

Questions:

Questions regarding this transmittal letter should be directed to the following:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Health Plan Policy

Financial Management and Hospital Benefit Section

30 East Broad Street, 27th floor

Columbus, OH 43215-3414

614-466-6420

HHTL 3352-05-05 (Cost Report)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-05-05

September 14, 2005

To: All Hospital Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Barbara E. Riley, Director

Subject: Cost Report

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to the Cost Report rule. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Cost Reports

The Ohio Administrative Code rule 5101:3-2-23 entitled "Cost Reports" will become effective on September 17, 2005. The rule was reviewed due to the five year rule review requirement of ORC 119 and to update the appendix with the SFY 2005 cost report and instructions as well as to update rule references. The rule reflects technical changes only. There were no policy changes made to the cost report rule.

Department Web Page

The Ohio Department of Job and Family Services has a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is **http://jfs.ohio.gov/**. The web address for the Office of Ohio Health Plans is **http://jfs.ohio.gov/ohp/**.

OAC rule 5101:3-2-23 may be accessed from the following web address: http://emanuals.odjfs.state.oh.us/emanuals. Select "Ohio Health Plans-Provider" (left column), "Hospital Services"(right column), and then select the appropriate rules from the menu on the left side of the screen under "Hospital Services Ohio Administrative Code." If you do not have access to the Internet and wish to request a copy of this HHTL with attachments, please complete the attached JFS 03400 and submit it via the fax number or address shown on the form.

HHTL 3352-05-04 (Hospital General Provisions Updated)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-05-04

September 28, 2005

TO: All Hospital Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: Hospital general provisions updated

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding rule OAC 5101:3-2-02, General provisions: hospital services. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

General provisions: hospital services

The rule entitled "General provisions: hospital services," Ohio Administrative Code (OAC) 5101:3-2-02, describes and defines general provisions for hospital services. The rule was amended to update definitions and add the national uniform billing committee (NUBC) website. Also, to be in compliance with the national uniform billing requirements, appendix A was updated to add two new revenue codes, 0343 Diagnostic Radiopharmaceuticals and 0344 Therapeutic Radiopharmaceuticals.

Instructions:

To update your handbook, replace the previous version of OAC rule 5101:3-2-02 and appendix A with the updated version of OAC 5101:3-2-02 and appendix A effective 10/1/2005.

Web Page and Paper Distribution:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, and handbooks. The URL is as follows:

http://emanuals.odjfs.state.oh.us/emanuals/

This transmittal letter, and its attachments, may be viewed as follows:

(1) elect "Ohio Health Plans - Provider" (left column).

(2) elect "Hospital Services" (right column).

(3) elect "Hospital Handbook Transmittal Letters" and "Hospital Services - Ohio Administrative Code" (left column).

Providers will receive one hard copy of this transmittal letter and one hard copy of the JFS 03400 "Ohio Department of Job and Family Services, Service Provider Update Request Form." If a provider does not have access to the Internet and wishes to request a paper copy of this transmittal letter with all attachments, the Provider should complete the attached JFS 03400 and return it to the Ohio Department of Job and Family according to the instructions at the top of the form.

Questions:

Questions regarding this transmittal letter should be directed to the following:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Health Plan Policy

Financial Management and Hospital Benefit Section

30 East Broad Street, 27th floor

Columbus, OH 43215-3414

614-466-6420

For pre-certification, call 1-800-772-2179.

HHTL 3352-05-03 (Audits)

Hospital Handbook Transmittal Letter (HHTL) No. 3352-05-03

September 14, 2005

To: All Hospital Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Barbara E. Riley, Director

Subject: Audits

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to the Audits rule. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Audits

The Ohio Administrative Code rule 5101:3-2-24 entitled "Audits" is effective on September 4, 2005. The audit rule was reviewed due to the five year rule review requirement of Ohio Revised Code section 119.032 and the rule reflects technical changes only. There were no policy changes made to the audit rule.

Department Web Page

The Ohio Department of Job and Family Services has a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is **http://jfs.ohio.gov/**. The web address for the Office of Ohio Health Plans is **http://jfs.ohio.gov/ohp/**.

OAC rule 5101:3-2-24 may be accessed from the following web address: http://emanuals.odjfs.state.oh.us/emanuals. Select "Ohio Health Plans-Provider" (left column), "Hospital Services"(right column), and then select the appropriate rules from the menu on the left side of the screen under "Hospital Services Ohio Administrative Code." If you do not have access to the Internet and wish to request a copy of this HHTL with attachments, please complete the attached JFS 03400 and submit it via the fax number or address shown on the form.

HHTL 3352-05-02 (Payment/Data Policies for Disproportionate Share and Indigent Care Rules)

Hospital Handbook Transmittal Letter (HHTL) 3352-05-02

September 13, 2005

To: All Hospital Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Barbara E. Riley, Director

Subject: Payment/Data Policies for Disproportionate Share and Indigent Care Rules

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to payment and data policies for disproportionate share and indigent care rules for general hospitals and freestanding psychiatric hospitals. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Rule 5101:3-2-08 entitled Data policies for disproportionate share and indigent care adjustments for hospital services sets forth the data policies for the Hospital Care Assurance Program (HCAP). The rule has been amended to add the definitions of the following costs: ambulance service, durable medical equipment sold and durable medical equipment rented, to aid in the exclusion of these costs along with skilled nursing, home health facility, hospice facility and other non-hospital costs from "total facility costs" to determine the hospital's "adjusted total facility costs."

Rule 5101:3-2-08.1 entitled Assessment rates sets forth the assessment rate for the Hospital Care Assurance Program (HCAP). This rule has been amended to establish the assessment rates and the cost levels to which those rates apply to fund HCAP for the 2005 program year.

Rule 5101:3-2-09 entitled Payment policies for disproportionate share and indigent care adjustments for hospital services sets forth the conditions, requirements, and operation of HCAP as well as the distribution formula. This rule has been amended to update the distribution formula for payment policies for disproportionate share hospitals (DSH) for use in Program Year 2005.

Rule 5101:3-2-10 entitled Payment policies for disproportionate share and indigent care adjustments for psychiatric hospitals sets forth the conditions, requirements, and operation of the Institutions for Mental Diseases Disproportionate Share (IMD DSH) program, as well as the distribution formula. The rule has been amended to update a technical reference to another OAC rule which was modified. There are no changes to disproportionate share payment policies described in the rule.

Department Web Page

The Ohio Department of Job and Family Services have a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is **http://jfs.ohio.gov/**. The web address for the Office of Ohio Health Plans is **http://jfs.ohio.gov/ohp/**. Relative weight tables and information regarding payment policies may be accessed from the Bureau of Health Plan Policy's web page by going to **http://jfs.ohio.gov/ohp/bhpp/** and selecting the option for provider payment policies.

OAC rules referenced above can all be accessed from the following web address: http://emanuals.odjfs.state.oh.us/emanuals/Medicaid. Select "Hospital Services" and then select the appropriate Rule from the menu on the left side of the screen.

Hospital providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form". If a hospital provider does not have access to the Electronic Manuals Internet Site referenced above, the JFS 03400 form may be used to request hard-copies of the rules referenced in the HHTL. The JFS 03400 form, completed in full, may be faxed or mailed to ODJFS as directed on the form at no cost to the hospital provider.

HHTL 3352-05-01 (Pre-Certification Rules Updated)

Hospital Handbook Transmittal Letter (HHTL) 3352-05-01

May 18, 2005

TO: All Hospital Providers

FROM: Barbara E. Riley, Director

SUBJECT: Pre-certification rules updated

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding the following rules: Pre-certification review (5101:3-2-40) and Reimbursement for elective care subject to pre-certification review (5101:3-2-42). A complete updated list of procedures that require pre-certification is contained within HHTL 3352-04-10. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Pre-certification review

The rule entitled "Pre-certification review," Ohio Administrative Code (OAC) 5101:3-2-40, describes the pre-certification review program for inpatient and outpatient services. The rule was amended to update terminology and correct references to other rules. This rule was also updated to combine OAC rule 5101:3-2-42, "Reimbursement for elective care subject to pre-certification review," into its text. OAC rule 5101:3-2-42, "Reimbursement for elective care subject to pre-certification review," was rescinded.

To update your handbook, replace the previous version of OAC rule 5101:3-2-40 and 5101:3-2-42 with the updated version of OAC 5101:3-2-40 effective 4/1/2005. Please note that a copy of this transmittal letter (as well as electronic copies of hospital rules) is available on the web at: http://emanuals.odjfs.state.oh.us/emanuals/medicaid/Hospital.

Questions pertaining to this HHTL should be addressed to:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Health Plan Policy

Financial Management and Hospital Benefit Section

30 East Broad Street, 27th floor

Columbus, OH 43215-3414

614-466-6420

For pre-certification, call 1-800-772-2179.

HHTL 3352-04-10 (Pre-Certification List Update and Notice of Change in Medical Review Guidelines)

Hospital Handbook Transmittal Letter (HHTL) 3352-04-10

February 17, 2005

TO: All Hospital Providers

FROM: Barbara E. Riley, Director

SUBJECT: Pre-certification list update and notice of change in medical review guidelines

This Hospital Handbook Transmittal Letter (HHTL) is being sent to hospitals to notify them that the list of hospital services that require pre-certification is being revised and to provide hospitals with the revised list. The revised list is effective 30 days following the publishing date of this HHTL and is being published in accordance with Ohio Administrative Code 5101:3-2-40. The revision adds five additional CPT codes (63030, 63035, 63042, 63044 and 63047) that correlate to two procedure categories (80.51 and 81.08) to assist providers in the identification of services that require pre-certification. The revision also adds one new hysterectomy code (58552) that will need pre-certification for both inpatient and outpatient settings. A complete updated list of procedures that require pre-certification is contained within this HHTL. To view further billing instructions for services that require pre-certification, please visit our website at the following address:

http://emanuals.odjfs.state.oh.us/emanuals/medicaid/Hospital

In addition, this HHTL notifies hospitals regarding "Standards of Medical Practice" as defined in Ohio Administrative Code 5101:3-2-40(A)(4). The Ohio Department of Job and Family Services (ODJFS) will use Milliman *Care Guidelines* ® in quality and appropriateness care reviews for Ohio Medicaid claims. ODJFS previously used Physician Developed Criteria (PDC) for quality and appropriateness care reviews. The use of Milliman Care Guidelines will be effective for claims selected for review 30 days after the published date of this HHTL.

Care Guidelines are nationally accepted guidelines, founded on the use of evidence-based research methodology to support the development and understanding of medical care processes. The clinical criteria were developed and are updated on a regular basis with input from health care providers in active clinical practice. Sources of information for all *Care Guidelines* include medical literature and textbooks, nationally recognized guidelines published in all fields of medicine, practice observation, and database analyses.

The following is a list of the procedures that require pre-certification. Please note that, except for hysterectomies, pre-certification for the listed procedures is required only when the procedures occur as inpatient services. The pre-certification program is part of the Ohio Medicaid Utilization Review Program for hospital services.

OHIO DEPARTMENT OF JOB AND FAMILY SERVICES

HOSPITAL PRE-CERTIFICATION LIST

The following procedures require pre-certification when performed electively in an inpatient setting only:

- **Arthroplasty, arthrotomy or arthroscopy, temporomandibular joint**

  ICD9 codes 76.5, 80.29, and 80.19

  CPT codes 21010, 21050, 21060, 21070, 21240-21243, 29800, and 29804

- **Arthroscopy knee**

  ICD9 code 80.26

  CPT codes 29870, 29871, 29874-29877, and 29879 - 29889

- **Cervical laminectomy**

  ICD9 code 81.02-81.03

CPT codes 22554, 22556, 22558, 22585, 22808, 22810, 22812, 22590, 22600, 22610, 22612, 22614, 22800, 22802, 22804, 22840, 22851, 63075, and 63076

- **Laparoscopic cholecystectomy**

  ICD9 codes 51.23, 51.24

  CPT codes 47562 - 47564

- **Laparoscopic-diagnostic**

  ICD9 code 54.21

  CPT codes 49320 - 49323, 49329

- **Lumbar laminectomy - posterior**

  ICD9 codes 80.51 and 81.08

  CPT codes 22600, 22610, 22612, 22614, 22630, 22632, 22800, 22802, 22804, 22842, 22843, 22844, 22851, 63030, 63035, 63042, 63044, and 63047.

- **Percutaneous angioplasty-non coronary vessel**

  ICD9 code 39.50

  CPT codes 35470 - 35476

- **Peripheral vascular shunt or bypass**

  ICD9 code 39.29

  CPT codes 33619, 34520, 35516, 35518, 35521, 35533, 35551, 35556, 35558, 35566, 35571, 35583, 35585, 35587, 35616, 35621, 35623, 35650, 35654, 35656, 35661, 35666, and 35671

- **PTCA-coronary angioplasty**

  ICD9 code 36.01

  CPT codes 92982, 92984, 92995, and 92996

- **Shoulder arthroscopy**

  ICD9 code 80.21

  CPT codes 29826, 29805, and 29819

- **Total hip replacement**

  ICD9 code 81.51

  CPT codes 27130 and 27132

- **Total knee replacement**

  ICD9 code 81.54

  CPT codes 27437, 27438, 27445, 27446, and 27447

- **Transurethral resection of the prostate**

  ICD9 code 60.21 and 60.29

  CPT codes 52601, 52612, 52614, 52620, 52630, 52647, and 52648

The following procedures will continue to require pre-certification in both **inpatient and outpatient settings:**

- **Hysterectomy**

  ICD9 codes 68.3, 68.4, 68.51, and 68.59

  CPT codes 51925, 58150, 58152, 58180, 58200, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58550, 58552, and 58951

As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Please note that a copy of this transmittal letter (as well as electronic copies of hospital rules) is available on the web at: http://emanuals.odjfs.state.oh.us/emanuals/medicaid/Hospital. **For pre-certification, call 1-800-772-2179. For questions**, please refer to Ohio Administrative Code 5101:3-2-40, call Permedion at 1- 800-473-0802 ext. 3430, or contact the Department at:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Health Plan Policy

Financial Management and Hospital Benefit Section

30 East Broad Street, 27th floor

Columbus, OH 43215-3414

614-466-6420

HHTL 3352-04-09 (Policy Changes Effective January 1, 2005)

Hospital Handbook Transmittal Letter (HHTL) 3352-04-09

January 27, 2005

To: All Hospital Providers
Directors, County Departments of Job and Family Services
Directors, District OFFICES

From: Barbara Riley, Director

Subject: Policy Changes Effective January 1, 2005

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding the rule pertaining to inpatient hospital payments, the Grouper 15 Relative Weight table and the inflation of the excessive outlier threshold. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Inpatient Hospital Payments

The attached rule entitled "Basic Methodology for determining prospective payment rates,: Ohio Administrative Code (OAC) 5101:3-2-07.4, became effective on August 21, 2003. This rule was amended at that time to reflect increases to inpatient hospital payments effective January 1, 2005.

Inpatient hospital rates will be increased by 3 percent to non-children's "general" hospitals and by 3.3 percent for children's hospitals effective 01/01/05. A separate letter has been sent to all hospitals with the hospital specific rates effective January 1, 2005.

Charge High Trim for Outliers

Rule 5101:3-2-07.9 describes the reimbursement methodology used in paying for all types of outliers for inpatient hospitals subject to the prospective payment system. The charge high trims of the relative weight tables were inflated by 3.3 percent to reflect current market rates and will be effective for discharge dates on or after January 1, 2005. A new relative weight table that includes the new charge high trim points is included in this transmittal and is available on the department's web-site.

Excessive Outlier Threshold

Rule 5101:3-2-07.9 (A)(7) defines a base exceptional outlier threshold and provides that the threshold amount will be inflated on an annual basis on January 1 of each year. According to this rule, the exceptional outlier threshold effective January 1, 2005 has been inflated by 3.3 percent to $493,098. All inpatient discharges on or after 01/01/2005 will be subject to the new threshold (the threshold for calendar year 2004 was $477,346).

Medicare Co-Insurance and Deductible Amounts (Part A and B)

The coinsurance and deductible amounts for Medicare's hospital insurance program (Part A) have been updated effective January 1, 2005. The inpatient hospital deductible amount is updated to $912. The daily coinsurance amounts are updated as follows: (a) $228 coinsurance for the 61st through 90th day of hospitalization in a benefit period; (b) $456 for lifetime reserve days; and (c) $114 for the 21st through 100th days of extended care services in a skilled nursing facility in a benefit period.

Medicare Part (B) deductibles have also been updated. Effective January 1, 2005 the deductible amount will reflect $110.

Outpatient Hospital Rule

The rule entitled "Policies for outpatient hospital services," Ohio Administrative Code (OAC) rule 5101:3-2-21, describes the outpatient payment rates and policies for hospitals that are subject to DRG prospective payment. The rule will become effective for dates of service on or after January 1, 2005. The rule was amended to implement the following actions: (1) to delete from and add to the HCPCS codes listed in appendices C, F, and G of the rule to be consistent with the CPT-2005 manual; (2) to include non-Ohio

hospitals in Ohio's prospective payment system for outpatient hospital services; and (3) to update the definition of "outpatient invoice" to include electronic 837I claim transmission.

Reasonable Cost and Cost-Related Reimbursement for Hospital Services

Rule 5101:3-2-22 describes the cost-related reimbursement methodology used to pay DRG-exempt hospitals. The rule will become effective for dates of service on or after January 1, 2005 and was amended to omit outpatient hospital services provided by non-Ohio hospitals from this provision.

Department Web Page

The Ohio Department of Job and Family Services have a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is **http://jfs.ohio.gov/**. Relative weight tables and information regarding payment policies may be accessed from the Bureau of Health Plan Policy's web page by going to **http://jfs.ohio.gov/ohp/bhpp/** and selecting the option for provider payment policies. The Office of Ohio Health Plans' web page is **http://jfs.ohio.gov/ohp/**.

OAC rules 5101:3-2-07.4, 5101:3-2-21, 5101:3-2-22, 5101:3-2-07.9 can all be accessed from the following web address: http://emanuals.odjfs.state.oh.us/emanuals/Medicaid. Select "Hospital Services" and then select the appropriate Rule from the menu on the left side of the screen.

HHTL 3352-04-08 (Hospital Disproportionate Share Payment Rules)

Hospital Handbook Transmittal Letter (HHTL) 3352-04-08

September 16, 2004

TO: All Hospital Providers

Directors, County Departments of Job and Family Services

FROM: Thomas J. Hayes, Director

SUBJECT: Hospital Disproportionate Share Payment Rules

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding the Hospital Care Assurance Program (HCAP) disproportionate share payments. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by this rule.

Hospital Care Assurance Program Rule

Ohio Administrative Code rule 5101:3-2-09 entitled Payment policies for disproportionate share and indigent care adjustments for hospital services will become effective on a permanent basis on September 30, 2004. This rule sets forth the conditions, requirements, and operation of HCAP as well as the distribution formula. The rule has been amended to make technical corrections.

Department Web Page

The Ohio Department of Job and Family Services has a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is **http://jfs.ohio.gov/index.stm**. The web address for the Office of Ohio Health Plans front page is **http://jfs.ohio.gov/ohp/index.stm**. Information regarding payment policies may be accessed from the department's web page by going to **http://jfs.ohio.gov/ohp/bhpp/index.stm** and selecting the option for provider payment policies and relative weight tables.

To update your handbook, remove the previous version of OAC rule 5101:3-2-09 with the updated version of OAC rule 5101:3-2-09.

Questions pertaining to this HHTL should be addressed to:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Health Plan Policy

Financial Management and Hospital Benefit Section

30 East Broad Street, 27th floor

Columbus, OH 43215-3414

(614) 466-6420

HHTL 3352-04-07 (Cost Reports)

Hospital Handbook Transmittal Letter (HHTL) 3352-04-07

September 16, 2004

TO: All Hospital Providers

Directors, County Departments of Job and Family Services

FROM: Thomas J. Hayes, Director

SUBJECT: Cost Reports

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding the SFY 2004 cost report rule. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by this rule.

SFY 2004 Medicaid Cost Report

Ohio Administrative Code rule 5101:3-2-23 entitled "Cost reports" will become effective on a permanent basis on September 2, 2004. The cost report rule was amended to replace the appendix with the State Fiscal Year 2004 cost report. Please note the requirement for hospitals to report hospital outpatient visits and HMO encounter data, and clarifies external auditor requirements when cost report data changes are made. These requirements commence with the SFY 2004 Medicaid Cost report.

Department Web Page

The Ohio Department of Job and Family Services has a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is **http://jfs.ohio.gov/index.stm**. The web address for the Office of Ohio Health Plans front page is **http://jfs.ohio.gov/ohp/index.stm**. Information regarding payment policies may be accessed from the department's web page by going to **http://jfs.ohio.gov/ohp/bhpp/index.stm** and selecting the option for provider payment policies and relative weight tables.

To update your handbook, remove the previous version of OAC rule 5101:3-2-23 from the rules section of your handbook, and insert the new OAC rules 5101:3-2-23.

Questions pertaining to this HHTL should be addressed to:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Health Plan Policy

Financial Management and Hospital Benefit Section

30 East Broad Street, 27th floor

Columbus, OH 43215-3414

(614) 466-6420

HHTL 3352-04-06 (Hospital Disproportionate Share Payment Rules)

Hospital Handbook Transmittal Letter (HHTL) 3352-04-06

July 13, 2004

TO: All Hospital Providers

Directors, County Departments of Job and Family Services

FROM: Thomas J. Hayes, Director

SUBJECT: Hospital Disproportionate Share Payment Rules

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding the Hospital Care Assurance Program (HCAP) and free standing psychiatric hospital disproportionate share payments. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by this rule.

Hospital Care Assurance Program Rules

Rule 5101:3-2-08.1 entitled Assessment rates will become effective on a permanent basis on July 1, 2004. This rule establishes the assessment rate for the Hospital Care Assurance Program (HCAP) and was amended to amend the assessment rates and the cost levels to which those rates apply to fund HCAP for the 2004 program year.

Ohio Administrative Code rule 5101:3-2-09 entitled Payment policies for disproportionate share and indigent care adjustments for hospital services will become effective on a permanent basis on July 1, 2004. This rule sets forth the conditions, requirements, and operation of HCAP as well as the distribution formula. The distribution formula was updated to reflect more current hospital data, to implement the disproportionate share hospital funding increases required by the Medicare Prescription and Drug Improvement and Modernization Act of 2003 (MMA 2003, and to allow for increasing the amount of funds allocated to hospitals meeting the strictest definition of a disproportionate share hospital (High DSH).

Free Standing Psychiatric Hospital Disproportionate Share Payment Rule

Rule 5101:3-2-10 entitled Payment policies for disproportionate share and indigent care adjustments for psychiatric hospitals will become effective on July 1, 2004. This rule sets forth the conditions, requirements, and operation of the Institutions for Mental Diseases Disproportionate Share (IMD DSH) program, as well as the distribution formula. This rule was amended to update information and cost reporting period references, and to account for increased federal funding resulting from (MMA 2003).

Department Web Page

The Ohio Department of Job and Family Services has a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is **http://jfs.ohio.gov/index.stm**. The web address for the Office of Ohio Health Plans front page is **http://jfs.ohio.gov/ohp/index.stm**. Information regarding payment policies may be accessed from the department's web page by going to **http://jfs.ohio.gov/ohp/bhpp/index.stm** and selecting the option for provider payment policies and relative weight tables.

To update your handbook, remove the previous version of OAC rule 5101:3-2-08.1 from the rules section of your handbook, and insert the new OAC rules 5101:3-2-08.1, and replace the previous version of OAC rule 5101:3-2-09 with the updated version of OAC rule 5101:3-2-09 and the updated version of OAC rule 5101:3-2-10 with the updated version of 5101:3-2-10.

Questions pertaining to this HHTL should be addressed to:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Health Plan Policy

Financial Management and Hospital Benefit Section
30 East Broad Street, 27th floor
Columbus, OH 43215-3414
(614) 466-6420

HHTL 3352-04-05 (Change in Norplant Reimbursement and Update to Revenue Center Codes)

Hospital Handbook Transmittal Letter (HHTL) 3352-04-05

May 12, 2004

TO: All Hospital Providers

FROM: Thomas J. Hayes, Director

SUBJECT: Change in Norplant Reimbursement and Update to Revenue Center Codes

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding the following rules: General provisions: hospital services (5101:3-2-02), Hospital services subject to and excluded from DRG prospective payment (5101:3-2-07.1) and Payment methodology (5101:3-2-07.11). As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these rules.

General provisions: hospital services

The rule entitled "General provisions: hospital services," Ohio Administrative Code (OAC) rule 5101:3-2-02, defines terms used in the hospital chapter of the OAC. Appendix A of the rule defines the coverage of Revenue Center Codes used for billing purposes. Changes made to this rule were made only to the Appendix to include updated revenue center codes as published by The National Uniform Billing Committee.

Hospital services subject to and excluded from DRG prospective payment

This rule, OAC 5101:3-2-07.1, describes services subject to the DRG prospective payment system and exclusions to this system. One such exclusion provided payment for Norplant contraceptive devices in accordance with Appendix F of rule 5101:3-2-21 (in effect, a supplemental payment). The change made to this rule removes this exclusion.

Payment Methodology

OAC Rule 5101:3-2-07.11, paragraph A, makes a reference to payment methodology for the exclusion that was removed from rule 5101:3-2-07.1 (above). The reference was deleted as it is no longer relevant.

OAC rules 5101:3-2-02, 5101:3-2-07.1 and 5101:3-2-07.11 can be accessed from the following web address: http://emanuals.odjfs.state.oh.us/emanuals/medicaid. Select "Hospital Services" and then select the appropriate Rule from the menu on the left side of the screen.

Department Web Page

The Ohio Department of Job and Family Services has a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is **www.jfs.ohio.gov**. The web address for the Office of Ohio Health Plans front page is **www.jfs.ohio.gov/ohp/index.stm**. Information regarding hospital payment policies may be accessed from the department's web page by going to **www.jfs.ohio.gov/ohp/bhpp/hbfm.stm** and selecting the option for provider payment policies and relative weight tables.

To update your handbook, replace the previous version of Appendix A (Revenue Center Codes) OAC rule 5101:3-2-02, OAC rule 5101:3-2-07.1 and 5101:3-2-07.11 with the updated versions of the same rules.

Questions pertaining to this HHTL should be addressed to:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Health Plan Policy

Financial Management and Hospital Benefit Section

30 East Broad Street, 27th floor

Columbus, OH 43215-3414
(614) 466-6420

HHTL 3352-04-04 (Hospital Billing Instructions for Medicare HMO Crossover Claims)

Hospital Handbook Transmittal Letter (HHTL) 3352-04-04

May 6, 2004

TO: Ohio Medicaid Hospital Providers

FROM: Thomas J. Hayes, Director

SUBJECT: Hospital Billing Instructions for Medicare HMO Crossover Claims

This Hospital Handbook Transmittal Letter (HHTL) contains billing instructions for Medicare HMO (Part C) crossover claims. As only one paper copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by this transmittal. As the department continues to implement HIPAA-related changes, additional transmittals will be published and the hospital billing instructions will be revised.

Section C has been added to Chapter 1 and Chapter 2 of the hospital billing instructions (revised 11/14/03) to provide instructions for billing inpatient and outpatient hospital claims for Medicaid consumers enrolled in Medicare HMO plans. Additionally, the Table of Contents has been revised to include the addition of Section C. To update your handbook, replace the previous version of the Ohio Medicaid Hospital Billing Instructions Table of Contents with the new Table of Contents (revised 04/21/04) contained in this transmittal, insert Section C for Medicare HMO Inpatient Billing Instructions (revised 04/21/04) in Chapter 1, and insert Section C for Medicare HMO Outpatient Billing Instructions (revised 04/21/04) in Chapter 2.

Please make note of the following form locators when reviewing the billing instructions. The instructions included in these form locators are new and/or are highlighted here as essential to Medicare HMO crossover claims processing:

- **Form Locators 9 and 10 - Co-insurance Days and Lifetime Reserve Days.** Hospitals are responsible for reporting co-insurance days and lifetime reserve days, when applicable. Absence of this information, if applicable, will impact reimbursement.
- **Form Locator 32 through 35 - Occurrence Codes and Dates.** For paper claims submission and electronic submissions using Flat File formats, occurrence code 57 is required and must include the date of payment by the Medicare HMO plan. The date should match the date on the remittance advice from the Medicare HMO plan.
- **Form Locators 39 through 41 - Value Codes and Dollar Amounts.** For Medicare HMO crossover claims submitted on paper or electronically using Flat File formats, applicable value codes E1, E2, E3, or E7 must be used for services provided under a non-capitated arrangement with the Medicare HMO Plan. For Medicare HMO crossover claims submitted on paper or electronically using Flat File formats, applicable value codes F1, F2, F3, or F7 must be used for services provided under a capitated arrangement with the Medicare HMO Plan. Value code dollar amounts should be obtained from the Medicare HMO remittance advice.
- **Form Locator 54 - Prior Payments.** The actual payment from the Medicare HMO plan as it appears on the Medicare HMO remittance advice is required to be reported in this form locator, and should correspond to the payer code in Form Locator 50.

This Hospital Handbook Transmittal Letter, revised hospital billing instructions, other HHTLs, and OAC rules can be accessed on our web site at http://emanuals.odjfs.state.oh.us/emanuals/medicaid/.

Department Web Page

The Ohio Department of Job and Family Services has a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is **www.jfs.ohio.gov**. The web address for the Office of Ohio Health Plans front page is **www.jfs.ohio.gov/ohp/**. Information regarding hospital payment policies may be accessed from the department's web page by going to

www.jfs.ohio.gov/ohp/bhpp/hbfm.stm and selecting the option for provider payment policies and relative weight tables.

Questions pertaining to this HHTL should be addressed to:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Health Plan Policy

Financial Management and Hospital Benefit Section

30 East Broad Street, 27th floor

Columbus, OH 43215-3414

(614) 466-6420

HHTL 3352-04-03 (Policies for Outpatient Hospital Services)

Hospital Handbook Transmittal Letter (HHTL) 3352-04-03

May 12, 2004

TO: All Hospital Providers
Directors, County Departments of Job and Family Services
Directors, District Offices

FROM: Thomas J. Hayes, Director

SUBJECT: Policies for Outpatient Hospital Services

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding the outpatient hospital services rule. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these rules.

Outpatient Hospital Rule

The rule entitled "Policies for outpatient hospital services," Ohio Administrative Code (OAC) rule 5101:3-2-21, describes the outpatient payment rates and policies for hospitals that are subject to DRG prospective payment. The rule is a permanent version of the rule that was submitted as an emergency filing (effective January 2, 2004). The permanent version of the rule (effective April 1, 2004) followed normal clearance and hearing procedures. The rule was amended to delete obsolete HCPCS codes and add new codes listed in appendices C, F, and G to be consistent with the CPT coding manual. The amendment also extends to April 1, 2004 the use of CPT vision codes 92004 and 92014 as described in paragraph (B)(3) of the rule and adds new CPT code 59897 as an unlisted surgery code in paragraph (F)(2)(a) of the rule. The amendment also clarifies the use of existing observation codes.

OAC rule 5101:3-2-21 can be accessed from the following web address: http://emanuals.odjfs.state.oh.us/emanuals/medicaid. Select "Hospital Services" and then select the appropriate Rule from the menu on the left side of the screen. A hard copy of the rule may also be requested by referencing HHTL 3352-04-03 on the JFS form 03400.

Department Web Page

The Ohio Department of Job and Family Services has a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is **www.jfs.ohio.gov**. The web address for the Office of Ohio Health Plans front page is **www.jfs.ohio.gov/ohp/index.stm**. Information regarding hospital payment policies may be accessed from the department's web page by going to **www.jfs.ohio.gov/ohp/bhpp/hbfm.stm** and selecting the option for provider payment policies and relative weight tables.

To update your handbook, replace the previous version of OAC rule 5101:3-2-21 in the rules section of your handbook with the updated version of OAC rule 5101:3-2-21.

Questions pertaining to this HHTL should be addressed to:

Ohio Department of Job and Family Services
Office of Ohio Health Plans
Bureau of Health Plan Policy
Financial Management and Hospital Benefit Section
30 East Broad Street, 27th floor
Columbus, OH 43215-3414
(614) 466-6420

HHTL 3352-04-02 (Supplemental Inpatient UPL for State Hospitals)

Hospital Handbook Transmittal Letter (HHTL) 3352-04-02

January 27, 2004

TO: Ohio State-Owned Hospital Providers
Directors, County Departments of Job and Family Services
Directors, District Offices
Ohio Department of Mental Health

FROM: Thomas J. Hayes, Director

SUBJECT: Supplemental Inpatient Upper Payment Limit (UPL) for State Hospitals

This Hospital Handbook Transmittal Letter (HHTL) contains the rule pertaining to UPL for state hospitals. As only one paper copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by this transmittal.

Rule 5101:3-2-51 entitled Supplemental Inpatient Hospital Upper Limit Payments for State Hospitals has been rescinded and filed new effective 9/1/03 on a permanent basis to make modifications to the methodology for calculating supplemental upper limit payments to state hospitals.

Modifications have been made to the methodology for calculating Supplemental Upper Limits Payments (UPL) to state hospitals. Specifically, the new methodology applies each participating hospital's Medicare payment to charge ratio to its Medicaid charges to estimate what Medicare would pay for its Medicaid consumers.

Updated OAC rule 5101:3-2-51 should be added to update your handbook.

This Hospital Handbook Transmittal Letter, revised hospital billing instructions, other HHTLs, and OAC rules can be accessed on our web site at http://emanuals.odjfs.state.oh.us/emanuals.

Questions pertaining to this HHTL should be addressed to:

Ohio Department of Job and Family Services
Office of Ohio Health Plans
Bureau of Health Plan Policy
Financial Management and Hospital Benefit Section
30 East Broad Street, 27th floor
Columbus, OH 43215-3414
(614) 466-6420

HHTL 3352-04-01 (Policy Changes Effective January 1, 2004)

Hospital Handbook Transmittal Letter (HHTL) 3352-04-01

January 20, 2004

TO: All Hospital Providers
Directors, County Departments of Job and Family Services
Directors, District Offices

FROM: Thomas J. Hayes, Director

SUBJECT: Policy Changes Effective January 1, 2004

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding the outpatient hospital services rule and the outlier payment rule. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these rules.

Outpatient Hospital Rule

The rule entitled "Policies for outpatient hospital services," Ohio Administrative Code (OAC) rule 5101:3-2-21, describes the outpatient payment rates and policies for hospitals that are subject to DRG prospective payment. The rule became effective on an emergency basis for dates of service on or after January 1, 2004. The rule was amended to delete from and add to the HCPCS codes listed in appendices C, F, and G of the rule to be consistent with the CPT-2004 manual. The emergency amendment also extends to April 1, 2004 the use of CPT vision codes 92004 and 92014 as described in paragraph (B)(3) of the rule and adds new CPT code 59897 as an unlisted surgery code in paragraph (F)(2)(a) of the rule. A permanent version of this rule will be filed in January, 2004 and will follow normal clearance and hearing procedures.

Charge High Trim for Outliers

Enacted rule 5101:3-2-07.9 describes the reimbursement methodology used in paying for all types of outliers for inpatient hospitals subject to the prospective payment system. In accordance with paragraph (C)(1) of the rule, the charge high trims of the relative weight tables were inflated by 3.6% to reflect current market rates and will be effective for discharge dates on or after January 1, 2004. The updated relative weight table can be viewed on the ODJFS website at the following address: http://jfs.ohio.gov/ohp/bhpp/hosppol1.stm.

Exceptional Outliers

Rule 5101:3-2-07.9 (A)(7) defines a base exceptional outlier threshold and provides that the threshold amount will be inflated on an annual basis on January 1 of each year. According to this rule, the exceptional outlier threshold effective January 1, 2004 has been inflated by 3.6%, to $477,346. All inpatient discharges on or after 1/1/2004 will be subject to the new threshold (the threshold for calendar year 2003 was $460,758).

OAC rules 5101:3-2-21 and 5101:3-2-07.9 can be accessed from the following web address: http://emanuals.odjfs.state.oh.us/emanuals/medicaid. Select "Hospital Services" and then select the appropriate Rule from the menu on the left side of the screen.

Department Web Page

The Ohio Department of Job and Family Services has a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is www.jfs.ohio.gov. The web address for the Office of Ohio Health Plans front page is www.jfs.ohio.gov/ohp/index.stm. Information regarding hospital payment policies may be accessed from the department's web page by going to www.jfs.ohio.gov/ohp/bhpp/hbfm.stm and selecting the option for provider payment policies and relative weight tables.

To update your handbook, replace the previous version of OAC rule 5101:3-2-21 in the rules section of your handbook with the updated version of OAC rule 5101:3-2-21.

Questions pertaining to this HHTL should be addressed to:

Ohio Department of Job and Family Services
Office of Ohio Health Plans
Bureau of Health Plan Policy
Financial Management and Hospital Benefit Section
30 East Broad Street, 27th floor
Columbus, OH 43215-3414
(614) 466-6420

HHTL 3352-03-9 (Revised Hospital Billing Instructions)

Hospital Handbook Transmittal Letter (HHTL) 3352-03-9

December 9, 2003

TO: Ohio Medicaid Hospital Providers
Directors, County Departments of Job and Family Services
Directors, District Offices

FROM: Thomas J. Hayes, Director

SUBJECT: Revised Hospital Billing Instructions

This Hospital Handbook Transmittal Letter (HHTL) contains revised hospital billing instructions. As only one paper copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by this transmittal. As the department continues to implement HIPAA-related changes, additional transmittals will be published and the hospital billing instructions will be revised.

The hospital billing instructions have been revised to make the following changes:

- Instructions regarding reporting of prior payments in UB-92 billing form locator 54 were clarified.
- Department web addresses were updated to reflect a new department URL.
- Grammatical/technical errors were corrected throughout the billing instructions.
- The contact name for precertification was updated to reflect that Permedion is now the precertification vendor. Please note the telephone number and policies for precertification have not changed.
- Outlier payment information was revised to clarify the effective date of the outlier threshold used in the payment calculation example. Please note that outlier thresholds are updated annually for inflation.
- Clarified instructions for including decimal points when reporting birth weight in grams in conjunction with value code 54.

This Hospital Handbook Transmittal Letter, revised hospital billing instructions, other HHTLs, and OAC rules can be accessed on our web site at http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid.

Department Web Page

The Ohio Department of Job and Family Services has a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is www.jfs.ohio.gov. The web address for the Office of Ohio Health Plans front page is www.jfs.ohio.gov/ohp/index.stm. Information regarding hospital payment policies may be accessed from the department's web page by going to www.jfs.ohio.gov/ohp/bhpp/hbfm.stm and selecting the option for provider payment policies and relative weight tables.

To update your handbook, replace the previous version of the Ohio Medicaid Hospital Billing Instructions with the billing instructions published with this transmittal (revision date, 11/14/03).

Questions pertaining to this HHTL should be addressed to:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Health Plan Policy

Financial Management and Hospital Benefit Section

30 East Broad Street, 27th floor

Columbus, OH 43215-3414

(614) 466-6420

HHTL 3352-03-5 (Summary of HIPAA Related Changes for Hospital Claims and Revised Hospital Billing Instructions)

Hospital Handbook Transmittal Letter (HHTL) 3352-03-5

October 3, 2003

TO: All Hospital Hospitals

Directors, County Departments of Job and Family Services

Directors, District Offices

FROM: Thomas J. Hayes, Director

SUBJECT: Summary of HIPAA Related Changes for Hospital Claims and Revised Hospital Billing Instructions

This Hospital Handbook Transmittal Letter (HHTL) outlines hospital policy and billing-related changes required by the department due to the federally mandated Health Insurance Portability and Accountability Act (HIPAA), and contains revised hospital billing instructions. to reflect these changes. As only one paper copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by this rule. Unless otherwise noted, all HIPAA-related changes described in this transmittal are effective for dates of service on or after October 16, 2003. As the department continues to implement HIPAA-related changes, additional transmittals will be published.

HIPAA Changes Pertaining to INPATIENT Claims Only

Newborn Birth Weight

Local-level condition codes 88 through 96 are no longer valid for reporting newborn birth weight. Newborn birth weight must now be reported using value code 54, with the birth weight in grams reported in the amount field. Newborn birth weight is required on all newborn claims that group into DRG 385 through 391, or 892 through 898.

Private Room Charges

Local-level condition code 81 is no longer valid to report instances in which a patient chooses a private room and agrees to pay the room differential. In this instance, Hospitals must use value code 31 to report the patient liability amount to include the difference between the private room and the semi-private room rate. Hospitals must also include the difference between the private room and the semi-private room rate as non-covered charges for revenue code 011X.

As described in Ohio Administrative Code (OAC) rule 5101:3-2-03, private room charges will continue to be covered in instances when a private room is medically necessary. Condition code 39 should continue to be used to indicate when a private room is medically necessary. Private room charges will also continue to be covered when a hospital has no semi-private rooms available, and should continue to be reported using value code 02.

Norplant

Local-level condition code 85 is no longer required to indicate instances when Norplant was inserted postpartum prior to discharge.

DRG 468

Local-level condition code 98 is no longer required to indicate that data associated with DRG 468 has been validated. The department will review claims that group into DRG 468 (Extensive O.R. procedure unrelated to principal diagnosis) upon retrospective review.

HIPAA Changes Pertaining to OUTPATIENT Claims Only

Vaccines

Per OAC rule 5101:3-2-21, local-level vaccine codes W0703 (Tetanus, adult), W0706 (Rubella, adult), W0718 (Tetanus and diphtheria toxoids absorbed, adult), and W0731 (Hepatitis B, adult) are no longer valid codes for billing vaccines provided in the outpatient setting. Hospitals must use the appropriate Current Procedural Terminology (CPT) codes to bill for vaccine services. A list of the covered vaccination CPT codes can be found in Appendix F of OAC rule 5101:3-2-21.

Vaccines that are covered under the Vaccines for Children (VFC) program will continue to be reimbursed at the administration rate only ($5.00) when administered to children age 18 and younger. All other vaccines will be reimbursed at the fee listed in Appendix F of OAC rule 5101:3-2-21.

Outpatient Re-bills

Local-level condition code 86 is no longer valid for identifying outpatient claims for services that were originally billed as inpatient services, but denied upon retrospective review due to the location of service. Hospitals must now use condition code C3 to identify these claims. The coverage policies related to these re-bills have not changed and are described in OAC rule 5101:3-2-42.

Emergency Room Trauma Services

Per OAC rule 5101:3-2-21, local-level condition code 87 is no longer valid for reporting trauma services in the emergency room on outpatient bills. Hospitals should use CPT modifier -22 to indicate unusual emergency room procedural services, for cases in which the services provided were greater than usual because the procedure involved stabilizing a patient in a life-threatening condition prior to transferring the patient to another hospital or if the patient died in the emergency room following treatment or resuscitation efforts. These trauma service emergency room claims will continue to be reimbursed in accordance with paragraph (H) of OAC rule 5101:3-2-21.

Contraceptive Implants

Per OAC rule 5101:3-2-21, local-level code X1454 is no longer valid for billing for sub-dermal contraceptive implants. Hospitals should now use the appropriate Healthcare Common Procedure Coding System (HCPCS) code to indicate the contraceptive implant. HCPCS code A4260 (Levonorgestrel contraceptive implants system) has been added to the outpatient fee schedule as a covered code (see Appendix F of OAC rule 5101:3-2-21).

Counseling and Education Services

Per OAC rule 5101:3-2-21, local-level procedure codes X6400 (Initial counseling/education, pediatric patient, chronically or severely ill), X6410 (Periodic counseling/education, pediatric patient, chronically or severely ill), X6420 (Initial care coordination, pediatric patient, chronically or severely ill), X6430 (Continuing care coordination, pediatric patient, chronically or severely ill), X6500 (Rape counseling), X6600 (Alcohol rehabilitation visit), X6610 (drug rehabilitation visit), X6700 (Cardiac rehabilitation visit), X7000 (Individual counseling/education, adult chronic illness), and X7010 (Group counseling/education, adult chronic illness) are no longer valid for billing counseling and other educational services provided in the outpatient hospital setting. Hospitals must use appropriate CPT and HCPCS codes, including existing psychotherapy codes when applicable. HCPCS codes S9445 (Patient education, individual), S9446 (Patient education, group), S9472 (Cardiac rehabilitation program), G9001 (Coordinated care fee, initial rate), and G9002 (Coordinated care fee, maintenance rate) have been added to the outpatient fee schedule. These new counseling and education service codes will only be reimbursed once per day per recipient, as consistent with the standard definitions of the codes.

As described in OAC rule 5101:3-2-21, modifier -U1 has been designated as 'Pediatric patient, chronically or severely ill,' and modifier -U2 has been designated as 'Adult chronic illness.' Reimbursement for HCPCS code S9445 is only allowed for chronically ill pediatric or adult patients, which must be indicated by appropriate modifier -U1 or -U2. HCPCS code S9446 is only covered for adults with chronic illness, which must be indicated by modifier -U2. HCPCS codes G9001 and G9002 are only covered for chronically or severely ill pediatric patients and must be billed with modifier -U1.

Observation Services

Per OAC rule 5101:3-2-21, local-level codes X7100 (Observation for admission determination) and X7500 (Test/procedure requiring more than six hours) are no longer valid for reporting observation services on

outpatient claims. Hospitals must now use the appropriate CPT codes. CPT codes 99218 (Initial observation care, per day, low complexity), 99219 (Initial observation care, per day, moderate complexity), 99220 (Initial observation care, per day, high complexity), 99234 (Observation, admission and discharge on same date, low complexity), 99235 (Observation, admission and discharge on same date, moderate complexity), and 99236 (Observation, admission and discharge on same date, high complexity) have been added to the outpatient fee schedule in OAC rule 5101:3-2-21.

Please refer to the CPT definitions for determination of complexity levels for billing observation services. Payment for the new observation CPT codes will continue to be made in addition to the surgery, when applicable. Reimbursement of the new observation CPT codes is limited to one observation service per recipient per day for the same provider.

Canceled Surgeries

Per OAC rule 5101:3-2-21, local-level codes X7200 and X7201 are no longer valid for reporting canceled surgeries on outpatient claims. Hospitals must now use CPT modifier -73 to indicate discontinued procedures prior to anesthesia, and CPT modifier -74 to indicate discontinued procedures after anesthesia with the appropriate surgery procedure code. Reimbursement for surgical procedures canceled after anesthesia (indicated by modifier -74) will continue to be reimbursed at 100%, while surgical procedures canceled prior to anesthesia (indicated by modifier -73) will continue to be reimbursed at 50%, as described in OAC rule 5101:3-2-21.

Outpatient claims for canceled surgeries must continue to include occurrence code 43 with the date of the canceled surgery. Additionally, outpatient claims for canceled surgeries must continue to include a primary diagnosis code of V64.1, V64.2, or V64.3 to indicate that the scheduled surgical procedure was discontinued.

Occupational Therapy

Per OAC rule 5101:3-2-21, local-level procedure codes H5220, H5230, and H5240 for rehabilitation evaluations; X7300 (unlisted occupational therapy service); X7320 (transfer training); X7321 (sensory integration); X7322 (work simplification); X7323 (motor function); X7324 (sensory retraining); X7325 (perceptual training); X7326 (work therapy); X7340 (assisted daily living training); X7350 (cognitive battery evaluation), X7360 (adaptive skills evaluation); X7370 (coordination evaluation); X7380 (orthotics training); X7390 (hand evaluation); X7400 (pediatric sensorimotor evaluation); X7410 (coordination treatments); and X7420 (swallowing training) are no longer valid for reporting occupational therapy services on outpatient claims. Hospitals must now use the appropriate HCPCS or CPT codes. In addition to CPT therapy codes, CPT codes 97003 (occupational therapy evaluation) and 97535 (self-care/home management training) have been added to the outpatient fee schedule in OAC rule 5101:3-2-21. CPT code 97003 will only be reimbursed once per recipient per day, while multiple units of CPT code 97535 will be reimbursed when applicable.

Pregnancy Related Services

Local-level codes 59420 (antepartum care), X5400 (prenatal risk assessment), X5411 (individual pregnancy related counseling and education), X5412 (pregnancy related group education), X5422 (nutritional intervention during and post pregnancy), X5431 (prenatal care coordination), and X5432 (high risk patient monitoring) are no longer valid for reporting pregnancy related services on outpatient claims. Hospitals must now use appropriate HCPCS or CPT codes, including existing clinic visit codes when applicable. HCPCS codes H1000 (prenatal care, at-risk assessment), H1001 (prenatal care service, antepartum management), H1002 (prenatal care coordination), H1003 (prenatal care education), S9436 (childbirth preparation classes), S9437 (childbirth refresher class), S9444 (parenting classes), S9447 (infant safety classes), S9452 (nutrition classes), and S9470 (nutrition counseling) have been added to the outpatient fee schedule for reporting pregnancy related services. As described in OAC rule 5101:3-2-21, procedure codes S9444, S9447, S9452, and S9470 are only covered when billed in conjunction with modifier -TH to indicate that services are obstetrical in nature. Additionally, when modifier -TH is used with clinic visit codes 99201, 99202, 99203, 99211, 99212, 99213, and 99214, reimbursement for Level 1 reimbursement (for Teaching or Children's hospitals) will be $85.86, and Level 2 reimbursement (for all other hospitals) will be $56.51.

HIPAA Changes Pertaining to Both

INPATIENT and OUTPATIENT Claims

Abortions

Condition code A7 is no longer valid for reporting abortions induced to avoid danger to a woman's life. Hospitals should report abortions using the appropriate HIPAA-compliant condition codes (AA through AH) as designated by the National Uniform Billing Committee (NUBC). There are no other changes to the requirements for billing/coverage of abortion services. Hospitals must continue to submit abortion claims using the appropriate certification form. Policies related to coverage of abortions are described in OAC rule 5101:3-17-01.

Hysterectomy and Sterilization Claims

Local-level condition codes X0 and X1 are no longer valid for identifying hysterectomy and sterilization claims. Hospitals should report sterilizations using HIPAA-compliant condition code AI. There are no other changes to the requirements for billing or coverage of hysterectomy/sterilization services. Hospitals must continue to submit hysterectomy/sterilization claims using the appropriate consent form. Policies related to coverage of hysterectomy/sterilization are described in OAC rule 5101:3-21-01.

Revenue Center Codes

OAC rules 5101:3-2-02 and 5101:3-2-03 have been updated (to be effective October 1, 2003) to reflect four-digit revenue codes. Hospitals can refer to OAC rule 5101:3-2-02 for a listing of covered and non-covered revenue codes. Rule 5101:3-2-03 describes conditions and limitations related to coverage of hospital services.

Codes that will remain temporarily during the transition to HIPAA

Changes to the use of these codes will be announced through a future transmittal letter.

835 Health Care Claim Payment Advice for Medicare Crossovers

Temporarily, 835 Health Care Claim Payment Advice for Medicare Crossovers that are sent from Medicaid to providers will continue our current practice of reporting payment information at the header level. At a later date 835 Health Care Claim Payment Advice for Medicare Crossovers that are sent from Medicaid to providers will report at the line level.

Line Item Limit on Claims

The policy that has been in effect for invoices containing more than 50 line items will continue to be in effect temporarily. If a claim or invoice contains more than 50 line items, the entire claim or invoice will be rejected. Bills which exceed the 50 line item limit must continue to be broken down into more than one invoice.

Occurrence Codes

Please continue to use the following occurrence codes:

CODE	DESCRIPTION
Codes apply to both inpatient and outpatient	
01	Auto accident
02	Auto accident/No fault insurance involved
03	Accident/Tort liability
04	Accident/employment related
05	Other accident
06	Crime victim
10	The date of the last menstrual period. Applicable when the patient is being treated for a maternity related condition.

24	Date insurance denied
25	Date benefits terminated by primary payer
42	Date of discharge when "through" date in Item 6 is not the actual discharge date and frequency code in Form Locator 4 is that of final bill.
50	Medicaid benefits exhaust date. Applies when limits are placed on Medicaid coverage
51	No response from carrier for 90 days following 1st service date. Do not bill this claim until the 91st day from the first service date on the claim
52	No coverage for this Medicaid or ADC number
53	Non-covered service
54	Disputed or contested liability
55	Recipient denies coverage for all case identification numbers
56	Non-cooperative recipient
A3	Benefits exhausted - payer A
B3	Benefits exhausted - payer B
C3	Benefits exhausted - payer C

Vision Codes

Please continue to use the following local-level codes for comprehensive vision services provided to patients age 1-20 and 60 and over:

CODE	DESCRIPTION
W2004	Comprehensive vision services, new patient, ages 1-20 and 60 and over
W2014	Comprehensive vision services, established patient, ages 1-20 and 60 and over

Type of Admission

Please continue to use the following codes and definitions for type of admission:

CODE	DESCRIPTION
INPATIENT CODES:	
1	Emergency
2	Urgent and for all other admission types excluded from preadmission certification: -Substance abuse admissions

	-Maternity admissions -Recipients enrolled in Medicaid HMOs -Patients who are jointly eligible for Medicare and Medicaid and who are being admitted under the Medicare Part A benefits. -Transfers from one hospital to another Please see rule 5101:3-2-40 for a complete description of Ohio Medicaid's pre-certification policy including other conditions exempt from pre-certification. HHTL 3352-03-1 provides the list of services that currently require pre-certification.
3	Elective, must include pre-certification number
4	Newborn, must use value code 54 for birthweight
5	Pending Medicaid
6	Medicaid recipient not reviewed until after admission and admission denied by review agency
7	An admission for which pre-certification was obtained, but patient was transferred to another hospital
8	Rehabilitation admission
OUTPATIENT CODES:	
1	Emergency
3	Elective

Source of Admission

Please continue to use the following codes and definitions for source of admission:

CODE	DESCRIPTION
INPATIENT CODES (not required for outpatient):	
1	Physician referral
2	Clinic referral
4	Transfer from an acute care, general hospital subject to prospective payment system. This stay paid on a per diem basis.
5	Transfer from a nursing facility (NF)
6	Transfer from another health care facility (other than an acute care hospital subject to prospective payment system or a NF)
7	Emergency room
Codes for Newborn admissions (These codes must be used when Type of	

Admission is code 4).	
1	Normal delivery
2	Premature delivery
3	Sick baby
4	Extramural birth

Patient Status

Please continue to use the following codes and definitions for patient status:

CODE	DESCRIPTION
INPATIENT and OUTPATIENT CODES:	
01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to another acute care general hospital, subject to prospective payment system (paid on per diem)
03	Discharged/transferred to a nursing facility
04	Discharged/transferred to an intermediate care facility (ICF). This code is appropriate for use when a discharge/transfer is made to a freestanding rehabilitation hospital.
06	Discharged/transferred to home under care of home health service organization
07	Left against medical advice
10	Discharged/transferred to or from a distinct part psychiatric unit within the same hospital. If your hospital is not recognized as a Medicare approved distinct part psychiatric unit, do not use this code.
20	Expired
30	Still patient (must only be used on bill types 112, 113, 122, and 123)
Note: Patient status code 05 is not acceptable for Ohio Medicaid	

Sources For Additional Information Related To Hipaa

This Hospital Handbook Transmittal Letter and the revised billing instructions, as well as additional information about Ohio Medicaid's transition to HIPAA is available at: http://www.state.oh.us/odjfs/ohp/hipaa.stm. From this site select "HIPAA compliant codes" to view this transmittal letter for hospital policy, information regarding billing for other providers (including physicians), and a crosswalk from pre-HIPAA EOB codes to HIPAA Remittance Advice Remark Codes. Or select "EDI-Electronic Data Interchange" to view useful information about ODJFS' transition to HIPAA including links to the ODJFS HIPAA Transaction Set Companion Guides (837 Health Care Claim Institutional, 837 Health Care Claim Professional, 835 Health Care Claim Payment Advice, etc).

Sources For General Medicaid Information

This Hospital Handbook Transmittal Letter, revised hospital billing instructions, other HHTLs, and OAC rules can be accessed on our web site at http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid. **The outpatient fee schedule is located in the appendix to OAC rule 5101:3-2-21.**

Department Web Page

The Ohio Department of Job and Family Services has a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is www.state.oh.us/odjfs/index.stm. The web address for the Office of Ohio Health Plans front page is http://www.state.oh.us/odjfs/ohp/index.stm Information regarding payment policies may be accessed from the department's web page by going to http://www.state.oh.us/odjfs/ohp/bhpp/index.stm and selecting the option for provider payment policies and relative weight tables.

To update your handbook, your billing instructions should be updated to reflect the HIPAA changes described in this transmittal, you should ensure that you have replaced the previous version of OAC rule 5101:3-2-21 in the rules section of your handbook with the updated version of OAC rule 5101:3-2-21 (effective September 1, 2003, see HHTL 3352-03-4), and replace the previous versions of OAC rules 5101:3-2-02 and 5101:3-2-03 with the updated versions of the rules.

Questions pertaining to this HHTL should be addressed to:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Health Plan Policy

Financial Management and Hospital Benefit Section

30 East Broad Street, 27th floor

Columbus, OH 43215-3414

(614) 466-6420

HHTL 3352-03-6 (Administrative Fees on Supplemental Upper Limit Payments)

Hospital Handbook Transmittal Letter (HHTL) 3352-03-6

October 2, 2003

TO: All Ohio Public and State Hospital Providers
Directors, County Departments of Job and Family Services
Directors, District Offices

FROM: Thomas J. Hayes

SUBJECT: Administrative Fees on Supplemental Upper Limit Payments

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding the rule pertaining to administrative fees on supplemental upper limit payments to public and state hospitals. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by this new program.

Rule 5101:3-2-52 titled "Administrative fees on supplemental upper limit payments" establishes an administrative fee on supplemental upper limit payments made to public and state hospital providers. Hospital providers to which the provisions of this rule are applicable include Ohio public and state hospitals, as defined in Ohio Administrative Code (OAC) rules 5101:3-2-50 and 5101:3-2-51.

Beginning with the upper limit payment for the six-month period ending June 30, 2003, and for each payment period thereafter, the department shall collect or retain an administrative fee equal to ten per cent of the federal financial participation amount of the total supplemental upper limit payment. The administrative fee payments must be made by the due date established by the department for the receipt of the required intergovernmental transfer (IGT) for each supplemental upper limit payment, except for the first administrative fee payment. For the first administrative fee payment, the due date has been extended to the due date for the IGT for the supplemental upper limit payment for the six-month period ending on December 31, 2003.

Please note the total supplemental upper limit payment amount (including the IGT and the administrative fee) will be included as a Medicaid program payment in the calculation of each hospital's disproportionate share limit.

OAC rule 5101:3-2-52 should be added to update your handbook.

Questions pertaining to this HHTL should be addressed to:

Ohio Department of Job and Family Services
Office of Ohio Health Plans
Bureau of Health Plan Policy
Financial Management and Hospital Benefit Section
30 East Broad Street, 27th floor
Columbus, OH 43215-3414
614-466-6420

HHTL 3352-03-7 (HCAP Rules)

Hospital Handbook Transmittal Letter (HHTL) 3352-03-7

September 23, 2003

TO: All Hospital Providers
Directors, County Departments of Job and Family Services
Directors, District Offices

FROM: Thomas J. Hayes, Director

SUBJECT: Hospital Care Assurance Program (HCAP) Rules

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding the Hospital Care Assurance Program (HCAP). As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by this rule.

Hospital Care Assurance Program Rules

Ohio Administrative Code rule 5101:3-2-08 entitled "Data Policies for Disproportionate Share and Indigent Care Adjustments for Hospital Services" will become effective on a permanent basis on July 28, 2003. This rule sets forth the data policies used to determine disproportionate share indigent care adjustments and used to calculate hospital assessments, and replaces a portion of rule 5101:3-2-08 that is being rescinded effective July 28, 2003.

Ohio Administrative Code rule 5101:3-2-08.1 entitled "Assessment rates" will become effective on a permanent basis on July 28, 2003. This rule establishes the assessment rate to fund HCAP, for the 2003 program year, and replaces a portion of rule 5101:3-2-08 that is being rescinded effective July 28, 2003.

Ohio Administrative Code rule 5101:3-2-09 entitled "Payment Policies for Disproportionate Share and Indigent Care Adjustments for Hospital Services" will become effective on a permanent basis on July 28, 2003. This rule sets forth the conditions, requirements, and operation of HCAP as well as the distribution formula. This rule provides for a revised distribution formula for program year 2003, and payment policies for disproportionate share hospitals (DSH).

Department Web Page

The Ohio Department of Job and Family Services has a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is www.state.oh.us/odjfs/index.stm. The web address for the Office of Ohio Health Plans front page is www.state.oh.us/odjfs/ohp/index.stm. Information regarding payment policies may be accessed from the department's web page by going to www.state.oh.us/odjfs/ohp/bhpp/index.stm and selecting the option for provider payment policies and relative weight tables.

To update your handbook, remove the previous version of OAC rule 5101:3-2-08 from the rules section of your handbook, and insert the new OAC rules 5101:3-2-08 and 5101:3-2-08.1, replace the previous version of OAC rule 5101:3-2-09 with the updated version of OAC rule 5101:3-2-09.

Questions pertaining to this HHTL should be addressed to:

Ohio Department of Job and Family Services
Office of Ohio Health Plans
Bureau of Health Plan Policy
Financial Management and Hospital Benefit Section
30 East Broad Street, 27th floor
Columbus, OH 43215-3414
(614) 466-6420

HHTL 3352-03-4 (Outpatient Hospital Rule and Medical Education Rule)

Hospital Handbook Transmittal Letter (HHTL) 3352-03-4

September 17, 2003

TO: All Hospital Providers
Directors, County Departments of Job and Family Services
Directors, District Offices

FROM: Thomas J. Hayes, Director

SUBJECT: Outpatient Hospital Rule and Medical Education Rule

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding the outpatient hospital services rule. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by this rule.

Outpatient Hospital Rule

The rule entitled "Policies for outpatient hospital services," Ohio Administrative Code (OAC) rule 5101:3-2-21, describes the outpatient payment rates and policies for hospitals that are subject to DRG prospective payment. The rule will become effective on an emergency basis for dates of service on or after September 1, 2003. This rule implements the outpatient hospital rate increases required by Am. Sub. HB 95 for the 2004-2005 biennium. The rule was amended to increase the rate the department pays for certain outpatient surgical services provided under the Medicaid program by general hospitals that are not children's hospitals.

Additionally, the amended outpatient hospital rule contains coding changes to be effective October 16, 2003 that are required as a result of the Health Insurance Portability and Accountability Act (HIPAA). The department also has made changes necessary to meet HIPAA standardization requirements in rules 5101:3-2-02 and 5101:3-2-03 of the OAC. All of these HIPAA required changes from all rule filings will be effective October 16, 2003 and will be explained in a detailed transmittal letter that will be distributed prior to the effective date.

Medical Education Rule

Rule 5101:3-2-07.7 entitled "Medical education" describes the method used to determine the medical education allowance that will be added to the DRG base price for teaching hospitals. Rule 5101:3-2-07.7 of the OAC was amended to make technical corrections regarding Medicare cost report citations in paragraphs (A) and (B) of the rule. The rule will become effective September 12, 2003.

OAC rules 5101:3-2-21 and 5101:3-2-07.7 can be accessed on our web site at http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid.

Department Web Page

The Ohio Department of Job and Family Services has a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is www.state.oh.us/odjfs/index.stm. The web address for the Office of Ohio Health Plans front page is www.state.oh.us/odjfs/ohp/index.stm. Information regarding payment policies may be accessed from the department's web page by going to www.state.oh.us/odjfs/ohp/bhpp/index.stm and selecting the option for provider payment policies and relative weight tables.

To update your handbook, replace the previous version of OAC rules 5101:3-2-21 and 5101:3-2-07.7 in the rules section of your handbook with the updated version of OAC rules 5101:3-2-21 and 5101:3-2-07.7.

Questions pertaining to this HHTL should be addressed to:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Health Plan Policy
Financial Management and Hospital Benefit Section
30 East Broad Street, 27th floor
Columbus, OH 43215-3414
(614) 466-6420

HHTL 3352-03-3 (Outpatient Hospital Rule)

Hospital Handbook Transmittal Letter (HHTL) 3352-03-3

June 26, 2003

TO: All Hospital Providers
Directors, County Departments of Job and Family Services
Directors, District Offices

FROM: Thomas J. Hayes, Director

SUBJECT: Outpatient Hospital Rule

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding the outpatient hospital services rule and the cost report rule. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by this rule.

Outpatient Hospital Rule

The rule entitled "Policies for outpatient hospital services," Ohio Administrative Code (OAC) rule 5101:3-2-21, will become effective on a permanent basis on July 1, 2003. This rule incorporates 2003 Current Procedural Terminology (CPT) codes effective for services rendered on or after July 1, 2003. The 2002 CPT codes will no longer be accepted for services provided on or after July 1, 2003. OAC rule 5101:3-2-21 contains the fee schedules for outpatient procedures. The outpatient laboratory fee schedule is contained in Appendix DD of OAC rule 5101:3-1-60.

Additionally, the amended outpatient hospital rule contains coding changes to be effective October 1, 2003 that are required as a result of the Health Insurance Portability and Accountability Act (HIPAA). However, the department intends to make additional coding changes that will be necessary to meet HIPAA standardization requirements. These additional changes will be made through another filing of the rule in the near future. All of these HIPAA required changes from both rule filings will be effective October 1, 2003 and will be explained in a detailed transmittal letter that will be distributed prior to the effective date.

SFY 2003 Medicaid Cost Report

Ohio Administrative Code rule 5101:3-2-23 entitled "Cost reports" will become effective on a permanent basis on July 17, 2003. The cost report rule was amended to replace the appendix with the State Fiscal Year 2003 cost report. Please note the requirement for hospitals to have an independent party, a certified public account, verify the data reported on Schedule E/F of the cost report. This requirement commences with the SFY 2003 Medicaid Cost report.

OAC rules 5101:3-2-21, 5101:3-2-23, and 5101:3-1-60 can be accessed on our web site at http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid.

Department Web Page

The Ohio Department of Job and Family Services has a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is www.state.oh.us/odjfs/index.stm. The web address for the Office of Ohio Health Plans front page is www.state.oh.us/odjfs/ohp/index.stm. Information regarding payment policies may be accessed from the department's web page by going to www.state.oh.us/odjfs/ohp/bhpp/index.stm and selecting the option for provider payment policies and relative weight tables.

To update your handbook, replace the previous versions of OAC rules 5101:3-2-21 and 5101:3-2-23 in the rules section of your handbook with the updated versions of OAC rules 5101:3-2-21 and 5101:3-2-23.

Questions pertaining to this HHTL should be addressed to:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Health Plan Policy
Financial Management and Hospital Benefit Section
30 East Broad Street, 27th floor
Columbus, OH 43215-3414
(614) 466-6420

HHTL 3352-03-2 (Hospital Medicaid Cost Reports)

Hospital Handbook Transmittal Letter (HHTL) 3352-03-2

May 14, 2003

TO: All Hospital Providers
Directors, County Departments of Job and Family Services
Directors, District Offices

FROM: Thomas J. Hayes, Director

SUBJECT: Hospital Medicaid Cost Reports

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding the rule pertaining to the State Fiscal Year (SFY) 2002 Medicaid Cost Report effective March 27, 2003. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

SFY 2002 Medicaid Cost Report

The attached OAC rule 5101:3-2-23 entitled "Cost Reports" was amended to replace the appendix with the State Fiscal Year 2002 cost report. Changes to the cost report and rule include, updating the cost report to reflect new hospital inpatient upper limit payment reporting category, and the requirement for hospitals to have an independent party, a certified public account, verify the data reported on Schedule E/F of the cost report - this requirement commences with the SFY 2003 Medicaid Cost report.

Department Web Page

The Ohio Department of Job and Family Services has a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is www.state.oh.us/odjfs/index.stm The web address for the Office of Ohio Health Plans front page is www.state.oh.us/odjfs/ohp/index.stm Information regarding payment policies may be accessed from the department's web page by going to www.state.oh.us/odjfs/ohp/bhpp/index.stm and selecting the option for provider payment policies and relative weight tables.

To update your handbook, replace OAC rule 5101:3-2-23 in the rules section of your handbook.

Questions pertaining to this HHTL should be addressed to:

Ohio Department of Job and Family Services
Office of Ohio Health Plans
Bureau of Health Plan Policy
Financial Management and Hospital Benefit Section
30 East Broad Street, 27th floor
Columbus, OH 43215
614-466-6420

HHTL 3352-03-1 (Revised List of Hospital Services that Require Pre-Certification)

Hospital Handbook Transmittal Letter (HHTL) 3352-03-1

April 4, 2003

TO: All Ohio Hospital Providers
Directors, County Departments of Job and Family Services
Directors, District Offices

FROM: Thomas J. Hayes

SUBJECT: Revised list of hospital services that require pre-certification

This Hospital Handbook Transmittal Letter (HHTL) is being sent to hospitals to notify them that the list of hospital services that require pre-certification is being revised and to provide hospitals with the revised list. The pre-certification program is part of the Ohio Medicaid Utilization Review Program for hospital services. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Effective June 1, 2003 the following procedures when performed electively will require pre-certification in an inpatient setting only:

- **Arthroplasty, arthrotomy or arthroscopy, temporomandibular joint**

  ICD9 codes 76.5, 80.29, and 80.19

  CPT codes 21010, 21050, 21060, 21070, 21240-21243, 29800, and 29804

- **Arthroscopy knee**

  ICD9 code 80.26

  CPT codes 29870, 29871, 29874-29877, and 29879 - 29889

- **Cervical laminectomy**

  ICD9 code 81.02-81.03

  CPT codes 22554, 22556, 22558, 22585, 22808, 22810, 22812, 22590, 22600, 22610, 22612, 22614, 22800, 22802, 22804, 22840, 22851, 63075, and 63076

- **Laparosocopic cholecystectomy**

  ICD9 codes 51.23, 51.24

  CPT codes 47562 - 47564

- **Laparoscopic-diagnostic**

  ICD9 code 54.21

  CPT codes 49320 - 49323, 49329

- **Lumbar laminectomy - posterior**

  ICD9 codes 80.51 and 81.08

  CPT codes 22600, 22610, 22612, 22614, 22630, 22632, 22800, 22802, 22804, 22842, 22843, 22844 and 22851

- **Percutaneous angioplasty-non coronary vessel**

  ICD9 code 39.50

  CPT codes 35470 - 35476

- **Peripheral vascular shunt or bypass**

ICD9 code 39.29

CPT codes 33619, 34520, 35516, 35518, 35521, 35533, 35551, 35556, 35558, 35566, 35571, 35583, 35585, 35587, 35616, 35621, 35623, 35650, 35654, 35656, 35661, 35666, and 35671

- **PTCA-coronary angioplasty**

  ICD9 code 36.01

  CPT codes 92982, 92984, 92995 and 92996

- **Shoulder arthroscopy**

  ICD9 code 80.21

  CPT codes 29826, 29805 and 29819

- **Total hip replacement**

  ICD9 code 81.51

  CPT codes 27130 and 27132

- **Total knee replacement**

  ICD9 code 81.54

  CPT codes 27437, 27438, 27445, 27446, and 27447

- **Transurethral resection of the prostate**

  ICD9 code 60.21 and 60.29

  CPT codes 52601, 52612, 52614, 52620, 52630, 52647 and 52648

The following procedure will continue to require pre-certification in both inpatient and outpatient settings:

- **Hysterectomy**

  ICD9 codes 68.3, 68.4, 68.51, 68.59

  CPT codes 51925, 58150, 58152, 58180, 58200, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58550, and 58951

By May 1, 2003, each hospital's utilization review contact, as designated by the hospital, will receive a memo from Permedion instructing them on how to access the revised edition of the "Ohio Medicaid Utilization Review Program, Pre-certification Program" manual. The manual will contain another copy of the new pre-certification list, an overview of the pre-certification program, coverage criteria, and instructions for obtaining a pre-certification number. Hospitals will be given instructions for how to access the manual on Permedion's web site: www.Permedion.com or how to request to have a paper copy mailed to them.

Please note that a copy of this transmittal letter (as well as electronic copies of hospital rules) are available on the web at: http://www.state.oh.us/odjfs/ohp/bhpp/handbook and then following the links Ohio Health Plans Provider Handbooks, Hospital Services.

For pre-certification call - 1-800-772-2179. For questions, please refer to Ohio Administrative Code 5101:3-2-40, call Permedion at 1- 800- 473-0802 ext. 3362, or contact the Department at:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Health Plan Policy

Financial Management and Hospital Benefit Section

30 East Broad Street, 27th floor

Columbus, OH 43215-3414

614-466-6420

HHTL 3352-02-7 (Hospital Provider Rules)

Hospital Handbook Transmittal Letter (HHTL) 3352-02-7

August 27, 2002

TO: All Ohio Hospital Providers
Directors, County Departments of Job and Family Services
Directors, District Offices

FROM: Thomas J. Hayes

SUBJECT: Hospital Provider Rules

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding hospital rules reviewed and amended in accordance with the Ohio Revised Code, which requires state agencies to review its rules a minimum of once every five years. All of the Ohio Administrative Code (OAC) rules described in this transmittal will become effective on August 1, 2002. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes. The following is a summary of changes made to each of the hospital provider rules. Please note that with the exception of OAC rule 5101:3-2-07.9 in which the outlier threshold was updated, most other changes were technical in nature and the amendments do not make substantial changes.

Hospital Rules

Rule 5101:3-2-01 entitled "Eligible providers" describes the requirements for participation as a hospital provider for the Medicaid program. It was amended to clarify bed size relative to allowable participation for psychiatric providers.

Rule 5101:3-2-02 entitled "General Provisions: hospital services" describes general provisions related to hospital services provided to Medicaid consumers. The rule has been clarified to update Ohio Administrative Code references, add a definition of a Level II nursery, and update revenue center codes to those currently in use by Ohio Uniform Billing.

Rule 5101:3-2-03 entitled "Conditions and limitations" describes the conditions and limitations applicable to inpatient and outpatient hospital services rendered to Medicaid consumers. This rule was amended to update Federal Regulation and Ohio Administrative Code citations, and clarify policy related to conditions and limitations of hospital services rendered to Medicaid consumers.

Rule 5101:3-2-04 entitled "Coverage of hospital provided pharmaceutical, dental, vision care, medical supply and equipment, and ambulance or ambulette services" describes coverage of hospital provided pharmaceutical, dental, vision care, medical supply and equipment, and ambulance or ambulette services. This rule was amended to update a reference to the department.

Rule 5101:3-2-07.11 entitled "Payment methodology" specifies the payment method for hospitals. The changes update the references to the Ohio Administrative Code.

Rule 5101:3-2-07.12 entitled "Appeals and reconsideration of departmental determinations regarding hospital inpatient and outpatient services" explains the rights hospitals have and the procedures hospitals may take to appeal a determination regarding hospital inpatient and outpatient services. The changes made to this rule update the references to the Ohio Administrative Code and make other technical corrections.

Rule 5101:3-2-07.13 entitled "Utilization control" specifies the work done to monitor and enforce compliance with Medicaid hospital policy. The changes made to this rule update references to the Ohio Administrative Code and make other technical corrections.

Rule 5101:3-2-07.1 entitled "Hospitals subject to and excluded from DRG prospective payments" specifies the hospital services subject to and excluded from DRG prospective payment. The changes update references to the Ohio Administrative Code, update names of organizations, and clarify prior authorization requirements for transplants.

Rule 5101:3-2-07.2 entitled "Classification of hospitals" describes how hospitals are classified into mutually exclusive peer groups for purposes of setting rates and making payments under the DRG prospective payment system. The changes update references to the Ohio Administrative Code and other legal documents, and make other technical corrections.

Rule 5101:3-2-07.7 entitled "Medical education" describes payment policies related to medical education for hospital providers. The proposed rule has been modified to update references to Ohio Administrative Code rules.

Rule 5101:3-2-07.8 entitled "Redetermination of prospective payment rates" describes how prospective payment rates may change. The changes to this rule update references to the Ohio Administrative Code and make other technical corrections.

Rule 5101:3-2-07.9 entitled "Payment for outliers" describes the payment policies for inpatient cost and day outlier claims. This rule was amended to update references to Ohio Administrative Code rules and to reflect updates made to Ohio Administrative Code rule 5101:3-2-07.3. The rule also allows for an annual update to the cost threshold and charge trims used to determine if a claim qualifies for an outlier payment. This amendment updates the threshold amount of $250,000 to a threshold amount of $443,463. For cases in which costs exceed this threshold, reimbursement is made on a reasonable cost basis. While this is not a change in methodology, this amendment updates the threshold amount and clarifies that this threshold will be updated on an annual basis by an inflation factor.

Rule 5101:3-2-25 entitled "Third-party liability" identifies other requirements regarding third- party liability applicable to services provided by hospitals in addition to those set forth in Rule 5101:3-1-08 of the Administrative Code. The changes update references to the Ohio Administrative Code and other legal documents.

Department Web Page

The Ohio Department of Job and Family Services maintains a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is www.state.oh.us/odjfs/index.stm The web address for the Office of Ohio Health Plans front page is www.state.oh.us/odjfs/ohp/index.stm Relative weight tables and information regarding payment policies may be accessed from the department's web page by going to * http://www.state.oh.us/odjfs/ohp/bhpp/hbfm.stm and selecting the option for provider payment policies and relative weight tables. Information regarding the HCAP program may be accessed at www.state.oh.us/odjfs/ohp/bhpp/hcap.stm.

To update your handbook, replace OAC rules 5101:3-2-01, 5101:3-2-02, 5101:3-2-03, 5101:3-2-04, 5101:3-2-07.11, 5101:3-2-07.12, 5101:3-2-07.13, 5101:3-2-07.1, 5101:3-2-07.2, 5101:3-2-07.7, 5101:3-2-07.8, 5101:3-2-07.9, and 5101:3-2-25 in the rules section of your handbook.

Questions pertaining to this HHTL should be addressed to:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Health Plan Policy

Financial Management and Hospital Benefit Section

30 East Broad Street, 27th floor

Columbus, OH 43215-3414

614-466-6420

**The hardcopy erroneously states the URL as: www.state.oh.us/odjfs/ohp/bhpp.index.stm. The electronic copy has been updated to reflect the correct URL.*

HHTL 3352-02-6 (HCAP Rules)

Hospital Handbook Transmittal Letter (HHTL) 3352-02-6

August 27, 2002

TO: All Ohio Hospital Providers
Directors, County Departments of Job and Family Services
Directors, District Offices

FROM: Thomas J. Hayes

SUBJECT: Hospital Care Assurance Program (HCAP) Rules

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding the rules pertaining to the Hospital Care Assurance Program (HCAP). As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Hospital Care Assurance Program Rules

OAC rule 5101:3-2-08 entitled "Assessment policies for disproportionate share and indigent care adjustments for hospital services" establishes the assessment rate at which hospitals pay the state monies which are used to draw down federal matching funds to be used in the 2002 HCAP program year. This rule was filed on an emergency basis this year in order to allow for a cost report filing extension, and was effective July 1, 2002. Changes were made to this rule to revise the assessment rate to fund HCAP, to provide for an extension deadline for finalization of HCAP distribution data, and to make other technical changes. You will receive a copy of the permanent version of OAC rule 5101:3-2-08 in a separate HHTL to be published at a later date.

OAC rule 5101:3-2-09 entitled "Payment policies for disproportionate share and indigent care adjustments for hospital services" sets forth the conditions, requirements, and operation of the HCAP program as well as the distribution formula. The permanent version of this rule was effective July 22, 2002. This rule provides a revised distribution to reflect more current hospital data, and includes additional funding provided by the Benefits Improvement and Protection Act of 2000 in the distribution model.

Department Web Page

The Ohio Department of Job and Family Services maintains a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is www.state.oh.us/odjfs/index.stm The web address for the Office of Ohio Health Plans front page is www.state.oh.us/odjfs/ohp/index.stm Relative weight tables and information regarding payment policies may be accessed from the department's web page by going to * http://www.state.oh.us/odjfs/ohp/bhpp/hbfm.stm and selecting the option for provider payment policies and relative weight tables. Information regarding the HCAP program may be accessed at www.state.oh.us/odjfs/ohp/bhpp/hcap.stm.

To update your handbook, replace OAC rules 5101:3-2-08 and 5101:3-2-09 in the rules section of your handbook.

Questions pertaining to this HHTL should be addressed to:

Ohio Department of Job and Family Services
Office of Ohio Health Plans
Bureau of Health Plan Policy
Financial Management and Hospital Benefit Section
30 East Broad Street, 27th floor
Columbus, OH 43215-3414
614-466-6420

The hardcopy erroneously states the URL as: www.state.oh.us/odjfs/ohp/bhpp.index.stm. The electronic copy has been updated to reflect the correct URL.

HHTL 3352-02-5 (IMD DSH Rule)

Hospital Handbook Transmittal Letter (HHTL) 3352-02-5

August 27, 2002

TO: All Ohio Psychiatric Hospital Providers
Directors, County Departments of Job and Family Services
Directors, District Offices

FROM: Thomas J. Hayes

SUBJECT: Institutions for Mental Diseases Disproportionate Share Hospital (IMD DSH) Rule

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to the rule regarding the IMD DSH program. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

IMD DSH rule

OAC rule 5101:3-2-10 entitled "Payment policies for disproportionate share and indigent care adjustments for psychiatric hospitals" sets forth the conditions, requirements, and operation of the IMD DSH program, as well as the distribution formula. This rule was amended to update references and make other technical changes. The rule was effective on July 22, 2002.

To update your handbook, update OAC rule 5101:3-2-10 in the rules section of your handbook.

Questions pertaining to this HHTL should be addressed to:

Ohio Department of Job and Family Services
Office of Ohio Health Plans
Bureau of Health Plan Policy
Financial Management and Hospital Benefit Section
30 East Broad Street, 27th floor
Columbus, OH 43215-3414
614-466-6420

HHTL 3352-02-4 (Medicaid Eligibility Verification for the Medicare DSH Formula)

Hospital Handbook Transmittal Letter (HHTL) 3352-02-4

March 29, 2002

TO: All Ohio Hospital Providers

Directors, County Departments of Job and Family Services

Directors, District Offices

FROM: Thomas J. Hayes

SUBJECT: Medicaid Eligibility Verification for the Medicare Disproportionate Share (DSH) Formula

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding the verification of Ohio Medicaid eligibility information for Medicare Disproportionate Share (DSH) purposes. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by this information.

As a result of the HCFA 97-2 ruling in 1997, Ohio hospitals may be eligible to recover Federal dollars under the Medicare disproportionate share (DSH) methodology. This ruling allows hospitals to use Medicaid eligible days for the Medicare DSH formula, and requires that hospitals confirm the number of Medicaid eligible days with their respective state agencies. Several hospitals have contacted the Ohio Department of Job and Family Services asking how they could retrieve historical information. The department provides this information through Eligibility Verification System (EVS) vendors, which is the current process used by hospitals to verify Medicaid eligibility.

The EVS vendors will have the opportunity to access historical tapes of Medicaid's Recipient Master File (RMF). Hospitals should contact an EVS vendor directly to make arrangements for comparing patient records to the RMF tapes. The EVS vendors sign confidentiality agreements with the Ohio Department of Job and Family Services (ODJFS), so the vendors will only be able to provide limited information back to the hospital, namely the number of Medicaid eligible days. Your technical questions should be directed to the EVS vendors.

The following is a list of EVS vendors that currently have contracts with ODJFS:

WebMD dba Envoy Corporation

27110 Jones Loop Road, #160

Punta Gorda, FL 33982

Healthcare Data Exchange

467 Creamery Way

Exton, PA 19341

Medifax EDI, Inc.

1283 Murfreesboro Road, Bldg. II

Nashville, TN 37229-0037

National Data Corporation

NDC Plaza

5th Floor

Atlanta, GA 30329

Questions pertaining to this HHTL should be addressed to:

Ohio Department of Job and Family Services
Office of Ohio Health Plans
Bureau of Health Plan Policy
Financial Management and Hospital Benefit Section
30 East Broad Street, 27th floor
Columbus, OH 43266-0423
614-466-6420

HHTL 3352-02-3 (Outpatient Hospital Rule)

Hospital Handbook Transmittal Letter (HHTL) 3352-02-3

March 25, 2002

TO: All Hospital Providers
Directors, County Departments of Job and Family Services
Directors, District Offices

FROM: Thomas J. Hayes

SUBJECT: Outpatient Hospital Rule

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding the rule pertaining to outpatient hospital services. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by this rule.

Outpatient Hospital Rule

The attached rule entitled "Policies for outpatient hospital services," OAC rule 5101:3-2-21, will become effective on a permanent basis on March 24, 2002. This rule incorporates the 2001 CPT codes effective for services rendered on or after January 1, 2002. To give the providers ample time to make the transition to the 2001 CPT codes, the department will continue to accept the 2001 CPT codes for services rendered through March 31, 2001. Providers may choose to bill either the 2001 codes or the 2002 codes during the transition period from January 1, 2001 to March 31, 2001. Providers may not use both the 2001 and the 2002 codes during the transition period. Beginning April 1, 2002, the 2001 codes will no longer be accepted for services provided on or after that date.

In addition to minor technical changes, the outpatient rule also includes changes in payments for outpatient dialysis services. Outpatient dialysis will be paid according to the rates specified in the ancillary fee schedule. The outpatient laboratory fee schedule can be found in Appendix DD of OAC rule 5101:3-1-60 (which is also attached). This laboratory fee schedule includes the 2002 CPT codes effective on January 1, 2002. Medicaid provider handbooks with both OAC rules 5101:3-1-60 and 5101:3-2-21 can be found on our web site at http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid.

Department Web Page

The Ohio Department of Job and Family Services has a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is http://www.state.oh.us/odjfs The web address for the Office of Ohio Health Plans front page is http://www.state.oh.us/odjfs/ohp

Relative weight tables and information regarding payment policies may be accessed from the department's web page by going to http://www.state.oh.us/odjfs/ohp/bhpp/hbfm.stm and selecting the option for provider payment policies and relative weight tables.

To update your handbook, replace the previous version of OAC rule 5101:3-2-21 in the rules section of your handbook with this updated version of OAC rule 5101:3-2-21.

Questions pertaining to this HHTL should be addressed to:

Ohio Department of Job and Family Services
Office of Ohio Health Plans
Bureau of Health Plan Policy
Hospital Benefit Section
30 East Broad Street, 27th floor
Columbus, OH 43215-3414
(614) 466-6420

HHTL 3352-02-2 (Policies for Outpatient Hospital Services)

Hospital Handbook Transmittal Letter (HHTL) 3352-02-2

February 5, 2002

TO: All Hospital Providers

Directors, County Departments of Job and Family Services

Directors, District Offices

FROM: Thomas J. Hayes

SUBJECT: Policies for Outpatient Hospital Services

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding the outpatient hospital rule. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by this rule.

Emergency Rule

From December 31, 2001 to March 31, 2002, Ohio Administrative Code (OAC) rule 5101:3-2-21 titled "Policies for outpatient hospital services" will be effective on an emergency basis. This rule was amended to reflect additions, deletions, and revisions to procedure codes as published in the American Medical Association's "Current Procedural Terminology (CPT), Fourth Edition, 2002."

In addition to minor changes made to the body of the rule, the existing versions of Appendix C, Appendix F, and Appendix G were rescinded and replaced with new versions to reflect the 2002 CPT updates. The emergency version of Rule 5101:3-2-21 can be accessed on our web site at http://www.state.oh.us/odjfs/ols/pubhearings/#legal. Hard copies will be made available upon special request.

Permanent Rule

Beginning April 1, 2002, Rule 5101:3-2-21 will be effective on a permanent basis. In addition to the revisions made as a result of the CPT 2002 updates in the emergency rule, the permanent version of the rule will include updates to the outpatient dialysis payment rates, as well as other technical corrections. You will receive another HHTL with the permanent version of the outpatient rule to be effective April 1, 2002. Please use the link above to access the emergency version of OAC rule 5101:3-2-21 until the permanent version of this rule is effective.

Questions pertaining to this HHTL should be addressed to:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Health Plan Policy

Financial Management and Hospital Benefit Section

30 East Broad Street, 27th floor

Columbus, OH 43266-0423

614-466-6420

HHTL 3352-02-1 (Inpatient Hospital Payment, and Relative Weights)

Hospital Handbook Transmittal Letter (HHTL) 3352-02-1

January 22, 2002

TO: All Hospital Providers

Directors, County Departments of Job and Family Services

Directors, District Offices

FROM: Thomas J. Hayes

SUBJECT: Inpatient hospital payment, and Relative Weights

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding the rule pertaining to inpatient hospital payments, and the Grouper 15 relative weight table effective January 1, 2002. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Inpatient Hospital Payments

The attached rule entitled "Basic methodology for determining prospective payment rates," Ohio Administrative Code (OAC) rule 5101:3-2-07.4, will become effective on January 1, 2002. This rule was amended to reflect a 2.2 percent increase to inpatient hospital payments effective January 1, 2002. A separate letter has been sent to all hospitals with the hospital specific rates effective on January 1, 2002.

Grouper 15 Relative Weights

The relative weights for Grouper 15 were implemented on November 7, 2000.

The charge high trim points have been inflated by 3.2 % effective January 1, 2002. A new relative weight table that includes the new charge high trim points is included in this transmittal and is available on the department's web-site at http://www.state.oh.us/odjfs/ohp/bhpp/hosppol1.stm *(The hardcopy erroneously cites this URL as: www.state.oh.us/odjfs/ohp/bhpp.index.stm)*

Department Web Page

The Ohio Department of Job and Family Services has a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is www.state.oh.us/odjfs/index.stm. The web address for the Office of Ohio Health Plans front page is www.state.oh.us/odjfs/ohp/index.stm. Relative weight tables and information regarding payment policies may be accessed from the department's web page by going to http://www.state.oh.us/odjfs/ohp/bhpp/hbfm.stm *(The hardcopy erroneously cites this URL as: www.state.oh.us/odjfs/ohp/bhpp.index.stm)* and selecting the option for provider payment policies and relative weight tables.

To update your handbook, replace OAC rule 5101:3-2-074 in the rules section of your handbook and add the relative weight table for discharges on or after January 1, 2002.

Questions pertaining to this HHTL should be addressed to:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Health Plan Policy

Financial Management and Hospital Benefit Section

30 East Broad Street, 27th floor

Columbus, OH 43266-0423

614-466-6420

HHTL 3352-01-4 (Supplemental Upper Limit Payment for Public Hospital Rule)

Hospital Handbook Transmittal Letter (HHTL) 3352-01-4

December 13, 2001

TO: All Ohio Public Hospital Providers
Directors, County Departments of Job and Family Services
Directors, District Offices

FROM: Thomas J. Hayes

SUBJECT: Supplemental Upper Limit Payment for Public Hospital Rule

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding the rule pertaining to the supplemental upper limit payment program for public hospitals. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by this new program.

Rule 5101:3-2-50 titled "Supplemental inpatient hospital upper limit payments for public hospitals" provides access to available funding up to 100 percent of the Medicare upper payment limit for inpatient hospital services rendered by Ohio public hospitals to Ohio Medicaid consumers. For purposes of this rule, Ohio public hospitals are defined as those hospitals that are owned or operated by a governmental entity other than the state. For each Ohio public hospital the Department estimates what Medicare would pay for the inpatient hospital services received by Medicaid patients in the relevant reporting period, and calculates the difference between what the Department paid the public hospital and what it is estimated that Medicare would have paid those public hospitals for caring for Medicaid consumers. This payment differential is called the available inpatient hospital payment gap.

Methodology as described in Rule 5101:3-2-50:

- The calculation of the available inpatient payment gap is based on Medicare and Medicaid cost-reporting data which reflects a completed interim settled state fiscal year cost report for all Ohio public hospitals and is available prior to the inpatient gap payment effective date.
- The available inpatient payment gap is used to calculate the available per discharge supplemental inpatient hospital payment amount by dividing the available inpatient payment gap by the number of Medicaid discharges reported on the Ohio public hospital's Medicaid cost report.
- Ohio public hospitals are eligible for supplemental upper limit payments twice a year. Payments are based on actual Ohio Medicaid discharge experience during a current six month time period multiplied by the available per discharge supplemental inpatient hospital payment amount.
- Public hospitals will be notified of the maximum supplemental upper payment limit available to them. Public hospitals will have fourteen days after the date of this notice to notify the Department of their intent to participate, and within thirty days must provide the state share in the form of an intergovernmental transfer (via electronic funds transfer), up to but not to exceed the maximum amount available. Failure to meet this deadline will preclude the hospital from receiving a supplemental payment for the six month time period.

Please note the following additional limitations of the supplemental upper limit payment program described in Rule 5101:3-2-50, and as required by federal regulations:

- If the total funds that will be paid to public hospitals in a program year exceeds the aggregate upper payment limit for all public hospitals, then the Department will limit each hospital's payment to their proportion of the aggregate upper payment limit for all public hospitals.
- Ohio public hospitals that are cost reimbursed by Medicaid and Medicare are assumed to have a zero payment gap because Medicare would have paid them their costs and therefore there is no payment gap, and no supplemental upper limit payment can be made.

- The total supplemental upper limit payment paid to each public hospital electing to participate will be included in the calculation of each hospital's disproportionate share limit as a Medicaid program payment.

OAC rule 5101:3-2-50 should be added to update your handbook.

Questions pertaining to this HHTL should be addressed to:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Health Plan Policy

Financial Management and Hospital Benefit Section

30 East Broad Street, 27th floor

Columbus, OH 43266-0423

614-466-6420

HHTL 3352-01-3 (HCAP Rules, IMD DSH Rules, and Changes to the Precertification List)

Hospital Handbook Transmittal Letter (HHTL) 3352-01-3

November 1, 2001

TO: All Ohio Hospital Providers

Directors, County Departments of Job and Family Services

Directors, District Offices

FROM: Thomas J. Hayes

SUBJECT: Hospital Care Assurance Program (HCAP) Rules, Institutions for Mental Diseases Disproportionate Share Hospital (IMD DSH) Rules, and changes to the Precertification List

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding the rules pertaining to the Hospital Care Assurance Program (HCAP), the rules regarding the IMD DSH program, a copy of the final summary report on the prospective reviews of the 2001 Hospital Care Assurance Program, and a revised precertification list. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Hospital Care Assurance Program Rules

Ohio Administrative Code (OAC) rule 5101:3-2-07.5 entitled "Disproportionate share adjustment" describes the criteria used for determining which Ohio hospitals qualify as disproportionate share hospitals and which hospitals qualify for special outlier payment policies. The permanent version of this rule became effective on August 3, 2001. This rule has been changed to add the managed care shortfall into the calculation of the disproportionate share limit and to make technical corrections including removing the separate calculation for outpatient radiology as these services are now included with all the other outpatient services in the cost report.

OAC rule 5101:3-2-08 entitled "Assessment policies for disproportionate share and indigent care adjustments for hospital services" establishes the assessment rate at which hospitals pay the state monies which are used to draw down federal matching funds to be used in the 2001 HCAP program year. The permanent version of this rule became effective on August 3, 2001. Changes were made to this rule to revise the assessment rate to fund HCAP, to update the hospital cost reporting period used in the calculations, and to make technical corrections.

OAC rule 5101:3-2-09 entitled "Payment policies for disproportionate share and indigent care adjustments for hospital services" sets forth the conditions, requirements, and operation of the HCAP program as well as the distribution formula. The permanent version of this rule became effective August 3, 2001. This rule provides a revised distribution to reflect more current hospital data, includes additional funding provided by the Benefits Improvement and Protection Act of 2000 in the distribution model, modifies the calculation of Medicaid shortfall, and modifies the distribution pools to improve the ability of funding to follow indigent patients. Changes also allow for partial payments to a hospital that closes during a program year and provide for a redistribution of the remainder of that closed hospital's full year payment within the community in the year the closing occurs and in the following year. In addition, the formulas for three of the five existing distribution pools have been amended further and two new distribution pools, the Rural and Critical Access Payment Pool and the County Redistribution of Closed Hospitals Payment Pool, have been created. The new HCAP distribution is based on seven distribution pools.

Prospective review of the 2001 Hospital Care Assurance Program

In a continued effort to improve the data used for HCAP, the department selected twenty hospitals for data reviews this year. Thirty additional hospitals were selected for a cost report data verification process. Enclosed in this HHTL is a copy of the final summary report of the review findings. Please review this information to ensure that your hospital is in compliance with the operational and reporting requirements for HCAP. The department required that all deficiencies identified be corrected; all required corrections to the

data reported on Schedule F of the cost report were made prior to the implementation of the 2001 HCAP program. The most significant problems found in the 2001 HCAP data reviews were the inability of many hospitals to produce accurate logs of accounts to substantiate reporting on Schedule F, inclusion of charges for Medicaid consumers, and inadequate or missing documentation. A sample HCAP application, a sample log, and an HCAP checklist are included in the summary report for your reference.

IMD DSH rule

OAC rule 5101:3-2-10 entitled "Payment policies for disproportionate share and indigent care adjustments for psychiatric hospitals" sets forth the conditions, requirements, and operation of the IMD DSH program, as well as the distribution formula. This rule was amended to update fiscal year references and will become effective on September 27, 2001.

Cost Report Filing Information

A revised filing schedule for filing dates of the Medicare Cost Report has been issued by the Centers for Medicare and Medicaid Services. Unfortunately these dates are past the dates needed by the Ohio Department of Job and Family Services (ODJFS) to compile data for the FFY 2002 Hospital Care Assurance Program (HCAP). As a result, it is necessary to modify the normal cost report submission process and implement the following requirements:

**** The completed Ohio Medicaid Cost Report is required to be filed and postmarked on/or before December 31, 2001.**	
**** Medicare Worksheet S-3**	**Medicare Worksheet B Parts I thru III**
Medicare Worksheet A	**Medicare Worksheet C**
Medicare Worksheet A-7	**Medicare Worksheet D-1 parts I thru IV (XVIII Hosp PPS)**
Medicare Worksheet A-8	**Medicare Worksheet D-2**
Medicare Worksheet A-8-2	
are required to be filed with the Medicaid Cost Report.	
**** No filing extensions will be granted and the $100.00 per day penalty will be enforced for each day postmarked after 12/31/01.**	
**** There will continue to be a 30 day review period after your receipt of the interim settled cost report for corrections.**	
**** A completed, signed Medicare Cost Report is required to be filed with ODJFS when filed with Medicare.**	

Although this is an inconvenience for your staff as well as ours, these modifications are required in order to comply with federal requirements of current data being used for the next HCAP model. If you have any questions regarding cost report filing, please telephone Kurt Brooks at (614) 644-2190.

Precertification List

ODJFS and Permedion have reviewed data analysis on monthly volumes for both retrospective and precertification claims for the last 12 months. This data analysis demonstrates that **effective November 1, 2001 the following procedures will be deleted from the Ohio Medicaid precertification list:**

- **Carpal Tunnel Release**

  ICD9 Code 04.43

  CPT codes 29848, 64721, 64727

- **Cholecystectomy**

  ICD9 Codes 51.22, 51.41, 51.42, 51.51

  CPT codes 47260, 47600, 47605, 47610, 47612, 47620, 47700

- **Coronary Artery Bypass**

  ICD9 codes 36.10-36.17, 36.19

- **Orthopedic**

  ICD9 Codes 77.37, 78.07, 78.28, 78.38, 79.37, 81.11, 81.45, 81.83, 83.13

  CPT codes 24310, 25290, 27006, 27306, 27307, 27390-27392, 27405, 27407, 27409, 27637, 27638, 27709, 27722, 27724, 28010, 28011, 28230, 28232, 28234, 28306-28308, 28465, 28485, 28705, 29826

- **Tonsillectomy and Adenoidectomy**

  ICD9 codes 28.2, 28.3, 28.6

Effective November 1, 2001, the following procedures will continue to require precertification:

- **Arthroscopy knee**

  ICD9 Code 80.26

  CPT codes 29870, 29871, 29874-29877, 29879 - 29889

- **Hysterectomy**

  ICD9 Codes 68.3, 68.4, 68.51, 68.59

  CPT codes 51925, 58150, 58152, 58180, 58200, 58550, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58951

- **Laparosocopic cholecystectomy**

  ICD9 Codes 51.23, 51.24

  CPT codes 47562 - 47564

- **Laparoscopic-Diagnostic**

  ICD9 Code 54.21

  CPT codes 49320 - 49323, 49329

Department Web Page

The Ohio Department of Job and Family Services maintains a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is www.state.oh.us/odjfs/index.stm. The web address for the Office of Ohio Health Plans front page is www.state.oh.us/odjfs/ohp/index.stm. Relative weight tables and information regarding payment policies may be accessed from the department's web page by going to www.state.oh.us/odjfs/ohp/bhpp/hosppol1.stm and selecting the option for provider payment policies and relative weight tables. Information regarding the HCAP program may be accessed at www.state.oh.us/odjfs/ohp/bhpp/hcap.stm.

To update your handbook, replace OAC rules 5101:3-2-07.5, 5101:3-2-08, 5101:3-2-09 and 5101:3-2-10 in the rules section of your handbook and update your list of procedures requiring precertification.

Questions pertaining to this HHTL should be addressed to:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Health Plan Policy

Financial Management and Hospital Benefit Section
30 East Broad Street, 27th floor
Columbus, OH 43266-0423
614-466-6420

HHTL 3352-01-2 (Cost Report Rule and Federal Poverty Guidelines)

Hospital Handbook Transmittal Letter (HHTL) 3352-01-2

Attachment: Flyer publicizing the dates and locations of the forums

April 9, 2001

TO: All Hospital Providers
Directors, County Departments of Job and Family Services
Directors, District Offices

FROM: Jo Ann Davidson

SUBJECT: Cost Report Rule and Federal Poverty Guidelines

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding the amended rule pertaining to the State Fiscal Year 2001 cost report and the federal poverty guidelines effective February 16, 2001. As only one copy of this transmittal is sent to each hospital, please ensure that copies are forwarded to all hospital personnel affected by these changes.

Amended cost report rule

The attached Ohio Administrative Code (OAC) rule 5101:3-2-23 has been proposed for amendment for an effective date of May 17, 2001. OAC rule 5101:3-2-23 entitled "Cost Reports" was amended to replace the appendix with the State Fiscal Year 2001 cost report. Changes to the rule for the State Fiscal Year 2001 cost report include the elimination of the requirement to file audited financial statements with the cost report, changing the threshold for cost report filing for out-of-state providers to outpatient billings of three hundred thousand dollars, reporting of non-DRG transplant services on schedule D of the cost report, and the elimination of schedule D-2 of the cost report. If changes are made to the rule, the final rule will be distributed once it becomes available.

Federal Poverty Guidelines

The U.S. Department of Health and Human Services released the 2001 federal poverty guidelines on February 16, 2001. The full text of the federal poverty guidelines may be obtained in Volume 66, Number 33, February 16, 2001, pages 10695-10697 of the federal register. The federal poverty guidelines for current and previous years may also be obtained at the U.S. Department of Health and Human Services web site at http://aspe.hhs.gov/poverty/poverty.htm Please use these new guidelines for eligibility determinations for the Hospital Care Assurance Program (HCAP), as specified in OAC rule 5101:3-2-0717.

Size of family unit	Poverty Guideline
1	$8,590
2	$11,610
3	$14,630
4	$17,650
5	$20,670
6	$23,690
7	$26,710
8	$29,730

For additional family members add	$3,020

Please be certain when you print your billing statements with the required notice regarding the HCAP program, that you reference the notice on the front of the billing statement, as now required by paragraph (C)(3) of OAC rule 5101:3-2-07.17.

2001 HCAP Public Forums

The Department of Job and Family Services is hosting a series of public forums regarding the 2001 HCAP distribution formula, prior to filing the Ohio Administrative Code rule. The Department will begin each forum with a brief presentation of a proposed distribution model. Following the brief presentation, the Department will accept oral and written comments. The Department will then propose the rule in mid-April. A flyer publicizing the dates and locations of the forums is attached to this transmittal.

Electronic Claim Submission

Providers submitting claims electronically must ensure they are prepared for upcoming changes in the way in which electronic claims will be accepted by the department. Submission of claims using flat file version 6 or a non-HIPPA compliant version of ANSI 837 will be mandatory in April of 2001. Once HIPPA is fully implemented, claims will only be accepted in the ANSI 4010 X12N format. Providers using vendors to submit claims electronically should contact the vendors to ensure they will be ready for these changes.

Department Web Page

The Ohio Department of Job and Family Services has a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is www.state.oh.us/odjfs/index.stm. The web address for the Office of Ohio Health Plans front page is www.state.oh.us/odjfs/ohp/index.stm. Relative weight tables and information regarding payment policies may be accessed from the department's web page by going to www.state.oh.us/odjfs/ohp/bhpp/index.stm and selecting the option for provider payment policies and relative weight tables. Information regarding the HCAP program may be accessed at www.state.oh.us/odjfs/ohp/bhpp/hcap.stm. Weekly Remittance Advice Notices can be viewed on the Provider Network Management Section page by selecting the remittance advice notices option at www.state.oh.us/odjfs/ohp/bpo/provrel.stm.

To update your handbook, replace OAC rule 5101:3-2-23 in the rules section of your handbook.

Questions pertaining to this HHTL should be addressed to:

The Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Health Plan Policy

Financial Management and Hospital Benefit Section

30 East Broad Street, 27th floor

Columbus, OH 43266-0423

614-466-6420

Miscellaneous Medicaid Handbook Transmittal Letters (MHTLs)

MHTL 3334-09-02(Discontinuing the Disability Medical Assistance (DMA) Program and the Rescission of Ohio Administrative Code (OAC) Rule 5101:3-23-01)

Medicaid Handbook Transmittal Letter (MHTL) No. 3334-09-02 is maintained in the General Information e-book.

Hospital Services Ohio Administrative Code

5160-2-01 Eligible Providers

HHTL 3352-15-04

Effective Date: April 30, 2015

***Most Current Prior Effective Date:* October 16, 2006**

(A) ~~To participate in the medicaid program, a hospital must have a valid, current provider agreement. A "provider agreement" is a contractual agreement whereby the provider agrees to adhere to conditions of participation with the Ohio department of job and family services as described in rule 5101:3-1-17.2 of the Administrative Code~~.

All hospitals, except those excluded in paragraphs (A)(1) and (A)(2) of this rule, that meet medicare (Title XVIII) conditions of participation as described in 42 C.F.R 482 effective as of October 1, 2013, are eligible to participate in the Ohio medicaid (Title XIX) program upon execution of a provider agreement. Also considered to be eligible is a hospital that is currently determined to meet the requirements for Title XVIII participation and has in effect a hospital utilization review plan applicable to all patients who receive medical assistance under Title XIX. The following hospitals are excluded from participation:

(1) Tuberculosis facilities, and

(2) Facilities that have fifty per cent or more of their beds registered pursuant to Chapter 3701-59 of the Administrative Code as alcohol and/or drug abuse rehabilitation beds, and have no beds licensed as psychiatric beds pursuant to Chapter 5122-14 of the Administrative Code.

(B) The following facilities with more than sixteen beds shall be eligible to participate in Title XIX only for the provision of inpatient psychiatric services to recipients age sixty-five or older in accordance with paragraph (C) of this rule and to recipients under age twenty-one in accordance with paragraph (D) of this rule:

(1) A hospital with fifty per cent or more of its beds registered as alcohol and/or drug abuse rehabilitation beds that also has beds licensed as psychiatric beds pursuant to Chapter 5122-14 of the Administrative Code;

(2) Hospitals that have at least half of their beds licensed as psychiatric beds pursuant to Chapter 5122-14 of the Administrative Code or operated under the authority of the state mental health authority in accordance with section 5119.01 of the Revised Code; and

(3) Hospitals that have half or more of their discharges in any six-month time period reviewed by the ~~Ohio department of job and family services~~ the department and determined to be for psychiatric and/or substance abuse treatment.

(C) Hospitals that are eligible to participate only for the provision of inpatient psychiatric services in accordance with paragraph (B) of this rule and are rendering inpatient psychiatric services to recipients age sixty-five or older must be licensed by the ~~Ohio department of mental health~~ Ohio department of mental health and addiction services in accordance with Chapter 5122-14 of the Administrative Code or operated under the authority of the state mental health authority in accordance with section 5119.01 of the Revised Code, and must provide services in accordance with Chapter 5122-14 of the Administrative Code. Hospitals shall operate pursuant to the provisions of 42 C.F.R. 441 subpart C effective as of October 1, 2013.

(D) Hospitals that are eligible to participate only for the provision of inpatient psychiatric services in accordance with paragraph (B) of this rule and are rendering inpatient psychiatric services for recipients under age twenty-one must:

(1) Provide services under the direction of a physician;

(2) Operate pursuant to the provisions of 42 C.F.R. 441 subpart D effective as of October 1, 2013;

(3) Be a psychiatric hospital or an inpatient program in a psychiatric hospital, either of which is accredited by the "Joint Commission on Accreditation of Hospitals," and must be licensed by the

~~Ohio department of mental health~~Ohio department of mental health and addiction services in accordance with Chapter 5122-14 of the Administrative Code or operated under the authority of the state mental health authority in accordance with section 5119.01 of the Revised Code, and must provide services in accordance with Chapter 5122-14 of the Administrative Code; and

(4) Provide services before the recipient reaches age twenty-one or, if the recipient was receiving services immediately before ~~he/she~~ he or she reached age twenty-one, before the earlier of the following:

(a) The date ~~he/she~~he or she no longer requires the services; or

(b) The date ~~he/she~~he or she reaches age twenty-two.

(E) The following facilities with sixteen or fewer beds shall be eligible to participate in Title XIX only for the provision of inpatient psychiatric services to recipients in accordance with paragraph (F) of this rule:

(1) A hospital with fifty per cent or more of its beds registered as alcohol and/or drug abuse rehabilitation beds that also has beds licensed as psychiatric beds pursuant to Chapter 5122-14 of the Administrative Code;

(2) Hospitals that have at least half of their beds licensed as psychiatric beds pursuant to Chapter 5122-14 of the Administrative Code or operated under the authority of the state mental health authority in accordance with section 5119.01 of the Revised Code; and

(3) Hospitals that have half or more of their discharges in any six-month time period reviewed by the ~~Ohio department of job and family services~~ the department and determined to be for psychiatric and/or substance abuse treatment.

(F) Hospitals that are eligible to participate only for the provision of inpatient psychiatric services in accordance with paragraph (E) of this rule and are rendering inpatient psychiatric services to recipients must be licensed by the ~~Ohio department of mental health~~Ohio department of mental health and addiction services in accordance with Chapter 5122-14 of the Administrative Code or operated under the authority of the state mental health authority in accordance with section 5119.01 of the Revised Code, and must provide services in accordance with Chapter 5122-14 of the Administrative Code. Hospitals shall operate pursuant to the provisions of 42 C.F.R. 482 subpart E effective as of October 1, 2013.

Effective: 04/30/2015

Five Year Review (FYR) Dates: 01/14/2015 and 04/30/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 04/15/2015

Promulgated Under: 119.03

Statutory Authority: 5164.02

Rule Amplifies: 5162.03, 5164.02

Prior Effective Dates: 4/7/77, 12/21/77, 6/1/85, 10/1/87, 9/3/91 (Emer.), 11/10/91, 6/1/95, 8/1/02, 10/16/06

HHTL 3352-15-04

Effective Date: April 30, 2015

Most Current Prior Effective Date: **December 6, 2010**

(A) ~~The Ohio medicaid program provides payment for medically necessary covered inpatient and outpatient services provided to eligible medicaid recipients by an eligible hospital provider as defined in rule 5101:3-2-01 of the Administrative Code, subject to the provisions of this chapter and Chapter 5101:3-1 of the Administrative Code (relating to general provisions).~~ This rule provides information about the general provisions for covering hospital services.

(B) The following words and terms, when used in this chapter have the following meanings, unless the context clearly indicates otherwise:

(1) "Inpatient" - A patient who is admitted to a hospital based upon the written orders of a physician or dentist and whose inpatient stay continues beyond midnight of the day of admission.

(2) "Inpatient services" - Services which are ordinarily furnished in a hospital as defined in rule ~~5101:3-2-01~~ 5160-2-01 of the Administrative Code for the care and treatment of inpatients. Inpatient services include all covered services provided to patients during the course of their inpatient stay, whether furnished directly by the hospital or under arrangement, except for direct-care services provided by physicians, podiatrists, and dentists. Inpatient hospital services exclude direct-care physician services except as provided in rule ~~5101:3-4-01~~ 5160-4-01 of the Administrative Code. Emergency room services are covered as an inpatient service when a patient is admitted from the emergency room.

(3) "Outpatient" - A patient who is not an inpatient as defined in paragraph (B)(1) of this rule and who receives outpatient services at a hospital or at a hospital's off-site unit which has been extended accreditation by the "Joint Commission of Accreditation ~~of Health Care Organizations~~," the "American Osteopathic Association" and/or is certified under ~~medicare~~medicare. Outpatient includes a patient admitted as an inpatient whose inpatient stay does not extend beyond midnight of the day of admission except in instances when, on the day of admission, a patient dies or is transferred to another inpatient unit within the hospital, to another hospital, or to a state psychiatric facility.

(4) "Outpatient services" - Diagnostic, therapeutic, rehabilitative, or palliative treatment or services furnished by or under the direction of a physician or dentist which are furnished to an outpatient by a hospital as defined in rule ~~5101:3-2-01~~ 5160-2-01 of the Administrative Code. Outpatient services do not include direct-care services provided by physicians, podiatrists and dentists. Outpatient services exclude direct-care physician services except as provided in rule ~~5101:3-4-01~~ 5160-4-01 of the Administrative Code.

(5) "Diagnostic related groups (~~DRGs~~DRGs)" - ~~DRGs~~DRGs are a patient classification system that reflects clinically cohesive groupings of services that consume similar amounts of hospital resources. The grouping logic used to develop relative weights is described in rule ~~5101:3-2-07.3~~ 5160-2-65 of the Administrative Code. The groupings used to assign cases to a ~~DRG~~DRG for claims payment are identified in rule ~~5101:3-2-07.11~~ 5160-2-65 of the Administrative Code.

~~(6) "Average" is the arithmetic mean obtained by dividing a sum by the number of its observations.~~

~~(7) "Geometric mean" is the nth root of the product of n factors.~~

~~(8)~~(6) "Distinct Part Psychiatric unit ~~distinct part~~" is a distinct part recognized by ~~medicare~~medicare.

~~(9) "Level I nursery" is a nursery unit within a hospital which is registered with and recognized by the Ohio department of health as a level I nursery.~~

~~(10) "Level II nursery" is a nursery unit within a hospital which is registered with and recognized by the Ohio department of health as a level II nursery.~~

~~(11) "Level III nursery" is a nursery unit within a hospital that is registered with and recognized by the Ohio department of health as a level III nursery.~~

~~(12) "Standard deviation" is the square root of the arithmetic mean of the squares of the deviations from the arithmetic mean.~~

~~(13)~~(7) "Principal diagnosis" is the diagnosis established after study to be chiefly responsible for causing the patient's admission to the hospital.

~~(14)~~(8) "Medically necessary services" are services as defined in rule 5160-1-01.~~which are necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part or significant pain and discomfort. A medically necessary service must:~~

~~(a) Meet accepted standards of medical practice;~~

~~(b) Be appropriate to the illness or injury for which it is performed as to type of service and expected outcome;~~

~~(c) Be appropriate to the intensity of service and level of setting;~~

~~(d) Provide unique, essential, and appropriate information when used for diagnostic purposes.~~

~~(15)~~(9) Transfer.

A patient is said to be "transferred" when he or she:

(a) Is moved from one eligible hospital's inpatient or outpatient department, as described in rule ~~5101:3-2-01~~5160-2-01 of the Administrative Code, to another eligible hospital's inpatient or outpatient department, including state psychiatric facilities.

(b) Is moved from an eligible hospital to the same hospital's distinct part psychiatric unit. ~~distinct part.~~

(c) Is moved to an eligible hospital from the same hospital's distinct part psychiatric unit ~~distinct part.~~

~~(16)~~(10) Readmissions.

For hospitals paid under the department's prospective payment system, a "readmission" is an admission to the same institution within thirty days of discharge.

~~(17)~~(11) Discharges.

A patient is said to be "discharged" when he or she:

(a) Is formally released from a hospital;

(b) Dies while hospitalized;

(c) Is discharged, within the same hospital, from an acute care bed and admitted to a bed in a distinct part psychiatric unit ~~distinct part~~ as described in paragraph ~~(B)(8)~~ (B) (6) of this rule or is discharged within the same hospital, from a bed in a distinct part psychiatric unit ~~distinct part~~ to an acute care bed. Rule ~~5101:3-2-07.11~~ 5160-2-65 of the Administrative Code explains the payment methodology for this type of a discharge; or

(d) Signs himself or herself out against medical advice (AMA).

~~(18)~~(12) "Observation services" are those services furnished on a hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for possible admission to the hospital as an inpatient.

~~(C) Billing: All inpatient and outpatient hospital services must be billed in accordance with national uniform billing requirements for hospital facilities (available on http://www.nubc.org/). Appendix A to this rule describes revenue codes that are covered under the medicaid hospital benefit.~~

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HHTL 3352-15-04

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(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 ~~5101:3-4-01~~5160-4-01 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~~below are not covered:

(a) Abortions other than those that meet the criteria for coverage set forth in rule ~~5101:3-17-01~~5160-17-01 of the Administrative Code.

(b) Sterilizations and hysterectomies other than those that meet the criteria for coverage set forth in rule ~~5101:3-21-01~~5160-21-01 of the Administrative Code.

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

~~(d) Treatment of obesity, including but not limited to gastroplasty, gastric stapling, ileo-jejunal shunt, or other gastric restrictive procedures.~~

~~(e)~~(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, facioplasty, osteoplasty (prognathism and micrognathism), dermabrasion, skin grafts, and lipectomy.

(e) Gender transformation.

(f) Acupuncture.

(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 ~~nonhospital~~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~~, 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~~.

(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 room will be covered only when such accommodations are medically necessary and the patient's condition requires the patient to be isolated for the patient's own health or the health of others.~~

(a) Private rooms are covered only when the patient's condition requires 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 Ohio 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 5160-2-65 of the Ohio 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. ~~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 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 that 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 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) The number of days of care charged by a hospital must be 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 0100-0179 are covered for the days on which the services were rendered, not for the days the charges were posted.

~~(a)~~(b) 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 that 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 diagnosis related group (DRG) basis.~~

~~(v) The hospital is recognized as a long-term care hospital 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 because of 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.

(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 and addiction services--Admissions of persons whose principal diagnosis is a mental disorder as described in Chapter 5122-14 of the Administrative Code into hospitals not licensed by the department of mental health and addiction services will not be reimbursed by the medicaid program.

(g) 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)(f) of this rule will be excluded for purposes of determining outliers in accordance with rule 5160-2-65 of the Administrative Code.

(h) For hospitals paid on a non-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)(f) of this rule, including associated inpatient services, are not covered and, accordingly, are not reimbursable.

(3) Coverage of surgical treatment for obesity--Effective for dates of service on and after January 1, 2015, surgical treatment for obesity is covered when prior authorized.

~~(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)~~(C) Coverage conditions and limitations applicable to hospitals eligible to provide services pursuant to paragraphs (C), (D) and (F) of rule ~~5101:3-2-01~~5160-2-01 of the Administrative Code.

(1) Coverage of inpatient services provided in hospitals to eligible recipients shall be provided in accordance with Chapter 5122-14 of the Administrative Code or section ~~5119.20~~5119.33 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~~5160-2 of the Administrative Code.

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5160-2-04 Coverage of Hospital- Provided Pharmaceutical, Dental, Vision Care, Medical Supply and Equipment, and Medically-Related Transportation Services

HHTL 3352-15-04

Effective Date: April 30, 2015

***Most Current Prior Effective Date:* November 1, 2007**

(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~~5160-2-21 of the Administrative Code. Take-home drugs must be billed in accordance with provisions in Chapter ~~5101:3-9~~5160-9 of the Administrative Code. Payment to hospitals for take-home drugs will be reimbursed according to the provisions of Chapter ~~5101:3-9~~5160-9 of the Administrative Code. ~~ODJFS may periodically require hospitals to produce evidence of invoice costs supporting amounts billed for take-home drugs.~~

(B) Medical supplies and equipment.

(1) Inpatient coverage: ~~Supplies and equipment for the care and treatment of the recipient during an inpatient stay, including 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 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.~~

(a) Supplies and equipment are covered for the care and treatment of the recipient during an inpatient stay and include:

(i) implants and devices that are part of a surgical, immediate post surgical, or early fitting procedure (e.g., pacemakers, halos, and prosthetic devices);

(ii) appliances that are generally applied prior to discharge (e.g., initial prostheses); and

(iii) other items that are medically necessary as described in rule 5160-1-01 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.

(b) Covered items must be included in the hospital's inpatient billing.

(c) Medical supplies and equipment provided to medicaid recipient for use outside the hospital are reimbursed accordance with Chapter 5160-10 of the Administrative Code.

(2) Outpatient coverage: ~~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.~~

(a) Rule 5160-10 the Administrative Code describes the coverage and reimbursement of medical supplies provided during the provision of an outpatient visit

(b) Medical supplies and equipment provided to the medicaid recipient for use outside the hospital are reimbursed in accordance with Chapter 5160-10 of the Administrative Code.

(C) Dental services: Except for dental services described in rule ~~5101:3-2-03~~5160-2-03 of the Administrative Code and emergency dental services provided in the emergency room, all dental services are covered and reimbursed as dental services under the provisions set forth in Chapter ~~5101:3-5~~5160-5 of the Administrative Code.

(D) Vision care services: All vision care 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~~5160-6 of the Administrative Code.

(E) ~~Ambulance and ambulette~~Medically-related transportation services: The services of hospital staff as ~~attendents~~attendants during transportation are covered and reimbursed as an inpatient or outpatient hospital service. Transportation to or from a hospital, including inter hospital transfer, that is provided in accordance with Chapter 5160-15 of the Administrative Code is not a hospital service and is reimbursed as described in Chapter 5160-15 of the Administrative Code. ~~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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5160-2-07.1 Hospital Services Subject to and Excluded from DRG Prospective Payment

Formerly **5101:3-2-07.1 Hospital Services Subject to and Excluded from DRG Prospective Payment**

HHTL 3352-04-05

Effective Date: June 1, 2004

Most Current Prior Effective Date: **August 1, 2002**

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)~~,~~ and (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) effective October 1,2003;

(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) effective October 1, 2003;

(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 insuring corporations licensed by the Ohio department of insurance and which limit services to medicaid recipients (either to recipients enrolled in a health insuring corporation or to short-term services provided on an emergency basis).

(5) Cancer hospitals as defined in rule 5101:3-2-07.2 of the Administrative Code for discharges on and after July 1, 1992.

(B) Transplant services are subject to the DRG prospective payment system with the following exceptions, as listed in paragraphs (B)(1) to (B)(3) of this rule.

(1) Heart/lung and pancreas transplantation services provided by eligible medicaid providers to eligible medicaid recipients;

(2) 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) Reimbursement for all organ transplant services, except for kidney transplants, 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) Reimbursement for bone marrow transplant and hematapoietic stem cell transplant, as defined in rule 3701-84-01 of the Administrative Code, is contingent upon review and the recommendation by the "Ohio Hematopoietic Stem Cell Transplant 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 Hematopoietic Stem Cell Transplant Consortium"; or

(b) Compliance with the performance standards described in rules 3701-84-24 to 3701-84-29 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 accordance with rule 5101:3-2-07.13 of the Administrative Code.~~

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5160-2-07.2 Classification of Hospitals

Formerly **5101:3-2-07.2 Classification of Hospitals**

HHTL 3352-07-09

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Most Current Prior Effective Date: **August 1, 2002**

For purposes of setting rates and making payments under the "Diagnosis Related Group" (DRG) prospective payment system, the department classifies most hospitals into mutually exclusive peer groups.

(A) Definitions.

(1) "Teaching hospitals" are hospitals with major teaching emphasis that meet one of the following definitions: the hospital, regardless of number of beds has an intern- and resident-to-bed ratio of at least.35 or the hospital has greater than five hundred beds and has an intern- and resident-to-bed ratio of.25. For purposes of this paragraph, the intern- and resident-to-bed ratio for Ohio hospitals is that recognized by the hospital's medicare fiscal intermediary for the hospital's cost-reporting period described in paragraph (D) of rule 5101:3-2-07.4 of the Administrative Code. For non-Ohio hospitals, the intern- and resident-to-bed ratio used to make this determination is derived from the medicare cost report for the cost-reporting period used in setting rates for rate period beginning July 1, 1990.

(2) "Children's hospitals" are those hospitals that primarily serve patients eighteen years of age and younger and that are excluded from medicare prospective payment in accordance with 42 C.F.R.~~CFR~~ 412.23(d) effective October 1, 2006.

(3) "Rural referral center hospitals" are those hospitals located in non-~~MSA~~ metropolitan statistical areas (MSAs)~~areas~~ that~~which~~ are recognized by medicare as rural referral centers in accordance with 42 C.F.R.~~CFR~~ 412.96 effective October 1, 2006.

(4) "MSA~~-area~~ hospitals" are those hospitals not defined in this rule as children's or teaching hospitals that are located in ~~metropolitan statistical areas (~~MSAs~~)~~ as those areas are established by the federal office of management and budget.

(5) "Non-MSA ~~area~~ hospitals" are those hospitals not defined in this rule as teaching, children's, or rural referral centers that are not located in ~~metropolitan statistical areas (~~MSAs~~)~~ as those areas are established by the federal office of management and budget.

(6) "Cancer hospitals" are hospitals recognized by medicare ~~which~~ that primarily treat neoplastic disease in accordance with 42 C.F.R.~~CFR~~ 412.23(f) effective October 1, 2006.

(7) For the purposes of this rule, the "number of beds" is the total number of beds reported in the December, 1986 "Directory of Registered Hospitals" published by the Ohio department of health.

(B) Ohio hospital prospective payment peer groups.

(1) For each Ohio children's hospital, a prospective rate will be determined in accordance with rule 5101:3-2-07.4 of the Administrative Code using data ~~which is~~ specific to each hospital.

(2) Rural referral center hospitals are grouped together and a peer group average cost per discharge is developed in accordance with rule 5101:3-2-07.4 of the Administrative Code using data from these hospitals.

(3) Teaching hospitals are grouped together and a peer group average cost per discharge is developed in accordance with rule 5101:3-2-07.4 of the Administrative Code using data from these hospitals.

(4) Non-MSA ~~area~~ hospitals with less than one hundred beds are grouped together and a peer group average cost per discharge is developed in accordance with rule 5101:3-2-07.4 of the Administrative Code using data from these hospitals.

(5) Non-MSA ~~area~~ hospitals with one hundred beds or more are grouped together and a peer group average cost per discharge is developed in accordance with rule 5101:3-2-07.4 of the Administrative Code using data from these hospitals.

(6) MSA~~-area~~ hospitals are peer grouped on the basis of wage index categories. MSA~~-area~~ hospitals that have adjusted gross wage index categories in their area, as published in the March 1985 "Report on Hospital Wage Index" required by section 2316(a) of Public Law 98-369 within.01 (rounded values) of each other are grouped together for payment purposes. For each of the groups formed, a peer group average cost per discharge is developed in accordance with rule 5101:3-2-07.4 of the Administrative Code using data from hospitals in the group.

(C) Non-Ohio prospective payment peer groups.

(1) For discharges on or after July 1, 1990, non-Ohio teaching hospitals will be reimbursed on the basis of a rate developed using data from Ohio teaching hospitals. The calculations used to develop this rate are described in paragraphs (C)(1)(a) to (C)(1)(b) of this rule.

(a) For each Ohio teaching hospital a fully adjusted, inflated peer group average cost per discharge is calculated as described in paragraphs (D) to (G)(3)(a) of rule 5101:3-2-07.4 of the Administrative Code except that the adjustment described in paragraphs (D)(9) to (D)(9)(b) of rule 5101:3-2-07.4 of the Administrative Code is not made.

(b) The fully adjusted, inflated peer group average cost per discharge described in paragraph (C)(1)(a) of this rule is multiplied by each hospital's medicaid discharges as described in paragraph (D)(11)(a) of rule 5101:3-2-07.4 of the Administrative Code. The results of these computations are summed for all Ohio teaching hospitals, and then divided by the sum of medicaid discharges for all Ohio teaching hospitals. The result of this computation is rounded to the nearest whole penny.

(2) For discharges on or after July 1, 1990, non-Ohio children's hospitals will be reimbursed on the basis of a rate developed using data from Ohio childrens hospitals. The calculations used to develop this rate are described in paragraph (C)(2)(a) to (C)(2)(b) of this rule.

(a) For each Ohio children's hospital a fully adjusted, inflated peer group average cost per discharge is calculated as described in paragraphs (D) to (G)(3)(b) of rule 5101:3-2-07.4 of the Administrative Code except that the adjustment described in paragraphs (D)(9) to (D)(9)(b) of rule 5101:3-2-07.4 of the Administrative Code is not made and except that the value of.12 is substituted for the value calculated in paragraph (F)(2)(e)(ii) of rule 5101:3-2-07.4 of the Administrative Code.

(b) The fully adjusted, inflated peer group average cost per discharge described in paragraph (C)(2)(a) of this rule is multiplied by each hospital's medicaid discharges as described in paragraph (D)(11)(a) of rule 5101:3-2-07.4 of the Administrative Code. The results of these computations are summed for all Ohio children's hospitals, and then divided by the sum of medicaid discharges for all Ohio children's hospitals. The result of this computation is rounded to the nearest whole penny.

(3) For discharges on or after July 1, 1990, non-Ohio hospitals that are not teaching or children's hospitals will be reimbursed on the basis of a rate developed using data from Ohio nonteaching and nonchildren's hospitals. The calculations used to develop this rate are described in paragraphs (C)(3)(a) to (C)(3)(b) of this rule.

(a) For each Ohio nonchildren's and nonteaching hospital, a fully adjusted, inflated peer group average cost per discharge is calculated as described in paragraphs (D) to (G)(3)(a) of rule 5101:3-2-07.4 of the Administrative Code except that the adjustment described in paragraphs (D)(9) to (D)(9)(b) of rule 5101:3-2-07.4 of the Administrative Code is not made.

(b) The fully adjusted, inflated peer group average cost per discharge described in paragraph (C)(3)(a) of this rule is multiplied by each hospital's medicaid discharges as described in paragraph (D)(11)(a) of rule 5101:3-2-07.4 of the Administrative Code. The results of

these computations are summed for all Ohio nonteaching and nonchildrens hospitals, and then divided by the sum of medicaid discharges for all Ohio nonteaching and nonchildrens hospitals. The result of this computation is rounded to the nearest whole penny.

(D) Classification procedures.

(1) A hospital is classified into a peer group at the beginning of each rate year based upon the data available to the department sixty days prior to the rate year. Once established, the classification of a hospital into a peer group remains in effect throughout the rate year unless the hospital is designated by medicare during the rate year to be a rural referral center hospital. In this instance the hospital must submit all documentation to the department that it has been designated as a rural referral center. After such documentation is received, the hospital will be reclassified into the rural referral center peer group effective for discharges occurring on or after the beginning of the rate year or the effective date of the designation, whichever is later.

(2) When an existing hospital is deleted or added to a peer group at a time other than when the department rebases the DRG system, the deletion or addition of a hospital from a peer group does not result in a redetermination of payment rates for the peer group except as otherwise provided in rule 5101:3-2-07.8 of the Administrative Code. If a new hospital is established at a time other than when the department rebases the DRG system, the department will assign that hospital to a peer group for payment purposes but will not recalculate any part of the prospective payment rate for that peer group.

(3) Facilities ~~which~~ that close at a time other than rebasing of the DRG system and that notify the department of closure thirty days prior to the beginning of a rate year are not included in the peer groups defined in this rule for the purpose of setting payment rates. Closure notifications received less than thirty days prior to a rate year do not result in a redetermination of peer group payment rates for that year.

(4) In the case of hospital mergers when all facilities involved in the merger retain separate provider numbers for the medicare program, each facility will be treated separately following the procedures outlined in this rule. In the case of hospital mergers when the merged facility retains only one medicare provider number, the department will either follow the determinations made by the medicare program with regard to treatment of the merged facilities or will make a separate determination. Such separate determinations will be made, on a case by case basis, in instances when medicare's determination would be appropriate in the context of medicare pricing and classification methods but inappropriate in the context of medicaid pricing methods and peer grouping logic as described in this rule.

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Prior Effective Dates: 10/4/84, 7/29/85, 7/3/86, 10/19/87, 7/1/90, 9/3/91 (Emer), 11/10/91, 7/1/92, 8/1/02

5160-2-07.3 Methodology for Determining Relative Weights

Formerly **5101:3-2-07.3 Methodology for Determining Relative Weights**

HHTL 3352-09-08

Effective Date: January 1, 2010

Most Current Prior Effective Date: **July 24, 2008**

(A) General description.

For hospitals subject to prospective payment for inpatient services, the Ohio department of job and family services~~,~~ (~~"~~ODJFS~~"~~) will reimburse for inpatient hospital services an amount per discharge in each diagnostic category. The payment is reflective of the relative hospital resources used by each diagnostic category in comparison to the statewide average resource use for an admission. The method for determining the weight of a diagnostic category is based on its average charge compared to an average charge for all discharges. This rule describes the diagnostic categories and the method for determining the relative weights for each category. Special consideration is given to psychiatric diagnostic related groups (DRGs) 425 to 435 and neonatal DRGs 385 to 390 as described in this rule.

(B) Diagnostic related groupings.

(1) Except as otherwise specified in paragraph (E) of this rule, relative weights are calculated for each classification of inpatient hospital discharge classified by "grouper," a software package distributed by~~,~~ "3M Health Information Systems," ~~",~~ used by medicare during federal fiscal year 1998, and modified as described in this rule. Services are classified into one of the diagnostic categories based on:

(a) The "International Classification of Diseases, 9th Revision, Clinical Modification" (ICD-9-CM), principal and secondary diagnoses;

(b) The ICD-9-CM surgical procedures provided to the recipient during a hospital stay;

(c) The recipient's sex;

(d) The recipient's age; and

(e) The recipient's discharge status.

(2) Cases ~~which~~that would be classified in DRG 385 or DRG 456 because of a transfer or death but ~~which~~that involve a length of stay greater than fifteen days are classified in the DRG ~~which~~that is appropriate in accordance with paragraphs (B)(1) to (B)(1)(e) of this rule if the transfer or death is not considered.

(3) For cases classified into DRG 386, three subgroups are identified and three different relative weights are calculated, based upon the ICD-9-CM codes and the level of the neonatal nursery. These levels are those recognized by the Ohio department of health as of March 29, 1987.

(a) One subgroup and relative weight is created based upon cases that~~which~~ have ICD-9-CM code 765.0 listed as one of its diagnoses.

(b) For cases that~~which~~ group as a DRG 386, and do not have ICD-9-CM code 765.0, two relative weights are calculated for this subgroup. One relative weight is calculated using data specific to hospitals with a level I or II nursery and a second relative weight is calculated using data specific to hospitals with a level III nursery.

(4) For cases classified into DRG 387, four subgroups are identified and four different relative weights are calculated, based upon the infant's birthweight and the level of the neonatal nursery. These levels are those identified by the Ohio department of health as of March 29, 1987. These subgroups are described in paragraphs (B)(4)(a) and (B)(4)(b) of this rule.

(a) For cases that~~which~~ group into DRG 387 and have a birthweight of zero to one thousand seven hundred fifty grams, two subgroups are identified and two relative weights are calculated within each subgroup. One relative weight is calculated using data specific to

hospitals with a level I or II nursery and a second relative weight is calculated using data specific to hospitals with a level III nursery.

(b) For cases thatwhich group into DRG 387 and have a birthweight of one thousand seven hundred fifty-one grams and above, two subgroups are identified and two relative weights are calculated within each subgroup. One relative weight is calculated using data specific to hospitals with a level I or II nursery and a second relative weight is calculated using data specific to hospitals with a level III nursery.

(C) Medicaid claim record.

For the purposes of determining the relative weight for each DRG, the sample includes all claims associated with discharges, as described in paragraphs (C)(1) and (C)(2) of this rule.

(1) Effective for discharges on January 1, 2006 through December 31, 2009December 31, 2011: For the purposes of determining the relative weight for each DRG, the sample includes all claims associated with discharges on or after July 1, 2001 through June 30, 2003 and paid by December 31, 2003. All claims included in the sample were previously paid and passed through the edits created by the department'sODJFS's prospective payment system. Claims were adjusted as described in paragraphs (C)(3) to (C)(4)(b) of this rule.

(2) Effective for discharges on or after January 1, 2010January 1, 2012, and every calendar year thereafter, relative weights shall be determined on an annual basis. For the purposes of determining the relative weight for each DRG, the sample includes all claims associated with discharges during the state fiscal year ending in the calendar year preceding the immediate past calendar year prior to January first of the calendar year to which the new relative weights shall apply. All claims included in the sample were previously paid and passed through the edits created by the department'sODJFS's prospective payment system. Claims were adjusted as described in paragraphs (C)(3) to (C)(4)(b) of this rule.

(3) Claims deleted from computation.

(a) Claims that were submitted by an out-of-state provider.

(b) Claims that were submitted by hospitals excluded from the prospective payment system as described in rule 5101:3-2-07.1 of the Administrative Code.

(c) Claims that were originally grouped into DRG 000, 469 or 470.

(d) When two or more records existed with the same provider, same recipient number, and exact dates of services, the latest paid claim was retained and the earlier paid claim or claims were deleted.

(e) If multiple claims for the same provider, same recipient number, and overlapping dates of service occurred, and the date span of the most recently paid claim included the date span of any and all overlap claims, and none of the claims grouped into DRGs 425 to 435, the most recently paid claim was retained and all others were deleted.

(f) Claims associated with cases that were incorrectly billed to ODJFS, e.g., where third party covered the entire stay.

(g) Claims that were for an inpatient discharge but had charges of less than one hundred dollars, unless there were ten or fewer claims that grouped into the DRG.

(h) Transfer claims unless there were ten or fewer claims that grouped into the DRG.

(i) Nontransfer claims paid on a per diem basis.

(j) Claims with net charges equal to zero.

(4) Adjustments to claims.

(a) Claim-specific adjustments were included if processed by the Ohio department of job and family servicesODJFS on or before the last day of the medicaid claim record period as described in paragraphs (C)(1) and (C)(2) of this rule.

(b) Organ acquisition and transportation costs for heart, liver, and bone marrow transplants were removed from the claim prior to submission to the grouper.

(D) Development of the relative weights.

The relative weights were calculated based upon the total allowable charge for each case for the sample of claims as described in paragraphs (C) to (C)(4)(b) of this rule, subject to the edits as described in paragraphs (D)(3)(a) and (D)(3)(b) of this rule.

(1) Computation of the geometric mean charge for each DRG.

(a) For DRGs 1 to 385, 391 to 424, and 439 to 503, the geometric mean charge was determined for each of these DRGs.

(b) For each subgroup in DRG 386 as described in paragraphs (B)(3) to (B)(3)(b) of this rule, and for each subgroup of DRG 387 as described in paragraphs (B)(4) to (B)(4)(b) of this rule, the geometric mean charge was calculated.

(c) For DRGs 388, 389, and 390, the geometric mean charge was calculated three times to determine a geometric mean charge specific to hospitals with a level I nursery, hospitals with a level II nursery, and hospitals with a level III nursery. For example, three geometric mean charges were calculated for DRG 388, one reflecting data from hospitals with a level I nursery; one reflecting data from hospitals with a level II nursery; and one reflecting data from hospitals with a level III nursery.

(d) For DRGs 425 to 435, two geometric mean charges were calculated for each DRG in this category. One geometric mean charge was calculated using the charge for each case within these DRGs from free-standing psychiatric hospitals, and hospitals ~~which~~that have a psychiatric unit distinct part. A "psychiatric unit distinct part" is one ~~which~~that is recognized by medicare as described in rule 5101:3-2-02 of the Administrative Code and where the hospital has notified ~~the department~~ODJFS of medicare's certification. A second geometric mean charge was calculated for each DRG 425 to 435 using data from all other hospitals (hospitals ~~which~~that do not have a recognized psychiatric unit distinct part under medicare). In accordance with rule 5101:3-2-03 of the Administrative Code, ~~the department~~ODJFS does not pay for DRG 436 and DRG 437.

(e) If no cases were grouped by the medicare fiscal year 1998 grouper into any DRG, the geometric mean charge for these DRGs is the geometric mean charge that was used for these DRGs prior to the effective date of this rule.

(2) Calculation of the statewide geometric mean length of stay for each DRG.

(a) For DRGs 1 to 385, 391 to 424, and 439 to 503, the geometric mean length of stay was calculated using all cases within each of these DRGs as determined in paragraph (C) of this rule.

(b) For each subgroup in DRG 386 as described in paragraphs (B)(3) to (B)(3)(b) of this rule and for each subgroup of DRG 387 as described in paragraphs (B)(4) to (B)(4)(b) of this rule, the geometric mean length of stay was calculated.

(c) For DRGs 388, 389, and 390, the geometric mean length of stay was calculated three times to determine geometric mean length of stay specific to hospitals with a level I nursery, hospitals with a level II nursery, and hospitals with a level III nursery. For example, three geometric mean lengths of stay were calculated for DRG 388; one geometric mean length of stay was calculated using all cases in DRG 388 within a hospital ~~which~~that has a level I nursery; one geometric mean length of stay was calculated based on data from hospitals with a level II nursery; and one geometric mean length of stay was calculated based on data from hospitals with a level III nursery.

(d) For DRGs 425 to 435, the geometric mean length of stay was calculated two times for each of these DRGs to reflect the difference in the geometric mean length of stay in hospitals with and without psychiatric unit distinct parts. To determine the geometric

mean length of stay for cases treated in hospitals with no distinct part psychiatric unit, the geometric mean length of stay was calculated using all cases in these hospitals. To determine the geometric mean length of stay for cases in hospitals with psychiatric unit distinct parts, the geometric mean length of stay was calculated using all cases in these hospitals.

(e) If no cases were grouped by the medicare fiscal year 1998 grouper into any DRG, the geometric mean length of stay for these DRGs is the geometric mean length of stay that was used for these DRGs prior to the effective date of this rule.

(3) Deletion of outlier cases.

(a) For each DRG and each subgroup within DRGs 386 to 390 and 425 to 435, a standard deviation for charge and length of stay was calculated based upon the cases used in the calculation of the geometric mean as described in paragraphs (D)(1) to (D)(2)(d) of this rule.

(b) Cases ~~which~~that had charges or reflected a length of stay that was two standard deviations above the geometric mean as calculated in paragraphs (D)(1) to (D)(2)(d) of this rule were deleted except for DRGs 385 to 390. For DRGs 385 to 390 cases ~~which~~that had charges or reflected a length of stay that is one standard deviation above the geometric mean as calculated in paragraphs (D)(1) to (D)(2)(d) of this rule were deleted.

(4) Recalculation of geometric mean length of stay and geometric mean charge for each DRG and subgroups in DRGs 386 to 390 and 425 to 435 was done excluding outlier cases as described in paragraphs (D)(3)(a) and (D)(3)(b) of this rule.

(5) Computation of the arithmetic mean charge for each DRG.

Computation of the arithmetic mean charge for each DRG and subgroups was calculated using all cases as described in paragraphs (C)(1) to (C)(4)(b) of this rule, excluding outlier cases, as described in paragraphs (D)(3)(a) and (D)(3)(b) of this rule.

(a) For DRGs 1 to 385, 391 to 424, and 439 to 503, the arithmetic mean charge was determined for each of these DRGs using the total charge per case for each DRG for all hospitals excluding outlier cases.

(b) For each subgroup in DRG 386 as described in paragraphs (B)(3) to (B)(3)(b) of this rule, and for each subgroup of DRG 387 as described in paragraphs (B)(4) to (B)(4)(b) of this rule, the arithmetic mean charge was determined excluding outlier cases.

(c) For DRGs 388, 389, and 390, three separate arithmetic means were calculated for each DRG using data specific to either hospitals with a level I nursery, with a level II nursery, or hospitals with a level III nursery unit. In each instance, the claims used within a DRG, and within a specific level nursery, excluded outlier cases.

(d) For DRGs 425 to 435, two arithmetic mean charges were calculated for each DRG in this category. One arithmetic mean charge was calculated using the total charge for each case within these DRGs, excluding outlier cases, from hospitals ~~which~~that had a psychiatric unit distinct part. A second arithmetic mean charge was calculated for DRGs 425 to 435 using data, excluding outlier cases, from all other hospitals (hospitals ~~which~~that did not have a recognized psychiatric unit distinct part under medicare).

(e) If no cases were grouped by the medicare fiscal year 1998 grouper into any DRG, the arithmetic mean charge for these DRGs is the arithmetic mean charge that was used for these DRGs prior to the effective date of this rule.

(6) Calculation of the statewide arithmetic mean charge per discharge.

The statewide arithmetic mean charge per discharge was calculated using the total allowable charge for all cases used in the calculation described in paragraphs (D)(5) to (D)(5)(d) of this rule.

(7) Computation of the relative weight for each DRG and DRG subgroups.

The relative weight of each DRG is a function of the relationship between the arithmetic mean charge per DRG and DRG subgroups and the arithmetic mean charge across all cases. To determine the relative weight, the arithmetic mean charge for each DRG and DRG subgroup calculated as described in paragraphs (D)(5)(a) to (D)(5)(d) of this rule was divided by the statewide arithmetic mean charge per discharge as described in paragraph (D)(6) of this rule.

(E) Relative weights for small cell DRGs.

When ten or less claims grouped into a DRG, ~~the department~~ODJFS established relative weights taking into consideration the weights that previously were used for the DRG, as well as the DRG case mix. When ten or less claims grouped into a new DRG, ~~the department~~ODJFS used relative weights currently used by medicare.

Effective: 01/01/2010

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5160-2-07.4 Basic Methodology for Determining Prospective Payment Rates

Formerly **5101:3-2-07.4 Basic Methodology for Determining Prospective Payment Rates**

HHTL 3352-11-05

Effective Date: September 19, 2011

Most Current Prior Effective Date: **October 15, 2009**

5101:3-2-07.4 Appendix A

(A) General description.

Except as provided in paragraph (B) of this rule, in computing the payment rate, the average cost per discharge determined and adjusted as described in paragraphs (D) to (G)(3)(b) of this rule is multiplied by the relative weight as described in rule 5101:3-2-07.3 of the Administrative Code for the diagnosis related group (DRG) as defined in rule 5101:3-2-02 of the Administrative Code. Applicable allowances for capital and medical education, as described in this rule, are added after the average cost per discharge component is multiplied by the relative weight. The components of the prospective payment rates for each recipient discharged from a hospital are:

(1) The DRG assigned to that discharge;

(2) The adjusted inflated average cost per discharge component described in paragraphs (D) to (G)(3)(b) of this rule;

(3) Relative weights defined in rule 5101:3-2-07.3 of the Administrative Code for each DRG;

(4) An allowance for capital described in rule 5101:3-2-07.6 of the Administrative Code; and

(5) For certain hospitals, a medical education allowance as described in rule 5101:3-2-07.7 of the Administrative Code.

(B) Payment rates.

Payment rates consist of the components described in paragraphs (A) to (A)(5) of this rule, subject to special payment provisions for certain types of cases, as described in rules 5101:3-2-07.9 and 5101:3-2-07.11 of the Administrative Code.

(C) Determination of average cost per discharge component.

(1) For children's hospitals as defined in rule 5101:3-2-07.2 of the Administrative Code, the average cost per discharge component is one hundred per cent hospital specific and is determined in accordance with paragraphs (D) to (G)(3)(b) of this rule.

(2) For out-of-state hospitals for discharges on or after July 1, 1990, the average cost per discharge component is determined in accordance with the methodology described in paragraphs (C)(1) to (C)(3)(b) of rule 5101:3-2-07.2 of the Administrative Code.

(3) For hospitals other than those identified in paragraphs (C)(1) and (C)(2) of this rule, the average cost per discharge component will be one hundred per cent of the peer group average costs per discharge determined in accordance with paragraphs (E) to (G)(3)(a) of this rule using the peer groups defined in rule 5101:3-2-07.2 of the Administrative Code.

(D) Calculation of hospital-specific adjusted average cost per discharge.

Unless otherwise indicated, two types of source documents are used to obtain information needed to calculate the hospital-specific average cost per discharge defined in this rule. Those documents are the ODHS 2930 "Cost Report" and the HCFA 2552-85, as submitted to the department (ODHS or JFS as appropriate) as required in rule 5101:3-2-23 of the Administrative Code. The ODHS 2930 will be adjusted by the department in accordance with rules 5101:3-2-22, 5101:3-2-23, and 5101:3-2-24 of the Administrative Code using data made available to the department as of June 15, 1987. The documents used are those reflecting costs associated with the hospital's 1985 or 1986 fiscal year reporting period. For purposes of this rule, the 1985 cost report will be used for those hospitals with fiscal periods ending

September thirtieth, October thirty-first, or December thirty-first; the 1986 cost report will be used for those hospitals with fiscal periods ending March thirty-first, May thirty-first, June thirtieth, or August thirty-first. The hospital-specific average cost per discharge component is calculated in accordance with the provisions set forth in paragraphs (D)(1) to (D)(13) of this rule.

(1) For those hospitals that have merged since the end of the fiscal year period specified in paragraph (D) of this rule and had the same fiscal reporting period, the cost reports for the hospitals will be combined. The department will combine the total cost, total charges, total days, medicaid charges, and medicaid discharges for the hospitals. A new report will be prepared by the department for the merged hospital.

(2) For those hospitals that have merged since the end of the fiscal year period specified in paragraph (D) of this rule and had different fiscal reporting periods, the procedures described in paragraphs (D)(3) to (D)(13)(d) of this rule will be followed. At that point, the average cost per discharge for the hospitals will be combined by:

(a) Multiplying the average cost per discharge for each hospital derived from paragraph (D)(12)(g) of this rule, as applicable, by the number of discharges for each hospital derived from paragraph (D)(11)(a) of this rule. Round the result to the nearest whole dollar.

(b) Sum the products.

(c) Divide the resulting sum by the sum of the hospital's discharges. Round the result to the nearest whole penny.

(3) The case-mix computation for merged providers will be performed by combining the hospital's claim records as described in paragraphs (D)(13) to (D)(13)(d) of this rule.

(4) Determination of medicaid inpatient cost adjusted to remove the cost of blood replaced by patient donors.

(a) Identify medicaid inpatient service cost on ODHS 2930, schedule H, section I, line 1, column 12.

(b) Identify cost of blood replaced by donor for medicaid inpatients on ODHS 2930, schedule H, section I, line 2, column 12.

(c) Subtract the amount identified in paragraph (D)(4)(b) of this rule from the amount identified in paragraph (D)(4)(a) of this rule.

(5) Determination of medicaid inpatient cost adjusted to include PSRO/UR cost separately identified.

(a) Identify PSRO/UR cost on ODHS 2930, schedule H, section I, line 3, column 12.

(b) Add the amount derived from paragraph (D)(5)(a) of this rule to the amount described in paragraph (D)(4)(c) of this rule.

(6) Determination of medicaid inpatient cost adjusted to include the cost of malpractice insurance.

(a) Identify the hospital's malpractice insurance premium cost on HCFA 2552-85, worksheet D-8, part II, line 11, for the hospital's fiscal reporting period ending in 1986.

(b) Compute the hospital's per cent of medicaid inpatient charges to total charges.

(i) Identify medicaid inpatient charges on ODHS 2930, schedule H, section I, line 11, column 12.

(ii) Identify total charges for all patients on ODHS 2930, schedule A, line 101B, column 1.

(iii) Divide the amount identified in paragraph (D)(6)(b)(i) of this rule by the amount identified in paragraph (D)(6)(b)(ii) of this rule. Round the result to six decimal places.

(c) For those hospitals whose fiscal year ends on or prior to December 31, 1985, divide the amount identified in paragraph (D)(6)(a) of this rule by the appropriate deflation factor described in paragraph (G)(1) of this rule. Round to the nearest whole dollar.

(d) Multiply the amount identified in paragraph (D)(6)(a) or (D)(6)(c) of this rule, as applicable, by the percentage derived from paragraph (D)(6)(b)(iii) of this rule. Round the result to the nearest dollar.

(e) Add the amount computed in paragraph (D)(6)(d) of this rule to the amount derived in paragraph (D)(5)(b) of this rule.

(7) Determination of medicaid inpatient cost adjusted to remove the direct cost of medical education.

(a) Identify the hospital direct medical education on the HCFA 2552-85, worksheet B, part I, line 95, columns 20, 21, 22, 23, and 24.

(b) Multiply the sum of the amounts in paragraph (D)(7)(a) of this rule by the percentage derived from paragraph (D)(6)(b)(iii) of this rule. Round the result to the nearest dollar.

(c) Subtract the amount computed in paragraph (D)(7)(b) of this rule from the amount computed in paragraph (D)(6)(e) of this rule.

(8) Determination of medicaid inpatient cost adjusted to remove capital-related cost.

(a) Identify the hospital capital-related cost on the HCFA 2552-85, worksheet B, part II, line 95, column 25.

(b) Multiply the amount in paragraph (D)(8)(a) of this rule by the percentage derived from paragraph (D)(6)(b)(iii) of this rule. Round the result to the nearest dollar.

(c) Subtract the amount derived from paragraph (D)(8)(b) of this rule from the amount derived from paragraph (D)(7)(c) of this rule.

(9) Determination of medicaid inpatient cost adjusted to remove the indirect cost of medical education.

(a) Identify the hospital's indirect medical education percentage described in rule 5101:3-2-07.7 of the Administrative Code. Add 1.00.

(b) Divide the amount derived from paragraph (D)(8)(c) of this rule by the factor derived in paragraph (D)(9)(a) of this rule. Round the result to the nearest dollar.

(10) Determination of medicaid inpatient cost adjusted to remove the effects of wage differences for hospitals in the teaching hospital peer group defined in rule 5101:3-2-07.2 of the Administrative Code.

(a) The labor portion of hospital cost is.7439.

(b) Multiply the amount derived from paragraph (D)(9)(b) of this rule by the labor portion of hospital cost identified in paragraph (D)(10)(a) of this rule. Round the result to the nearest whole dollar.

(c) Subtract the amount derived from paragraph (D)(10)(b) of this rule from the amount derived in paragraph (D)(9)(b) of this rule.

(d) Divide the labor portion of medicaid inpatient cost derived from paragraph (D)(10)(b) of this rule by the wage index for urban areas as published in Federal Register, Volume 51, Number 170, Wednesday, September 3, 1986, as applicable for the geographic area in which the teaching hospital is located. Round the result to the nearest whole dollar.

(e) Add the amount derived from paragraph (D)(10)(c) of this rule to the amount derived from paragraph (D)(10)(d) of this rule.

(11) Determination of medicaid inpatient hospital-specific average cost per discharge.

(a) Identify total medicaid discharges on adjusted ODHS 2930, schedule D, section II, line 6.

(b) Divide the adjusted medicaid inpatient cost derived from paragraph (D)(10)(e) or (D)(9)(b) of this rule, as applicable, by the discharges identified in paragraph (D)(11)(a) of this rule. Round the result to the nearest whole penny.

(c) For hospitals exceeding the limits described in section (III)(A) or (III)(B) of appendix A of this rule, the average cost per discharge is reduced by multiplying the amount derived from paragraph (D)(11)(b) of this rule is multiplied by.97.

(12) Determination of medicaid average cost per discharge adjusted to account for varying fiscal year ends.

(a) Compute a daily inflation factor by dividing the inflation factor for 1986 or 1987, as applicable, described in paragraph (G)(1) of this rule, by three hundred sixty-five. Round the result to six decimal places.

(b) With the exception of those hospitals whose fiscal years end on August thirty-first, compute the number of days between the hospital's fiscal year end and June 30, 1986.

(c) With the exception of those hospitals whose fiscal years end on August thirty-first, multiply the applicable daily inflation factor from paragraph (D)(12)(a) of this rule by the days computed in paragraph (D)(12)(b) of this rule. Round the result to six decimal places, then add 1.0 to yield an inflation adjustment factor.

(d) With the exception of those hospitals whose fiscal years end on August thirty-first, multiply the medicaid average cost per discharge derived from paragraph (D)(11)(b) or (D)(11)(c) of this rule by the inflation factor derived from paragraph (D)(12)(c) of this rule, as applicable. Round the result to the nearest whole penny.

(e) For those hospitals whose fiscal year ends on August thirty-first, determine the number of days from June 30, 1986 to the hospitals' fiscal year-end.

(f) For those hospitals whose fiscal year ends on August thirty-first, multiply the applicable daily inflation factor derived from paragraph (D)(12)(a) of this rule by the days derived from paragraph (D)(12)(e) of this rule. Round the result to six decimal places, then add 1.0 to yield an inflation adjustment factor.

(g) For those hospitals whose fiscal year ends on August thirty-first, divide the hospital-specific average cost per discharge derived from paragraph (D)(11)(b) or (D)(11)(c) of this rule, as applicable, by the inflation adjustment factor derived from paragraph (D)(12)(f) of this rule, as applicable. Round the result to the nearest whole penny.

(13) Determination of medicaid average cost per discharge adjusted for case mix.

For each hospital the average cost per discharge, adjusted as described in paragraphs (D)(12)(a) to (D)(12)(g) of this rule, is adjusted to remove the effects of the hospital's case mix. The data used to compute the hospital's case mix index are the hospital's claim records for discharges occurring during the hospital's fiscal period as described in paragraph (D) of this rule and paid as of May 1, 1987. For purposes of this paragraph, case mix is determined using the DRG categories and relative weights described in rule 5101:3-2-07.3 of the Administrative Code and includes outlier cases described in rule 5101:3-2-07.9 of the Administrative Code.

(a) For each hospital the number of cases in each DRG is multiplied by the relative weight for each DRG. Round the result to five decimal places. The relative weights are those described in rule 5101:3-2-07.3 of the Administrative Code.

(b) Sum the result of each computation in paragraph (D)(13)(a) of this rule.

(c) Divide the product from paragraph (D)(13)(b) of this rule by the number of cases in the hospital's sample as described in paragraph (D)(13) of this rule. Round the result to five decimal places. This produces a hospital-specific case mix index.

(d) Divide the medicaid inpatient hospital-specific average cost per discharge derived from paragraphs (D)(12)(a) to (D)(12)(g) of this rule by the hospital-specific case mix index

computed in paragraph (D)(13)(c) of this rule. Round the result to the nearest whole penny.

(E) Computation of peer group average cost per discharge.

(1) Within each peer group (except for the children's hospital peer group as defined in rule 5101:3-2-07.2 of the Administrative Code), multiply each hospital's average cost per discharge from paragraph (D)(13)(d) of this rule by each hospital's number of medicaid discharges from paragraph (D)(11)(a) of this rule.

(2) Sum the results of each computation in paragraph (E)(1) of this rule.

(3) Sum the number of medicaid discharges described in paragraph (E)(1) of this rule.

(4) Divide the result derived from paragraph (E)(2) of this rule by the result derived from paragraph (E)(3) of this rule. Round the result to the nearest whole penny.

(F) Adjustments to the peer group average cost per discharge component described in paragraphs (E)(1) to (E)(4) of this rule and each children's hospital average cost per discharge component described in paragraph (D)(13)(d) of this rule are those described in paragraphs (F)(1) to (F)(3) of this rule.

(1) Disproportionate share payments will be made in accordance with rules 5101:3-2-09 and 5101:3-2-10 of the Administrative Code.

(2) An outlier set-aside is determined for each peer group except the teaching hospital and children's hospitals peer groups as described in rule 5101:3-2-07.2 of the Administrative Code. For teaching hospitals and children's hospitals identified in rule 5101:3-2-07.2 of the Administrative Code, an amount is calculated using each hospital's information to determine a hospital-specific group set-aside amount. This set-aside amount is calculated using the methodology described in paragraphs (F)(2)(a) to (F)(2)(f) of this rule.

(a) The additional payments that would be paid for outlier cases for discharges on and after July 1, 1985 to June 30, 1986 is determined using payment rates developed in accordance with this rule except that payment rates do not reflect the adjustment described in paragraph (F)(2)(f) of this rule. Relative weights as described in rule 5101:3-2-07.3 of the Administrative Code, and the day thresholds, cost thresholds, and geometric mean length of stay, excluding outliers, for each DRG as described in rule 5101:3-2-07.9 of the Administrative Code are used.

(b) For each hospital, the total additional payments made for outlier cases is divided by the sum of the total payment amount for all cases in that hospital, less payment amounts for teaching and capital allowances as described in paragraphs (H)(1) and (H)(2) of this rule and payments made for day outliers as described in paragraph (F)(2)(a) of this rule. The resulting per cent is rounded to four decimal places and represents the hospital-specific outlier per cent.

(c) For all hospitals, the total additional payment for outlier cases is calculated by summing each hospital's additional payments described in paragraph (F)(2)(a) of this rule and is divided by the summed total payment amounts for all cases in all hospitals, less payment amounts for teaching and capital allowances as described in paragraphs (H)(1) and (H)(2) of this rule, plus total payments in all hospitals for day outliers. The resulting per cent is rounded to four decimal places and represents the statewide average outlier per cent.

(d) For hospitals that have a hospital-specific outlier per cent (as described in paragraph (F)(2)(b) of this rule) over the statewide average outlier per cent as described in paragraph (F)(2)(c) of this rule, the outlier payments that are used in the peer group calculation described in paragraph (F)(2)(e) of this rule are capped by multiplying the hospital-specific additional payment amount described in paragraph (F)(2)(a) of this rule by seventy-five per cent.

(e) The outlier set-aside amount is calculated on a peer group basis using the following methodology:

(i) For each peer group except the teaching hospital and children's hospital peer groups as described in rule 5101:3-2-07.2 of the Administrative Code and for each teaching hospital and children's hospital (identified in rule 5101:3-2-07.2 of the Administrative Code), sum the total additional payments for outliers as described in paragraph (F)(2)(a) or (F)(2)(d) of this rule, as applicable.

(ii) For each peer group except the teaching hospital and children's hospital peer groups and for each teaching and children's hospital, divide the sum from paragraph (F)(2)(e)(i) of this rule by the sum of the total payment amount, less payment amounts for teaching and capital allowances as described in paragraphs (H)(1) and (H)(2) of this rule, plus total day outlier payments.

(f) The outlier adjustment amount is calculated by multiplying the percentage described in paragraph (F)(2)(e)(ii) of this rule by the applicable average cost per discharge component for each peer group as described in paragraphs (E) to (E)(4) of this rule and for each children's hospital as described in paragraph (D)(13)(d) of this rule. Round the result to the nearest whole penny to determine the outlier adjustment amount. Subtract the outlier adjustment amount from the applicable average cost per discharge component described in paragraph (F)(1)(a) of this rule for discharges occurring on and after July 1, 1988 and prior to February 1, 1989. For discharges occurring on and after February 1, 1989, subtract the outlier adjustment amount from the average cost per discharge component for each peer group as described in paragraph (E)(4) of this rule and for each children's hospital as described in paragraph (D)(13)(d) of this rule. Round the result to the nearest whole penny.

(3) For purposes of coding adjustment, the applicable average cost per discharge component described in paragraph (F) of this rule is divided by 1.005. Round the result to the nearest whole penny.

(4) For Ohio hospitals meeting the teaching hospital peer group criteria defined in rule 5101:3-2-07.2 of the Administrative Code, the peer group average cost per discharge described in paragraph (F)(3) of this rule is multiplied by a wage factor and rounded to the nearest whole penny. The wage factor is determined by dividing the amount derived from paragraph (D)(9)(b) of this rule by the amount derived from paragraph (D)(10)(e) of this rule, rounded to six decimal places.

(G) Adjustments for inflation.

In calculating the prospective payment rate, it is necessary to adjust costs to reflect inflation at various points in the calculation.

(1) In order to assure hospitals an annual allowance for inflation except as provided in paragraph (G)(2) of this rule, an inflation factor is developed. The Ohio specific "inflation factor" is a weighted average of twenty-three price and wage indexes, either regional or national. The weights are those published weights shown in this paragraph. Price growth increase values for these weighted items are determined by "Global Insight" for the department. Annual inflation factors are derived from summing the result of the following calculation for each item and adding one to produce a factor:

"Factor X Weight X Projected Price Increase"

The categories and indexes are those identified in paragraphs (G)(1)(a) to (G)(1)(t) of this rule. When more than one period is being inflated, annual factors are multiplied by one another to produce a composite factor.

(a) Wages: average hourly earnings (AHE), general medical and surgical hospitals, midwest region. The weight is.4339.

(b) Benefits: supplements to wages and salaries per employee, east north central (ENC). The weight is.0949.

(c) Professional fees, nonmedical: "Employment Cost Index" (ECI) wages and salaries, midwest region. The weight is.0213.

(d) Malpractice insurance: Health care financing administration, professional liability insurance premium index. The weight is.0119.

(e) Utilities: producer price index (PPI) - electricity, commercial sector, ENC (the weight is.0093); price of natural gas for the commercial sector, ENC (the weight is.0037); "Consumer Price Index - All Urban" CPIU - water and sewerage maintenance, U.S. (the weight is.0025). The combined weight is.0155.

(f) Prescription pharmaceuticals: PPI - pharmaceutical preparations, prescription (chemicals), U.S. The weight is.0416.

(g) Food: direct purchase, PPI - processed foods and feeds, U.S. (the weight is.0231); contract purchase, CPIU, food at home, ENC (the weight is.0107).

(h) Chemicals: PPI - industrial chemicals, U.S. The weight is.0367.

(i) Medical instruments: PPI - surgical and medical instruments and apparatus, U.S. The weight is.0308.

(j) Photographic supplies: PPI - photographic supplies, U.S. the weight is.0039.

(k) Rubber and plastics: PPI - rubber and plastics products, U.S. The weight is.0475.

(l) Paper products: PPI - paper and paperboard, U.S. The weight is.0208.

(m) Apparel: PPI - textile products and apparel, U.S. The weight is.0087.

(n) Machinery and equipment: PPI - machinery and equipment, U.S. The weight is.0021.

(o) Miscellaneous products: PPI - finished goods, U.S. The weight is.0224.

(p) Postage: CPIU - postage, U.S. The weight is.0027.

(q) Telephone services: CPIU - telephone services, U.S. The weight is.0058.

(r) All other, labor intensive: ECI - compensation business services, U.S. The weight is.0728.

(s) All other, non-labor intensive: CPIU - all items, ENC. The weight is.0080.

(t) Miscellaneous: CPIU - medical care, ENC. The weight is.0849.

(2) Application of estimated inflation factors.

The inflation values applied at the beginning of each rate year to produce a new composite inflation factor shall be based on the estimate of price indicators outlined in paragraphs (G) and (G)(1) of this rule that have been supplied to the department by three months prior to the beginning of a new rate year, except for ~~the rate year beginning January 1, 2009 and ending December 31, 2009, and the rate year beginning January 1, 2010 and ending December 31, 2010 and the rate year beginning January 1, 2011 and ending December 31, 2011~~ rate years beginning on or after January 1, 2009 and ending on or before December 31, 2013 the composite inflation factor will be adjusted to 0.00 per cent. Not withstanding the 0.00 per cent composite inflation factor updates in this paragraph, for discharges occurring during the period beginning October 1, 2009 and ending ~~June 30, 2011~~ June 30, 2013 a five per cent increase shall be applied to the rates in effect on September 30, 2009. The inflation factors shall be uniformly applied to the average cost per discharge component and shall remain fixed for that rate period.

(3) Calculation of inflated peer group adjusted average cost per discharge, including each children's hospital adjusted average cost per discharge.

(a) For each hospital/peer group, the peer group adjusted average cost per discharge derived from paragraph (F)(3) or (F)(4) of this rule, as applicable, is multiplied by an inflation factor derived from paragraph (G)(2) of this rule. Round the result to the nearest whole penny.

(b) For each children's hospital as defined in rule 5101:3-2-07.2 of the Administrative Code, the hospital-specific adjusted average cost per discharge derived from paragraph (F)(4) of this rule is multiplied by an inflation factor derived from paragraph (G)(2) of this rule. Round the result to the nearest whole penny.

(H) Addition of hospital-specific allowances.

Hospital-specific allowances include those described in paragraphs (H)(1) to (H)(3) of this rule.

(1) For Ohio hospitals having approved teaching programs as defined in 42 C.F.R. 405.421 as effective on October 1, 1985, an education allowance amount is added. The medical education allowance amount is described in rule 5101:3-2-07.7 of the Administrative Code.

(2) For Ohio hospitals, a hospital-specific capital allowance amount is added. The capital allowance amount is described in rule 5101:3-2-07.6 of the Administrative Code.

(3) For non-Ohio hospitals, a single capital allowance amount is added. The capital allowance amount is described in rule 5101:3-2-07.6 of the Administrative Code.

(I) The final prospective payment rate is calculated by multiplying the adjusted inflated average cost per discharge, derived from paragraphs (G)(3)(a) and (G)(3)(b) of this rule, by the relative weight appropriate to the DRG (see rule 5101:3-2-07.3 of the Administrative Code), rounding the result to the nearest whole penny, then adding all applicable hospital-specific allowance amounts described in paragraphs (H)(1) to (H)(3) of this rule, i.e.:

"Adjusted Inflated Average Cost Per Discharge	X	DRG Relative Weight	+	Hospital-Specific Capital Allowance (as applicable)	+	Hospital-Specific Education Allowance (as applicable)	=	Final Prospective Payment Rate"

Effective: 09/29/2011

R.C. 119.032 review dates: 10/01/2014

Certification: CERTIFIED ELECTRONICALLY

Date: 09/19/2011

Promulgated Under: 119.03

Statutory Authority: 5111.02, section 309.30.35 of Am. Sub. H.B. 153, 129th G.A.

Rule Amplifies: 5111.01, 5111.02, section 309.30.35 of Am. Sub. H.B. 153, 129th G.A.

Prior Effective Dates: 10/4/84, 7/1/85, 7/5/86, 10/19/87, 7/1/88 (Emer), 9/29/88, 7/1/89, 6/29/90 (Emer), 9/23/90, 9/3/91 (Emer), 11/10/91, 7/1/92, 7/1/93, 12/29/95 (Emer), 3/16/96, 7/1/96, 7/2/98, 1/1/00, 1/1/02, 12/31/02 (Emer), 2/6/03, 8/21/03, 12/8/05, 12/31/07 (Emer), 3/30/08, 10/1/09 (Emer), 10/15/09, 7/1/11 (Emer)

5160-2-07.5 Disproportionate Share Adjustment

Formerly **5101:3-2-07.5 Disproportionate Share Adjustment**

HHTL 3352-10-06

Effective Date: December 25, 2010

Most Current Prior Effective Date: **September 15, 2006**

This rule describes the disproportionate share definition and limitations on payment methods described in rule 5101:3-2-09 of the Administrative Code ~~and assessment determinations described in rule 5101:3-2-08.1 of the Administrative Code~~ for the program year specified in paragraph (A)(9) of rule 5101:3-2-08 of the Administrative Code.

(A) For the program year specified in paragraph (A)(9) of rule 5101:3-2-08 of the Administrative Code, paragraphs (B) to (D) of this rule set forth the definition of disproportionate share as well as other procedures and data used for the disproportionate share calculations ~~and assessment determinations as described in rule 5101:3-2-08.1 of the Administrative Code and payment determinations~~ as described in rule 5101:3-2-09 of the Administrative Code.

(B) Source data for calculations.

The source data used for the calculations made in paragraphs (C) and (D) of this rule will be the hospital's cost-reporting period ending in the state fiscal year as specified in paragraph (B) of rule 5101:3-2-08 of the Administrative Code.

(C) Determination of disproportionate share qualification.

(1) For each hospital calculate the medicaid utilization rate by dividing the sum of total medicaid days and managed care plan (MCP) days as defined in paragraph (A) of rule 5101:3-2-09 of the Administrative Code by total facility days as defined in paragraph (A) of rule 5101:3-2-09 of the Administrative Code.

(2) Each hospital with a medicaid utilization rate greater than or equal to one per cent qualifies as a disproportionate share hospital for the purposes of rule 5101:3-2-09 of the Administrative Code.

(3) Each hospital with a medicaid utilization rate less than one per cent qualifies as a nondisproportionate share hospital for the purposes of rule 5101:3-2-09 of the Administrative Code.

(D) Limitations on disproportionate share and indigent care payments made to hospitals.

(1) For purposes of this rule, for each hospital, calculate medicaid fee for service (FFS) shortfall by subtracting from total medicaid costs, as defined in paragraph (A) of rule 5101:3-2-09 of the Administrative Code, total medicaid payments, as described in paragraph (A) of rule 5101:3-2-09 of the Administrative Code. For those hospitals exempt from the prospective payment system as described in rule 5101:3-2-07.1 of the Administrative Code, the medicaid shortfall equals zero.

(2) For each hospital, calculate the total medicaid shortfall by adding the medicaid FFS shortfall as defined in paragraph (D)(1) of this rule to the medicaid MCP shortfall as defined in paragraph (E)(2)(d) of rule 5101:3-2-09 of the Administrative Code.

(3) For each hospital, determine the total cost of uncompensated care for people without insurance as described in paragraphs (D)(3)(a) to (D)(3)(c) of this rule.

(a) For each hospital, "total inpatient uncompensated care costs for people without insurance" means the sum of the inpatient disability assistance medical costs, uncompensated care costs below the poverty level, and uncompensated care costs above the poverty level amounts from the JFS 02930, schedule F, column 5, line 11.

(b) For each hospital, "total outpatient uncompensated care costs for people without insurance" means the sum of the outpatient disability assistance medical costs,

uncompensated care costs below the poverty level, and uncompensated care costs above the poverty level amounts from the JFS 02930, schedule F, column 5, line 15.

(c) For each hospital, total uncompensated care costs for patients without insurance is equal to the sum of paragraphs (D)(3)(a) and (D)(3)(b) of this rule.

(4) For each hospital, determine the amount received under section 1011 - federal reimbursement of emergency health services furnished to undocumented aliens from the JFS 02930, schedule E, line 7b.

~~(4)~~(5) For each hospital, calculate the hospital disproportionate share limit by adding the total medicaid shortfall as described in paragraph (D)(2) of this rule and total uncompensated care costs for people without insurance as described in paragraph (D)(3)(c) of this rule and subtracting section 1011 payments as described in paragraph (D)(4) of this rule.

~~(5)~~(6) The hospital will receive the lesser of the disproportionate share limit as described in paragraph ~~(D)(4)~~ (D)(5) of this rule or the disproportionate share and indigent care payment as calculated in rule 5101:3-2-09 of the Administrative Code.

Effective: 12/25/2010

R.C. 119.032 review dates: 09/23/2010 and 12/01/2015

Certification: CERTIFIED ELECTRONICALLY

Date: 12/15/2010

Promulgated Under: 119.03

Statutory Authority: 5111.02, 5112.03

Rule Amplifies: 5111.02, 5111.021, 5112.01, 5112.03

Prior Effective Dates: 10/19/87, 7/1/88 (Emer), 9/29/88, 7/2/92 (Emer), 9/20/92, 7/16/93 (Emer), 9/30/93, 7/24/94, 3/10/95 (Emer), 5/18/95, 3/16/96, 8/7/96 (Emer), 10/21/96, 8/25/97 (Emer), 11/1/97, 8/6/98 (Emer), 9/18/98, 9/15/99, 8/2/01, 9/15/06

5160-2-07.6 Capital Costs

Formerly **5101:3-2-07.6 Capital Costs**

HHTL 3352-14-03

Effective Date: March 27, 2014

Most Current Prior Effective Date: **January 1, 2014 (Emergency)**

(A) For purposes of this rule, capital costs include the categories of costs recognized by medicare on the centers for medicare and medicaid services (CMS) 2552-96 revised April 1, 2005~~,~~ or CMS 2552-10 revised October 2012 and filed in accordance with CMS instructions, available at ~~http://www.cms.hhs.gov/manuals/pub152/PUB_15_2.asp~~ http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html (revised September 2013).

(B) Capital-related costs for services provided on or before December 31, 2013 by Ohio hospitals paid under prospective payment will be subject to reasonable cost reimbursement. The program reimbursable amount will be reconciled during settlement to the total amount of interim capital payments associated with discharges occurring during the cost-reporting period.

Capital-related costs for services provided on or after January 1, 2014 by Ohio hospitals paid under prospective payment will be subject to prospective payment without subsequent settlement to actual capital costs.

(C) Annual update of interim capital payments.

~~The calculation of interim capital payments resulting in the capital allowance identified in paragraph (I) of rule 5101:3-2-07.4 of the Administrative Code is based on the hospital's cost-reporting period.~~

~~On an annual basis, the interim capital payments will be redetermined by identifying the capital-related costs reported on CMS 2552-96; multiplying that cost by the per cent of medicaid inpatient charges to total charges; and dividing the result by the number of medicaid discharges that occurred during the cost-reporting period. The cost report used to complete these calculations is the interim settled cost report ending in the state fiscal year ending in the calendar year preceding the immediate past calendar year prior to January first of the calendar year to which the new capital rate shall apply.~~

(1) The calculation of interim capital payments resulting in the capital allowance identified in paragraph (I) of rule 5160-2-07.4 of the Administrative Code is based on the hospital's cost-reporting period.

On an annual basis, the interim capital payments will be redetermined by identifying the capital-related costs reported on CMS 2552-96; multiplying that cost by the per cent of medicaid inpatient charges to total charges; and dividing the result by the number of medicaid discharges that occurred during the cost-reporting period. The cost report used to complete these calculations is the interim settled cost report ending in the state fiscal year ending in the calendar year preceding the immediate past calendar year prior to January first of the calendar year to which the new capital rate shall apply.

(2) For services provided on or after January 1, 2014, the calculation of interim capital payments resulting in the capital allowance identified in rule 5160-2-65 of the Administrative Code is based on the hospital's cost-reporting period.

On an annual basis, the interim capital payments will be redetermined by identifying eighty-five per cent of the capital-related costs reported on CMS 2552-96 or CMS 2552-10; multiplying that cost by the per cent of medicaid inpatient charges to total charges; and dividing the result by the number of medicaid discharges that occurred during the cost-reporting period. The cost report used to complete these calculations is the interim settled cost report ending in the state fiscal year ending in the calendar year preceding the immediate past calendar year prior to January first of the calendar year to which the new capital rate shall apply.

(D) Non-Ohio hospital capital reimbursement.

(1) The average statewide capital cost is computed by summing, for all Ohio hospitals, the ~~total~~ identified capital costs ~~for all Ohio hospitals~~ as described in paragraph (C) of this rule and multiplying that cost by the per cent of medicaid inpatient charges to total charges for all Ohio hospitals, and~~, divided~~ dividing by total discharges for all Ohio hospitals as described in paragraph (C)~~(2)~~ of this rule.

(2) For services provided on or before December 31, 2013, the capital allowance for non-Ohio hospitals shall be one hundred per cent of the amount calculated in paragraph (D)(1) of this rule.

(3) For services provided on or after January 1, 2014, the capital allowance for non-Ohio hospitals shall be eighty-five per cent of the amount calculated in paragraph (D)(1) of this rule.

~~(2)~~(4) The average statewide capital cost is updated annually using capital costs from cost reports as described in paragraph (C) of this rule.

~~(3)~~(5) The amounts derived in paragraph (D)~~(1)~~ of this rule will reflect a statewide average calculated to be in effect at the beginning of the prospective rate year and not subject to retrospective adjustments.

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R.C. 119.032 review dates: 01/10/2014 and 03/27/2019

Certification: CERTIFIED ELECTRONICALLY

Date: 03/17/2014

Promulgated Under: 119.03

Statutory Authority: 5164.02

Rule Amplifies: 5164.02, 5164.70

Prior Effective Dates: 10/1/84, 7/4/85, 7/3/86, 10/19/87, 6/19/00, 1/27/06, 1/1/14 (Emer.)

5160-2-07.7 Medical Education

Formerly **5101:3-2-07.7 Medical Education**

HHTL 3352-05-15

Effective Date: January 30, 2006

Most Current Prior Effective Date: **September 12, 2003**

Ohio hospitals that have an approved medical education program as defined in 42 ~~CFR~~ C.F.R. ~~413.86~~ 405.421 effective September 1, 1983 qualify for an allowance for medical education. This rule describes the method used to determine the medical education allowance that will be added to the diagnostic related group (DRG) ~~DRG~~ base price for teaching hospitals. Source documents used are those described in paragraph (D) of rule 5101:3-2-07.4 of the Administrative Code.

(A) Direct medical education allowance.

(1) Identify the hospital's intern and resident cost as reported on the health care finance administration ~~HCFA~~ H.C.F.A. 2552-85 effective July 1, 1985 and available at~~,~~ http://www.cms.hhs.gov/manuals/pub152/PUB_15_2.asp, worksheet B, part I, line 95, column 21 and divide that cost by the number of full-time equivalent (FTE) residents and interns reported by the hospital on ~~HCFA~~ H.C.F.A. 2552-85, worksheet S-3, column 9, lines 8, 9, and 10.

(2) Determine the value of one standard deviation above the statewide mean cost per intern/resident. The statewide mean cost per intern/resident is determined by dividing the statewide total cost for interns and residents by the total number of FTE interns and residents in the state. The numbers used in this computation are identified in paragraph (A)(1) of this rule.

(3) Compare the hospital-specific average cost per intern/resident as described in paragraph (A)(1) of this rule with the amount derived from paragraph (A)(2) of this rule. The allowable cost per intern/resident for hospitals ~~which~~ that have a hospital-specific average cost per intern/resident below the amount derived from paragraph (A)(2) of this rule is the amount derived as described in paragraph (A)(1) of this rule. The allowable cost per intern/resident for hospitals ~~which~~ that have a hospital-specific average cost per intern/resident above the amount derived from paragraph (A)(2) of this rule is the amount as described in paragraph (A)(2) of this rule.

(4) Multiply the hospital's allowable cost per intern/resident, as described in paragraph (A)(3) of this rule, by the hospital's number of FTE interns and residents.

(5) Add to the total allowed cost for interns and residents computed in paragraph (A)(4) of this rule, the hospital's costs for nursing and paramedical education from ~~HCFA~~ H.C.F.A.2552-85, worksheet B, line 95, columns 20, 22, 23, and 24.

(6) Multiply the total allowed direct medical education cost derived in paragraph (A)(5) of this rule by the per cent derived in paragraph (D)(6)(b)(iii) of rule 5101:3-2-07.4 of the Administrative Code. Divide this product by the number of discharges used to calculate the average cost per discharge as described in rule 5101:3-2-07.4 of the Administrative Code.

(B) Indirect medical education allowance.

(1) The hospital's indirect medical education percentage will bedetermined by applying the following logarithmic formula:

Click here to view the above mentioned logarithmic formula

The number of interns and residents will be the number described in paragraph (A)(1) of this rule. The number of beds will be the number reported on ~~HCFA~~ H.C.F.A. 2552-85, worksheet S-3, lines 8, 9, and 10, column 1.

(2) Determine the total indirect medical education cost for a hospital by subtracting the amount derived in paragraph (D)(9)(b) of rule 5101:3-2-07.4 of the Administrative Code from the amount derived in paragraph (D)(8)(c) of rule 5101:3-2-07.4 of the Administrative Code.

(3) Determine a hospital-specific unit cost of indirect medical education by dividing the amount derived from paragraph (B)(2) of this rule by the product of one hundred times~~,~~ the percentage calculated in paragraph (B)(1) of this rule. This amount is then divided by the number of discharges used to calculate the average cost per discharge as described in rule 5101:3-2-07.4 of the Administrative Code.

(4) A statewide mean unit cost for indirect medical education is determined by summing all hospitals' unit cost as described in paragraph (B)(3) of this rule, eliminating the two values that represent the highest and the lowest values, and dividing this sum by the number of values used in this calculation. The values of one standard deviation above this statewide mean cost is then determined.

(5) Compare the hospital-specific unit cost of indirect medical education as described in paragraph (B)(3) of this rule to the statewide mean unit cost plus one standard deviation as described in paragraph (B)(4) of this rule. The allowable indirect medical education unit cost for hospitals ~~which~~ that have a hospital-specific unit cost below the statewide mean plus one standard deviation is the amount derived in paragraph (B)(3) of this rule. The allowable unit cost for hospitals with a unit cost above the statewide mean plus one standard deviation is the amount derived in paragraph (B)(4) of this rule.

(6) The allowable unit cost for indirect medical education is multiplied by one hundred~~,~~ times the indirect medical education percentage described in paragraph (B)(1) of this rule to determine the indirect medical education allowance.

(C) The total medical education allowance is the sum of the indirect medical education allowance derived in paragraph (B)(6) of this rule and the direct medical education amount derived in paragraph (A)(6) of this rule, adjusted for inflation as described in paragraphs (D)(12) and (G) of rule 5101:3-2-07.4 of the Administrative Code.

(D) The total medical education allowance as described in paragraph (C) of this rule is adjusted to remove the effects of the hospital's case mix. The data used to compute the hospital's case mix index are the hospital's claim records for discharges occurring during the hospital's fiscal period, on or after April 1, 1990 through December 31, 1991, and paid by December 31, 1992. For purposes of this paragraph, case mix is determined using the DRG categories and relative weights described in rule 5101:3-2-07.3 of the Administrative Code and includes outlier cases as described in rule 5101:3-2-07.9 of the Administrative Code.

(1) For each hospital the number of cases in each DRG is multiplied by the relative weight for each DRG. Round the result to five decimal places. The relative weights are those described in rule 5101:3-2-07.3 of the Administrative Code.

(2) Sum the result of each computation in paragraph (D)(1) of this rule.

(3) Divide the product from paragraph (D)(2) of this rule by the number of cases in the hospital's sample as described in paragraph (D) of this rule. Round the result to five decimal places. This produces a hospital-specific case mix index.

(4) Divide the total medical education allowance as described in paragraph (C) of this rule by the hospital-specific case mix index computed in paragraph (D)(3) of this rule to determine the adjusted total medical education allowance. Round the result to the nearest whole penny.

(E) The adjusted total medical education allowance as described in paragraph (D) of this rule is multiplied by the relative weight appropriate to the DRG as described in rule 5101:3-2-07.3 of the Administrative Code, rounding the result to the nearest whole penny, to determine the hospital specific medical education allowance amount for the DRG.

Effective Date: 01/27/2006

R.C. 119.032 review date: 01/01/2011

Certification

Promulgated Under: 119.03

Statutory Authority: 5111.02, 5111.19

Rule Amplifies: 5111.01, 5111.02, 5111.19

Prior Effective Dates: 10/4/84, 7/1/85, 7/3/86, 10/19/87, 1/20/95, 8/1/02, 9/12/03

5160-2-07.8 Redetermination of Prospective Payment Rates

Formerly **5101:3-2-07.8 Redetermination of Prospective Payment Rates**

HHTL 3352-07-09

Effective Date: December 22, 2007

Most Current Prior Effective Date: **August 1, 2002**

(A) General description.

In future years, prospective payment rates may be determined by application of a projected inflation value as set forth in paragraph (B) of this rule leaving base-year costs and relative weights unchanged. Alternatively, through revision of relevant rules in this chapter, either or both the rebasing of base-year costs or the recalibration of relative weights for DRGs may occur and may result in a significant change in the prospective payment rate. In addition to redetermination of rates associated with the beginning of a new rate year, redetermination may occur within a rate year. At the beginning of each new rate year, a ninety-day period will be provided to both the department and the hospitals for the verification of all data used in rate calculations and the detection of errors in the calculations of rate amounts following the methodologies detailed in rules 5101:3-2-07.4, 5101:3-2-07.6, and 5101:3-2-07.7 of the Administrative Code. Rule 5101:3-2-07.12 of the Administrative Code describes the procedures by which a hospital may request reconsideration of a rate component during the first ninety days of a rate year as well as the conditions under which subsequent reconsideration may be requested. Rule 5101:3-2-24 of the Administrative Code describes the conditions under which the department may initiate rate adjustments after the initial ninety-day verification period has passed. This rule describes the applicability of and procedures for redetermination of prospective rates.

(B) Application of inflation allowance.

At the start of each succeeding state fiscal year, the department shall apply a projected inflation value as defined in rule 5101:3-2-07.4 of the Administrative Code.

(C) Redetermination of peer group average cost per discharge component of the prospective payment rate.

The peer group average cost per discharge component described in paragraphs (E)(1) to (E)(4) of rule 5101:3-2-07.4 of the Administrative Code may be redetermined in accordance with paragraphs (C)(1) to (C)(3) of this rule.

(1) When reclassification of hospitals among peer groups occurs as described in paragraph (D)(2) of rule 5101:3-2-07.2 of the Administrative Code, the peer group average cost per discharge component will be redetermined if such redetermination would result in at least a two per cent difference, negative or positive, in the peer group average cost per discharge amount.

(2) The peer group average cost per discharge component will be redetermined if the use of revised or corrected hospital-specific average cost per discharge data would result in at least a two per cent difference in the peer group average cost per discharge amount subject to the provisions of this paragraph. In order to redetermine the peer group average cost per discharge under the provisions of this paragraph and paragraph (C) of this rule, the following conditions apply:

(a) Revised or corrected hospital-specific average cost per discharge data are identified under the provisions described in paragraphs (C) to (C)(3) of this rule, rule 5101:3-2-07.12, or rule 5101:3-2-24 of the Administrative Code.

(b) Data described in paragraph (C)(2)(a) of this rule is identified within two rate periods following implementation of rebased rate components.

(3) For the purposes of paragraphs (C)(1) and (C)(2) of this rule, any redeterminations of the peer group average cost per discharge component will be made in accordance with the provisions set forth in rule 5101:3-2-07.4 of the Administrative Code. If peer group rates are subject to redetermination because they meet the provision of paragraph (C)(1) or (C)(2) of this rule, the timing of the adjustment to the rate and the mechanism for retrospectively adjusting previously

paid claims depends upon the magnitude of the adjustment. If the use of revised hospital-specific data for one or more hospitals in a peer group results in a change of at least five per cent in the peer group average cost per discharge, the rate adjustment will be made prospectively for admissions on or after the thirtieth day following the final administrative decision described in rule 5101:3-2-07.12 of the Administrative Code, or following the recognition by the department that an adjustment in the peer group average cost per discharge calculation is warranted, whichever is earlier. Claims previously paid that are subject to the adjustment will be adjusted retrospectively at interim settlement or can be mass adjusted if the provider requests in writing that a mass adjustment of that provider's claims be performed. If the use of revised data for one or more hospitals in a peer group results in a change of less than five per cent in the peer group average cost per discharge, the adjustment will be made prospectively for admissions on or after the first day of the next rate year and retrospectively during interim or final settlement. The retrospective adjustment of previously paid claims will be accomplished by determining the difference between the amount paid during the period that incorrect rates were in effect and the amount that would have been paid if the correct rates had been in effect and adjusting this amount by case-mix.

(D) Redetermination of ~~the~~ a hospital-specific rate component.

Redetermination of a hospital-specific rate component as described in rules 5101:3-2-07.6 and 5101:3-2-07.7 of the Administrative Code will not be implemented until the beginning of the next prospective rate year unless the need for the change in the rate component is detected within the first ninety days of a new rate year. Adjustments to claims paid during a period when a rate component was incorrect will be made retrospectively at interim settlement. Corrections to these rate components will be made prospectively at the beginning of the following rate year.

(E) Notification of effective rates.

Prior to the beginning of each prospective payment rate year, each Ohio hospital will be given notice regarding payment rates for the upcoming prospective payment years. The payment rate information described in this paragraph will be effective for the prospective payment year, except as otherwise provided in rules 5101:3-2-07.12 and 5101:3-2-24 of the Administrative Code and this rule. Information provided in the notice described in this paragraph shall include:

(1) Peer group average cost per discharge adjusted as described in rule 5101:3-2-07.4 of the Administrative Code;

(2) Hospital-specific allowances, as applicable, for ~~capitaland~~ capital and medical education as described in rules 5101:3-2-07.4, 5101:3-2-07.6, and 5101:3-2-07.7 of the Administrative Code; and

(3) Indication of whether the hospital is recognized as operating a distinct-part psychiatric unit, and/or level I, II, or III nursery unit as each are described in rule 5101:3-2-02 of the Administrative Code. Hospitals must notify the department immediately when a change in psychiatric unit distinct part and/or nursery unit occurs. Retrospective adjustment of previously paid claims to reflect the change in status of the psychiatric unit or nursery will be processed for claims with discharges beginning on the later of the effective date of the change or the first day of the rate year in which the department was notified of the change. No adjustments to paid claims will be made for claims with discharge dates that were prior to the beginning of the rate year in which the department was notified of the change.

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5160-2-07.9 Payment for Outliers

Formerly **5101:3-2-07.9 Payment for Outliers**

HHTL 3352-11-06

Effective Date: October 1, 2011

Most Current Prior Effective Date: **September 15, 2006**

This rule defines cost and day outliers and exceptional outliers, and describes the reimbursement methodology that will be used ~~in paying~~ to pay for all types of outliers for inpatient hospitals subject to the prospective payment system. The payment policies contained in this rule are effective for dates of discharge on or after ~~January 1, 2006~~October 1, 2011.

(A) The Ohio department of job and family services ("ODJFS") will provide for an additional payment to a hospital for covered inpatient hospital services to a medicaid recipient that ~~exceeds~~exceed the thresholds as described in paragraphs (A)(1) to (A)(6) of this rule.

(1) For diagnostic related groups (DRGs) 1 to 384; 391 to 468; 471 to 503: The total allowed charges for an inpatient stay exceeds the statewide arithmetic mean charge, as described in rule 5101:3-2-07.3 of the Administrative Code, for the appropriate DRG by two standard deviations.

(2) For DRGs 385; 388 to 390; 892 to 898: The total allowed charges for the inpatient stay exceeds the statewide arithmetic mean charge, as described in rule 5101:3-2-07.3 of the Administrative Code, for the applicable DRG by one standard deviation.

(3) For DRGs 1 to 384; 391 to 468; 471 to 503: The recipient's covered length of stay exceeds the statewide geometric mean length of stay for the applicable DRG by two standard deviations.

(4) For DRGs 388 to 390 and 892 to 898: The recipient's covered length of stay exceeds the statewide geometric mean length of stay for the applicable DRG by one standard deviation.

(5) If a hospital that does not meet the criteria described in paragraphs (E)(1) and (E)(2) of this rule has a discharge that qualified for both a cost and a day outlier payment, then the hospital receives payment for the case as a cost outlier only.

(6) Effective August 1, 2002, if the cost for a case determined by multiplying the allowed charges from the claim by the hospital-specific cost-to-charge ratio, determined in accordance with the provisions of paragraph (B)(2) of rule 5101:3-2-22 of the Administrative Code, exceeds four hundred forty-three thousand, four hundred sixty-three dollars, then payment will be as described in paragraph (D) of this rule. This threshold amount will be inflated on an annual basis on January first of each year by using the inflation factor described in paragraph (G)(1) of rule 5101:3-2-07.4 of the Administrative Code, that has been supplied to the department by three months prior to the beginning of the rate year.

(B) Payment for extended length of stay (day outliers).

(1) If the hospital stay reflected by a discharge includes covered days of care beyond the threshold as described in paragraphs (A)(3) and (A)(4) of this rule, an additional payment shall be made.

(2) Any case that qualifies for a day outlier payment is subject to review as described in rule 5101:3-2-07.13 of the Administrative Code.

(3) For ~~discharges in~~ DRGs 1 to 384; 391 to 468; 471 to 503: Except as provided in paragraph (B)(5) of this rule, the per diem payment will be based on sixty per cent of the per diem rate, except that for hospitals meeting the criteria described in paragraphs (E)(1) and (E)(2) of this rule, per diem payment will be eighty per cent of the per diem rate. The per diem rate is calculated by dividing the hospital's final prospective rate for that DRG as described in ~~paragraph (I) of~~ rule 5101:3-2-07.4 of the Administrative Code, less capital and teaching allowance for the applicable DRG by the statewide geometric mean length of stay, calculated excluding outliers, for that DRG.

The total day outlier payment is then determined by multiplying the number of covered days beyond the day threshold times the per diem payment amount. The total payment is the final prospective payment rate as described in ~~paragraph (I) of~~ rule 5101:3-2-07.4 of the Administrative Code, plus the outlier payment. If the total payment exceeds allowable charges, reimbursement is limited to allowable charges.

(4) For DRGs 388 to 390 and 892 to 898: The per diem payment will be based on eighty per cent of the per diem rate determined by dividing the hospital's final prospective payment rate for that DRG as described in paragraph (I) of rule 5101:3-2-07.4 of the Administrative Code, less capital and teaching allowance for the applicable DRG by the statewide geometric mean length of stay, calculated excluding outliers, for that DRG. The total day outlier payment is then determined by multiplying the number of covered days beyond the day threshold times the per diem payment amount. The total payment is the final prospective payment rate as described in ~~paragraph (I) of~~ rule 5101:3-2-07.4 of the Administrative Code, plus the outlier payment. If the total payment exceeds allowable charges, reimbursement is limited to allowable charges.

(5) For DRG 488, DRG 489 and DRG 490: The per diem payment for hospitals meeting the criteria described in paragraph (G) of this rule ~~If a hospital meeting the criteria described in paragraph (G) of this rule has a discharge that groups into DRG 488, DRG 489, or DRG 490, the per diem payments made under paragraph (A)(1) of this rule~~ will be based on eighty per cent of the per diem rate. The per diem rate is calculated by dividing the hospital's final prospective rate for that DRG as described in ~~paragraph (I) of~~ rule 5101:3-2-07.4 of the Administrative Code, less capital and teaching allowance for the applicable DRG by the statewide geometric mean length of stay, calculated excluding outliers, for that DRG. The total day outlier payment is then determined by multiplying the number of covered days beyond the day threshold times the per diem payment amount. The total payment is the final prospective payment rate as determined in ~~paragraph (I) of~~ rule 5101:3-2-07.4 of the Administrative Code, plus the outlier payment. If the total payment exceeds allowable charges, reimbursement is limited to allowable charges.

(C) Payment for extraordinary high-charge cases (cost outliers).

(1) If the allowable charges ~~exceeds~~exceed the statewide charge threshold for the applicable DRG as described in paragraphs (A)(1) and (A)(2) of this rule, an additional payment shall be made. The threshold amount for each DRG will be inflated ~~on an annual basis on January first of each year~~ by using the cost outlier inflation factor described in ~~paragraph (G) of rule 5101:3-2-07.4 of the Administrative Code, that has been supplied to the department by three months prior to the beginning of the rate year~~ paragraphs (C)(1)(a) and (C)(1)(b) of this rule.

(a) For discharges on or after October 1, 2011 through December 31, 2011, the threshold amount for each DRG in effect on September 30, 2011 shall be inflated by 13.6 per cent.

(b) For discharges on or after January 1, 2012 through the implementation of the new DRGs established by section 309.30.30 of Amended Substitute House Bill 153 of the 129th General Assembly, the threshold amount for each DRG in effect on December 31, 2011 shall be inflated by 9.72 per cent.

(2) Any case that qualifies for a cost outlier payment is subject to review as described in rule 5101:3-2-07.13 of the Administrative Code.

(3) For ~~discharges in~~ DRGs 1 to 384; 391 to 468; 471 to 503: Except as otherwise provided in paragraghs (C)(5) and (C)(6) of this rule, the difference determined by subtracting the statewide charge threshold, as described in paragraph (A)(1) of this rule from allowable charges, is multiplied by the hospital-specific cost to charge ratio to determine the additional payment to be made for the outlier portion. The total payment for cost outlier claims except those described in paragraphs (C)(5) and (C)(6) of this rule is the final prospective payment rate as described in ~~paragraph (I) of~~ rule 5101:3-2-07.4 of the Administrative Code, plus the outlier amount.

Total reimbursement is limited to the lower of allowable claim charges or claim cost. Claim cost is calculated by multiplying allowable claim charges by the hospital specific, medicaid inpatient

cost-to-charge ratio, as described in ~~paragraph (B)(2) of~~ rule 5101:3-2-22 of the Administrative Code.

(4) For DRGs 385; 388 to 390; and 892 to 898: Except as otherwise provided in paragraph (C)(5) of this rule, the~~The~~ difference determined by subtracting the statewide charge threshold, as described in paragraph (A)(2) of this rule from the allowable charges, is multiplied by the hospital-specific cost to charge ratio to determine the additional payment to be made for the outlier portion ~~except as provided in paragraph (C)(5) of this rule~~. The total payment for cost outlier claims except those described in paragraph (C)(5) of this rule is the final prospective payment rate as described in ~~paragraph (I) of~~ rule 5101:3-2-07.4 of the Administrative Code, plus the outlier amount. Total reimbursement is limited to the lower of allowable claim charges or claim cost. Claim cost is calculated by multiplying allowable claim charges by the hospital specific, medicaid inpatient cost-to-charge ratio, as described in ~~paragraph (B)(2) of~~ rule 5101:3-2-22 of the Administrative Code.

(5) For hospitals meeting the criteria described in paragraphs (E)(1) and (E)(2) of this rule, payment for cost outlier claims will be eighty-five per cent of the product of allowed claim charges times the hospital-specific, medicaid inpatient cost-to-charge ratio as described in ~~paragraph (B)(2) of~~ rule 5101:3-2-22 of the Administrative Code.

(6) For DRG 488, DRG 489 and DRG 490: The payment for cost outlier claims for hospitals meeting the criteria described in paragraph (G) of this rule, ~~payment for cost outlier claims~~ will be eighty-five per cent of the product of allowed claim charges times the hospital-specific, medicaid inpatient cost-to-charge ratio as described in ~~paragraph (B)(2) of~~ rule 5101:3-2-22 of the Administrative Code ~~for cases grouping into DRG 488, DRG 489, or DRG 490~~.

(D) Cases that meet the criteria described in paragraph (A)(6) of this rule will be paid the product of the hospital's allowable charges times the hospital-specific cost-to-charge ratio, as described in ~~paragraph (B)(2) of~~ rule 5101:3-2-22 of the Administrative Code.

(E) Hospitals that meet the criteria described in paragraphs (E)(1) and (E)(2) of this rule are subject to the special outlier payment policies described in paragraphs (A)(6), and (C)(5) of this rule.

(1) The hospital-specific outlier per cent as described in paragraph (F)(2)(b) of rule 5101:3-2-07.4 of the Administrative Code is greater than one standard deviation over the statewide mean outlier per cent as described in paragraph (F)(2)(c) of rule 5101:3-2-07.4 of the Administrative Code.

(2) The hospital's ratio of medicaid, general assistance, and Title V inpatient days to total inpatient days as described in paragraph (F)(1)(b) of this rule is greater than one standard deviation above the statewide mean ratio of medicaid, general assistance, and Title V inpatient days to total inpatient days as described in paragraph (F)(2)(c) of this rule.

(F) The calculations described in paragraphs (F)(1) to (F)(2)(c) of this rule were performed using ODHS 2930 cost-report data submitted by hospitals as described in rule 5101:3-2-23 of the Administrative Code. For hospitals with fiscal periods ending September thirtieth, October thirty-first, or December thirty-first, the 1985 cost-report is used. For hospitals with fiscal periods ending March thirty-first, May thirty-first, June thirtieth, or August thirty-first, the 1986 cost report is used.

(1) Determination of each hospital's ratio of medicaid, general assistance, and Title V inpatient days to total inpatient days.

(a) Sum the number of days shown on the ODHS 2930, schedule D, section 1, column 6, total, for medicaid, general assistance, and Title V schedules.

(b) Divide the sum derived from paragraph (F)(1)(a) of this rule by total inpatient days as reported on the ODHS 2930, schedule D, section 1, column 4, total. Round to six decimal places.

(2) Determination of one standard deviation above the statewide mean ratio of medicaid, general assistance, and Title V inpatient days to total inpatient days.

(a) Sum the ratios derived from paragraph (F)(1)(b) of this rule across all Ohio hospitals. Divide the resulting sum by the number of hospitals to determine the statewide mean ratio.

(b) Determine the value of one standard deviation above the statewide mean ratio. Round the ratio to six decimal places.

(c) Sum the values calculated as described in paragraphs (F)(2)(a) and (F)(2)(b) of this rule to determine the value of one standard deviation above the statewide mean ratio of medicaid, general assistance, and Title V inpatient days to total inpatient days.

(G) Hospitals whose total number of cases in the claim files used for setting relative weights in accordance with rule 5101:3-2-07.3 of the Administrative Code that group into DRG 488, DRG 489, or DRG 490 is greater than two standard deviations above the statewide mean for all cases that fall into these DRGs, as described in paragraphs (G)(1)(a) to (G)(1)(c) of this rule, are subject to the special outlier payment policies described in paragraphs (B)(5) and (C)(6) of this rule.

(1) Determination of two standard deviations above the statewide mean total cases that group into DRG 488, DRG 489, or DRG 490.

(a) Sum the number of cases that group into DRG 488, DRG 489, and DRG 490 using the claim base described in paragraphs (C) to (C)(4)(b) of rule 5101:3-2-07.3 of the Administrative Code. Divide the resulting sum by the number of hospitals that had any claim group into DRG 488, DRG 489, or DRG 490.

(b) Determine the value of two standard deviations above the statewide mean number of cases.

(c) Sum the values calculated as described in paragraphs (G)(1)(a) and (G)(1)(b) of this rule to determine the value of two standard deviations above the statewide mean total number of cases in DRG 488, DRG 489, and DRG 490.

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Sub. H.B. 153, 129th G.A.

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5160-2-07.11 Payment Methodology

Formerly **5101:3-2-07.11 Payment Methodology**

HHTL 3352-04-05

Effective Date: June 1, 2004

Most Current Prior Effective Date: **August 1, 2002**

5101:3-2-07.11 Appendix A, Diagnosis Related Groups, Version 15.0

(A) Payments under the prospective payment system.

For inpatient hospitals subject to prospective payment as described in rule 5101:3-2-07.1 of the Administrative Code, payments are made on the basis of a prospectively determined rate as provided in rule 5101:3-2-07.4 of the Administrative Code. Additional payments for cases which qualify as outliers are described in rule 5101:3-2-07.9 of the Administrative Code. ~~Additional payments may be made for services described in accordance with paragraph (C) of rule 5101:3-2-07.1 of the Administrative Code.~~ The amount paid represents final payment based on a submission of a discharge bill. No year-end retrospective adjustment is made for prospective payment except as provided in rules 5101:3-2-07.8 and 5101:3-2-24 of the Administrative Code. Except as provided in rules 5101:3-2-24, 5101:3-2-07.13, and 5101:3-2-42 of the Administrative Code, a hospital may keep the difference between its prospective payment rate and costs incurred in furnishing inpatient services and is at risk for costs which exceed the prospective payment amounts.

(B) Amounts of payment, including all components of the prospective payment rate, DRG categories and relative weights associated with such categories, identification of outlier cases and payment methods for outliers, transfers and readmissions, and other provisions affecting amounts of payment are based on applying the provisions of this chapter to claims associated with dates of discharge on or after the effective dates of the rules in this chapter, unless otherwise specified.

(C) Hospitals must submit a claim for payment only upon a recipient's final discharge as defined in rule 5101:3-2-02 of the Administrative Code including those discharges which meet the criteria for outlier payments defined in rule 5101:3-2-07.9 of the Administrative Code unless the claim qualifies for interim billing as described in paragraph (C)(3) of this rule. Transfers and readmissions are defined and paid in accordance with the provisions of this rule. The department shall assign a DRG by using the DRG "grouper," modified as described in this paragraph. For discharges on or after February 1, 2000, the department uses the "grouper" distributed by "Health Services, Incorporated," a software package used by medicare during federal fiscal year 1998. A listing of DRG classifications is shown in appendix A of this rule. The relative weights assigned are those described in rule 5101:3-2-07.3 of the Administrative Code.

Cases which would be classified in DRG 385 or DRG 456 because of a transfer or death, but which involve a length of stay greater than fifteen days, are classified in the DRG which is otherwise appropriate if the transfer or death is not considered. For cases classified into DRG 386, two subgroups are created based upon the ICD-9-CM code. One subgroup is determined by cases which have ICD-9-CM code 765.0 listed as one of its diagnoses. The second subgroup is comprised of those cases that are grouped into DRG 386, but do not have 765.0 listed as a diagnosis. In accordance with rule 5101:3-2-07.3 of the Administrative Code, different relative weights are assigned to the second DRG 386 subgroup depending on whether one, the hospital operates a level I or level II nursery, or two, a level III nursery. For cases classified into DRG 387, two subgroups are created based upon birthweight. Infants with weights of zero to one thousand seven hundred fifty grams are grouped into one subgroup and infants with weights of one thousand seven hundred fifty-one grams and above are grouped into another subgroup. In accordance with rule 5101:3-2-07.3 of the Administrative Code, different relative weights are assigned to each DRG 387 subgroup depending on whether one, the hospital operates a level I or II nursery, or two, a level III nursery.

Prior to submitting a claim to the DRG "Grouper," each claim will be submitted to the medicare clinical editor to ensure that the information on the claim is complete and consistent. Each discharge will be

assigned to only one DRG regardless of the number of conditions treated or services furnished by a hospital, except as provided in paragraph (C)(1) of this rule.

(1) For inpatient services provided to patients who are discharged, within the same hospital, from an acute care bed and admitted to a bed in a psychiatric unit distinct part, payment will be made based on the DRG representing services provided in the acute care section and the services provided in the psychiatric unit distinct part if the services are assigned to DRGs 425 to 435. If the services provided in both the acute care section and the psychiatric unit distinct part are assigned to any combination of DRGs 425 to 435, payment will be made only for that DRG assigned as a result of the information on a claim submitted by the hospital for services provided from the date of admission to the hospital through the date of discharge or transfer from the hospital. If separate claims are submitted for any combination of DRGs 425 to 435, only the first claim processed will be paid. In order to receive payment for the entire period of hospitalization, the hospital will need to submit an adjustment claim reflecting services and charges for the entire hospitalization.

In accordance with rule 5101:3-2-03 of the Administrative Code, no coverage is available for days of inpatient care which occur solely for the provision of rehabilitation services related to a chemical dependency. Therefore, ICD-9-CM procedure codes which must be present for a claim to group to either DRG 436 or 437, will not be submitted to the DRG "grouper."

(2) For claims with discharge dates after September 3, 1991 which are rejected by the clinical editor as a result of an age, diagnosis code conflict, and the accuracy of the information contained on the claim is confirmed by the hospital, the prospective payment amount will be eighty-five per cent of the product of allowed claim charges times the hospital-specific, medicaid inpatient cost-to-charge ratio as described in paragraph (B)(2) of rule 5101:3-2-22 of the Administrative Code.

(3) A claim for inpatient services qualifies for interim payment on the thirtieth day of a consecutive inpatient stay and at thirty-day intervals thereafter. Under interim payment, hospitals will be paid on a percentage basis of charges. The percentage will represent the hospital-specific cost-to-charge ratio as described in paragraph (B)(2) of rule 5101:3-2-22 of the Administrative Code. For those hospitals which are not required to file a cost report under the provisions of rule 5101:3-2-23 of the Administrative Code, the statewide average inpatient cost-to-charge ratio as described in paragraph (B)(2) of rule 5101:3-2-22 of the Administrative Code will be used. Interim payments are made as a credit against final payment of the final discharge bill. Amounts of difference between interim payment made and the prospective payment described in paragraph (A) of this rule for the final discharge will be reconciled when the final discharge bill is processed.

(D) Payments for transfers as defined in rule 5101:3-2-02 of the Administrative Code are subject to the provisions of paragraphs (D)(1) and (D)(2) of this rule.

(1) Payment to the transferring hospital.

If a hospital paid under the prospective payment system transfers an inpatient to another hospital and that transfer is appropriate as defined in rule 5101:3-2-07.13 of the Administrative Code, then the transferring hospital is paid a per diem rate for each day of the patient's stay in that hospital, plus capital and teaching allowances, as applicable, not to exceed, for nonoutlier cases, the final prospective payment rate that would have been paid for the appropriate DRG as described in paragraph (I) of rule 5101:3-2-07.4 of the Administrative Code, except when that case is grouped into DRG 385 or DRG 456. Cases which are grouped into DRG 385 or DRG 456 are paid the full DRG payment in accordance with rule 5101:3-2-07.4 of the Administrative Code. Except for DRG 385 and DRG 456, when a patient is transferred, the department's payment is based on the DRG under which the patient was treated at each hospital.

The per diem rate is determined by dividing the product of the hospital's adjusted inflated average cost per discharge multiplied by the DRG relative weight as described in paragraph (I) of rule 5101:3-2-07.4 of the Administrative Code by the statewide geometric mean length of stay

calculated excluding outliers for the specific DRG as described in rule 5101:3-2-07.3 of the Administrative Code into which the case falls.

(2) Payment to the discharging hospital.

A hospital which receives a transfer and subsequently discharges that individual (as defined in rule 5101:3-2-02 of the Administrative Code) is paid a per diem rate for each day of the patient's stay in that hospital, plus capital and teaching allowances, as applicable, not to exceed, for nonoutlier cases, the final prospective payment rate amount that would have been paid for the appropriate DRG as described in paragraph (I) of rule 5101:3-2-07.4 of the Administrative Code. When a patient is transferred, the department's payment is based on the DRG under which the patient was treated at each hospital.

The per diem rate is determined by dividing the product of the hospital's adjusted inflated average cost per discharge multiplied by the DRG relative weight as described in paragraph (I) of rule 5101:3-2-07.4 of the Administrative Code by the geometric mean length of stay calculated excluding outliers for the specific DRG as described in rule 5101:3-2-07.3 of the Administrative Code into which the case falls.

(E) Outlier payments.

In addition to the payment provisions described in this rule, any hospital that is involved in discharging or transferring a patient as defined in rule 5101:3-2-02 of the Administrative Code or that provides services to a medicaid patient who is partially eligible as described in paragraph (K) of this rule may qualify for additional payments in the form of outlier payments as described in rule 5101:3-2-07.9 of the Administrative Code.

(F) Readmissions are defined in rule 5101:3-2-02 of the Administrative Code. A readmission within one calendar day of discharge, to the same institution, is considered to be one discharge for payment purposes so that one DRG payment is made. If two claims are submitted, the second claim processed will be rejected. In order to receive payment for the entire period of hospitalization, the hospital will need to submit an adjustment claim reflecting services and charges for the entire hospitalization.

(G) Claims for payment for inpatient hospital services must be submitted on the UB-92 as provided in rule 5101:3-2-02 of the Administrative Code and include the data essential to assignment of a DRG. Claims assigned to DRGs 469, and 470 will be denied due to ungroupable coding.

(H) Claims for payment for discharges that may qualify for outlier payment may be billed only after discharge unless the claim qualifies for interim billing as described in paragraph (C)(3) of this rule. The claim will be processed for payment of the appropriate DRG prospective discharge payment rate as described in paragraph (I) of rule 5101:3-2-07.4 of the Administrative Code and outlier payments as described in rule 5101:3-2-07.9 of the Administrative Code.

(I) Providers must submit a new claim with a copy of the remittance statement and a completed adjustment request form as described in rule 5101:3-1-19.3 of the Administrative Code in order to adjust any claim which results in an improper assignment of a DRG or to correct any information provided.

(J) In the case of deliveries, the department requires hospitals to submit separate UB-92 invoices based respectively on the mother's individual eligibility and the child's individual eligibility.

(K) In instances when a recipient's eligibility begins after the date of admission to the hospital or is terminated during the course of a hospitalization, payment will be made on a per diem basis plus the allowance for capital and teaching, as applicable. The per diem payment will be determined by dividing the product of the hospital's adjusted inflated average cost per discharge multiplied by the DRG relative weight for the DRG as described in paragraph (I) of rule 5101:3-2-07.4 of the Administrative Code by the statewide geometric mean length of stay calculated excluding outliers for that DRG as described in rule 5101:3-2-07.3 of the Administrative Code. The per diem amount will be multiplied times the number of covered days for which the patient was medicaid-eligible during the hospitalization. Payment for a nonoutlier case cannot exceed the final prospective payment rate for the DRG as described in paragraph (I) of rule 5101:3-2-07.4 of the Administrative Code.

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5160-2-07.12 Appeals and Reconsideration of Departmental Determinations Regarding Hospital Inpatient and Outpatient Services

HHTL 3352-15-05

Effective Date: April 30, 2015

Most Current Prior Effective Date: **May 1, 2007**

(A) General.

Pursuant to rules ~~5101:3-1-57~~5160-1-57 and 5101:6-50-01 of the Administrative Code, final settlements that are based upon final audits by the department may be appealed by hospitals ~~may appeal~~ under Chapter 119. of the Revised Code ~~final settlements that are based upon final audits by the department~~. Rule ~~5101:3-2-24~~5160-2-24 of the Administrative Code describes final fiscal audits and final settlements performed by the department. Rules ~~5101:3-1-29~~5160-1-29 and ~~5101:3-1-27~~5160-1-27 of the Administrative Code describe the audits performed by the department~~'s surveillance and utilization review section,~~ which ~~are also~~may be appealable under Chapter 119. of the Revised Code. Since the scope and substance of these two types of audits differ, in no instance will the conduct and implementation of one type of audit preclude the conduct and implementation of the other.

(B) Utilization review reconsideration.

Pursuant to rule ~~5101:3-2-07.13~~5160-2-07.13 of the Administrative Code, the department or a medical review entity under contract to the department may make determinations regarding utilization review in accordance with the standards set forth in rules ~~5101:3-2-02~~5160-1-01, 5160-2-02, ~~5101:3-2-07.9~~5160-2-65, ~~5101:3-2-07.13~~5160-2-07.13, and ~~5101:3-2-40~~5160-2-40 of the Administrative Code. These determinations are subject to the reconsideration process described in rule ~~5101:3-1-57~~5160-1-57 of the Administrative Code as follows:

(1) A written request for a reconsideration must be submitted to the department or the medical review entity, whichever made the initial determination as indicated by the denial letter, within sixty calendar days of the date of the determination. The department or the medical review entity shall have thirty ~~working~~business days from receipt of the request for reconsideration to issue a ~~written~~final and binding decision accepting, modifying, or rejecting its previous determination. The request for reconsideration must include:

(a) A copy of the written determination;

(b) A copy of the patient's medical record (if not already submitted to the review entity); and

(c) Copies of any and all additional information that may support the provider's position.

(2) The department will conduct an administrative review of the reconsideration decision if the provider submits its request within thirty calendar days of that decision. The department shall have thirty ~~working~~business days from receipt of the request for review to issue a final and binding decision. A request for an administrative review must include:

(a) A letter requesting a review of the reconsideration;

(b) A statement as to why the provider believes that the reconsideration decision was in error; and

(c) Any further documentation supporting the provider's position.

(3) The department may extend time frames described in paragraphs (B)(1) and (B)(2) of this rule, where adherence to time frames causes exceptional hardships to a large number of hospitals or where adherence to time frames as described in paragraphs (B)(1) and (B)(2) of this rule causes exceptional hardship to a hospital because potential determinations constitute a large portion of that hospital's total medicaid business.

(C) Reconsideration of inpatient hospital payments.

(1) Except when the department's determination is based on a finding made by medicare, the proper application of ~~rules~~rule ~~5101:3-2-07.1 and 5101:3-2-07.2~~5160-2-65 of the Administrative Code and the proper calculation of amounts (including source data used to calculate the amounts) determined in accordance with rules ~~5101:3-2-07.4, 5101:3-2-07.6~~5160-2-07.6, and ~~5101:3-2-07.7~~5160-2-07.7 of the Administrative Code are subject to the reconsideration process described in rule ~~5101:3-1-57~~5160-1-57 of the Administrative Code as follows:

(a) Requests for reconsideration authorized by paragraph (C)(1) of this rule must be submitted to the department in writing. If the request for reconsideration involves a rate component or determination made at the beginning of the rate year, the request must be submitted within ninety calendar days of the beginning of the rate year. If the request involves an adjustment or a determination made by the department after the beginning of the rate year, the request must be submitted within thirty calendar days of the date the adjustment or determination was implemented. The request must include a statement as to why the provider believes that the rate component or determination was incorrect as well as all documentation supporting the provider's position.

(b) The department shall have thirty business days from receipt of the request for reconsideration to issue a final and binding decision.

(2) When a medicare audit finding was used by the department in establishing a rate component and the finding is subsequently overturned on appeal, the provider may request reconsideration of the affected rate component. Such requests must be submitted to the department in writing prior to final settlement as described rule ~~5101:3-2-24~~5160-2-24 of the Administrative Code and within thirty calendar days of the date the hospital receives notification from medicare of the appeal decision. The request for reconsideration of a medicare audit finding that has been overturned on appeal must include all documentation that explains the appeal decision. The department shall have thirty business days in which to notify the provider of its final and binding decision regarding the medicare audit finding.

~~(3) Reconsideration may also be requested if a hospital believes that a claim or claims were paid in error because of an incorrect DRG (diagnosis related groups) assignment or incorrect payment calculation. In such an instance, the hospital must resubmit the claim(s) for an adjustment as described in rule 5101:3-1-19.8 of the Administrative Code. Following the adjustment process, if the hospital continues to believe that the department's DRG assignment or payment calculation was in error, the provider may submit a written request for reconsideration that includes all documentation supporting the providers position. In this instance, the department shall have sixty days in which to notify the provider of its final and binding decision.~~

(D) State hearings for medicaid recipients whose claim for inpatient hospital services is denied.

Any recipient whose claim for inpatient hospital services is denied may request a state hearing in accordance with division 5101:6 of the Administrative Code. The determination of whether outlier payments will be made or the amounts of outlier payments as described in rule ~~5101:3-2-07.9~~5160-2-65 of the Administrative Code is not a denial of a claim for inpatient hospital services. Similarly, the determination of amounts payable for inpatient hospital services involving readmissions or transfers is not a denial of a claim for inpatient hospital services.

(E) The following items are not subject to the department's reconsideration process:

(1) The use of the Diagnosis related groups (DRG) classification system and the method of classification of discharges within DRGs.

(2) The assignment of DRGs and Severity of Illness (SOI).

~~(2)~~(3) The assignment of relative weights to DRGs based on the methodology set forth in rule ~~5101:3-2-07.3~~5160-2-65 of the Administrative Code.

~~(3)~~(4) The establishment of peer groups as set forth in rule ~~5101:3-2-07.2~~5160-2-65 of the Administrative Code.

~~(4)~~(5) The methodology used to determine prospective payment rates as described in ~~rules~~rule ~~5101:3-2-07.4~~5160-2-65 ~~and 5101:3-2-07.6 to 5101:3-2-07.8~~ of the Administrative Code.

~~(5)~~(6) The methodology used to identify cost and day thresholds for services that may qualify for outlier payments as described in rule ~~5101:3-2-07.9~~ 5160-2-65 of the Administrative Code.

~~(6)~~(7) The formulas used to determine rates of payment for outliers, certain transfers and readmissions, and services subject to preadmission certification, as described, respectively, in rules ~~5101:3-2-07.9~~5160-2-65~~, 5101:3-2-07.11,~~ and ~~5101:3-2-40~~ 5160-2-40 of the Administrative Code.

~~(7)~~(8) The peer group average cost per discharge for all hospitals except when the conditions detailed in rule ~~5101:3-2-07.8~~ 5160-2-65 of the Administrative Code are met.

~~(8)~~(9) Statewide calculations of the direct and indirect medical education threshold for allowable costs per intern and resident as described in rule ~~5101:3-2-07.7~~5160-2-07.7 of the Administrative Code and of the threshold for establishing which hospitals will be recognized as providing a disproportionate share of indigent care as described in rule ~~5101:3-2-07.5~~5160-2-07.5 of the Administrative Code.

Effective: 04/30/2015

Five Year Review (FYR) Dates: 01/14/2015 and 04/30/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 04/15/2015

Promulgated Under: 119.03

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5160-2-07.13 Utilization Control

HHTL 3352-15-05

Effective Date: April 30, 2015

Most Current Prior Effective Date: **May 1, 2007**

(A) The Ohio department of ~~job and family services~~ medicaid (ODM) shall perform or shall require a medical review entity to perform utilization review for medicaid inpatient services regardless of the payment methodology used for reimbursement of those services. ~~The nature of this program is described in paragraphs (A) to (E) of this rule. Utilization review of outpatient hospital services is described in paragraph (F) of this rule.~~ For the purposes of this rule, ~~"ODJFS" means ODJFS or its contractual designee~~. ~~ODJFS~~"ODM" means ODM or its contracted medical review entity.~~,~~ ~~during~~During the course of its analyses, ODM may request information or records from the hospital and may conduct on-site medical record reviews. ~~Reviews shall be completed within twelve months of the payment date and in the case of interim payments described in rule 5101:3-2-07.11 of the Administrative Code within twelve months after the last payment has been made. Paragraphs (C) to (D)(3) of this rule provide examples of reviews to be completed by ODJFS.~~

Reviews shall be completed within twelve months of the payment date and in the case of interim payments described in rule 5160-2-65 of the Administrative Code within twelve months after the last payment has been made.

(1) The nature of the utilization review program for medicaid inpatient services is described in paragraphs (A) to (E) of this rule. Paragraphs (C) to (D)(3) of this rule provide examples of reviews to be completed by ODM.

(2) Utilization review of outpatient hospital services is described in paragraph (F) of this rule.

(B) ~~ODJFS~~ODM shall review a minimum of two per cent of all admissions retrospectively. ~~Admissions selected for review will be drawn from several categories including but not limited to those identified in paragraphs (C)(1) to (D)(3) of this rule.~~

(1) While the nature of the review will vary depending on the category of admission, all admissions selected will be reviewed to determine whether care was medically necessary on an inpatient hospital basis; to determine if the care was medically necessary as defined in rule ~~5101:3-2-02~~5160-1-01 of the Administrative Code; to determine whether the discharge occurred at a medically appropriate time, to assess the quality of care rendered as described in 42 C.F.R. 456.3(b), in effect as of October 1, 2013, and to assess compliance with agency ~~division 5101:3~~ 5160 of the Administrative Code.

(2) If any of the cases reviewed for a hospital do not meet the conditions described in paragraph (B)(1) of this rule, then ~~ODJFS~~ODM may deny payment or recoup payment beginning with the first inappropriate admission and/or discharge. Any negative determinations must be made by a physician.

(3) If the diagnostic and/or procedural information on the claim form is found to be inconsistent with that found in the medical records in conjunction with the physician attestation, then changes may be made in the coding and payment may be adjusted as described in paragraph (D)(3) of this rule.

(C) ~~ODJFS~~ ODM may include in its retrospective review sample the categories of admissions described in paragraphs (C)(1) to (D)(3) of this rule.

(1) ~~ODJFS~~ODM may review transfers as defined in rule ~~5101:3-2-02~~5160-2-02 of the Administrative Code. The purpose of the transfer review will be to examine the documented reasons for and appropriateness of the transfer. ~~ODJFS~~ODM considers a transfer as appropriate if the transfer is required because the individual requires some treatment or care that is unavailable at the transferring hospital or if there are other exceptional circumstances that justify transfer. ~~Because this provision addresses exceptional cases, it is impossible to delineate exact criteria to cover all~~

~~possible circumstances. Cases will be individually considered by ODJFS based on the merits of each case. If any of the hospital's transfer cases reviewed are found to be inappropriate transfers, then ODJFS may intensify the review, including the addition of prepayment review and pretransfer certification. ODJFS may deny payment to or recoup payment from a provider who has transferred patients inappropriately.~~

Because this provision addresses exceptional cases, it is impossible to delineate exact criteria to cover all possible circumstances. Cases will be individually considered by ODM based on the merits of each case. If any of the hospital's transfer cases reviewed are found to be inappropriate transfers, then ODM may intensify the review, including the addition of prepayment review and pretransfer certification. ODM may deny payment to or recoup payment from a provider who has transferred patients inappropriately.

(2) ~~ODJFS~~ ODM may review readmissions to determine if the ~~as readmissions are~~ readmission as defined in rule ~~5101:3-2-02~~5160-2-02 of the Administrative Code~~. The purpose of readmission review is to determine if the readmission~~ is appropriate. ~~If the readmission is related to the first hospitalization, ODJFS will determine if the readmission resulted from complications or other circumstances that arose because of an early discharge and/or other treatment errors. If the readmission is unrelated, ODJFS will determine if the treatment or care provided during the readmission should have been provided during the first hospitalization. If it is determined the readmission was inappropriate, then any payment made for the separate admissions will be recouped. A new payment amount will be determined by collapsing any affected admissions into one payment.~~

(a) If the readmission is related to the first hospitalization, ODM will determine if the readmission resulted from complications or other circumstances that arose because of an early discharge and/or other treatment errors.

(b) If the readmission is unrelated, ODM will determine if the treatment or care provided during the readmission should have been provided during the first hospitalization.

(c) If it is determined the readmission was inappropriate, then any payment made for the separate admissions will be recouped. A new payment amount will be determined by collapsing any affected admissions into one payment.

(3) ~~ODJFS~~ODM may review claims for which outlier payments are made to determine if days or services were covered and were medically necessary. For outliers, review will be made to determine that all services were medically necessary, appropriately billed based on services rendered, ordered by the physician, and not duplicatively billed. If it is determined that services were inappropriately billed or if days or services are determined to be noncovered or not medically necessary as described in rules ~~5101:3-2-02~~ 5160-1-01 and ~~5101:3-2-03~~5160-2-03 of the Administrative Code, recoupment of any overpayments will occur. Overpayments will be determined by calculating the difference between the amount paid and the amount that would be paid if the nonallowable or noncovered days or services were excluded from the claim.

(4) ~~ODJFS~~ ODM may review admissions with short lengths of stay. Reviews in this category will be concentrated on any admission with a length of stay greater than two standard deviations below the mean length of stay for the DRG (diagnosis related groups) of that admission. This is based on the distribution, by DRG, of lengths of stay of admissions in Ohio medicaid inpatient claims. Reviews will be conducted to determine if the inpatient stay was medically necessary to provide services or if the services rendered could have been provided in an outpatient setting using observation codes as described in rule ~~5101:3-2-21~~5160-2-21 of the Administrative Code.

(5) ~~ODJFS~~ ODM shall review cases in which a denial letter has been issued by the hospital. In addition, ~~ODJFS~~ODM shall review all cases in which the attending physician and/or recipient (or family member) disagrees with the hospital's decision and requests a review of the case. The hospital must send a copy of each denial letter to ~~ODJFS~~ODM's medical review entity.

(D) ~~ODJFS~~ODM may review medical records to validate DRG assignment for any admission.

(1) The physician attestation process is to be completed for the medicaid program by following the medicare procedure for attestation as delineated in 42 C.F.R. 412.46, in effect as of October 1, 2012.

(2) DRG validation will be done on the basis of a review of medical records by verifying that the diagnostic and procedural coding used by the hospital is substantiated in these records.

(3) If the diagnostic and procedural information on the claim form is found to be inconsistent with that found in the medical records in conjunction with the physician attestation, the provider must submit a corrected claim reflecting this information.~~ODJFS may correct the claim information and recalculate payment based on the appropriate DRG assignment. If the recalculation shows an overpayment was made to the hospital, the overpayment will be reconciled as an adjustment to the claim. In all instances, the information found in the medical record when used in conjunction with the physician attestation is controlling~~.

(E) Pre-certification review as detailed in rule ~~5101:3-2-40~~5160-2-40 of the Administrative Code shall be conducted in addition to the utilization review activities described in this rule.

(F) Outpatient hospital services may also be reviewed by ~~ODJFS~~ ODM to determine whether the care or services were medically necessary as defined in rule ~~5101:3-2-02~~5160-1-01 of the Administrative Code, to determine whether the services were appropriately billed, and to assess the quality of care rendered as described in 42 C.F.R. 456.3(b), in effect as of October 1, 2013.

(G) Intensified reviews may result whenever ~~ODJFS~~ ODM identifies inappropriate admission or billing practices during reviews conducted in accordance with this rule. These reviews may periodically result in the requirement that hospitals produce evidence of invoice costs supporting amounts billed for take-home drugs.

(H) Medical records must be maintained in accordance with 42 C.F.R. 482.24~~.~~, in effect as of October 1, 2013. Records requested by ~~ODJFS~~ODM for review must be supplied within thirty calendar days of the request as described in rule ~~5101:3-1-17.2~~5160-1-17.2 of the Administrative Code. Failure to produce records within thirty days shall result in withholding or recoupment of medicaid payments.

(I) Decisions made by ~~the medical review entity~~ ODM as described in this rule are appealable to ~~the medical review entity~~ ODM and are subject to the reconsideration process described in rule ~~5101:3-2-07.12~~5160-2-07.12 of the Administrative Code.

(J) ~~ODJFS~~ ODM has delegated to the Ohio department of mental health and addiction services (ODMHAS) the authority to make determinations regarding utilization review for inpatient psychiatric services in accordance with paragraphs (B), (C), (D), and (E) of this rule.

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Five Year Review (FYR) Dates: 01/14/2015 and 04/30/2020

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5160-2-07.17 Provision of Basic, Medically Necessary Hospital-Level Services

Formerly **5101:3-2-07.17 Provision of Basic, Medically Necessary Hospital-Level Services**

HHTL 3352-11-03

Effective Date: January 1, 2006 (No Change)

Most Current Prior Effective Date: **January 1, 2006**

Under the provisions of section 5112.17 of the Revised Code, each hospital that receives payment under the provisions of Chapter 5112. of the Revised Code, shall provide, without charge to the individual, basic, medically necessary hospital-level services to the individual who is a resident of this state, is not a recipient of the medicaid program and whose income is at or below the federal poverty line. Residence is established by a person who is living in Ohio voluntarily and who is not receiving public assistance in another state. Current recipients of the disability assistance (DA) program as defined in Chapter 5115. of the Revised Code or its successor program, qualify for services under the provisions of this rule.

(A) Definitions.

(1) "Basic, medically necessary hospital level services" are defined as all inpatient and outpatient services covered under the medicaid program in Chapter 5101:3-2 of the Administrative Code with the exception of transplantation services and services associated with transplantation. These covered services must be ordered by an Ohio licensed physician and delivered at a hospital where the physician has clinical privileges and where such services are permissible to be provided by the hospital under its certificate of authority granted under Chapters 3711., 3727., and/or 5119. of the Revised Code. Hospitals will be responsible for providing basic, medically necessary hospital-level services to those persons described in paragraph (B) of this rule.

(2) "Third-party payer" means any private or public entity or program that may be liable by law or contract to make payment to or on behalf of an individual for health care services. Third-party payer does not include a hospital.

(B) Determination of eligibility.

A person is eligible for basic, medically necessary hospital-level services under the provisions of this rule if the person is a current recipient of the disability assistance (DA) program or its successor program, or the person's individual or family income is at or below the current poverty guideline issued by the department of health and human services (available at: http://aspe.hhs.gov/poverty/figures-fed-reg.shtml), that applies to the individual or family when calculated by either of the methods described in paragraphs (B)(2)(a) and (B)(2)(b) of this rule on the date these services were provided.

(1) For purposes of this rule, a "family" shall include the patient, the patient's spouse (regardless of whether they live in the home), and all of the patient's children, natural or adoptive, under the age of eighteen who live in the home. If the patient is under the age of eighteen, the "family" shall include the patient, the patient's natural or adoptive parent(s) (regardless of whether they live in the home), and the parent(s)' children, natural or adoptive under the age of eighteen who live in the home. If the income of a spouse or parent who does not live in the home cannot be obtained, or the absent spouse or parent does not contribute income to the family, determination of eligibility shall proceed with the available income information. If the patient is the child of a minor parent who still resides in the home of the patient's grandparents, the "family" shall include only the parent(s) and any of the parent(s)' children, natural or adoptive who reside in the home.

(2) "Income" shall be defined as total salaries, wages, and cash receipts before taxes; receipts that reflect reasonable deductions for business expenses shall be counted for both farm and non-farm self-employment. Income will be calculated by:

(a) Multiplying by four the person's or family's income, as applicable, for the three months preceding the date hospital services were provided;

(b) Using the person's or family's income, as applicable, for the twelve months preceding the date hospital services were provided.

(3) For outpatient hospital services, a hospital may consider an eligibility determination to be effective for ninety days from the initial service date, during which a new eligibility determination need not be completed. Eligibility for inpatient hospital services must be determined separately for each admission, unless the patient is readmitted within forty-five days of discharge for the same underlying condition. Eligibility for recipients of the disability assistance (DA) program or its successor program must be verified on a monthly basis.

(4) A complete application for the hospital care assurance program is required prior to determination of eligibility. Each hospital shall develop an application that, at a minimum, must document income, family size and eligibility for the Medicaid program. The patient or a legal representative is required to sign the application. An unsigned application can be deemed acceptable if the patient is physically unable to sign the application or does not live in the vicinity of the hospital and is unable to return a signed application by mail. In these situations, the hospital representative should complete all questions on the application, sign it and must document why the patient is unable to sign the application.

(5) The hospital shall accept application for services without charge until three years from the date of the follow-up notice, as described in paragraphs (C)(2) and (C)(3) of this rule, has elapsed.

(6) Applicants shall cooperate in supplying information about health insurance or medical benefits available so a hospital may determine any potential third-party resources that may be available.

(7) Nothing in this rule shall be construed to prevent a hospital from requiring an individual to apply for eligibility under the medical assistance program before the hospital processes an application under this rule.

(C) Billing requirements.

Hospitals may bill any third-party payer that has a legal liability to pay for services rendered under the provisions of this rule. Hospitals may bill the medicaid program in accordance with Chapter 5111. of the Revised Code and the rules adopted under that chapter for services rendered under the provisions of this rule if the individual becomes a recipient of the medicaid program. Hospitals may bill individuals for services if all of the following apply:

(1) The hospital has an established post-billing procedure for determining the individual's income and canceling the charges if the individual is found to qualify for services under the provisions of this rule;

(2) The initial bill, and at least the first follow-up bill is accompanied by a written statement that does all of the following:

(a) Explains that individuals with income at or below the federal poverty guidelines are eligible for services without charge;

(b) Specifies the federal poverty guideline for individuals and families of various sizes at the time the bill is sent; and

(c) Describes the procedure required by paragraph (C)(1) of this rule.

(3) If the written statement as described in paragraph (C)(2) of this rule is printed on the back of the hospital's bill or data-mailer, the hospital must reference the statement on the front of the bill or data-mailer.

(4) Notwithstanding paragraph (B) of this rule, a hospital providing care to an individual under the provisions of this rule is subrogated to the rights of any individual to receive compensation or benefits from any person or governmental entity for the hospital goods and services rendered.

(D) Notice requirements.

Each hospital that receives payment under Chapter 5112. of the Revised Code shall post notices in appropriate areas in the facility, including but not limited to the admissions areas, the business office

and the emergency room that specify the rights of persons with incomes at or below the federal poverty line to receive, without charge to the individual, basic, medically necessary hospital-level services at the hospital.

Posted notices must contain the following in order to comply with the requirement as described in this paragraph:

(1) At a minimum, the posted notices must specify the rights of these individuals to receive without charge, basic, medically necessary hospital-level services;

(2) The wording of the posted notice must be clear and in simple terms understandable by the population serviced;

(3) Posted notice must be printed in English and other languages that are common to the population of the area serviced;

(4) The posted notice must be clearly readable at a distance of twenty feet or the expected vantage point of the patrons;

(5) The facility shall make reasonable efforts to communicate the contents of the posted notice to persons it has reason to believe cannot read the notice.

(E) Documentation requirements.

Each hospital shall establish and maintain a written policy outlining its internal policy for administration of the hospital care assurance program in compliance with this rule and with rule 5101:3-2-23 of the Administrative Code. Each hospital may change its written policy as needed, but policy changes may not be implemented retroactively. The written policy shall include, but is not limited to, the following:

(1) Procedure for taking applications and a copy of the current application in use as described in paragraph (B) of this rule,

(2) Procedure for eligibility determination including the determination of family size and determination of income. If the hospital requires verification of income other than the application, the written policy should describe what constitutes acceptable income documentation.

(F) Reporting requirements.

Each hospital shall collect and report to the department information on the number and categorical identity of persons served under the provisions of this rule.

(1) This information will be reported on the JFS 02930, schedule F which must be submitted annually along with a certification of the accuracy of this reported data as required by rule 5101:3-2-23 of the Administrative Code. The JFS 02930 and instructions for completion are located in appendix A of rule 5101:3-2-23 of the Administrative Code.

(2) The use of estimation methods to determine amounts for charges related to non-hospital level services or to determine the health insurance status of patients charges on patient accounts is not permitted.

(3) Each hospital shall maintain, make available for department review and provide to the department on request, any records necessary to document its compliance with the provisions of this rule, including:

(a) Any documents, including medical records of population served, from which the information required to be reported on the JFS 02930 was obtained;

(b) Accounts that clearly segregate the services rendered under the provisions of this rule from other accounts; and

(c) Copies of the determinations of eligibility under paragraph (B) of this rule.

(d) A copy of the disability assistance card or other evidence of eligibility for any person who is a recipient of the disability assistance (DA) program or its successor program at the time the services defined in paragraph (A) of this rule were delivered.

(4) Hospitals must retain these records for a period of six years from the date of receipt of payment based upon those records or until any audit initiated within the six year period is completed.

(G) This rule in no way alters the scope or limits the obligation of any governmental entity or program, including the program awarding reparations to victims of crime under sections 2743.51 to 2743.72 of the Revised Code and the program for medically handicapped children established under section 3701.023 of the Revised Code, to pay for hospital services in accordance with state or local law.

R.C. 119.032 review dates: 12/22/2010 and 12/22/2015

Certification: CERTIFIED ELECTRONICALLY

Date: 12/22/2010

Promulgated Under: 119.03

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Rule Amplifies: 5112.03, 5112.17

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5160-2-08 Data Policies for Disproportionate Share and Indigent Care Adjustments for Hospital Services

Formerly **5101:3-2-08 Data Policies for Disproportionate Share and Indigent Care Adjustments for Hospital Services**

HHTL 3352-10-06

Effective Date: December 25, 2010

Most Current Prior Effective Date: **July 22, 2005**

This rule sets forth the data used to determine assessments and adjustments, and the data policies that are applicable for each program year for all providers of hospital services included in the definition of "hospital" as described under section 5112.01 of the Revised Code.

(A) Definitions.

(1) "Disproportionate share hospital" means a hospital that meets the requirements for disproportionate share status as defined in rule 5101:3-2-07.5 of the Administrative Code.

(2) "Governmental hospital" means a county hospital with more than five hundred beds or a state-owned and -operated hospital with more than five hundred beds.

(3) "Hospital" means a hospital that is described under section 5112.01 of the Revised Code.

(4) "Hospital care assurance program fund" means the fund described under section 5112.18 of the Revised Code.

(5) "Hospital care assurance match fund" means the fund described under section 5112.18 of the Revised Code.

(6) "Intergovernmental transfer" means any transfer of money by a governmental hospital.

(7) "Legislative budget services fund" means the fund described under section 5112.19 of the Revised Code.

(8) "Health care services administration fund" means the fund described under section 5111.94 of the Revised Code.

(9) "Program year" means the twelve-month period beginning on the first day of October and ending on the thirtieth day of September.

(10) "Total facility costs" for each hospital means the amount from the JFS 02930, "Hospital Cost Report", for the applicable state fiscal year, schedule B, column 3, line 101. For non-medicaid participating hospitals, total facility costs shall be determined from the medicare cost report.

(11) "Total skilled nursing facility costs" for each hospital means the amount on the JFS 02930, schedule B, column 3, line 34. For non-medicaid participating hospitals, total skilled nursing facility costs shall be determined from the medicare cost report.

(12) "Total home health facility costs" for each hospital means the amount on the JFS 02930, schedule B, column 3, line 67. For non-medicaid participating hospitals, total home health facility costs shall be determined from the medicare cost report.

(13) "Total hospice facility costs" for each hospital means the amount on JFS 02930, schedule B, column 3, line 68. For non-medicaid participating hospitals, total hospice facility costs shall be determined from the medicare cost report.

(14) "Total ambulance costs" for each hospital means the amount on JFS 02930, schedule B, column 3, line 64. For non-medicaid participating hospitals, total ambulance costs shall be determined from the medicare cost report.

(15) "Total Durable Medical Equipment (DME) rental costs" for each hospital means the amount on JFS 02930, schedule B, column 3, line 65. For non-medicaid participating hospitals, total DME rental costs shall be determined from the medicare cost report.

(16) "Total DME sold costs" for each hospital means the amount on JFS 02930, schedule B, column 3, line 66. For non-medicaid participating ~~hosptials~~hospitals, total DME sold costs shall be determined from the medicare cost report.

(17) "Other non-hospital costs" for each hospital means separately identifiable non-hospital operating costs found on worksheet B, Part I of the medicare cost report, as determined by the department upon the request of the hospital, that are permitted to be excluded from the provider tax in compliance with section 1903(w) of the Social Security Act.

(18) "Adjusted total facility costs" means the result of subtracting the sum of the amounts defined in paragraphs (A)(11), (A)(12), (A)(13), (A)(14), (A)(15) and (A)(16) of this rule from the amount defined in paragraph (A)(10) of this rule.

(B) Source data for calculations.

(1) The calculations described in this rule for each program year will be based on cost-reporting data described in rule 5101:3-2-23 of the Administrative Code that reflects the completed interim settled medicaid cost report (JFS 02930) for each hospital's cost reporting period ending in the state fiscal year that ends in the federal fiscal year preceding each program year. For non-medicaid participating hospitals, the calculations will be based on the medicare cost report for the same time period.

(a) For new hospitals, the first available cost report filed with the department in accordance with rule 5101:3-2-23 of the Administrative Code will be used until a cost report that meets the requirements of this paragraph is available. If, for a new hospital, there is no available or valid cost report filed with the department, the hospital will be excluded until valid data is available.

(b) Data ~~For~~ for hospitals that have changed ownership~~,~~ shall be treated as described in paragraphs (B)(1)(b)(i) to (B)(1)(b)(ii) of this rule ~~the cost reporting data filed by the previous owner that reflects that hospital's most recent completed interim settled medicaid cost report and the cost reporting data filed by the new owner that reflects that hospital's most recent completed interim settled medicaid cost report, will be combined and annualized by the department to reflect one full year of operation. If there is no available or valid cost report from the previous owner, the department shall annualize the cost report from the new owner to reflect one full year of operation~~.

(i) For a change of ownership that occurs during the program year, the cost reporting data filed by the previous owner that reflects that hospital's most recent completed interim settled medicaid cost report shall be annualized to reflect one full year of operation. The data will be allocated to each owner based on the number of days in the program year the hospital was owned.

(ii) For a change of ownership that occurred in the previous program year, the cost reporting data filed by the previous owner that reflects that hospital's most recent completed interim settled medicaid cost report and the cost reporting data filed by the new owner that reflects that hospital's most recent completed interim settled medicaid cost report, will be combined and annualized by the department to reflect one full year of operation. If there is no available or valid cost report from the previous owner, the department shall annualize the cost report from the new owner to reflect one full year of operation.

(c) For hospitals involved in mergers during the program year that result in the hospitals using one provider number, the cost reports from the merged providers will be combined and annualized by the department to reflect one full year of operation.

Cost report data used in the calculations described in this rule will be the cost report data described in this paragraph and are subject to any adjustments made upon departmental review that is completed each year and subject to the provisions of paragraph (E) of this rule.

(2) Closed hospitals with unique medicaid provider numbers.

For a hospital facility, identifiable to a unique medicaid provider number, that closes during the current program year as defined in paragraph (A) of this rule, the cost report data shall be adjusted to reflect the portion of the year that the hospital was open during the current program year. That partial year data shall be used to determine the assessment owed by that closed hospital.

Hospitals identifiable to a unique medicaid provider number that closed during the immediate prior program year will not owe an assessment for the current program year.

(3) Replacement hospital facilities.

(a) If a new hospital facility is opened for the purpose of replacing an existing (original) hospital facility identifiable to a unique medicaid provider number and the original facility closes during the program year defined in paragraph (A) of this rule, the cost report data from the original facility shall be used to determine the assessment for the new replacement facility if the following conditions are met:

(i) Both facilities have the same ownership,

(ii) There is appropriate evidence to indicate that the new facility was constructed to replace the original facility,

(iii) The new replacement facility is so located as to serve essentially the same population as the original facility, and

(iv) The new replacement facility has not filed a cost report for the current program year.

(b) For a replacement hospital facility that opened in the immediate prior program year, the assessment for that facility will be based on the cost report data for that facility and the cost report data for the original facility, combined and annualized by the department to reflect one full year of operation.

(C) Deposits into the legislative budget services fund.

From the first installment of the assessments paid under rule 5101:3-2-08.1 of the Administrative Code and intergovernmental transfers made under rule 5101:3-2-08.1 of the Administrative Code during each program year beginning in an odd-numbered calendar year, the department shall deposit into the state treasury to the credit of the legislative budget services fund a total amount equal to the amount by which the biennial appropriation from that fund exceeds the amount of the unexpended, unencumbered monies in that fund.

(D) Deposits into the health care services administration fund.

From the first installment of assessments paid under rule 5101:3-2-08.1 of the Administrative Code and intergovernmental transfers made under rule 5101:3-2-08.1 of the Administrative Code during each program year, the department shall deposit into the state treasury to the credit of the health care services administration fund, a total amount equal to the amount allocated by the appropriations act from assessments paid under section 5112.06 of the Revised Code and intergovernmental transfers made under section 5112.07 of the Revised Code during each program year.

(E) Finalization of data used for disproportionate share and indigent care adjustments.

During each program year, the department may mail any data the department may choose to use for disproportionate share and indigent care adjustments, described in rule 5101:3-2-09 of the Administrative Code to each hospital. Not later than thirty days after the department mails the data, any hospital may submit to the department a written request to correct data. Any documents, data, or other information that supports the hospital's request to correct data must be submitted with the request. On the basis of the information submitted to the department, the department may adjust the data.

(1) For each program year, upon the expiration of all hospitals' thirty-day data correction periods, the department shall consider the data correction period closed and all data final, subject to review and acceptance by the department.

(2) Any hospital that requests to correct data after the expiration of its thirty-day correction period but before the data correction period is closed for all hospitals as described in paragraph (E)(1) of this rule, shall be subject to an administrative fee. The administrative late fee shall be 0.03 per cent of the hospital's adjusted total facility cost as calculated in paragraph (A)(15) of this rule. The hospital shall include payment of the administrative late fee with the written request to correct data.

(3) All amounts received by the department under this paragraph shall be deposited into the state treasury to the credit of the health care services administration fund, described under paragraph (A)(8) of this rule.

(4) The department shall accept at any time, data from any hospital that has ~~overstated~~ misstated its reported data used to make disproportionate share and indigent care adjustments and that resulted in a disproportionate share and indigent care payment that was greater than the payment would have been with the corrected data.

(F) Confidentiality.

Except as specifically required by the provisions of this rule and rule 5101:3-2-24 of the Administrative Code, information filed shall not include any patient-identifying material. Information including patient-identifying information is not a public record under section 149.43 of the Revised Code and no patient-identifying material shall be released publicly by the department of job and family services or by any person under contract with the department who has access to such information.

Effective: 12/25/2010

R.C. 119.032 review dates: 09/23/2010 and 12/01/2015

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5160-2-08.1 Assessment Rates

Formerly **5101:3-2-08.1 Assessment Rates**

HHTL 3352-13-06

Effective Date: January 1, 2014

Most Current Prior Effective Date: **February 21, 2013**

The provisions of this rule are applicable for the program year(s) specified in this rule for all hospitals as defined under section ~~5112.01~~5168.01 of the Revised Code.

(A) Applicability.

The requirements of this rule apply as long as the United States centers for medicare and medicaid services (CMS) determines that the assessment imposed under section ~~5112.06~~5168.01 of the Revised Code is a permissible health care related tax. Whenever the ~~office~~department of ~~medical assistance~~medicaid is informed that the assessment is an impermissible health care-related tax, the ~~office~~department shall promptly refund to each hospital the amount of money currently in the hospital care assurance match fund that has been paid by the hospital, plus any investment earnings on that amount.

(B) The program years to which this rule applies are identified in paragraphs (B)(1) and (B)(2) of this rule. When the ~~office~~department is notified by the centers for medicare and medicaid services that an additional disproportionate share allotment is available for a prior program year, the ~~office~~department may amend the assessment rates for the prior program year.

(1) The assessment rates applicable to the program year that ends in calendar year ~~2012~~2013 are specified in paragraph (C) of this rule.

(2) The revised assessment rates applicable to the program year that ends in calendar year ~~2009~~2012 are specified in paragraph (D) of this rule.

(C) Calculation of assessment amounts.

The calculations described in this rule will be based on cost-reporting data described in rule ~~5101:3~~5160-2-23 of the Administrative Code that reflect the most ~~recent~~recently completed interim settled medicaid cost report for all hospitals. For non-medicaid participating hospitals, the calculations shall be based on the most recent as-filed medicare cost report.

The assessment is calculated as follows:

(1) Determine each hospital's adjusted total facility costs as the amount calculated in paragraph (A)(18) of rule ~~5101:3~~5160-2-08 of the Administrative Code.

(2) For hospitals with adjusted total facility costs, as described in paragraph (C)(1) of this rule, that are less than or equal to $216,372,500, multiply the hospital's adjusted total facility costs as described in paragraph (C)(1) of this rule by ~~0.008396619575~~0.0083584. The product will be each hospital's assessment amount. For hospitals with adjusted total facility costs, as described in paragraph (C)(1) of this rule, that are greater than $216,372,500, multiply a factor of ~~0.008396619575~~0.0083584 times the hospital's adjusted total facility costs as described in paragraph (C)(1) of this rule, up to $216,372,500. Multiply a factor of ~~0.006~~0.00665 times the hospital's adjusted total facility costs as described in paragraph (C)(1) of this rule, that are in excess of $216,372,500. The sum of the two products will be each hospital's assessment amount.

(3) The assessment amounts calculated in paragraph (C)(2) of this rule are subject to adjustment under the provisions of paragraph (F) of this rule.

(D) For the program year specified in paragraph (B)(2) of this rule, the assessment rates specified in rule ~~5101:3~~5160-2-08.1 of the Administrative Code, effective ~~August 13, 2009~~February 21, 2013 are revised in paragraphs (D)(1) to (D)(3) of this rule.

(1) The original adjusted total facility cost threshold of ~~$216,374,000~~$216,372,500 is unchanged.

(2) The original tier one assessment rate of ~~0.010338~~0.0083966197575 is increased to ~~0.01040209~~0.0084222.

(3) The original tier two assessment rate of ~~0.00738093~~0.006 is ~~increased to 0.00738107~~unchanged.

(E) Determination of intergovernmental transfer amounts.

The ~~office~~department may require governmental hospitals, as described in paragraph (A)(2) of rule ~~5101:3~~5160-2-08 of the Administrative Code, to make intergovernmental transfers each program year.

The ~~office~~department shall notify each governmental hospital of the amount of the intergovernmental transfer it is required to make during the program year.

Each governmental hospital shall make intergovernmental transfers in periodic installments, executed by electronic funds transfer.

(F) Notification and reconsideration procedures.

(1) The ~~office~~department shall mail by certified mail, return receipt requested, the results of the determinations made under paragraph (C) of this rule to each hospital. If no hospital submits a request for reconsideration as described in this rule, the preliminary determinations constitute the final reconciliation of the amounts that each hospital must pay under this rule.

(2) Not later than fourteen days after the ~~office~~department mails the preliminary determinations as described in paragraph (C) of this rule, any hospital may submit to the ~~office~~department a written request for reconsideration of the preliminary determination made under paragraph (C) of this rule. The request must be accompanied by written materials setting forth the basis for the reconsideration.

If one or more hospitals submit such a request, the ~~office~~department shall hold a public hearing in Columbus, Ohio not later than thirty days after the preliminary determinations have been mailed by the ~~office~~department for the purpose of reconsidering its preliminary determinations. The ~~office~~department shall mail written notice of the date, time, and place of the hearing to every hospital at least ten days before the date of the hearing.

On the basis of the evidence submitted to the ~~office~~department or presented at the public hearing, the ~~office~~department shall reconsider and may adjust the preliminary determinations. The result of the reconsideration is the final reconciliation of the amounts that each hospital must pay under the provisions of this rule.

(3) The ~~office~~department shall mail each hospital written notice of the amount it must pay under the final reconciliation as soon as practical. Any hospital may appeal the amount it must pay to the court of common pleas of Franklin county.

(4) In the course of any program year, the ~~office~~department may adjust the assessment rate defined in paragraph (C) of this rule or adjust the amount of the intergovernmental transfers required under paragraph (E) of this rule, and, as a result of the adjustment, adjust each hospital's assessment and intergovernmental transfer, to reflect refinements made by the CMS during that program year.

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5160-2-09 Payment Policies for Disproportionate Share and Indigent Care Adjustments for Hospital Services

Formerly **5101:3-2-09 Payment Policies for Disproportionate Share and Indigent Care Adjustments for Hospital Services**

HHTL 3352-10-06

Effective Date: December 25, 2010

Most Current Prior Effective Date: **August 13, 2009**

This rule is applicable for each program year for all medicaid-participating providers of hospital services included in the definition of "hospital" as described under section 5112.01 of the Revised Code.

(A) Definitions.

(1) "Total medicaid costs" for each hospital means the sum of the amounts reported in JFS 02930, for the applicable state fiscal year, schedule H, section I, columns 1 and 3, line 1 and section II, column 1, line 10.

(2) "Total medicaid managed care plan inpatient costs" for each hospital means the amount on JFS 02930 schedule I, column 3, line 101.

(3) "Total medicaid managed care plan outpatient costs" for each hospital means the amount on JFS 02930 schedule I, column 5, line 101.

(4) "Total Title V costs" for each hospital means the amount on JFS 02930, schedule H, section I, column 2, line 1 and section II, column 2, line 10.

(5) "Total inpatient disability assistance medical costs" for each hospital means the amount on the JFS 02930, schedule F, columns 4 and 5, line 8.

(6) "Total inpatient uncompensated care costs under one hundred per cent" for each hospital means the amount on the JFS 02930, schedule F, columns 4 and 5, line 9.

(7) "Total inpatient uncompensated care costs above one hundred per cent without insurance" for each hospital means the amount on the JFS 02930, schedule F, column 5, line 10.

(8) "Total outpatient disability assistance medical costs" for each hospital means the amount on the JFS 02930, schedule F, columns 4 and 5, line 12.

(9) "Total outpatient uncompensated care costs under one hundred per cent" for each hospital means the amount on the JFS 02930, schedule F, columns 4 and 5, line 13.

(10) "Total outpatient uncompensated care costs above one hundred per cent without insurance" for each hospital means the amount on the JFS 02930, schedule F, column 5, line 14.

(11) "Total disability assistance medical costs" means the sum of total inpatient disability assistance costs as described in paragraph (A)(5) of this rule, and total outpatient disability assistance costs as described in paragraph (A)(8) of this rule.

(12) "Total uncompensated care costs under one hundred per cent" means the sum of total inpatient uncompensated care costs under one hundred per cent as described in paragraph (A)(6) of this rule, and total outpatient uncompensated care costs under one hundred per cent as described in paragraph (A)(9) of this rule.

(13) "Total uncompensated care costs above one hundred per cent without insurance" means the sum of total inpatient uncompensated care costs above one hundred per cent without insurance as described in paragraph (A)(7) of this rule, and total outpatient uncompensated care costs above one hundred per cent without insurance as described in paragraph (A)(10) of this rule.

(14) "Managed care plan days" (MCP days) means for each hospital the amount on the JFS 02930, schedule I, column ~~1~~2, line 103.

(15) "High federal disproportionate share hospital" means a hospital with a ratio of total medicaid days plus MCP days to total facility days greater than the statewide mean ratio of the sum of total medicaid days plus MCP days to total facility days plus one standard deviation.

(16) "Total medicaid payments" for each hospital means the sum of the amounts reported on the JFS 02930, schedule H, column 1, lines 7, 15, 26, and column 3, lines 7 and 26.

(17) "Total medicaid days" means for each hospital the amount on the JFS 02930, schedule C, column 6, line 35 and column 10, line 35.

(18) "Total facility days" means for each hospital the amount reported on the JFS 02930, schedule C, column 4, line 35.

(19) "Medicaid inpatient payment-to-cost ratio" for each hospital means the sum of the amounts reported on the JFS 02930, schedule H, columns 1 and 3, line 7, less the amount described in paragraph (A)(30) of this rule, divided by the sum of the amounts reported on the JFS 02930, schedule H, section I, columns 1 and 3, line 1.

(20) "Medicaid outpatient payment-to-cost ratio" for each hospital means the amount reported on the JFS 02930, schedule H, column 1, line 15, divided by the amount reported on the JFS 02930, schedule H, section II, column 1, line 10.

(21) "Total medicaid managed care plan (MCP) costs" means the actual cost to the hospital of care rendered to medical assistance recipients enrolled in a managed care plan that has entered into a contract with the department of job and family services and is the amount on JFS 02930, schedule I, column 3, line 101 and column 5, line 101.

In the event the hospital cannot identify the costs associated with recipients enrolled in a health maintenance organization, the department shall add the payments made or charges incurred for the recipient, as reported by the health maintenance organization and verified by the department, to total medicaid managed care costs.

(22) "Medicaid managed care plan (MCP) inpatient payments" for each hospital means the amount on JFS 02930 schedule I, column 2, line 107.

(23) "Medicaid managed care plan (MCP) outpatient payments" for each hospital means the amount on JFS 02930 schedule I, column 4, line 107.

(24) "Total medicaid managed care plan (MCP) payments" for each hospital is the sum of the amount calculated in paragraph (A)(22) of this rule, and the amount calculated in paragraph (A)(23) of this rule.

(25) "Adjusted total facility costs" means the amount described in paragraph (A) of rule 5101:3-2-08 of

the Administrative Code.

(26) "Rural Access Hospital (RAH)" means a hospital that is classified as a rural hospital by the centers for medicare and medicaid services (CMS).

(27) "Critical Access Hospital (CAH)" means a hospital that is certified as a critical access hospital by CMS and that has notified the Ohio department of health and the Ohio department of job and family services of such certification. Beginning in the program year that ends in calendar year 2004, the Ohio department of job and family services must receive notification of critical access hospital certification by the first day of October, the start of the program year, in order for the hospital to be considered a critical access hospital for disproportionate share payment purposes. Hospitals shall notify the Ohio department of job and family services of any change in their critical access hospital status, including continued CAH designations, immediately following notification from CMS.

(28) "Hospital-specific disproportionate share limit" means the limit on disproportionate share and indigent care payments made to hospitals as defined in paragraph (D) of rule 5101:3-2-07.5 of the Administrative Code.

(29) "Children's hospitals" are those hospitals that meet the definition in paragraph (A)(2) of rule 5101:3-2-07.2 of the Administrative Code

(30) "Other medicaid payments" for each hospital means the amount reported in JFS 02930, schedule H, section I, column 1, line 5.

(31) "Total program amount" means the sum of the amounts in paragraphs (J)(2) and (J)(3) of this rule.

(B) Applicability.

The requirements of this rule apply as long as CMS determines that the assessment imposed under section 5112.06 of the Revised Code is a permissible health care related tax. Whenever the department of job and family services is informed that the assessment is an impermissible health care-related tax, the department shall promptly refund to each hospital the amount of money currently in the hospital care assurance program fund that has been paid by the hospital, plus any investment earnings on that amount.

(C) Source data for calculations.

(1) The calculations described in this rule will be based on cost-reporting data described in paragraph (B)(1) of rule 5101:3-2-08 of the Administrative Code.

(2) For new hospitals, the first available cost report filed with the department in accordance with rule 5101:3-2-23 of the Administrative Code will be used until a cost report that meets the requirements of this paragraph is available. If, for a new hospital, there is no available or valid cost report filed with the department, the hospital will be excluded until valid data is available. ~~For hospitals that have changed ownership, the cost reporting data filed by the previous owner that reflects that hospital's completed interim settled medicaid cost report and the cost reporting data filed by the new owner that reflects that hospital's completed interim settled medicaid cost report, will be combined and annualized by the department to reflect one full year of operation. If there is no available or valid cost report from the previous owner, the department shall annualize the cost report from the new owner to reflect one full year of operation. Cost reports for hospitals involved in mergers during the program year that result in the hospitals using one provider number will be combined and annualized by the department to reflect one full year of operation.~~

Cost reports for hospitals involved in mergers during the program year that result in the hospitals using one provider number will be combined and annualized by the department to reflect one full year of operation.

(3) Closed hospitals with unique medicaid provider numbers.

For a hospital facility, identifiable to a unique medicaid provider number, that closes during the program year defined in paragraph (A) of rule 5101:3-2-08 of the Administrative Code, the cost report data used shall be adjusted to reflect the portion of the year the hospital was open during the current program year. That partial year data shall be used to determine the distribution to that closed hospital. The difference between the closed hospital's distribution based on the full year cost report and the partial year cost report shall be redistributed to the remaining hospitals in accordance with paragraph (G) of this rule.

For a hospital facility identifiable to a unique medicaid provider number that closed during the immediate prior program year, the cost report data shall be used to determine the distribution that would have been made to that closed hospital. This amount shall be redistributed to the remaining hospitals in accordance with paragraph (G) of this rule.

(4) Replacement hospital facilities.

If a new hospital facility is opened for the purpose of replacing an existing (original) hospital facility identifiable to a unique medicaid provider number and the original facility closes during the program year defined in paragraph (A) of rule 5101:3-2-08 of the Administrative Code, the cost report data from the original facility shall be used to determine the distribution to the new replacement facility if the following conditions are met:

(a) Both facilities have the same ownership,

(b) There is appropriate evidence to indicate that the new facility was constructed to replace the original facility,

(c) The new replacement facility is so located as to serve essentially the same population as the original facility, and

(d) The new replacement facility has not filed a cost report for the current program year.

For a replacement hospital facility that opened in the immediate prior program year, the distribution for that facility will be based on the cost report data for that facility and the cost report data for the original facility, combined and annualized by the department to reflect one full year of operation.

(5) Hospitals that have changed ownership.

For a change of ownership that occurs during the program year, the cost reporting data filed by the previous owner that reflects that hospital's most recent completed interim settled medicaid cost report shall be annualized to reflect one full year of operation. The data will be allocated to each owner based on the number of days in the program year the hospital was owned.

For a change of ownership that occurred in the previous program year, the cost reporting data filed by the previous owner that reflects that hospital's most recent completed interim settled medicaid cost report and the cost reporting data filed by the new owner that reflects that hospital's most recent completed interim settled medicaid cost report, will be combined and annualized by the department to reflect one full year of operation. If there is no available or valid cost report from the previous owner, the department shall annualize the cost report from the new owner to reflect one full year of operation.

~~(5)~~(6) Cost report data used in the calculations described in this rule will be the cost report data described in this paragraph subject to any adjustments made upon departmental review prior to final determination that is completed each year and subject to the provisions of rule 5101:3-2-08 of the Administrative Code.

(D) Determination of indigent care pool.

(1) The "indigent care pool" means the sum of the following:

(a) The total assessments paid by all hospitals less the assessments deposited into the legislative budget services fund and the health care services administration fund described in rule 5101:3-2-08 of the Administrative Code.

(b) The total amount of intergovernmental transfers required to be made by governmental hospitals less the amount of transfers deposited

into the legislative budget services fund and the health care services administration fund described in rule 5101:3-2-08 of the Administrative Code.

(c) The total amount of federal matching funds that will be made available to general acute care hospitals in the same program year as a result of the state's disproportionate share limit payment allotment determined by the United States center for medicare and medicaid services (CMS) for that program year.

(2) The funds available in the indigent care pool shall be distributed through policy payment pools in paragraphs (E) to (I) of this rule. Policy payment pools shall be allocated a percentage of the indigent care pool as described in paragraphs (D)(2)(a) to (D)(2)(f) of this rule.

(a) High federal disproportionate share hospital pool: ~~7.92~~ 7.85 per cent.

(b) Medicaid indigent care pool: ~~20.59~~ 20.40 per cent.

(c) Disability assistance medical and uncompensated care pool below one hundred per cent of poverty: ~~61.70~~ 61.12 per cent.

(d) Uncompensated care for persons above one hundred per cent of poverty: ~~5.29~~ 5.24 per cent.

(e) Critical access and rural hospitals: ~~3.16~~ 4.06 per cent.

(f) Children's hospitals: ~~1.34~~ 1.33 per cent.

(E) Distribution of funds through the indigent care payment pools.

The funds are distributed among the hospitals according to indigent care payment pools described in paragraphs (E)(1) to (E)(3) of this rule.

(1) Hospitals meeting the high federal disproportionate share hospital definition described in paragraph (A)(15) of this rule shall receive funds from the high federal disproportionate share indigent care payment pool.

(a) For each hospital that meets the high federal disproportionate share definition, calculate the ratio of the hospital's total medicaid costs and total medicaid MCP costs to the sum of total medicaid costs and total medicaid MCP costs for all hospitals that meet the high federal disproportionate share definition.

(b) For each hospital that meets the high federal disproportionate share definition, multiply the ratio calculated in paragraph (E)(1)(a) of this rule by the amount allocated in paragraph (D)(2)(a) of this rule to determine each hospital's high federal disproportionate share hospital payment amount, subject to the following limitations:

(i) If the hospital's payment amount calculated in paragraph (E)(1)(b) of this rule is greater than or equal to its hospital-specific disproportionate share limit defined in paragraph (A)(28) of this rule, the hospital's high federal disproportionate share hospital payment is the amount defined in paragraph (A)(28).

(ii) If the hospital's payment amount calculated in (E)(1)(b) of this rule is less than its hospital-specific disproportionate share limit defined in paragraph (A)(28) of this rule, the hospital's high federal disproportionate share hospital payment is equal to the amount in paragraph (E)(1)(b) of this rule and any additional amount provided by paragraph (E)(1)(b)(iv) of this rule.

(iii) If the hospital-specific disproportionate share limit defined in paragraph (A)(28) of this rule is equal to or less than zero, the hospital's high federal disproportionate share hospital payment is equal to zero.

(iv) If any hospital is limited as described in paragraph (E)(1)(b)(i) of this rule, calculate each hospital's ~~limitation~~ limited payment by subtracting the amount defined in paragraph (A)(28) of this rule from the amount determined in paragraph (E)(1)(b) of this rule and sum these amounts for all limited hospital(s). ~~Make the sum of the limitation amounts available to the remaining hospitals in the pool by repeating~~ Subtract the sum of the limited payments from the amount allocated in paragraph (D)(2)(a) of this rule and repeat the distribution described in paragraph (E)(1) of this rule until all funds for this pool are expended.

(2) Hospitals shall receive funds from the medicaid indigent care payment pool.

(a) For each hospital, calculate medicaid shortfall by subtracting from total medicaid costs, as defined in paragraph (A)(1) of this rule, the total medicaid payments, as defined in paragraph (A)(16) of this rule. For hospitals with a negative medicaid shortfall, the medicaid shortfall amount is equal to zero.

(b) For each hospital, calculate medicaid MCP inpatient shortfall by subtracting from the total medicaid managed care plan inpatient costs, as defined in paragraph (A)(2) of this rule, medicaid MCP inpatient payments, as defined in paragraph (A)(22) of this rule.

(c) For each hospital, calculate medicaid MCP outpatient shortfall by subtracting from the total medicaid managed care plan outpatient costs, as defined in paragraph (A)(3) of this rule, medicaid MCP outpatient payments, as defined in paragraph (A)(23) of this rule.

(d) For each hospital, calculate medicaid MCP shortfall as the sum of the amount calculated in paragraph (E)(2)(b) of this rule, and the amount calculated in paragraph (E)(2)(c) of this rule.

(e) For each hospital, sum the hospital's medicaid shortfall as calculated in paragraph (E)(2)(a) of this rule, medicaid MCP shortfall as calculated in paragraph (E)(2)(d) of this rule, total medicaid costs, total medicaid MCP costs, and total Title V costs.

(f) For all hospitals, sum all hospitals medicaid shortfall as calculated in paragraph (E)(2)(a) of this rule, medicaid MCP shortfall as calculated in paragraph (E)(2)(d) of this rule, total medicaid costs, total medicaid MCP costs, and total Title V costs.

(g) For each hospital, calculate the ratio of the amount in paragraph (E)(2)(e) of this rule to the amount in paragraph (E)(2)(f) of this rule.

(h) For each hospital, multiply the ratio calculated in paragraph (E)(2)(g) of this rule by the amount allocated in paragraph (D)(2)(b) of this rule to determine each hospital's medicaid indigent care payment amount subject to the following limitations:

(i) If the sum of a hospital's payment amounts calculated in paragraph (E)(1) of this rule is greater than or equal to its hospital-specific disproportionate share limit defined in paragraph (A)(28) of this rule, the hospital's medicaid indigent care payment pool amount is equal to zero.

(ii) If the sum of a hospital's payment amounts calculated in paragraphs (E)(1) and (E)(2)(h) of this rule is less than its hospital-specific disproportionate share limit defined in paragraph (A)(28) of this rule, then the payment is equal to the amount in paragraph (E)(2)(h) of this rule and any amount provided by paragraph (E)(2)(h)(iv) of this rule.

(iii) If the sum of a hospital's payment amounts calculated in paragraphs (E)(1) and (E)(2)(h) of this rule is greater than its hospital-specific disproportionate share limit defined in paragraph (A)(28) of this rule, then the payment is equal to the difference between the amount calculated in paragraph (A)(28) of this rule and the amount calculated in paragraph (E)(1) of this rule.

(iv) If any hospital is limited as described in paragraph (E)(2)(h)(iii) of this rule, calculate each hospital's ~~limitation~~ limited payment by subtracting the amount defined in paragraph (A)(28) of this rule from the amount determined in paragraph (E)(2)(h) of this rule and sum these amounts for all limited hospital(s). ~~Make the sum of the limitation amounts available to the remaining hospitals in the pool by repeating~~ Subtract the sum of the limited payments from the amount allocated in paragraph (D)(2)(b) of this rule and repeat the distribution described in paragraph (E)(2) of this rule until all funds for this pool are expended.

(v) For all hospitals, sum the amounts calculated in paragraph (E)(2)(h) of this rule. This amount is the hospital's medicaid indigent payment amount.

(3) Hospitals shall receive funds from the disability assistance medical and uncompensated care indigent care payment pool.

(a) For each hospital, sum total disability assistance medical costs defined in paragraph (A)(11) of this rule and total uncompensated care costs under one hundred per cent defined in paragraph (A)(12) of this rule. For hospitals with total negative disability assistance and uncompensated care costs, the resulting sum is equal to zero.

(b) For all hospitals, sum the amounts calculated in paragraph (E)(3)(a) of this rule.

(c) For each hospital, calculate the ratio of the amount in paragraph (E)(3)(a) of the rule to the amount in paragraph (E)(3)(b) of this rule.

(d) For each hospital, multiply the ratio calculated in paragraph (E)(3)(c) of this rule by the amount allocated in paragraph (D)(2)(c) of this rule to determine each hospital's disability assistance medical and uncompensated care under one hundred per cent payment, subject to the following limitations:

(i) If the sum of a hospital's payment amounts calculated in paragraphs (E)(1) and (E)(2) of this rule is greater than or equal to its hospital-specific disproportionate share limit defined in paragraph (A)(28) of this rule, the hospital's disability assistance medical and uncompensated care under one hundred per cent payment amount is equal to zero.

(ii) If the sum of a hospital's payment amount calculated in paragraphs (E)(1) and (E)(2) of this rule and the amount calculated in paragraph (E)(3)(d) of this rule is less than its hospital-specific disproportionate share limit defined in paragraph (A)(28) of this rule, the hospital's disability medical and uncompensated care under one hundred per cent payment amount is equal to the amount calculated in paragraph (E)(3)(d) of this rule and any amount provided by paragraph (E)(3)(d)(iv) of this rule.

(iii) If a hospital does not meet the condition described in paragraph (E)(3)(d)(i) of this rule, and the sum of its payment amounts calculated in paragraphs (E)(1) and (E)(2) of this rule and the amount calculated in paragraph (E)(3)(d) of this rule is greater than its hospital-specific disproportionate share limit defined in paragraph (A)(28) of this rule, the hospital's disability medical and uncompensated care under one hundred per cent payment amount is equal to the difference between the hospital's disproportionate share limit and the sum of the payment amounts calculated in paragraphs (E)(1) and (E)(2) of this rule.

(iv) If any hospital is limited as described in paragraph (E)(3)(d)(iii) of this rule, calculate each hospital's ~~limitation~~ limited payment by subtracting the amount defined in paragraph (A)(28) of this rule from the amount determined in paragraph (E)(3)(d) of this rule and sum these amounts for all limited hospital(s). ~~Make the sum of the limitation amounts available to the remaining hospitals in the pool by repeating~~ Subtract the sum of the limited payments from the amount allocated in paragraph (D)(2)(c) of this rule and repeat the distribution described in paragraph (E)(3) of this rule until all funds for this pool are expended or all unlimited hospitals have received one hundred per cent of the amount described in paragraph (E)(3)(a) of this rule.

(e) For all hospitals, sum the amounts calculated in paragraph (E)(3)(d) of this rule.

(f) For each hospital except those meeting either condition described in paragraph (E)(3)(d)(i) or (E)(3)(d)(iii) of this rule, multiply a factor of 0.30 by the hospital's total uncompensated care costs above one hundred per cent without insurance, as described in paragraph (A)(13) of this rule. For hospitals meeting the conditions described in paragraph (E)(3)(d)(i) or (E)(3)(d)(iii) of this rule, multiply the hospital's total uncompensated care costs above one hundred per cent by zero.

(g) For all hospitals, sum the amounts calculated in paragraph (E)(3)(f) of this rule.

(h) For each hospital, calculate the ratio of the amount in paragraph (E)(3)(f) of this rule to the amount in paragraph (E)(3)(g) of this rule.

(i) Subtract the amount calculated in paragraph (E)(3)(e) of this rule from the amount allocated in paragraph (D)(2)(c) of this rule and add the amount allocated in paragraph (D)(2)(d) of this rule.

(j) For each hospital, multiply the ratio calculated in paragraph (E)(3)(h) of this rule by the amount calculated in paragraph (E)(3)(i) of this rule to determine each hospital's uncompensated care above one hundred per cent without insurance payment, subject to the following limitations:

(i) If the sum of a hospital's payment amounts calculated in paragraphs (E)(1), (E)(2) and (E)(3)(d) of this rule is greater than or equal to its hospital-specific disproportionate share limit defined in paragraph (A)(28) of this rule, the hospital's uncompensated care above one hundred per cent without insurance amount is equal to zero.

(ii) If the sum of a hospital's uncompensated care above

one hundred per cent without insurance payment and the payment amounts calculated in paragraphs (E)(1), (E)(2), and (E)(3)(d) of this rule is less than the hospital's disproportionate share limit defined in paragraph (A)(28) of this rule, then the hospital's uncompensated care above one hundred per cent without insurance payment is equal to the product of multiplying the ratio calculated in paragraph (E)(3)(h) of this rule by the amount calculated in paragraph (E)(3)(i) of this rule and any amount provided by paragraph (E)(3)(j)(iv) of this rule.

(iii) If the sum of a hospital's uncompensated care above one hundred per cent without insurance payment and the payment amounts calculated in paragraphs (E)(1), (E)(2), and (E)(3)(d) of this rule is greater than the hospital's disproportionate share limit defined in paragraph (A)(28) of this rule, then the hospital's uncompensated care above one hundred per cent without insurance payment is equal to the difference between the hospital's disproportionate share limit and the sum of the payment amounts calculated in paragraphs (E)(1), (E)(2), and (E)(3)(d) of this rule.

(iv) If any hospital is limited as described in paragraph (E)(3)(j)(iii) of this rule, calculate each hospital's ~~limitation~~ limited payment by subtracting the amount defined in paragraph (A)(28) of this rule from the amount determined in paragraph (E)(3)(j) of this rule and sum these amounts for all limited hospital(s). ~~Make the sum of the limitation amounts available to the remaining hospitals in the pool by repeating~~ Subtract the sum of the limited payments from the amount calculated in paragraph (E)(3)(i) of this rule and repeat the distribution described in paragraph the distribution described in paragraphs (E)(3)(g) to (E)(3)(j) of this rule until all funds for this pool are expended.

(k) For each hospital, sum the amount calculated in paragraph (E)(3)(d) of this rule, and the amount calculated in paragraph (E)(3)(j) of this rule. This amount is the hospital's disability assistance medical and uncompensated care indigent care payment amount.

(F) Distribution of funds through the rural and critical access payment pools.

The funds are distributed among the hospitals according to rural and critical access payment pools described in paragraphs (F)(1) to (F)(2) of this rule.

(1) Hospitals meeting the definition described in paragraph (A)(27) of this rule, shall receive funds from the critical access hospital (CAH) payment pool.

(a) For each hospital with CAH certification, calculate the medicaid shortfall as described in paragraph (E)(2)(a) of this rule.

(b) For each hospital with CAH certification:

(i) Calculate the ratio of each CAH hospital's medicaid shortfall to total medicaid shortfall for all CAH hospitals.

(ii) For each CAH hospital, multiply the ratio calculated in paragraph (F)(1)(b)(i) of this rule by ~~26.67~~ 32.01 per cent of the amount allocated in paragraph (D)(2)(e) of this rule to determine each hospital's CAH payment amount.

(c) For all hospitals with CAH certification, sum the amounts calculated in paragraph (F)(1)(b) of this rule.

(d) For each hospital with CAH certification, if the amount described in paragraph (F)(1)(a) of this rule is equal to zero, the hospital shall be included in the RAH payment pool described in paragraph (F)(2)(a) of this rule.

(2) Hospitals meeting the definition described in paragraph (A)(26) of this rule but do not meet the definition described in paragraph (A)(27) of this rule, shall receive funds from the rural access hospital RAH payment pool.

(a) For each hospital with RAH classification, as qualified by paragraphs (F)(2) and (F)(1)(d) of this rule, sum the hospital's total payments allocated in paragraphs (E)(1)(b), (E)(2)(h), and (E)(3)(k) of this rule.

(b) For each hospital with RAH classification, as qualified by paragraphs (F)(2) and (F)(1)(d) of this rule subtract the amount calculated in paragraph (F)(2)(a) of this rule, from the amount calculated in paragraph (A)(28) of this rule. If this difference for the hospital is negative, then for the purpose of this calculation set the difference equal to zero.

(c) For all hospitals with RAH classification, as qualified by paragraphs (F)(2) and (F)(1)(d) of this rule, sum the amounts calculated in paragraph (F)(2)(b) of this rule.

(d) For each hospital with RAH classification, as qualified by paragraphs (F)(2) and (F)(1)(d) of this rule, determine the ratio of the amounts in paragraphs (F)(2)(b) and (F)(2)(c) of this rule.

(e) Subtract the amount calculated in paragraph (F)(1)(c) of this rule from the amount allocated in paragraph (D)(2)(e) of this rule.

(f) For each hospital with RAH classification, as qualified by paragraphs (F)(2) and (F)(1)(d) of this rule, multiply the ratio calculated in paragraph (F)(2)(d) of this rule, by the amount calculated in paragraph (F)(2)(e) of this rule, to determine each hospital's rural access hospital payment pool amount.

(g) For each hospital, sum the amount calculated in paragraph (F)(1)(b) of this rule, and the amount calculated in paragraph (F)(2)(f) of this rule. This amount is the hospital's rural and critical access payment amount.

(G) Distribution of funds through the county redistribution of closed hospitals payment pools.

If funds are available in accordance with paragraph (C) of this rule, the funds are distributed among the hospitals according to the county redistribution of closed hospitals payment pools described in paragraphs (G)(1) to (G)(3) of this rule.

(1) If a hospital facility that is identifiable to a unique medicaid provider number closes during the current program year, the payments that would have been made to that hospital under paragraphs (E), (F), (H), and (I) of this rule for the portion of the year it was closed, less any amounts that would have been paid by the closed hospital under provisions of rules 5101:3-2-08 and 5101:3-2-08.1 of the Administrative Code for the portion of the year it was closed, shall be distributed to the remaining hospitals in the county where the closed hospital is located. If another hospital does not exist in such a county, the funds shall be distributed to hospitals in bordering counties within the state.

For each hospital identifiable to a unique medicaid provider number that closed during the immediate prior program year, the payments that would have been made to that hospital under paragraphs (E), (F), (H), and (I) of this rule, less any amounts that would have been paid by the closed hospital under provisions of rules 5101:3-2-08 and 5101:3-2-08.1

of the Administrative Code, shall be distributed to the remaining hospitals in the county where the closed hospital was located. If another hospital does not exist in such a county, the funds shall be distributed to hospitals in bordering counties within the state.

If the closed hospital's payments under paragraphs (E), (F), (H), and (I), of this rule does not result in a net gain, nothing shall be redistributed under paragraphs (G)(2) and (G)(3) of this rule.

(2) Redistribution of closed hospital funds within the county of closure.

(a) For each hospital within a county with a closed hospital as described in paragraph (G)(1) of this rule, sum the amount calculated in paragraph (E)(3)(a) of this rule, and the amount calculated in paragraph (E)(3)(f) of this rule if the sum of a hospital's total payments calculated in paragraphs (E)(1), (E)(2), (E)(3), (F)(1), and (F)(2) of this rule does not exceed the hospital's disproportionate share limit defined in paragraph (A)(28) of this rule.

(b) For all hospitals within a county with a closed hospital, sum the amounts calculated in paragraph (G)(2)(a) of this rule.

(c) For each hospital within a county with a closed hospital, determine the ratio of the amounts in paragraphs (G)(2)(a) and (G)(2)(b) of this rule.

(d) For each hospital within a county with a closed hospital, multiply the ratio calculated in paragraph (G)(2)(c) of this rule, by the amount calculated in paragraph (G)(1) of this rule, to determine each hospital's county redistribution of closed hospitals payment amount, subject to the following limitation:

If the sum of a hospital's payment amounts calculated in paragraphs (E)(1), (E)(2), (E)(3)(d), (F)(1), and (F)(2) of this rule is less than the hospital's disproportionate share limit defined in paragraph (A)(28) of this rule, then the hospital's redistribution of closed hospital funds amount is equal to the amount in paragraph (G)(2)(d) of this rule, not to exceed the amount defined in paragraph (A)(28) of this rule.

(3) Redistribution of closed hospital funds to hospitals in a bordering county.

(a) For each hospital within a county that borders a county with a closed hospital where another hospital does not exist, as described in paragraph (G)(1) of this rule, sum the amount calculated in paragraph (E)(3)(a) of this rule, and the amount calculated in paragraph (E)(3)(f) of this rule if the sum of a hospital's total payments calculated in paragraphs (E)(1), (E)(2), (E)(3), (F)(1) and (F)(2) of this rule does not exceed the hospital's disproportionate share limit defined in paragraph (A)(28) of this rule.

(b) For all hospitals within counties that border a county with a closed hospital where another hospital does not exist, sum the amounts calculated in paragraph (G)(3)(a) of this rule.

(c) For each hospital within a county that borders a county with a closed hospital where another hospital does not exist, determine the ratio of the amounts in paragraphs (G)(3)(a) and (G)(3)(b) of this rule.

(d) For each hospital within a county that borders a county with a closed hospital where another hospital does not exist, multiply the ratio calculated in paragraph (G)(3)(c) of this rule, by the amount calculated in paragraph (G)(1) of this rule, to determine each hospital's county redistribution of closed hospitals payment amount subject to the following limitation:

If the sum of a hospital's payment amounts calculated in paragraphs (E)(1), (E)(2), (E)(3)(d), (F)(1), and (F)(2) of this rule is less than the hospital-specific disproportionate share limit defined in paragraph (A)(28) of this rule, the hospital's redistribution of closed hospital funds amount is the amount defined in paragraph (G)(3)(d) of this rule, not to exceed the amount defined in paragraph (A)(28) of this rule.

(H) Distribution of funds through the children's hospital pool.

(1) For each hospital meeting the children's hospital definition described in paragraph (A)(29) of this rule, sum the payment amounts as calculated in paragraphs (E), (F), and (G) of this rule. This is the hospital's calculated payment amount.

(2) For each hospital meeting the children's hospital definition described in paragraph (A)(29) of this rule, with a calculated payment amount that is not greater than the disproportionate share limit, as described in paragraph (A)(28) of this rule, subtract the amount in paragraph (H)(1) of this rule from the amount in paragraph (A)(28) of this rule.

(3) For hospitals meeting the children's hospital definition described in paragraph (A)(29) of this rule, with calculated payment amounts that are not greater than the disproportionate share limit, sum the amounts calculated in paragraph (H)(2) of this rule.

(4) For each hospital meeting the children's hospital definition described in paragraph (A)(29) of this rule, with a calculated payment amount that is not greater than the disproportionate share limit, determine the ratio of the amounts in paragraphs (H)(2) and (H)(3) of this rule.

(5) For each hospital meeting the children's hospital definition described in paragraph (A)(29) of this rule, with a calculated payment that is not greater than the disproportionate share limit, multiply the ratio calculated in paragraph (H)(4) of this rule by the amount allocated in paragraph (D)(2)(f) of this rule. This amount is the children's hospital payment pool payment amount, subject to the following limitation.

If the sum of the hospital's payment amounts calculated in paragraphs (E)(1), (E)(2), (E)(3)(d), (F)(1), (F)(2), and (G) of this rule is less than the hospital's disproportionate share limit defined in paragraph (A)(28) of this rule, then the hospital's children's hospital pool payment amount is equal to the amount calculated in paragraph (H)(5) of this rule, not to exceed the amount defined in paragraph (A)(28) of this rule.

If any hospital is limited as described in paragraph (H)(5) of this rule, calculate each hospital's ~~limitation~~ limited payment by subtracting the amount defined in paragraph (A)(28) of this rule from the amount determined in paragraph (H)(5) of this rule and sum these amounts for all limited hospital(s). ~~Make the sum of the limitation amounts available to the remaining hospitals in the pool by repeating~~ Subtract the sum of the limited payments from the amount in paragraph (D)(2)(f) of this rule and repeat the distribution described in paragraph (H) of this rule until all funds for this pool are expended.

(I) Distribution model adjustments and limitations through the statewide residual pool.

(1) For each hospital, sum the payment amounts as calculated in paragraphs (E), (F), (G), and (H), of this rule. This is the hospital's calculated payment amount.

(2) For each hospital, calculate the hospital's specific disproportionate share limit as defined in paragraph (A)(28) of this rule.

(3) For each hospital, subtract the hospital's disproportionate share limit as calculated in paragraph (I)(2) of this rule from the payment amount as calculated in paragraph (I)(1) of this rule to determine if a hospital's calculated payment amount is greater than its disproportionate share limit. If the hospital's calculated payment amount as calculated in paragraph (I)(1) of this rule is greater than the hospital's disproportionate share limit calculated in paragraph (I)(2) of this rule, then the difference is the hospital's residual payment funds.

(4) If a hospital's calculated payment amount, as calculated in paragraph (I)(1) of this rule, is greater than its disproportionate share limit defined in paragraph (I)(2) of this rule, then the hospital's payment is equal to the hospital's disproportionate share limit.

(a) The hospital's residual payment funds as calculated in paragraph (I)(3) of this rule is subtracted from the hospital's calculated payment amount as calculated in paragraph ~~(J)~~(I)(1) of this rule and is applied to and distributed as the statewide residual payment pool as described in paragraph (I)(5) of this rule.

(b) The total amount distributed through the statewide residual pool will be the sum of the hospital care assurance fund described in paragraph (J)(4) minus the sum of the lessor of each hospital's calculated payment amount calculated in (I)(1) of this rule or the hospital's disproportionate share limit calculated in paragraph (I)(2) of this rule.

(5) Redistribution of residual payment funds in the statewide residual payment pool.

(a) For each hospital with a calculated payment amount that is not greater than the disproportionate share limit, as described in paragraph (I)(4) of this rule, subtract the amount in paragraph (I)(1) of this rule from the amount in paragraph (I)(2) of this rule.

(b) For hospitals with calculated payment amounts that are not greater than the disproportionate share limit, sum the amounts calculated in paragraph (I)(5)(a) of this rule.

(c) For each hospital with a calculated payment amount that is not greater than the disproportionate share limit, determine the ratio of the amounts in paragraphs (I)(5)(a) and (I)(5)(b) of this rule.

(d) For each hospital with a calculated payment amount that is not greater than the disproportionate share limit, multiply the ratio calculated in paragraph (I)(5)(c) of this rule by the total amount distributed through the statewide residual pool described in paragraph (I)~~(5)~~(4)(b) of this rule. This amount is the hospital's statewide residual payment pool payment amount subject to the following limitation:

If the amount sum of the hospital's payment amounts calculated in paragraphs (E), (F), (G), and (H) of this rule is less than the amount of the hospital's disproportionate share limit defined in paragraph (A)(28) of this rule, then hospital's residual pool payment amount is equal to the amount defined in paragraph (I)(5)(d) of this rule, not to exceed the amount defined in paragraph (A)(28) of this rule.

(J) Payments and adjustments.

(1) Every hospital that must make payments of assessments and/or intergovernmental transfers to the department of job and family services under the provisions of rule 5101:3-2-08.1 of the Administrative Code shall make the payments in accordance with the payment schedule as described in this rule. If the final determination that the hospital must make payments was made by the department, the hospitals shall meet the payment schedule developed by the department after consultation with the hospitals or a designated representative thereof.

If the final determination that the hospital must make payments was made by the court of common pleas of Franklin county, the hospital shall meet the payment schedule developed by the department after consultation with the hospital or a designated representative thereof. Delayed payment schedules for hospitals that are unable to make timely payments under this paragraph due to financial difficulties will be developed by the department.

The delayed payments shall include interest at the rate of ten per cent per year on the amount payable from the date the payment would have been due had the delay not been granted until the date of payment.

(2) Except for the provisions of paragraphs ~~(C)~~(E) and ~~(D)~~(F) of rule 5101:3-2-08.1 of the Administrative Code, all payments of assessments and intergovernmental transfers, when applicable, from hospitals under rule 5101:3-2-08 of the Administrative Code shall be deposited to the credit of the hospital care assurance program fund. All investment earnings of the fund shall be credited to the fund. The department shall maintain records that show the amount of money in the fund at any time that has been paid by each hospital and the amount of any investment earnings on that amount. All moneys credited to the hospital care assurance program fund shall be used solely to make payments to hospitals under the provisions of this rule.

(3) All federal matching funds received as a result of hospital payments of assessments and intergovernmental transfers the department makes to hospitals under paragraph (J)(4) of this

rule shall be credited to the hospital care assurance match fund. All investment earnings of the fund shall be credited to the fund. All money credited to the hospital care assurance match fund shall be used solely to make payments to hospitals under the provisions of this rule.

(4) The department shall make payments to each medicaid participating hospital meeting the definition of hospital as described under section 5112.01 of the Revised Code. The payments shall be based on amounts that reflect the sum of amounts in the hospital care assurance program fund described in paragraph (J)(2) of this rule and the hospital care assurance match fund described in paragraph (J)(3) of this rule. Payments to each hospital shall be calculated as described in paragraphs (E), (F), (G), (H), and (I) of this rule. For purposes of this paragraph, the value of the hospital care assurance match fund is calculated as:

Sum of hospital care assurance program fund/{1-(federal medical assistance

percentage/100)}

The payments shall be made solely from the hospital care assurance program fund and the hospital care assurance match fund. If amounts in the funds are insufficient to make the total amount of payments for which hospitals are eligible, the department shall reduce the amount of each payment by the percentage by which the amounts are insufficient. Any amounts not paid at the time they were due shall be paid to hospitals as soon as moneys are available in the funds.

(5) All payments to hospitals under the provisions of this rule are conditional on:

(a) Expiration of the time for appeals under the provisions of rule 5101:3-2-08.1 of the Administrative Code without the filing of an appeal, or on court determinations, in the event of appeals, that the hospital is entitled to the payments;

(b) The availability of sufficient moneys in the hospital care assurance program fund and the hospital care assurance match fund to make payments after the final determination of any appeals;

(c) The hospital's compliance with the provisions of rule 5101:3-2-07.17 of the Administrative Code; and

(d) The payment made to hospitals does not exceed the hospital's disproportionate share limit as calculated in paragraph (D) of rule 5101:3-2-07.5 of the Administrative Code.

(6) If an audit conducted by the department of the amounts of payments made and received by hospitals under the provisions of this rule identifies amounts that, due to errors by the department, a hospital should not have been required to pay but did pay, should have been required to pay but did not pay, should not have received but did receive, or should have received but did not receive, the department shall:

(a) Make payments to any hospital that the audit reveals paid amounts it should not have been required to pay but did pay or did not receive amounts it should have received; and

(b) Take action to recover from a hospital any amounts that the audit reveals it should have been required to pay but did not pay or that it should not have received but did receive.

(7) Payments made under paragraph (J)(6)(a) of this rule shall be made from the hospital care assurance program fund. Amounts recovered under paragraph (J)(6)(b) of this rule shall be deposited to the credit of the hospital care assurance program fund. Any hospital may appeal the amount the hospital is to be paid under paragraph (J)(6)(a) of this rule or the amount to be recovered from the hospital under paragraph (J)(6)(b) of this rule to the court of common pleas of Franklin county.

(K) Confidentiality.

Except as specifically required by the provisions of this rule and rule 5101:3-2-24 of the Administrative Code, information filed shall not include any patient-identifying material. Information including patient-identifying information is not a public record under section 149.43 of the Revised Code and no patient-

identifying material shall be released publicly by the department of job and family services or by any person under contract with the department who has access to such information.

(L) Penalties for failure to report or make payment.

(1) Any hospital that fails to report the information required under this rule and under paragraph (A) of rule 5101:3-2-23 of the Administrative Code on or before the dates specified in this rule and in rule 5101:3-2-23 of the Administrative Code shall be fined one thousand dollars for each day after the due date that the information is not reported.

(2) In addition to any other remedy available to the department under law to collect unpaid assessments and transfers, any hospital that fails to make payments of the assessments and intergovernmental transfers to the department of job and family services on or before the dates specified in this rule or under any schedule for delayed payments established under paragraph (J)(1) of this rule shall be fined one thousand dollars for each day after the due date.

(3) The director of job and family services shall waive the penalties provided for in paragraphs (L)(1) and (L)(2) of this rule for good cause shown by the hospital.

(M) Payment schedule.

The assessments, intergovernmental transfers and payments made under the provisions of this rule will be made in installments.

(1) On or before the fourteenth day after the department mails the final determination as described in rule 5101:3-2-08.1 of the Administrative Code, the hospital must submit its first assessment to the department.

All subsequent assessments and intergovernmental transfers, when applicable, must be made on or before the fifth day after the date on the warrant or electronic funds transfer (EFT) issued as payment by the department as described in paragraph (M)(2) of this rule.

(a) Beginning in the program year that ends in calendar year 2006, and each year thereafter, each hospital shall submit its assessment amount to the Ohio department of job and family services via electronic funds transfer.

(2) On or before the tenth day after the ~~departments~~ department's deadline for receiving assessments and intergovernmental transfers, the department must make a payment to each hospital. However, the department shall make no payment to any hospital that has not paid assessments or made intergovernmental transfers that are due until the assessments and transfers are paid in full or a final determination regarding amounts to be paid is made under any request for reconsideration or appeal.

(3) If a hospital closes after the date of the public hearing held in accordance with rule 5101:3-2-08.1 of the Administrative Code, and before the last payment is made, as described in this paragraph, the payments to the remaining hospitals will be adjusted in accordance with paragraphs (E) to (J)(7) of this rule.

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R.C. 119.032 review dates: 08/01/2014

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5160-2-10 Payment Policies for Disproportionate Share and Indigent Care Adjustments for Psychiatric Hospitals

Formerly **5101:3-2-10 Payment Policies for Disproportionate Share and Indigent Care Adjustments for Psychiatric Hospitals**

HHTL 3352-06-03 / HHTL 3352-06-04

Effective Date: September 15, 2006

Most Current Prior Effective Date: **July 22, 2005**

This rule is applicable for each program year for all medicaid-participating psychiatric hospitals as described in paragraphs (B), (C), (D), (E) and ~~(E)~~ (F) of rule 5101:3-2-01 of the Administrative Code.

(A) Definitions.

(1) "Inpatient days" means for each psychiatric hospital the number of inpatient hospital days as reported in JFS 02930, for the applicable state fiscal year, schedule C, column 4.

(2) "Insurance revenues" are reported on JFS 02930, schedule F, section II, column 1, line 24 and mean for each psychiatric hospital the revenues received in the same twelve months of the hospital's cost-reporting period for inpatient services provided to, billed to, and received from all sources other than medicaid or self-pay revenues as described in paragraph (A)(4) of this rule.

(3) "Medicaid inpatient utilization rate" means for each psychiatric hospital the ratio of the hospital's number of inpatient days attributable to patients who were eligible for medical assistance as described in paragraph (A)(6) of this rule divided by the hospital's total inpatient days as described in paragraph (A)(1) of this rule.

(4) "Self-pay revenues" means for each psychiatric hospital the revenues received in the same twelve months of the hospital's cost-reporting period for inpatient services provided to, billed to, and received from either the person that received inpatient services or the family of the person that received inpatient services as reported on JFS 02930, schedule F, column 2, line 24.

(5) "Total inpatient allowable costs" for each psychiatric hospital means the sum of the general service and capital related costs for inpatient hospital services reported in JFS 02930 schedule B, column 7.

(6) "Total medicaid days" for each psychiatric hospital ~~means the amount on JFS 02930, schedule C, column 6, line 35~~means the sum of the amounts reported on JFS 02930, schedule F, section II, columns 6 and 8, line 24. For hospitals meeting the conditions set forth in paragraphs (E) and (F) of rule 5101:3-2-01 of the Administrative Code, total medicaid days means the sum of the amounts reported on JFS 02930, schedule F, section II, columns 6 to 8, line 24.

(7) "Total medicaid revenues" for each psychiatric hospital means the ~~the~~ amount reported on JFS 02930, schedule H, section I, column 1, line 7.

(8) "Uncompensated care costs" means for each psychiatric hospital the total inpatient allowable costs as described in paragraph (A)(5) of this rule less total facility revenue as described in paragraph (A)(12) of this rule less the uncompensated care costs rendered to patients with insurance for the services provided as described in paragraph (A)(9) of this rule.

(9) "Uncompensated care costs rendered to patients with insurance" means the costs for an individual that has insurance coverage for the service provided, but the full cost of the service was not reimbursed because of per diem caps or coverage limitations as reported on JFS 02930, schedule F, section II, column 5, line 24.

(10) "Charges for charity care" means for each psychiatric hospital the total charges for inpatient services provided to indigent patients as reported on JFS 02930, schedule F, section II, column 3, line 24. It includes charges for services provided to individuals who do not possess health insurance for the service provided. However, charity care does not include bad debts, contractual allowances or uncompensated care costs rendered to patients with insurance as described in paragraph (A)(9) of this rule.

(11) Except for free-standing, state-owned psychiatric hospitals, "Total charges for inpatient services" means for each psychiatric hospital the sum of the amounts reported for inpatient hospital services in JFS 02930, schedule B, column 6. For free-standing, state-owned psychiatric hospitals, "total charges for inpatient services" equals "total inpatient allowable costs" as defined in paragraph (A)(5) of this rule.

(12) "Total facility inpatient revenues" means for each psychiatric hospital the sum of the hospital's insurance revenues as described in paragraph (A)(2) of this rule, self-pay revenues as described in paragraph (A)(4) of this rule, and total medicaid revenues as described in paragraph (A)(7) of this rule.

(13) "Cash subsidies for inpatient services received directly from state and local governments" means for each psychiatric hospital the amount of cash subsidies each psychiatric hospital has received from state and local governments as reported on JFS 02930, schedule F, section II, column 4, line 24 and as reported by each hospital in accordance with paragraph (C) of this rule.

(B) Applicability.

The requirements of this rule are limited pursuant to section 1923 of the Social Security Act, 42 USC 1396r-4.

(C) Source data for calculations.

The calculations described in this rule will be based on cost-reporting data described in paragraph (B)(1) of rule 5101:3-2-08 of the Administrative Code.

(D) Determination of disproportionate share qualifications for psychiatric hospitals.

Psychiatric hospitals will be determined to be disproportionate share if based on data described in paragraph (C) of this rule they meet either qualification described in paragraph (D)(1) or (D)(2) of this rule and meet the qualification in paragraph (D)(3) of this rule.

(1) The hospital's medicaid inpatient utilization rate, as described in paragraph (A)(3) of this rule, is at least one standard deviation above the mean medicaid inpatient utilization rate for all hospitals receiving medicaid payments in the state; or

(2) A low-income utilization rate in excess of twenty-five per cent, where the low-income utilization rate, the fraction expressed as a percentage, is the sum of:

(a) The sum of total medicaid revenues as described in paragraph (A)(7) of this rule, for inpatient services and cash subsidies for inpatient services received directly from state and local governments as described in paragraph (A)(13) of this rule, divided by the sum of total facility inpatient revenues as described in paragraph (A)(12) of this rule, and cash subsidies for inpatient services received directly from state and local governments as described in paragraph (A)(13) of this rule, plus

(b) Total charges for inpatient services for charity care as described in paragraph (A)(10) of this rule (less cash subsidies above, and not including contractual allowances and discounts other than for indigent patients ineligible for medicaid) divided by the total charges for inpatient services, as described in paragraph (A)(11) of this rule.

(3) A medicaid inpatient utilization rate as described in paragraph (A)(3) of this rule greater than or equal to one per cent.

(E) Determination of hospital disproportionate share groupings for payment distribution.

Hospitals determined to be disproportionate share as described in paragraph (D) of this rule will be classified into one of ~~four~~ three tiers based on data described in paragraph (C) of this rule. The groupings for payment distribution are described in paragraphs (E)(1) to (E)~~(4)~~ (3) of this rule.

(1) Tier one includes hospitals that meet the criteria in either paragraph (E)(1)(a) or (E)(1)(b) of this rule.

(a) Hospitals deemed to be disproportionate share hospitals based on a low-income utilization rate as described in paragraph (D)(2) of this rule greater than twenty-five per cent but less than forty per cent.

(b) Hospitals with a low-income utilization rate as described in paragraph (D)(2) of this rule less than or equal to twenty-five per cent that are deemed a disproportionate share hospital based on a medicaid inpatient utilization rate as described in paragraph (D)(1) of this rule.

(2) Tier two includes all hospitals deemed to be disproportionate share hospitals based on a low-income utilization rate as described in paragraph (D)(2) of this rule greater than or equal to forty per cent but less than fifty per cent.

(3) Tier three includes all hospitals deemed to be disproportionate share hospitals based on a low-income utilization rate as described in paragraph (D)(2) of this rule greater than or equal to fifty per cent ~~but less than sixty per cent~~.

~~(4) Tier four includes all hospitals deemed to be disproportionate share hospitals based on a low-income utilization rate as described in paragraph (D)(2) of this rule greater than or equal to sixty per cent.~~

(F) Distribution of funds within each hospital tier.

The funds available to each psychiatric hospital tier as described in paragraph (E) of this rule are distributed among the hospitals in each tier based on data described in paragraph (C) of this rule and according to the payment formulas described in paragraphs (F)(1) to (F)~~(4)~~ (3) of this rule.

(1) A maximum of ~~five~~ ten per cent of the disproportionate share funds available to psychiatric hospitals as described in paragraph (H) of this rule will be distributed to the hospitals in tier one as described in paragraph (E)(1) of this rule according to the process described in paragraphs (F)(1)(a) to (F)(1)(f) of this rule.

(a) For each hospital in tier one, calculate the uncompensated care costs as described in paragraph (A)(8) of this rule.

(b) For all hospitals in tier one, sum all hospitals uncompensated care costs as described in paragraph (A)(8) of this rule.

(c) For each hospital in tier one, calculate the ratio of the amount described in paragraph (F)(1)(a) of this rule to the amount described in paragraph (F)(1)(b) of this rule.

(d) Multiply the ratio for each hospital calculated in paragraph (F)(1)(c) of this rule in tier one by the amount in paragraph (F)(1) of this rule to determine each hospital's disproportionate share payment amount.

(e) Each hospital will be distributed a payment amount based on the lesser of:

(i) Uncompensated care costs as determined in paragraph (A)(8) of this rule; or

(ii) The hospital's payment as determined in paragraph (F)(1)(d) of this rule.

(f) If no hospitals fall into tier one, or all funds are not distributed, then undistributed funds from tier one will be added to the funds available for distribution in tier ~~four~~ three and be distributed in accordance with the process described in paragraphs (F)~~(4)~~(3)(a) to (F)~~(4)~~(3)(e) of this rule.

(2) A maximum of ~~twenty-five~~ thirty per cent of the disproportionate share funds available to psychiatric hospitals as described in paragraph (H) of this rule will be distributed to the hospitals in tier two as described in paragraph (E)(2) of this rule according to the process described in paragraphs (F)(2)(a) to (F)(2)(f) of this rule.

(a) For each hospital in tier two, calculate the uncompensated care costs as described in paragraph (A)(8) of this rule.

(b) For all hospitals in tier two, sum all hospitals uncompensated care costs as described in paragraph (A)(8) of this rule.

(c) For each hospital in tier two, calculate the ratio of the amount described in paragraph (F)(2)(a) of this rule to the amount described in paragraph (F)(2)(b) of this rule.

(d) Multiply the ratio for each hospital calculated in paragraph (F)(2)(c) of this rule in tier two by the amount in paragraph (F)(2) of this rule to determine each hospital's disproportionate share payment amount.

(e) Each hospital will be distributed a payment amount based on the lesser of:

(i) Uncompensated care costs as determined in paragraph (A)(8) of this rule; or

(ii) The hospital's payment as determined in paragraph (F)(2)(d) of this rule.

(f) If no hospitals fall into tier two, or all funds are not distributed, then undistributed funds will be added to the funds available for distribution in tier ~~four~~ three and be distributed in accordance with the process described in paragraphs (F)~~(4)~~(3)(a) to (F)~~(4)~~(3)(e) of this rule.

(3) A ~~maximum~~ minimum of ~~forty-five~~ sixty per cent of the disproportionate share funds available to psychiatric hospitals as described in paragraph (H) of this rule will be distributed to the hospitals in tier three as described in paragraph (E)(3) of this rule according to the process described in paragraphs (F)(3)(a) to (F)(3)~~(f)~~ (e) of this rule.

(a) For each hospital in tier three, calculate the uncompensated care costs as described in paragraph (A)(8) of this rule.

(b) For all hospitals in tier three, sum all hospitals uncompensated care costs as described in paragraph (A)(8) of this rule.

(c) For each hospital in tier three, calculate the ratio of the amount described in paragraph (F)(3)(a) of this rule to the amount described in paragraph (F)(3)(b) of this rule.

(d) Multiply the ratio for each hospital calculated in paragraph (F)(3)(c) of this rule in tier three by the amount in paragraph (F)(3) of this rule to determine each hospital's disproportionate share payment amount.

(e) Each hospital will be distributed a payment amount based on the lesser of:

(i) Uncompensated care costs as determined in paragraph (A)(8) of this rule; or

(ii) The hospital's payment as determined in paragraph (F)(3)(d) of this rule.

~~(f) If no hospitals fall into tier three, or all funds are not distributed, then undistributed funds will be added to the funds available for distribution in tier four and be distributed in accordance with the process described in paragraphs (F)(4)(a) to (F)(4)(e) of this rule.~~

~~(4) A minimum of forty per cent of the disproportionate share funds available to psychiatric hospitals as described in paragraph (H) of this rule will be distributed to the hospitals in tier four as described in paragraph (E)(4) of this rule according to the process described in paragraphs (F)(4)(a) to (F)(4)(e) of this rule.~~

~~(a) For each hospital in tier four, calculate the uncompensated care costs as described in paragraph (A)(8) of this rule.~~

~~(b) For all hospitals in tier four, sum all hospitals uncompensated care costs as described in paragraph (A)(8) of this rule.~~

~~(c) For each hospital in tier four, calculate the ratio of the amount described in paragraph (F)(4)(a) of this rule to the amount described in paragraph (F)(4)(b) of this rule.~~

~~(d) Multiply the ratio for each hospital calculated in paragraph (F)(4)(c) of this rule in tier four by the amount in paragraph (F)(4) of this rule to determine each hospital's disproportionate share payment amount.~~

~~(e) Each hospital will be distributed a payment amount based on the lesser of:~~

~~(i) Uncompensated care costs as determined in paragraph (A)(8) of this rule; or~~

~~(ii) The hospital's payment as determined in paragraph (F)(4)(d) of this rule.~~

(G) Payments.

The department shall make payment in accordance with paragraphs (E) and (F) of this rule, for hospitals that are eligible to participate in ~~-~~the medicaid program only for the provision of inpatient psychiatric services as described in rule 5101:3-2-01 of the Administrative Code that meet the criteria described in paragraph (D) of this rule.

(H) Disproportionate share funds.

The maximum amount of disproportionate share funds available for distribution to psychiatric hospitals will be determined by subtracting the funds distributed in accordance with rule 5101:3-2-09 of the Administrative Code from the state's disproportionate share limit payment allotment determined by the United States center for medicare and medicaid services (CMS) for that program year.

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R.C. 119.032 review dates: 06/14/2006

Certification:

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HHTL 3352-15-06

Effective Date: April 30, 2015

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5160-2-21 Appendix A

5160-2-21 Appendix B

5160-2-21 Appendix C

5160-2-21 Appendix D

5160-2-21 Appendix E

5160-2-21 Appendix F

5160-2-21 Appendix G

5160-2-21 Appendix H

(A) All hospitals that are subject to DRG (diagnosis related group) prospective payment as described in rule 5160-2-07.1 of the Administrative Code and that provide covered outpatient hospital services to eligible medicaid beneficiaries as defined in rule 5160-2-02 of the Administrative Code are subject to the payment policies described in this rule.

(B) The words and terms described in paragraphs (B)(1) to (B)(4) of this rule have the following meanings, unless the context indicates otherwise.

(1) Outpatient invoice.

An "outpatient invoice" is a bill, submitted in accordance with Chapter 5160-1 of the Administrative Code, to the department for services rendered to one eligible medicaid beneficiary on one or more date(s) of service. An invoice encompassing more than one date of service is referred to in this rule as a "cycle bill."

(2) Outpatient claim.

An "outpatient claim" is defined as those outpatient services rendered to one eligible medicaid beneficiary on one date of service. In the instance of "cycle bills," as indicated in paragraph (B)(1) of this rule, more than one claim may appear on an invoice.

(3) Procedure code.

~~In this rule, a "procedure code" refers to the current procedural terminology (CPT) codes and healthcare common procedure coding system (HCPCS) as defined in rule 5160-1-19 of the Administrative Code. Guidelines and definitions for level of care determinations and for new and established patient definitions are as published in the CPT and HCPCS volumes. Applicable HCPCS modifiers are listed in appendix A to this rule.~~

~~CPT codes 92004 and 92014 for comprehensive vision exams are covered for eligible medicaid beneficiaries, and must be billed with HCPCS modifier -UB, as listed in appendix A to this rule, to indicate medicaid beneficiaries who are age twenty or younger or sixty or older. Comprehensive vision examinations are subject to the limitations defined in rule 5160-6-04 of the Administrative Code.~~

(a) In this rule, a "procedure code" refers to the current procedural terminology (CPT) codes and healthcare common procedure coding system (HCPCS) as identified in rule 5160-1-19 of the Administrative Code. Guidelines and definitions for level of care determinations and for new and established patient definitions are as published in the CPT and HCPCS volumes. Applicable HCPCS modifiers are listed in appendix A to this rule.

(b) At the beginning of each calendar year, the centers for medicare and medicaid services (CMS) and the American medical association (AMA) may add procedure codes, discontinue (delete) procedure codes, and revise the descriptions of a covered procedure, service, or supply represented by a HCPCS procedure code, that take effect on January first of the following calendar year. Coverage of new CPT and HCPCS codes will be determined by the department. Effective for dates of service on or after January 1, 2016, the initial maximum payment amount is set at seventy-six per cent of the medicare allowed amount but is not to exceed the medicaid allowed amount of similar procedure codes. For convenience, a list of such initial maximum payment amounts shall be posted no later than January first of each year on the department's web site, http://medicaid.ohio.gov/.

(4) Revenue center codes.

"Revenue center codes", as referenced in this rule, are as listed in appendix I of the department's hospital billing guidelines. ~~A to rule 5160-2-02 of the Administrative Code~~.

(5) National drug code

"National drug code" (NDC) is the actual coding used on the pharmaceutical container from which the product was dispensed and that satisfies the medicaid drug rebate requirements.

(C) Implementation and billing procedures.

The provisions of this rule are effective for claims associated with outpatient hospital services delivered on or after the effective date of this rule.

All outpatient services must be billed in accordance with Chapter 5160-1 of the Administrative Code. All revenue centers listed in appendix B to this rule require CPT or HCPCS coding. Additionally, a date of service is required on each line of the invoice for each service rendered. A diagnosis code(s) indicating the reasons for the outpatient treatment is required on each invoice. All physician, home health, and other professional services must continue to be billed separately.

(D) Dialysis service claims.

A dialysis service claim is identified by the presence of a CPT code in the range 90951 through 90999.

Dialysis services will be paid according to the fee schedule in appendix F to this rule. Radiology, pregnancy, and laboratory services will continue to be paid in accordance with paragraphs (I) and (K) of this rule. IV therapy will be paid in accordance with paragraph (G)(2)(e) of this rule and ancillary services will be paid in accordance with paragraph (J) of this rule.

(E) Chemotherapy service claims.

A chemotherapy service claim is identified by the presence of a CPT code in the range 96400 through 96549, excluding codes 96521, 96522, and 96523. Except for radiology services that will be paid in accordance with paragraph (I) of this rule, and laboratory and pregnancy services that will be paid in accordance with paragraph (K) of this rule, allowable charges submitted on chemotherapy service claims will be paid by multiplying those charges by the hospital's specific medicaid outpatient ~~per cent~~cost-to-charge ratio. The medicaid outpatient ~~per cent~~cost-to-charge ratio is ~~the per cent~~ described in paragraph (B)(2) of rule 5160-2-22 of the Administrative Code.

(F) Outpatient surgical service claims.

(1) Surgical service billing requirements.

An "outpatient surgical service claim" is a claim that does not include chemotherapy, or emergency room codes modified by modifier -22 (as described in paragraphs (E) and (H)(1) of this rule) and that carries a CPT code that is in the range 10021-69990 and that is also listed in appendix C to this rule as a grouped outpatient surgical code.

If a claim is submitted that carries a CPT code that is in the range 10021-69990 ~~that~~but is not a grouped outpatient surgical code because the procedure is primarily performed on an inpatient basis, the claim will be paid by multiplying those charges by the hospital's specific medicaid

outpatient cost-to-charge ratio. The medicaid outpatient cost-to-charge ratio is described in paragraph (B)(2) of rule 5160-2-22 of the Administrative Code~~a per cent of charges, to be determined by the medicaid outpatient per cent described in paragraph (B)(2) of rule 5160-2-22 of the Administrative Code~~. Claims for outpatient surgery services must include all outpatient services performed on that date of service.

(2) Surgical services claims payment.

(a) Unlisted surgical procedures.

A surgical procedure is defined as "unlisted" if the CPT code ends in "99" and is defined as an "unlisted procedure" in the description or is surgical CPT code number 23929, 26989, 37501, 38589, 43289, 43659, 44238, 44979, 47379, 47579, 49329, 49659, 50549, 50949, 55559, 58578, 58579, 58679, 59897, 59898, 60659, 69949, or 69979.

For dates of service between January 1, 2012 and December 31, 2013: When a surgical service claim carries an unlisted surgical procedure code, line item charges on the claim, except for those line items that carry radiology CPT codes (36251, 36252, 36253, 36254, 70010 to 79999), pregnancy codes, or laboratory CPT codes (36415, 36416, 80047 to 89399), will be paid by multiplying those charges by the hospital's specific medicaid outpatient ~~per cent~~cost-to-charge ratio. The medicaid outpatient ~~per cent~~cost-to-charge ratio is ~~the per cent~~ described in paragraph (B)(2) of rule 5160-2-22 of the Administrative Code. Radiology service line items will be paid in accordance with paragraph (I) of this rule; laboratory and pregnancy service line items will be paid in accordance with paragraph (K) of this rule; observation services will be paid in accordance with appendix F of this rule.

Unlisted surgical procedures, when used to bill a canceled surgery, must be billed with an attachment describing the surgical procedure(s) that were canceled. These unlisted canceled surgeries will be reviewed by the department and the reimbursement amount will be determined on a case-by-case basis.

For dates of service on or after January 1, 2014: Unlisted surgery codes will be assigned to a surgical group and paid according to the methodology in paragraphs (F)(2)(b) and (F)(2)(c) of this rule, except as provided in paragraph (F)(2)(b)(iii) of this rule.

(b) Surgical procedure codes that are not unlisted.

(i) When a claim carries a CPT surgery code and no unlisted surgical procedures, the claim will be assigned to a surgical grouping. If a hospital is a children's hospital as described in rule 5160-2-07.2 of the Administrative Code, surgeries will be reimbursed in accordance with the level 1 surgical group rates shown in appendix C to this rule. Payments for surgeries for all other hospitals subject to this rule, that are not children's hospitals, will be in accordance with the level 2 surgical group rate shown in appendix C to this rule. If the claim includes one surgical CPT code, payment will be based upon the surgical payment rate of the group listed in appendix C to this rule to which that CPT code is assigned.

If the claim includes two or more surgical procedure codes that are not identical, payment will be based on one hundred per cent of the surgical payment rate of the highest group listed in appendix C to this rule to which one of the surgical CPT procedure codes is assigned. Additional payment will be made by multiplying .50 times the surgical payment rate of the group(s) to which the other surgical CPT code(s) is(are) assigned.

If the claim includes identical surgical procedure codes, and the identical codes occur in conjunction with the same revenue center code, payment for the first surgery will be based on one hundred per cent of the surgical payment rate of the group to which that CPT code is assigned. Each additional occurrence of that

identical surgical procedure code will be reimbursed by multiplying .50 times the group payment rate.

If the claim includes identical surgical CPT codes but ~~those codes are not in conjunction with identical revenue center codes or if~~ those CPT codes represent procedures that would not be performed more than one time on the same patient on the same day, no surgical group payments in addition to the one payment of one hundred per cent of the group rate will be made.

The payment rates shown in appendix C to this rule represent payment in full for all services performed in conjunction with outpatient surgery except for radiology, pregnancy, laboratory services and observation services. Radiology service line items will be paid in accordance with paragraph (I) of this rule; laboratory and pregnancy service line items will be paid in accordance with paragraph (K) of this rule, and observation services will be paid in accordance with appendix F to this rule.

(ii) Surgical claim edits.

Surgical CPT codes that include the administration of anesthesia in the description of that CPT code will only be reimbursed when an anesthesia CPT code in the range 00100-01999 is also coded on the claim. These surgical CPT codes that must be used in conjunction with an anesthesia code are identified in appendix C to this rule.

Certain surgical CPT codes will be reimbursed only when they appear on a claim that contains no other CPT codes in the surgery range. The CPT codes that must appear alone for reimbursement are those in the surgical range that are usually performed as part of another surgery. These codes are identified in appendix C to this rule. ~~Certain surgical CPT codes will only be reimbursed if a prior authorization number is obtained from the department in accordance with rule 5160-2-03 of the Administrative Code.~~Certain surgical CPT codes will only be reimbursed if a prior authorization number is obtained from the department; ~~These~~ these codes are identified in appendix C to this rule.

(iii) Special unlisted dental surgery pricing for claims with an intellectual disability diagnosis code.

For hospitals that had a ratio of unlisted dental surgery services provided to patients with an intellectual disability diagnosis to total unlisted dental surgery services greater than the calendar year 2012 Ohio medicaid fee-for-service mean ratio of unlisted dental surgery claims with an ~~intellecutal~~intellectual disability diagnosis to total unlisted dental surgery services plus three standard deviations and also had an average cost for unlisted dental surgery services provided to individuals with intellectual disabilities greater than the calendar year 2012 Ohio medicaid fee-for-service mean cost for unlisted dental surgery services provided to individuals with an ~~intellecutal~~intellectual disability diagnosis: Claims billed with CPT code 41899 and an ICD-9 diagnosis code of 317, 318.0, 318.1, 318.2, or 319 will be paid $5,500 per claim, for dates of service on or between January 1, 2014 and December 31, 2015.

(c) Canceled surgeries.

It is the intent of the department to reimburse hospitals for canceled surgeries that are the result of medical complications arising after the patient is in the operating room.

To qualify for payment for a canceled surgery, the invoice must carry the occurrence code established to report the scheduled date of the canceled surgery and the CPT code for the surgery must be modified by the CPT modifier -73 or -74, as listed in appendix A to this rule, to report the canceled surgery.

If the code indicating that medical complications arose after patient prepping but before anesthesia is used, the payment will be based upon fifty per cent of the scheduled surgery group payment rate. If the code indicating that medical complications arose after anesthesia was induced is used, payment will be based upon one hundred per cent of the scheduled surgery group payment rate.

If a multiple surgery had been scheduled, the appropriate percentage (fifty or one hundred per cent) will be applied to the highest surgery payment group to which the scheduled surgery codes are assigned.

(G) Clinic service claims.

(1) Clinic service billing requirements.

A claim is identified as a "clinic claim" if it carries one of the clinic visit codes listed in appendix D to this rule and does not include dialysis, chemotherapy, or surgical services as described in paragraphs (D), (E), and (F) of this rule.

More than one clinic visit per beneficiary, per provider, per day is permissible and reimbursable if each clinic visit occurs in a distinct and separate clinic or if the patient visits the clinic, leaves the hospital, and subsequently returns on the same date of service. If the patient had a clinic visit on the same day as a visit to the emergency room of the same hospital, the emergency room visit may also qualify for payment as listed in appendix E to this rule.

(2) Clinic service claim payment.

Payments for clinic visits will be made in accordance with the fees listed in appendix D to this rule. If a hospital is a teaching hospital or a children's hospital as described in rule 5160-2-07.2 of the Administrative Code, clinic visits will be reimbursed in accordance with the level 1 clinic visit fee schedule shown in appendix D to this rule. Payments for clinic visits for all other hospitals subject to this rule will be in accordance with the level 2 clinic visit fee schedule shown in appendix D to this rule. Payments for clinic visits represent payment in full except for the additional payments that may be made for services described in paragraphs (G)(2)(a) to (G)(2)(f) of this rule.

(a) Additional payments may be made for ancillary services listed in appendix F to this rule.

(b) Additional payments may be made for laboratory services in accordance with paragraph (K) of this rule.

(c) Additional payments may be made for radiology services in accordance with paragraph (I) of this rule.

(d) Additional payments may be made for emergency room visits in accordance with appendix E to this rule.

(e) For dates of service between January 1, 2012 and December 31, 2013: Additional payments will be made for charges listed in line items that carry revenue center code 025X (with no CPT code present) and/or revenue center code 0636 (with a valid HCPCS J code) when the claim carries IV therapy CPT code 96365, 96366, 96367, or 96368. These additional payments will be calculated by multiplying those charges listed in those line items that carry revenue center code 025X (with no CPT code present) and/or revenue center code 0636 (with a valid HCPCS J code) by the hospital's specific medicaid outpatient ~~per cent~~cost-to-charge ratio. The medicaid outpatient ~~per cent~~cost-to-charge ratio is ~~the per cent~~ described in paragraph (B)(2) of rule 5160-2-22 of the Administrative Code.

For dates of service on or after January 1, 2014: Additional payments will be made for charges listed in line items that carry revenue center code 025X (with no CPT code present) and/or revenue center code 0636 (with a valid HCPCS J code) when the claim carries IV therapy CPT code 96365, 96366, 96367, or 96368. These additional payments will be calculated by multiplying those charges listed in those line items that carry

revenue center code 025X (with no CPT code present) and/or revenue center code 0636 (with a valid HCPCS J code) by sixty per cent of the hospital's specific medicaid outpatient ~~per cent~~cost-to-charge ratio. The medicaid outpatient ~~per cent~~cost-to-charge ratio is ~~the per cent~~ described in paragraph (B)(2) of rule 5160-2-22 of the Administrative Code.

(f) Additional payments may be made for pregnancy services in accordance with paragraph (K) of this rule.

(H) Emergency room visit claims.

(1) Emergency room visit billing requirements.

(a) A claim is identified as an "emergency room visit claim" if it carries one of the emergency room visit codes listed in appendix E to this rule and does not include dialysis, chemotherapy, surgical, or clinic services as described in paragraphs (D), (E), (F), and (G) of this rule.

(b) More than one emergency room visit per beneficiary, per provider, per day is permissible and reimbursable if the patient visits the emergency room, leaves the hospital, and subsequently returns to the emergency room on the same date of service.

(c) If the service provided is greater than that usually required for the emergency room procedure because the procedure involved stabilizing a patient in a life-threatening condition prior to transferring the patient to another hospital or if the patient died in the emergency room following treatment or resuscitation efforts, the emergency room procedure code should be modified by the CPT modifier -22. This modifier is not to be used when the hospital does not provide active treatment for the patient (for example, when a patient does not require stabilization prior to transfer or when a patient dies prior to treatment or resuscitation efforts being made).

(2) Emergency room claim payment.

Payments for emergency room procedure codes with CPT modifier -22 will be made by multiplying claim charges, except for charges for radiology, pregnancy, and laboratory services, by the hospital's specific medicaid outpatient ~~per cent~~cost-to-charge ratio. The medicaid outpatient ~~per cent~~cost-to-charge ratio is ~~the per cent~~ described in paragraph (B)(2) of rule 5160-2-22 of the Administrative Code. Radiology services reported on those claims will be paid in accordance with paragraph (I) of this rule; laboratory and pregnancy service line items will be paid in accordance with paragraph (K) of this rule.

Payment for other emergency room visits will be made in accordance with the fee schedule listed in appendix E to this rule. If a hospital is a teaching hospital, as defined in rule 5160-2-07.2 of the Administrative Code, payments for emergency room visits will be made in accordance with the level 1 emergency room fee schedule listed in appendix E to this rule. If a hospital is a children's hospital, as described in rule 5160-2-07.2 of the Administrative Code, emergency room visits will be reimbursed in accordance with the level 2 emergency room visit fee schedule shown in appendix E to this rule.

Payments for emergency room visits for all other hospitals subject to this rule will be made in accordance with the level 3 emergency room visit fee schedule shown in appendix E to this rule. Payments for emergency room visits represent payment-in-full except for the additional payments which may be made for services described in paragraphs (H)(2)(a) to (H)(2)(e) of this rule.

(a) Additional payments may be made for ancillary services listed in appendix F to this rule.

(b) Additional payments may be made for laboratory services in accordance with paragraph (K) of this rule.

(c) Additional payments may be made for radiology services in accordance with paragraph (I) of this rule.

(d) For dates of service between January 1, 2012 and December 31, 2013: Additional payments will be made for charges listed in line items that carry revenue center code 025X (with no CPT code present) and/or revenue center code 0636 (with a valid HCPCS J code) when the claim carries IV therapy CPT code 96365, 96366, 96367, or 96368. These additional payments will be calculated by multiplying those charges listed in those line items that carry revenue center code 025X (with no CPT code present) and/or revenue center code 0636 (with a valid HCPCS J code) by the hospital's specific medicaid outpatient ~~per cent~~cost-to-charge ratio. The medicaid outpatient ~~per cent~~cost-to-charge ratio is ~~the per cent~~ described in paragraph (B)(2) of rule 5160-2-22 of the Administrative Code.

For dates of service on or after January 1, 2014: Additional payments will be made for charges listed in line items that carry revenue center code 025X (with no CPT code present) and/or revenue center code 0636 (with a valid HCPCS J code) when the claim carries IV therapy CPT code 96365, 96366, 96367, or 96368. These additional payments will be calculated by multiplying those charges listed in those line items that carry revenue center code 025X (with no CPT code present) and/or revenue center code 066 (with a valid HCPCS J code) by sixty per cent of the hospital's specific medicaid outpatient ~~per cent~~cost-to-charge ratio. The medicaid outpatient ~~per cent~~cost-to-charge ratio is ~~the per cent~~ described in paragraph (B)(2) of rule 5160-2-22 of the Administrative Code.

(e) Additional payments may be made for pregnancy services in accordance with paragraph (K) of this rule.

(I) Radiology services.

Payments for radiology services will be made in accordance with the fee schedule listed in appendix G to this rule. Reimbursement for outpatient hospital radiology services shall be the lower of charges or the payment amounts in the outpatient hospital radiology fee schedule as published in appendix G to this rule.

(J) Ancillary services.

As of October 1, 1994, designated free vaccines, as listed in rule 5160-4-12 of the Administrative Code, shall include all immunizations covered under the federal "Vaccines for Children" (VFC) program. All designated free vaccines and nondesignated vaccines shall be administered in accordance with the requirements described in rule 5160-4-12 of the Administrative Code.

Payments for ancillary services, including designated free vaccines and nondesignated vaccines, listed in appendix F to this rule will be made in accordance with appendix F to this rule if the listed codes appear on a claim that does not include chemotherapy, surgery services, or emergency room procedure codes with CPT modifier -22 as described in paragraphs (E), (F), and (H)(1) of this rule. Reimbursement for all immunizations covered under the VFC program will be ~~five dollars for individuals eighteen years of age or younger. For dates of service on or after January 1, 2010, reimbursement for all immunizations covered under the VFC program will be increased to~~ ten dollars for individuals eighteen years of age or younger.

CPT codes 92004 and 92014 for comprehensive vision exams are covered for eligible medicaid beneficiaries, and must be billed with HCPCS modifier -UB, as listed in appendix A to this rule, to indicate medicaid beneficiaries who are age twenty or younger or sixty or older. Comprehensive vision examinations are subject to the limitations defined in rule 5160-6-04 of the Administrative Code.

Payments for ancillary services will be made in accordance with appendix F to this rule.

(1) Additional payments may be made for laboratory services in accordance with paragraph (K) of this rule.

(2) Additional payments may be made for radiology services in accordance with paragraph (I) of this rule.

(3) For dates of service between January 1, 2012 and December 31, 2013: Additional payments will be made for charges listed in line items that carry revenue center code 025X (with no CPT code present) and/or revenue center code 0636 (with a valid HCPCS J code) when the claim carries IV therapy CPT code 96365, 96366, 96367, or 96368. These additional payments will be calculated by multiplying those charges listed in those line items that carry revenue center code 025X (with no CPT code present) and/or revenue center code 0636 (with a valid HCPCS J code) by the hospital's specific medicaid outpatient ~~per cent~~cost-to-charge ratio. The medicaid outpatient ~~per cent~~cost-to-charge ratio is ~~the per cent~~ described in paragraph (B)(2) of rule 5160-2-22 of the Administrative Code.

For dates of service on or after January 1, 2014: Additional payments will be made for charges listed in line items that carry revenue center code 025X (with no CPT code present) and/or revenue center code 0636 (with a valid HCPCS J code) when the claim carries IV therapy CPT code 96365, 96366, 96367, or 96368. These additional payments will be calculated by multiplying those charges listed in those line items that carry revenue center code 025X (with no CPT code present) and/or revenue center code 0636 (with a valid HCPCS J code) by sixty per cent of the hospital's specific medicaid outpatient ~~per cent~~cost-to-charge ratio. The medicaid outpatient ~~per cent~~cost-to-charge ratio is ~~the per cent~~ described in paragraph (B)(2) of rule 5160-2-22 of the Administrative Code.

(4) Additional payments may be made for pregnancy services in accordance with paragraph (K) of this rule.

(K) Laboratory and pregnancy related services.

Payments for laboratory services will be made in accordance with the fee schedule listed in appendix H to this rule. Reimbursement for outpatient hospital laboratory services shall be the lower of charges or the payment amounts in the outpatient hospital laboratory fee schedule.

Payments for pregnancy related services will be made in accordance with the fee schedules listed in appendices D and F to this rule. When billing for pregnancy related services, bill the appropriate codes as identified in appendix D and/or F to this rule, with modifier -TH to indicate that obstetrical services, prenatal or post-partum, were provided.

(L) Independently billed services:

Claims submitted without dialysis, chemotherapy, surgical, clinic, emergency room, radiology, ancillary, laboratory, or pregnancy related services as defined in paragraphs (D) to (K) of this rule will be considered independently billed.

(1) Pharmacy.

For dates of service between January 1, 2012 and December 31, 2013: Claims submitted with line items that carry revenue center codes 025X (with no CPT code present) and/or 0636 (with a valid HCPCS J code) will be paid at the hospital's specific medicaid outpatient ~~per cent of charges~~cost-to-charge ratio. The medicaid outpatient ~~per cent~~ cost-to-charge ratio is ~~the per cent~~ described in paragraph (B)(2) of rule 5160-2-22 of the Administrative Code.

For dates of service on or after January 1, 2014: Claims submitted with line items that carry revenue center codes 025X (with no CPT code present) and/or 0636 (with a valid HCPCS J code) will be paid at sixty per cent of the hospital's specific medicaid outpatient ~~per cent of charges~~cost-to-charge ratio. The medicaid outpatient ~~per cent~~cost-to-charge ratio is ~~the per cent~~ described in paragraph (B)(2) of rule 5160-2-22 of the Administrative Code.

(2) Medical supply.

For dates of service between January 1, 2012 and December 31, 2013: Claims submitted with line items that carry revenue center codes 027X (with no CPT code present) will be paid at the hospital's specific medicaid outpatient ~~per cent of charges~~cost-to-charge ratio. The medicaid outpatient ~~per cent~~cost-to-charge ratio is ~~the per cent~~ described in paragraph (B)(2) of rule 5160-2-22 of the Administrative Code.

For dates of service on or after January 1, 2014: Claims submitted with line items that carry revenue center codes 027X (with no CPT code present) will be paid at sixty per cent of the hospital's specific medicaid outpatient ~~per cent of charges~~cost-to-charge ratio. The medicaid outpatient ~~per cent~~cost-to-charge ratio is ~~the per cent~~ described in paragraph (B)(2) of rule 5160-2-22 of the Administrative Code.

(M) Observation services

Payments for observation services will be made in accordance with appendix F to this rule. Payments for observation services will be made for up to two consecutive days only. To receive payment for a third consecutive date of service, the patient must have been discharged, and, for medically necessary reasons, readmitted as an outpatient.

Effective: 04/30/2015

Five Year Review (FYR) Dates: 02/13/2015 and 04/30/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 04/20/2015

Promulgated Under: 119.03

Statutory Authority: 5164.02

Rule Amplifies: 5164.02, 5164.70

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5160-2-21.1 Consumer Co-Payments for Non-Emergency Emergency Department Services

HHTL 3352-15-02

Effective Date: April 1, 2015

***Most Current Prior Effective Date:* September 15, 2006**

(A) This rule establishes a consumer co-payment for non-emergency emergency department services as authorized by section ~~5111.0112~~ 5162.20 of the Revised Code. ~~The provisions in this rule do not apply to consumers enrolled in the medicaid managed health care program.~~

(B) Definitions.

(1) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, as defined in paragraph (B)(2) of this rule, could reasonably expect the absence of immediate medical attention to result in any of the following: placing the health of the individual (or, with respect to a pregnant woman, the health of her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

(2) "Prudent lay person" means a person with an average knowledge of health and medicine to determine, within reason, that emergency services are necessary.

(3) "Non-emergency emergency department service" means an emergency department service that does not meet the definition of emergency medical condition, as defined in paragraph (B)(1) of this rule.

(C) Application of co-payment.

For dates of service on or after January 1, 2006, medicaid consumers shall pay a co-payment equal to three dollars for non-emergency emergency department services, as defined in paragraph (B)(3) of this rule, except as excluded in paragraphs (D) and (E) of this rule. ~~Hospital providers shall report, through claim submission, the applicable co-payment to the department in accordance with hospital billing instructions.~~

(D) Exclusions and additional limitations to the co-payment requirement for non-emergency care provided in an emergency department are in accordance with rule ~~5101:3-1-09~~ 5160-1-09 of the Administrative Code, except as provided in paragraph (E) of this rule.

(E) A hospital may take action to collect a co-payment as provided in Section 5162.20 of the Revised Code. ~~by providing, at the time services are rendered to a medicaid recipient, notice that a co-payment may be owed. If the hospital provides the notice and chooses not to take further action to pursue collection of the co-payment, the prohibition against waiving co-payments, as described in paragraph (B)(3) of rule 5101:3-1-09 of the Administrative Code, does not apply~~.

(F) Reimbursement for services subject to the co-payment for non-emergency emergency department services.

The department shall reimburse the emergency department claim the allowable medicaid payment, in accordance with rule ~~5101:3-2-21~~ 5160-2-21 of the Administrative Code, minus the applicable co-payment as described in paragraph (C) of this rule and any third party resources available to the patient, in accordance with rule ~~5101:3-2-25~~ 5160-2-25 of the Administrative Code.

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Five Year Review (FYR) Dates: 12/08/2014 and 04/01/2020

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Rule Amplifies: 5162.03, 5162.20, 5164.02

Prior Effective Dates: 1/1/06, 9/15/06

5160-2-22 Non-DRG Prospective Payment for Hospital Services

Formerly **5101:3-2-22 Reasonable Cost and Cost-Related Reimbursement for Hospital Services**

HHTL 3352-14-05

Effective Date: August 21, 2014

Most Current Prior Effective Date: **January 1, 2005**

This rule applies to all hospital services excluded from inpatient hospital, diagnosis related prospective payment.

(A) Applicability.

(1) Reasonable cost reimbursement, for services provided on or before September 30, 2014, where interim payments are made to approximate cost based on a historical cost-to-charge ratio, and where reasonable costs actually incurred during a period are subsequently reconciled to interim payments, applies to:

(a) All outpatient hospital services provided by non-Ohio hospitals excluded from inpatient prospective payment as set forth in rule ~~5101:3-2-07.1~~5160-2-07.1 of the Administrative Code which file the JFS 02930 cost report.

(b) All outpatient hospital services provided by Ohio hospitals excluded from inpatient prospective payment as set forth in rule ~~5101:3-2-07.1~~5160-2-07.1 of the Administrative Code.

(c) Inpatient services provided by hospitals excluded from prospective payment as set forth in rule ~~5101:3-2-07.1~~5160-2-07.1 of the Administrative Code.

~~(d) Certain transplant services excluded from prospective payment under the conditions described in rule 5101:3-2-07.1 of the Administrative Code.~~

~~(e)~~(d) Inpatient capital-related costs as set forth in rule ~~5101:3-2-7.6~~5160-2-07.6 of the Administrative Code.

(2) Cost-related reimbursement, where interim payments are made to approximate cost based on a historical cost-to-charge ratio but where no subsequent reconciliation occurs, applies to:

(a) Outpatient hospital services provided by non-Ohio hospitals excluded from inpatient prospective payment as set forth in rule ~~5101:3-2-07.1~~5160-2-07.1 of the Administrative Code which do not file the JFS 02930 cost-report.

(b) Certain outpatient hospital services as ~~defined in paragraphs (D), (E), and (H)(2) of~~as described in rule ~~5101:3-2-21~~5160-2-21 of the Administrative Code.

~~(c) Payment for extraordinary outlier cases described in paragraph (A)(7) of rule 5101:3-2-07.9 of the Administrative Code. Except that a hospital may request that interim payments for these cases as described in paragraph (B)(2) of this rule be adjusted subsequent to claim payment to reflect the hospital's medicaid inpatient cost-to-charge ratio calculated using cost-report data from the hospital's fiscal year period during which services were provided.~~

~~(d) Payments for cost outlier cases as described in paragraph (C) of rule 5101:3-2-07.9 of the Administrative Code, for discharges on or after September 3, 1991.~~

(3) Services described in paragraph (A)(1) of this rule and provided on or after October 1, 2014 shall not be subsequently reconciled.

(B) Payments under ~~reasonable cost reimbursement and cost-related reimbursement~~ non-DRG prospective payment.

(1) For hospital services ~~subject to reasonable cost reimbursement~~ provided on or before September 30, 2014, providers will receive an interim payment as described in paragraph (B)(2)

of this rule. These interim payments will be reconciled to the lower of reasonable cost incurred on behalf of medicaid recipients during the time period or total allowed charges for medicaid recipients during the time period.

(2) Interim payments for services subject to ~~both reasonable cost and cost-related reimbursement~~ non-DRG prospective payment are made by applying a historic cost-to-charge ratio to hospital allowed charges.

(a) For outpatient services, the ratio used is medicaid outpatient costs as reported on JFS 02930, schedule H, section II divided by medicaid outpatient charges as reported on JFS 02930, schedule H, section II. For inpatient hospital services, the ratio used is medicaid inpatient costs, as reported on the JFS 02930, schedule H, section I, divided by medicaid inpatient charges as reported on the JFS 02930, schedule H, section I.

(b) For those hospitals which do not file the JFS 02930 cost-report, the ratio used is the statewide average. For outpatient services, the ratio used is the sum of medicaid outpatient costs as reported on JFS 02930, schedule H, section II for all Ohio hospitals, divided by the sum of medicaid outpatient charges as reported on JFS 02930, schedule H, section II for all Ohio hospitals. For inpatient hospitals services, the ratio used is the sum of medicaid inpatient costs as reported on the JFS 02930, schedule H, section I for all Ohio hospitals, divided by the sum of medicaid inpatient charges as reported on the JFS 02930, schedule H, section I for all Ohio hospitals.

(c) The ratio used for an interim claim payment will be the ratio that is operational in the claims processing system on the date the claim is paid and effective on the date of admission. The ratios which are operational during a prospective rate year in the claims processing system reflect data from each hospital's cost-report filed with the department during the calendar year proceeding the year during which the prospective rate year begins.

(3) For services provided on or after October 1, 2014 by hospitals subject to non-DRG prospective payment, the historical cost-to-charge ratio described in paragraph (B)(2) of this rule shall be either:

(a) Ninety per cent of the calculated cost-to-charge ratio for freestanding rehabiliation hospitals and freestanding long-term care hospitals, as defined in rule 5160-2-07.2 of the Administrative Code;

(b) Or for cancer hospitals, as defined in rule 5160-2-07.2 of the Administrative Code, the reimbursement rate shall be:

(i) Ninety-seven per cent of the calculated cost-to-charge ratio for discharges on or after October 1, 2014 and on or before June 30, 2015;

(ii) Ninety-four per cent of the calculated cost-to-charge ratio for discharges on or after July 1, 2015 and on or before June 30, 2016;

(iii) Ninety-one and seven tenths per cent of the calculated cost-to-charge ratio for discharges on or after July 1, 2016.

(C) In general, reasonable cost reimbursement recognizes costs that are reasonable and allowable under Title XVIII standards and principles described in 42 CFR 413.1 through 413.40 effective as of October 1, ~~2003~~2013, except as otherwise provided in this paragraph. These Title XVIII standards and principles are applicable to those covered inpatient and outpatient hospital services as identified in Chapter ~~5101:3-2-~~ 5160-2 of the Administrative Code which are subject to reasonable cost reimbursement as described in this rule.

(1) The costs identified in paragraphs (C)(1)(a) to (C)(1)(f) of this rule are nonallowable.

(a) Cost of goods or services furnished free, by the hospital, or at less than fair market value. For example, the cost of office space or hospital employee time used to prepare physician invoices for physicians who invoice the department on a fee-for-service basis.

(b) Cost of services not reimbursable due to not having been billed timely as defined in rule ~~5101:3-1-19.3~~5160-1-19.3 of the Administrative Code.

(c) Cost of services which would be or are covered by a third-party payer as described in rule ~~5101:3-1-08~~5160-1-08 of the Administrative Code.

(d) The amount of any interest expense for money borrowed to alleviate cash flow problems resulting from rate reductions imposed for delinquent filing of cost reports as provided in rule ~~5101:3-2-23~~5160-2-23 of the Administrative Code.

(e) The amount of any interest on overpayments and any interest expense for money borrowed to alleviate cash flow problems resulting from an interest assessment as defined in rule ~~5101:3-1-25~~5160-2-25 of the Administrative Code.

(f) Costs which exceed limits described in 42 CFR 413.30 effective as of October 1, ~~2003~~2013 except that the department may exempt certain facilities from these limits as described in 42 CFR 413.30. The determinations to exempt facilities according to 42 CFR 413.30 will be made during the final settlement process.

(2) Provisions of Title XVIII related to prospective payment for inpatient hospital services as described in 42 CFR 412.1 through 412.125 effective as of October 1, ~~2003~~2013 are not applicable to hospital services reimbursed under the provisions of this rule. Hospital services described in this rule are reimbursed under the provisions described in paragraphs (C) to (C)(1)(f) of this rule except in instances when those regulations have been altered to accommodate the Title XVIII prospective payment system.

~~(D) Organ acquisition and transportation costs for heart, heart/lung, liver, pancreas, single/double lung, and liver/small bowel transplant services will be reimbursed at one hundred per cent of billed charges.~~

~~(E) For harvesting costs for bone marrow transplant services, the prospective payment amount will be either:~~

~~(1) The DRG amount as described in rule 5101:3-2-07.4 of the Administrative Code if the donor is a medicaid recipient or if the bone marrow transplant is autologous.~~

~~(2) The product of the allowed charges times the hospital-specific, medicaid inpatient cost-to-charge ratio as described in paragraph (B)(2) of this rule, if the donor is not a medicaid recipient.~~

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R.C. 119.032 review dates: 06/04/2014 and 08/21/2019

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5160-2-23 Cost Reports

Formerly **5101:3-2-23 Cost Reports**

HHTL 3352-11-07

Effective Date: November 14, 2011

Most Current Prior Effective Date: **October 1, 2010**

5101:3-2-23 Appendix A

(A) For cost-reporting purposes, the medicaid program requires each eligible provider, as defined in rule 5101:3-2-01 of the Administrative Code, to submit periodic reports that generally cover a consecutive twelve-month period of the provider's operations. Failure to submit all necessary items and schedules will only delay processing and may result in a reduction of payment or termination as a provider as described in paragraph (H) of this rule.

Effective for medicaid cost reports filed for cost-reporting periods ending in state fiscal year (SFY) 2003, and each cost-reporting period thereafter, any hospital that fails to submit cost reports on or before the dates specified by ODJFS shall be fined one thousand dollars for each day after the due date that the information is not reported.

The hospital shall complete and submit the JFS 02930 "Hospital Cost Report" in accordance with instructions contained in this rule. The JFS 02930 (rev. 4/~~2010~~2011) for SFY ~~2010~~2011 and its instructions are shown in the appendix to this rule. The hospital's cost report must:

(1) Be prepared in accordance with medicare principles governing reasonable cost reimbursement set forth in the providers' reimbursement manual "CMS Publications 15, 15-1 and 15-2," available at **http://www.cms.hhs.gov/Manuals/PBM/list.asp#TopOfPage** dated September 8, 2005.

(2) Include all information necessary for the proper determination of costs payable under medicaid, including financial records and statistical data.

(3) Be submitted in accordance with the instructions in the appendix to this rule an electronic copy of the medicare cost report, which must be identical in all respects to the cost report submitted to the medicare fiscal intermediary.

(4) Include the cost report certification executed by an officer of the hospital attesting to the accuracy of the cost report and to the accuracy of the OBRA survey. In addition, all subsequent revisions to the cost report must include an executed certification.

(5) Effective for medicaid cost reports filed for cost-reporting periods ending in SFY 2003, and each cost-reporting period thereafter, the executed certification shall require the officer of the hospital to acknowledge that an independent party, a certified public accountant, has successfully verified the data reported on "Schedule F" of the cost report in accordance with the procedures included in the cost report instructions. In addition, all subsequent revisions to "Schedule F" shall also be successfully verified by an independent, certified public accountant in accordance with the recertification procedures included in the cost report instructions.

(6) For hospital reporting periods ending between January first and June thirtieth the cost report is due by December thirty-first of the same calendar year. For hospital reporting periods ending between July first and December thirty-first, the cost report is due by June thirtieth of the following calendar year. Extensions may be granted as specified in the appendix to this rule.

(B) Hospitals having a distinct part psychiatric or rehabilitation unit recognized by medicare in accordance with the provisions of 42 C.F.R. 412.25 effective October 1, 2006, 42 C.F.R. 412.27 effective July 1, 2006, and 42 C.F.R. 412.29 effective January 1, 2005, must identify distinct part unit costs separately within the cost report as described in paragraph (A) of this rule.

(C) Ohio hospitals performing transplant services covered under medicaid as described in rule 5101:3-2-07.1 of the Administrative Code must identify transplant costs, charges, days, and discharges separately within the cost report as described in paragraph (A) of this rule.

(D) Ohio hospitals performing ambulatory surgery within the hospital outpatient setting must identify ambulatory surgery costs and charges separately within the cost report as described in paragraph (A) of this rule.

(E) Ohio hospitals providing services to medicaid managed care plan (MCP) enrollees must identify MCP costs, charges and payments separately within the cost report as described in paragraph (A) of this rule.

(F) It is not necessary for the hospital to wait for the medicare (Title XVIII) audit in order to file the initial cost report for the stated time period. The interim cost report filing can be audited by the ODJFS prior to any applicable final adjustment and settlement. If an amount is due ODJFS as a result of the filing, payment must be forwarded, in accordance with the instructions in the appendix to this rule, at the time the cost report is submitted for it to be considered a complete filing. Any revised interim cost report must be received within thirty days of the provider's receipt of the interim cost settlement. A desk audit will be performed by the hospital audit section on all as filed and interim cost reports. An interim cost settlement by ODJFS does not preclude the finding of additional cost exceptions in a final settlement for the same cost-reporting period.

(1) If an amended medicare cost report is filed with the medicare fiscal intermediary, a copy of the amended medicare cost report must be filed with the hospital audit section. Information contained in the amended medicare cost report will be incorporated into the interim cost report, as originally filed, if received prior to interim settlement; otherwise, it is subject to the provisions of paragraph (F) of this rule.

(2) Adjustments may be made to the interim cost report as described in rule 5101:3-2-24 of the Administrative Code.

(G) Out-of-state providers that are not paid on a prospective payment basis and provide inpatient and/or outpatient services to eligible Ohio Title XIX recipients will be required to file the cost report identified in this rule.

(H) Hospitals that fail to submit cost reports timely as defined in paragraph (A) of this rule will receive a delinquency letter from the ODJFS and are subject to notification that thirty days following the date on which the cost report was due, payments for hospital services will be suspended. Suspension of payments will be terminated on the fifth working day following receipt of the delinquent cost report. Claims affected by suspension of payment are not considered to be clean claims as "clean claims" are defined in rule 5101:3-1-19.3 of the Administrative Code. At the beginning of the third month following the month in which the hospital cost report became overdue, if the cost report has not yet been submitted, termination of the provider from the program will be recommended in accordance with Chapter 5101:3-1 of the Administrative Code.

Effective: 11/14/2011

R.C. 119.032 review dates: 09/01/2012

Certification: CERTIFIED ELECTRONICALLY

Date: 11/04/2011

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5160-2-24 Audits

Formerly **5101:3-2-24 Audits**

HHTL 3352-05-03

Effective Date: September 4, 2005

Most Current Prior Effective Date: **May 1, 2000**

(A) General provisions.

(1) Audits will be conducted by the ~~department~~ Ohio department of job and family services (herein referred to as the department) for services rendered by the hospital under the medicaid ~~and disability assistance~~ program ~~programs~~. The examination of hospital costs and charges will be made in accordance with generally accepted auditing standards necessary to fulfill the scope of the audit. To facilitate this examination, providers are required to make available all records necessary to fully disclose the extent of services provided to program recipients, the corresponding costs and charges made and payments received for such services, and the provider's audited financial statement for the period corresponding to the cost-reporting period. The principle objective of the audit is to enable the department to determine that payment has been, or will be made, in accordance with federal/state and department requirements. Based on the audit, adjustments in payments to the provider will be made as required by provisions of this rule. Records necessary to fully disclose the extent of services provided must be maintained for a period of six years or, if an audit has been initiated, until the audit is completed and every exception is resolved. Said records must be made available, upon request, to the ~~Ohio~~ department ~~of human services (ODHS)~~ for audit purposes. No payment for outstanding medical services can be made if a request for audit is refused.

(2) Additionally, audits will be performed to verify hospital costs and charges utilized in the determination of the hospital's contribution to and reimbursement from the hospital care assurance fund and disproportionate share fund as described in rules 5101:3-2-08, 5101:3-2-08.1, 5101:3-2-09 and 5101:3-2-10 of the Administrative Code.

(3) All audit activities described in this rule may be undertaken during any rate year for the purpose of assuring accuracy of data maintained by the department.

(B) Scope of audits for hospital services reimbursed on a reasonable cost basis.

(1) For hospital services reimbursed on a reasonable cost basis as identified in rule 5101:3-2-22 of the Administrative Code, audits are performed to determine whether:

(a) Services billed were provided;

(b) Services were provided to persons eligible as medicaid recipients on the date(s) services were rendered;

(c) Services billed are covered under the medicaid program in accordance with Chapter 5101:3-2 of the Administrative Code;

(d) Costs reported to the department represent actual incurred, reasonable, and allowable costs in accordance with the provisions of rule 5101:3-2-22 of the Administrative Code;

(e) Payments made to the hospital for services rendered during the cost period being audited were sufficient or insufficient in relation to audit findings;

(f) Payments made under medicaid are, in the aggregate on a statewide basis, equal to or less than amounts ~~which~~ that would have been recognized under Title XVIII (medicare) of the Social Security Act in accordance with C.F.R. 447.272 effective October 1, 2004 for comparable services and on a hospital-specific basis equal to or less than the provider's customary and prevailing charges for comparable services in accordance with 42 ~~CFR~~ C.F.R. 447.253 effective October 1, 2004;

(g) Amounts of third-party payments reported to the department as described in rules 5101:3-1-08 and 5101:3-2-25 of the Administrative Code reflect the actual amounts received;

(h) For the purpose of updating interim payment rates that are subject to cost settlement, desk audit procedures will take into consideration the relationship between prior year's reported costs and audited costs; and

(i) Amounts paid by the hospital and payments made by ~~ODHS~~ the department related to the indigent care adjustments described in rules 5101:3-2-09 and 5101:3-2-10 of the Administrative Code were based upon data described in rules 5101:3-2-09 and 5101:3-2-10 of the Administrative Code.

(2) Underpayments or overpayments determined as a result of findings made under the provisions of paragraphs (B)(1) to (B)(1)(h) of this rule will be reconciled at the time of final settlement as described in paragraph (D)(2) of this rule taking into account any adjustments made during interim settlements as provided in rule 5101:3-2-23 of the Administrative Code.

~~(3) Audits performed in relation to the disability assistance medical program are performed for the purposes described in paragraphs (B)(1)(a) to (B)(2) of this rule, except that the provisions of Chapter 5101:3-23 of the Administrative Code govern findings relative to service coverage and recipient eligibility.~~

(C) Scope of audits for hospital services reimbursed on a prospective payment basis.

(1) For hospitals services subject to prospective payment, audit activities are undertaken for several purposes. For each cost-reporting period, cost reports are audited, following the criteria outlined in paragraphs (C)(1)(a) to (C)(1)(e) of this rule for the purpose of reaching interim and final settlement with a hospital. For determination of amounts related to indigent care adjustment provisions described in rules 5101:3-2-09 and 5101:3-2-10 of the Administrative Code, audit steps will be performed following the criteria outlined in paragraph (C)(1)(h) of this rule. During years in which prospective payments are being rebased, additional activities such as those described in paragraphs (C)(1)(f) and (C)(1)(g) of this rule are undertaken to establish program costs used for the calculations described in rule ~~5101:3-2-074~~ 5101:3-2-07.4 of the Administrative Code. For hospital services identified in rule ~~5101:3-2-071~~ 5101:3-2-07.1 of the Administrative Code as being subject to prospective payment, desk or field audits of interim cost reports are performed to determine whether:

(a) Services billed were provided~~;~~.

(b) Services billed were provided to persons eligible as medicaid recipients on the date(s) services were rendered~~;~~.

(c) Services billed are covered under the medicaid program in accordance with Chapter 5101:3-2 of the Administrative Code~~;~~.

(d) Payments made under medicaid are, in the aggregate on a statewide basis, equal to or less than amounts ~~which~~ that would have been recognized under Title XVIII (medicare) of the Social Security Act in accordance with C.F.R. 447.272 effective October 1, 2004 for comparable services and on a hospital-specific basis equal to or less than the provider's customary and prevailing charges for comparable services in accordance with 42 ~~CFR~~ C.F.R. 447.253 effective October 1, 2004~~;~~.

(e) Amounts of third-party payments reported to the department as described in rules 5101:3-1-08 and 5101:3-2-25 of the Administrative Code reflect the actual amounts received~~;~~.

(f) Costs reported to the department represent actual incurred, reasonable, and allowable costs in accordance with rule 5101:3-2-22 of the Administrative Code~~; and~~.

(g) Medicaid discharges and associated charges and days as reported on the cost report are consistent with those reflected for the same period in the ~~ODHS~~ department's paid claims

history. In cases where data submitted by the hospital on the cost report are inconsistent with data in the ~~ODHS~~ department's paid claims data file, the cost report is subject to adjustment as described in paragraph (D)(2) of this rule. Inconsistencies subject to adjustment include, but are not limited to:

(i) Submitted discharges lower than those in the ~~ODHS~~ department's paid claims data file~~.~~;

(ii) Submitted charge-to-day ratio lower than that in the ~~ODHS~~ department's paid claims data file~~.~~;

(iii) Submitted charges lower than those in the ~~ODHS~~ department's paid claims data file~~.~~; and

(iv) Other inconsistencies that require analysis and auditor judgment to determine the appropriate type of adjustment.

(h) Amounts related to indigent care adjustments described in rules 5101:3-2-09 and 5101:3-2-10 of the Administrative Code were based upon data described in rules 5101:3-2-09 and 5101:3-2-10 of the Administrative Code.

(2) For hospitals subject to prospective payment for inpatient services, the audits may result in the following adjustments:

(a) If the review identified in paragraphs (C)(1)(g)(i) to (C)(1)(g)(iv) of this rule indicates that the cost report reflects fewer medicaid discharges and/or a discrepancy exists between reported medicaid charges and those reflected in the ODHS paid claims data file, the interim cost report may be adjusted to reflect inpatient days, charges, and discharge counts from the ~~ODHS~~ department's paid claims data file.

(b) If the reviews identified in paragraphs (C)(1)(a) to (C)(1)(c) and ~~(D)~~(C)(1)(e) of this rule indicate that inappropriate charges were attributed to medicaid program charges in the cost report, the interim cost report will be adjusted to remove such charges.

(c) If the review described in paragraph (C)(1)(f) of this rule identifies that nonallowable disallowed costs were included in the cost report, the interim cost report will be adjusted to remove such costs.

(3) Federal audit findings submitted to the department after September 1, 1987 will be implemented as described in rule ~~5101:3-2-078~~ 5101:3-2-07.8 of the Administrative Code if the affected rate has been in effect for less than two prospective rate periods following implementation of rebased rate components and if the department notifies the affected hospital of the audit finding within thirty days of receipt of the finding. Hospitals may request reconsideration of the adjustment within thirty days of notification following the procedures outlined in rule ~~5101:3-2-0712~~ 5101:3-2-07.12 of the Administrative Code.

(4) Overpayments determined as a result of findings made under the provisions of paragraphs (C)(1)(a) to (C)(1)(e) of this rule will be collected by the department.

(D) Interim and final settlement.

(1) Any adjustments described in paragraphs (C)(2) and (C)(3) of this rule will be reflected in the interim or final settlement cost report. Overpayments or underpayments, as described in paragraphs (C)(1)(a) to (C)(1)(d) of this rule, will be collected by the department at settlements based upon findings associated with the cost-reporting period being settled. Retrospective adjustments to payment rates as described in rule ~~5101:3-2-078~~ 5101:3-2-07.8 of the Administrative Code that are identified prior to interim settlement will be incorporated into interim settlement in instances when such adjustments to payment rates affect payments for discharges occurring during the cost-reporting period being settled.

(2) Final settlement constitutes the implementation of the final fiscal audit for a cost-reporting period.

(a) Any adjustments not incorporated into interim settlement and all applicable retrospective adjustments to payment rates in effect for discharges occurring during the cost-reporting period will be incorporated into final settlement for that cost-reporting period.

(b) Any pending request for reconsideration filed pursuant to paragraphs (B) and (C) of rule ~~5101:3-2-0712~~ 5101:3-2-07.12 of the Administrative Code will be incorporated into final settlement.

(c) If a hospital has an outstanding medicare appeal that has not been resolved and that could affect settlement of hospital-specific rate components, the hospital may accept, with reservations, final settlement incorporating adjustments not based on unresolved medicare audit exceptions and hold open that portion of the settlement, with all rights to appeal under Chapter 119. of the Revised Code, based on unresolved medicare audit exceptions.

(d) In no instance will adjustments to rates that were in effect during the period covered by final settlement be made following final settlement, and only components of rates that are based solely on hospital-specific data are subject to recalculation and adjustment after such rates have been in effect for two prospective payment periods following the implementation of rebased rate components.

Effective Date: 09/04/2005

R.C. 119.032 review dates: 05/27/2005 and 09/01/2010

Certification

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02

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5160-2-25 Coordination of Benefits: Hospital Services

Formerly **5101:3-2-25 Coordination of Benefits: Hospital Services**

HHTL 3352-11-08

Effective Date: January 1, 2012

Most Current Prior Effective Date: **October 1, 2005**

Rule 5101:3-1-08 of the Administrative Code sets forth general provisions regarding requirements that the department make payment for covered services only after any available third-party benefits are exhausted. In addition to those general provisions, this rule identifies other requirements applicable to services provided by hospitals.

(A) All hospitals are to utilize third-party resources for all services a consumer receives while in the hospital. If a hospital receives reimbursement from a third-party subsequent to submitting a claim or subsequent to receiving payment from the department, the hospital is to repay the department by submitting a claim adjustment. Patient liabilities associated with persons eligible for medicaid under spend-down provisions (see Chapter 5101:1-39 of the Administrative Code) are considered a third-party resource. Benefits available through Title XVIII of the Social Security Act under medicare, part A and part B, or through medicare part C (medicare advantage), are considered third-party resources, including medicare part A lifetime reserve days.

(B) The following payment provisions apply when billing for services provided to medicaid eligibles having available resources.

(1) For qualified medicare beneficiaries (QMB), including QMB plus and medicaid consumers enrolled in medicare part A, the following payment provisions apply to cost-sharing liability for inpatient services.

(a) For purposes of paragraph (B)(1) of this rule, the "medicaid maximum allowed amount" is the amount that would be payable by medicaid if the hospitalization were billed, in its entirety, to the department as a medicaid-only claim for a medicaid eligible consumer. The medicaid maximum allowed amount is calculated as:

(i) Described in rule 5101-3-2-07.11. of the Administrative Code in the case that a hospital is paid in accordance with the ~~diagnostic~~diagnosis related grouping (DRG) prospective payment system; or

(ii) Described in rule 5101-3-2-22 of the Administrative Code in the case that a hospital is paid on a reasonable cost basis.

(b) Except as described in paragraph ~~(C)~~(B)(3) of this rule, for persons described in paragraph (B)(1) of this rule, the department will pay as cost sharing for inpatient hospital services the lesser of:

(i) The sum of the deductible, coinsurance and co-payment amount as provided by medicare part A; or

(ii) The medicaid maximum allowed amount, as described in paragraph (B)(1)(a) of this rule, minus the total prior payment, not to equal less than zero. The total prior payment includes the amount paid or payable by medicare and any other applicable third party payment for services billed.

(c) If the department has a cost-sharing liability but is unable to calculate a medicaid maximum as described in paragraph (B)(1)(a) of this rule, the department may pay the sum of the deductible, coinsurance and co-payment amount as provided by medicare part A.

(d) If a patient who is jointly eligible for medicare part A and medicaid exhausts medicare part A benefits while hospitalized, and the patient's hospitalization exceeds the applicable medicare threshold, the department will pay the difference between that amount payable

by medicare and the medicaid maximum allowed amount as described in paragraph (B)(1)(a) of this rule.

~~(2) When a consumer is entitled to medicare part B benefits, the department pays the amount of the medicare deductible and coinsurance minus any other resources available to the recipient for hospital services including health insurance benefits.~~

(2) For qualified medicare beneficiaries (QMB), including QMB plus and medicaid consumers enrolled in medicare part B, the following payment provisions apply to cost-sharing liability for hospital services covered by part B:

(a) For purposes of paragraph (B)(2) of this rule, the "medicaid maximum allowed amount" is the amount that would be payable by medicaid if the hospitalization were billed, in its entirety, to the department as a medicaid-only claim for a medicaid eligible consumer. The medicaid maximum allowed amount is calculated as:

(i) Described in rules 5101-3-2-07.11 or 5101:3-2-21 of the Administrative Code in the case that a hospital is paid in accordance with the diagnostic related grouping (DRG) prospective payment system; or

(ii) Described in rule 5101-3-2-22 of the Administrative Code in the case that a hospital is paid on a reasonable cost basis.

(b) Except as described in paragraph (B) (3) of this rule, for persons described in paragraph (B)(2) of this rule, the department will pay as cost sharing for inpatient hospital services the lesser of:

(i) The sum of the deductible, coinsurance and co-payment amount as provided by medicare part B; or

(ii) The medicaid maximum allowed amount, as described in paragraph (B)(2)(a) of this rule, minus the total prior payment, not to equal less than zero. The total prior payment includes the amount paid or payable by medicare and any other applicable third party payment for services billed.

(c) If the department has a cost-sharing liability but is unable to calculate a medicaid maximum as described in paragraph (B)(2)(a) of this rule, the department may pay the sum of the deductible, coinsurance and co-payment amount as provided by medicare part B.

(3) For qualified medicare beneficiaries and medicaid consumers enrolled in medicare part C managed health care plans (medicare advantage plans) the department pays in accordance with rule 5101:3-1-05.1 of the Administrative Code.

(4) For inpatient hospital services, if a consumer is entitled to hospital insurance benefits other than medicare including health insurance benefits, the department pays either the applicable DRG prospective payment as described in rule 5101-3-2-07.11 of the Administrative Code or the payment applicable for services reimbursed on a reasonable cost basis as described in rule 5101:3-2-22 of the Administrative Code, minus any resources available to the patient for hospital services including health insurance benefits. Such resources may include medicare part B payments including health insurance benefits and patient liabilities associated with persons eligible on a spend-down basis as described in paragraph (A) of this rule. For outpatient hospital services, if a consumer is entitled to hospital insurance benefits other than medicare, the department pays either in accordance with rule 5101:3-2-21 of the Administrative Code for hospitals subject to DRG prospective payment or in accordance with rule 5101:3-2-22 of the Administrative Code for hospitals subject to reimbursement on a reasonable cost basis, minus any resources available to the patient. Such resources may include patient liabilities associated with persons eligible on a spend-down basis as described in paragraph (A) of this rule. For both inpatient and outpatient services, if the resources available to a recipient equal or exceed amounts payable in accordance with this paragraph, the department makes no payment for the hospital services.

Effective: 01/01/2012

R.C. 119.032 review dates: 10/14/2011 and 01/01/2017

Certification: CERTIFIED ELECTRONICALLY

Date: 12/19/2011

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.021

Prior Effective Dates: 10/1/84, 7/29/85, 9/3/91 (Emer), 8/1/02, 10/1/05

5160-2-30 Hospital Franchise Fee Program

HHTL 3352-15-07

Effective Date: April 30, 2015

***Most Current Prior Effective Date:* February 24, 2014**

This rule sets forth the hospital franchise fee assessment and payment schedule applicable for the assessment program year that ends in calendar year ~~2014~~2015, for the hospital franchise fee program implemented under sections 5168.20 to 5168.28 of the Revised Code.

(A) Definitions

For purposes of the hospital franchise fee program only, "total facility costs" are as defined in section 5168.20 of the Revised Code, and also exclude a hospital's costs associated with providing care to recipients of the medicare program as shown on the cost-reporting data used for purposes of determining the hospital's assessment under section 5168.21 of the Revised Code.

(B) Assessment

The amount of each hospital's franchise fee assessment for the assessment program year that ends in calendar year 2014 shall be ~~2.579425~~ 2.6463589 per cent of the hospital's total facility costs as defined in paragraph (A) of this rule.

(C) Payment schedule

Except as provided in paragraph (D)(3) of this rule, each hospital shall pay the amount it is assessed under paragraph (B) of this rule according to the following payment schedule:

(1) ~~Twenty-five~~ Fifty per cent due on ~~March 17, 2014~~April 30, 2015.

(2) ~~Twenty-five~~ Fifty per cent due on ~~April 7, 2014~~May 18, 2015.

~~(3) Fifty per cent due on May 5, 2014.~~

(D) Hospitals not enrolled as medicaid providers

(1) Hospitals, as defined in section 5168.20 of the Revised Code, that are not enrolled in the medicaid program shall, upon request, submit to the department an electronic copy of the hospital's medicare cost report (CMS 2552-10) or audited financial statements for the period described in section 5168.21 of the Revised Code.

(2) Hospitals not enrolled as medicaid providers shall be assessed a hospital franchise fee as described in paragraph (B) of this rule.

(3) Each hospital that is not enrolled as a medicaid provider shall pay the assessment according to a schedule established by the department at the time the department mails its written notice of the final determination of the hospital's assessment.

Effective: 04/30/2015

Five Year Review (FYR) Dates: 01/01/2016

Certification: CERTIFIED ELECTRONICALLY

Date: 04/20/2015

Promulgated Under: 119.03

Statutory Authority: 5164.02, 5168.23, 5168.26

Rule Amplifies: 5168.20, 5168.21, 5168.22, 5168.23, 5168.24, 5168.25, 5168.26, 5168.27, 5168.28

Prior Effective Dates: 10/14/10 (Emer), 1/1/11, 9/29/11 (Emer), 12/28/11, 3/10/13 (Emer), 7/29/13

5160-2-40 Pre-Certification Review

HHTL 3352-15-05

Effective Date: April 30, 2015

Most Current Prior Effective Date: **April 1, 2005**

This rule describes the pre-certification review program for inpatient ~~and outpatient~~ services. Paragraph (C) of this rule is specific to ~~For~~ the medical/surgical pre-certification program~~, paragraphs (A) to (C) and (E) to (G) of this rule are to be used~~. ~~For the psychiatric pre-certification program, paragraphs (A), (B) and~~ Paragraph (D) is specific to the psychiatric pre-certification program.~~to (G) of this rule are to be used as applicable.~~

(A) Definitions.

(1) An "emergency admission" is an admission to treat a condition requiring medical and/or surgical treatment within the next forty-eight hours when, in the absence of such treatment, it can reasonably be expected that the patient may suffer unbearable pain, physical impairment, serious bodily injury or death.

(2) "~~Medically~~Medical ~~necessary services~~necessity" ~~are~~ is defined in ~~paragraph (B) of~~ rule ~~5101:3-2-02~~5160-1-01 of the Administrative Code.

(3) "Standards of medical practice" are nationally recognized protocols for diagnostic and therapeutic care. These protocols are approved by the medicaid program. ~~ODJFS~~The Ohio department of medicaid (ODM) will notify providers of the standards of medical practice to be used by the department. If the department should change the protocols, providers will be notified sixty business days in advance.

(4) An "elective admission" is any admission that does not meet the emergency admission definition in paragraph (A)(1) of this rule.

(5) "Elective care" is medical or surgical treatment that may be postponed for at least forty-eight hours without causing the patient unbearable pain, physical impairment, serious bodily injury or death.

(6) For purposes of this rule, a "hospital" is a provider eligible under rule ~~5101:3-2-01~~5160-2-01 of the Administrative Code.

(7) A "surgical admission" is an admission to a hospital in which surgery is performed as part of the treatment plan.

(8) A "medical admission" is a nonsurgical, nonpsychiatric, and nonmaternity admission.

(9) "Pre-certification" is a process whereby ~~ODJFS~~ODM (or its ~~contractual designee~~contracted medical review entity) assures that covered medical and psychiatric services, and covered surgical procedures are medically necessary and are provided in the most appropriate and cost effective setting. ~~Since it may be determined that an inpatient stay is not required for the provision of that covered medical or covered surgical care, the location of service delivery may be altered as a result of pre-certification. The payment of that treatment or procedure is contingent upon the acceptance of the review agency's recommendation on the appropriate location of service, and medical necessity of the admission and/or procedure. The department will mail the precertification list and standards of medical practice to all providers thirty days in advance of requiring pre-certification.~~

(B) Guidelines for pre-certification

(1) The decision that the provision of elective diagnostic and/or therapeutic care is medically necessary will be based upon nationally recognized standards of medical practice, derived from indicators of severity of illness and intensity of services. Both severity of illness and intensity of service must be present to justify proposed care. When indicated, determinations will also include a consideration of relevant and appropriate psycho-social factors.

(2) The individual circumstances of each patient is taken into account when making a decision about the appropriateness of a hospital admission. Issues that will be considered in making the decision about whether or not an admission is medically necessary include psycho-social factors and factors related to the home environment including proximity to the hospital and the accessibility of alternative sites of care; these issues must be fully documented in the medical record in order to be considered as part of the review.

(3) If an inpatient stay is not required for the provision of covered medical or surgical care, the location of service delivery may be altered as a result of pre-certification.

(4) The payment of that treatment or procedure is contingent upon the acceptance of the review entity's recommendation on the appropriate service location and the medical necessity of the admission and/or procedure.

(5) The department will post the precertification list and standards of medical practice thirty business days prior to requiring pre-certification.

(C) Pre-certification of medical and surgical services provided in an inpatient or outpatient setting.

(1) Admission for individuals who are medicaid eligible at the time of the admission and who do not meet any of the exemptions in paragraph (C)(2) of this rule must be certified by the reviewing agency (~~ODJFS~~ODM or its contractual designee) prior to an admission to a hospital as defined in paragraph (A)(6) of this rule.

(2) Excluded from the pre-certification process are:

(a) Emergency admissions, with the exception of emergency psychiatric admissions.

(b) Substance abuse admissions.

(c) Maternity admissions.

(d) Recipients enrolled in health insuring corporations under contract with the department for provision of health services to recipients.

(e) Services provided in hospitals which are located in noncontiguous states.

(f) Elective care that is performed in a hospital inpatient setting on a patient who is already hospitalized for a medically necessary condition unrelated to the elective care or when an unrelated procedure which does not require pre-certification is being performed simultaneously.

(g) Persons whose eligibility is pending at the time of admission or who make application for medicaid subsequent to admission.

(h) Patients who are jointly eligible for medicare and medicaid and who are being admitted under the medicare "part A" benefit.

(i) Patients who are eligible for benefits through a third party insurance as the primary payer for the services subject to pre-certification.

(j) Transfers from one hospital to another hospital with the exception of those hospitals identified for intensified review in accordance with paragraph (C)(1) of rule ~~5101:3-2-07.13~~5160-2-07.13 of the Administrative Code.

(k) Admissions for those elective surgical procedures or diagnoses which are not included in the department's pre-certification list.

(l) If the patient is not identified as a medicaid recipient at the time of an elective admission or procedure. However, every effort should be made by both the attending and/or admitting physicians and hospital providers to identify medicaid recipients before an admission or procedure that requires precertification.

(3) The provider must request pre-certification for an admission and/or procedure that does not meet the exemption criteria listed in paragraphs (C)(2)(a) to (C)(2)(l) of this rule and is on the department's pre-certification list by ~~contacting the reviewing agency~~submitting an electronic

request to the department. The reviewing agency is to make a decision on a pre-certification request within three ~~working~~ business days of receipt of a properly submitted request, which is to include the information addressed in the standards of medical practice. "Receipt of a properly submitted request" means that all information needed by the reviewing agency to make a decision based upon the guidelines in paragraph (B) of this rule has been provided to the reviewing agency. All negative decisions shall be reviewed by a physician representing ~~ODJFS~~ODM or its contractual designee. The reviewing agency shall notify ~~in writing~~ the recipient, the requesting physician, the hospital, and ~~ODJFS~~ODM in writing of all decisions. The reviewing agency must provide that written notice is sent to the requesting physician, recipient, and hospital by the close of the fourth ~~working~~business day after the request is received.

(D) Pre-certification psychiatric.

(1) General information.

The following definitions pertain to psychiatric admissions:

(a) A "psychiatric admission" is an admission of an individual to a hospital with a primary diagnosis of mental illness and not a medical or surgical admission. A discharge from a medical/surgical unit and an admission to a distinct part psychiatric unit within the same facility is considered to be a psychiatric admission and is subject to pre-certification.

(b) An "emergency psychiatric admission" is an admission where the attending psychiatrist believes that there is likelihood of serious harm to the patient or others and that the patient requires both intervention and a protective environment immediately.

(2) All psychiatric admissions for individuals who are medicaid eligible at the time of the admission must be certified by the reviewing agency (~~ODJFS~~ODM or its contractual designee) prior to an admission to a hospital or ~~by the next working~~within two business days ~~after the~~of the admission ~~has occurred~~.

(3) The provider must request pre-certification for a psychiatric admission by ~~contacting the reviewing agency~~submitting an electronic request to the department. The reviewing agency is to make a decision on a pre-certification request within three ~~working~~ business days of receipt of a properly submitted request, which is to include the information addressed in the standards of medical practice. "Receipt of a properly submitted request" means that all information needed by the reviewing agency to make a decision based upon the guidelines set forth in paragraph (B) of this rule has been provided to the reviewing agency. All negative decisions shall be reviewed by a physician representing ~~ODJFS~~ ODM or its contractual designee. The reviewing agency shall notify the recipient, the requesting physician, the hospital, and ~~ODJFS~~ ODM of all decisions in writing by the close of the fourth ~~working~~business day after the request is received.

(E) Decisions made by the medical review entity as described in this rule are appealable to the medical review entity and are subject to the reconsideration process described in rule ~~5101:3-2-07.12~~ 5160-2-07.12 of the Administrative Code.

(F) Recipients have a right to a hearing in accordance with division ~~level~~ 5101:6 of the Administrative Code. This hearing is separate and distinct from the provider's appeal, as described in paragraph (E) of this rule.

(G) Reimbursement for elective care subject to pre-certification review.

(1) A certification that an inpatient stay is necessary for the provision of care and/or a procedure is medically necessary does not guarantee payment for that service. The individual must be a medicaid recipient at the time the service is rendered and the service must be a covered service.

(2) An elective admission, as defined in paragraph (A)(4) of this rule, is reimbursed according to the rates for inpatient hospital services pursuant to rule ~~5101:3-2-22~~5160-2-22 of the Administrative Code for hospital admissions reimbursed on a cost basis and rule ~~5101:3-2-07.11~~5160-2-65 of the Administrative Code for hospital admissions reimbursed on a prospective basis. Outpatient hospital services are reimbursed according to rule ~~5101:3-2-21~~5160-2-21 of the Administrative

Code for hospitals subject to prospective reimbursement, and according to rule ~~5101:3-2-22~~5160-2-22 of the Administrative Code for those hospitals reimbursed on a cost basis. Associated physician services are reimbursed according to medicaid maximums for physician services pursuant to appendix DD to rule ~~5101:3-1-60~~5160-1-60 of the Administrative Code.

(3) In any instance when an admission or a procedure that requires pre-certification is performed and the admission and/or procedure has not been approved, hospital payments will not be made. If physician payments have been made for services associated with the medically unnecessary procedure, such payments will be recovered by the department. Recipients may not be billed for charges associated with the admission and/or procedure except under circumstances described in paragraph (G)(4) of this rule.

(4) If the pre-certification process is initiated prospectively by the provider and hospital inpatient services are denied, or if an admission and/or procedure requiring pre-certification is not found to be medically necessary and the recipient chooses hospitalization or to have the medically unnecessary service, these admissions and/or procedures and all associated services would be considered noncovered services and the recipient ~~will~~may be liable for payment of these services in accordance with rule ~~5101:3-1-13.1~~5160-1-13.1 of the Administrative Code.

(5) The medical review entity may determine upon retrospective review, in accordance with rule ~~5101:3-2-07.13~~5160-2-07.13 of the Administrative Code, that the location of service was not medically necessary, but that services rendered were medically necessary. In this instance, the hospital may bill the department on an outpatient basis for those medically necessary services that were rendered on the date of admission in accordance with rule ~~5101:3-2-21~~5160-2-21 of the Administrative Code. Only laboratory and diagnostic radiology services rendered during the remainder of the medically unnecessary admission may be billed in accordance with rule ~~5101:3-2-02~~5160-2-02 of the Administrative Code on the outpatient claim. The outpatient bill must be submitted with a copy of the reconsideration affirming the original decision and/or the administrative decision issued in accordance with rule ~~5101:3-2-07.12~~5160-2-07.12 of the Administrative Code. The outpatient bill with attachments must be submitted to the department within sixty calendar days from the date on the remittance advice recouping the DRG payment for the medically unnecessary admission.

Effective: 04/30/2015

Five Year Review (FYR) Dates: 01/14/2015 and 04/30/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 04/15/2015

Promulgated Under: 119.03

Statutory Authority: 5164.02

Rule Amplifies: 5162.03, 5164.02

Prior Effective Dates: 3/20/84, 10/1/84, 10/1/87, 4/1/88, 7/1/90, 9/3/91 (Emer.), 11/10/91, 7/1/92, 7/1/93, 1/1/00, 04/01/05

5160-2-50 Supplemental Inpatient Hospital Upper Limit Payments for Public Hospitals

Formerly **5101:3-2-50 Supplemental Inpatient Hospital Upper Limit Payments for Public Hospitals**

HHTL 3352-10-04

Effective Date: April 8, 2010

Most Current Prior Effective Date: **April 1, 2009**

(A) Definitions.

(1) "Public hospital" means an Ohio hospital owned and operated by a governmental entity other than the state.

(2) "Available inpatient payment gap" means the difference between what is estimated using the methodology described in paragraph (C) of this rule that medicare would have paid for medicaid consumers and actual medicaid payments made in accordance with Chapter 5101:3-2 of the Administrative Code.

(3) "Intergovernmental transfer" means any transfer of money by a governmental hospital to the department.

(4) "Total medicaid inpatient payments" for each hospital means the amount paid by the medicaid program for services rendered to eligible medicaid patients, excluding supplemental payments, as reported on the medicaid cost report, as specified in paragraph (B) of this rule.

(5) "Total medicaid inpatient discharges" means for each public hospital the number of discharges from the facility for medicaid patients, as reported on the medicaid cost report, as specified in paragraph (B) of this rule.

(6) "Total medicaid inpatient charges" means for each public hospital the charges for covered medicaid inpatient services rendered, as reported on the medicaid cost report, as specified in paragraph (B) of this rule.

(7) "Medicare inpatient payments for hospitals exempt from medicare diagnosis related group (DRG) payments and Medicare inpatient payments for subproviders" means the inpatient payment amount as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(8) "Medicare inpatient DRG payments" means the DRG payment amount as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(9) "Medicare inpatient outlier payments" means the outlier payment amount as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(10) "Medicare inpatient indirect medical education" means the indirect medical education adjustment amount as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(11) "Medicare inpatient disproportionate share payments" means the inpatient disproportionate share adjustment amount as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(12) "Medicare inpatient hospital capital payments" means the payment for inpatient program capital as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(13) "Medicare inpatient direct medical education" means the direct graduate medical education payment amount as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(14) "Medicare inpatient hospital payments - other" means the sum of net organ acquisition cost, cost of teaching physicians, routine service other pass through costs, and ancillary service other pass through costs, as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(15) "Total medicare inpatient charges" means the amount of inpatient charges for each hospital and subprovider, as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(16) "Cost based hospitals" means hospitals excluded from the DRG prospective payment system, as specified in rule 5101:3-2-07.1 of the Administrative Code.

(B) Source data for calculations.

The calculations described in this rule will be based on cost reporting data described in rule 5101:3-2-23 of the Administrative Code, which reflects the most recent completed interim settled medicaid cost report for all hospitals, and the medicare cost report for the corresponding cost reporting period.

(C) Calculation of available inpatient payment gap for public hospitals.

(1) For each public hospital, calculate the total medicare inpatient payment by adding the amounts described in paragraphs (A)(7) to (A)(14) of this rule.

(2) For each public hospital, calculate the medicare payment to charge ratio by dividing the amount calculated in paragraph (C)(1) of this rule by the total medicare inpatient charges as described in paragraph (A)(15) of this rule.

(3) For each public hospital, calculate the total estimated medicare inpatient payment for medicaid inpatient discharges by multiplying the amount calculated in paragraph (C)(2) of this rule by the total medicaid inpatient charges as described in paragraph (A)(6) of this rule.

(4) For each public hospital, calculate the available inpatient payment gap by taking total estimated medicare inpatient payments for medicaid inpatient discharges as calculated in paragraph (C)(3) of this rule and subtracting actual total medicaid inpatient payments as described in paragraph (A)(4) of this rule. For each cost based hospital, as defined in paragraph (A)(16) of this rule, the available inpatient gap equals zero.

(5) For each public hospital that has an available inpatient payment gap greater than zero resulting from the calculations in paragraph (C)(4) of this rule, calculate the available per discharge supplemental inpatient hospital payment amount by dividing the amount in paragraph (C)(4) of this rule by the amount in paragraph (A)(5) of this rule.

(D) For each supplemental upper limit payment made after the effective date of this rule, the resulting per discharge supplemental payment amount calculated in paragraph (C) of this rule will be in effect from the first day of January through the thirty-first day of December for each supplemental upper limit payment program year.

(E) Payment of supplemental inpatient hospital upper limit payments.

(1) In January and July of each year, the department will notify public hospitals of the available per discharge supplemental inpatient hospital payment amount as described in paragraph (C)(5) of this rule, the number of actual medicaid inpatient discharges paid for through the department's medicaid management information system (MMIS) for each public hospital in the six months prior to the month of notification, and the maximum allowable supplemental payment that the public hospital is eligible to receive for the prior six months. The maximum allowable supplemental payment amount is the product of the actual number of medicaid discharges paid during the prior six months and the available per discharge supplemental inpatient hospital payment amount as described in paragraph (C)(5) of this rule, subject to the limitations described in paragraph (E)(2~~3~~) of this rule.

~~(2) Public hospitals electing to receive supplemental inpatient hospital payments must notify the department within fourteen days of the date of the notice described in paragraph (E)(1) of this rule of their intent to participate. Public hospitals that elect to participate and have notified the department of that intent shall provide an intergovernmental transfer, via electronic funds transfer, up to but not to exceed an amount that equals the maximum allowable supplemental payment amount as described in paragraph (E)(1) of this rule multiplied by [1-(federal medical assistance percentage)] by no later than thirty days from the date of the notice described in paragraph (E)(1) of this rule. Failure to submit the intergovernmental transfer by this deadline~~

~~will preclude the hospital from receiving the supplemental payment for the six-month payment period.~~

~~(3)~~(2) The total supplemental inpatient hospital payments funds that will be paid to each public hospital ~~electing to receive supplemental inpatient hospital payments~~ ~~from~~ by the department shall be the amount calculated in ~~supplied by each hospital in~~ paragraph (E)(1~~2~~) of this rule~~, divided by [1-(federal medical assistance percentage)]~~. If the total of the funds that will be paid to all public hospitals ~~electing to participate~~ exceeds the aggregate upper payment limit for all public hospitals calculated each supplemental inpatient upper limit payment program year as described in paragraph (C) of this rule, then the amount paid to each public hospital ~~electing to participate~~ will be limited to its proportion of the aggregate upper payment limit. The department may request adjustments to the amounts ~~transferred from and~~ paid to public hospitals ~~electing to participate~~ for the six-month time period.

(F) The total supplemental inpatient hospital payments funds that will be paid to each public hospital ~~electing to receive supplemental inpatient hospital payments~~ ~~from~~ by the department as described in paragraph (E)(2~~3~~) of this rule will be included in the calculation of disproportionate share limits as described in rule 5101:3-2-07.5 of the Administrative Code.

Effective: 04/08/2010

R.C. 119.032 review dates: 04/01/2014

Certification: CERTIFIED ELECTRONICALLY

Date: 03/29/2010

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.021, Section 309.30.17 of Am. Sub. H.B. 1 of the 128th G.A.

Prior Effective Dates: 11/15/01, 7/1/04, 4/1/09

5160-2-51 Supplemental Inpatient Hospital Upper Limit Payments for State Hospitals

Formerly **5101:3-2-51 Supplemental Inpatient Hospital Upper Limit Payments for State Hospitals**

HHTL 3352-10-04

Effective Date: April 8, 2010

Most Current Prior Effective Date: **April 1, 2009**

(A) Definitions.

(1) "State hospital" means an Ohio hospital owned and operated by the state.

(2) "Available inpatient payment gap" means the difference between what is estimated using the methodology described in paragraphs (C) and (D) of this rule that medicare would have paid for medicaid consumers and actual medicaid payments made in accordance with Chapter 5101:3-2 of the Administrative Code.

(3) "Intergovernmental transfer" means any transfer of money by a governmental hospital to the department.

(4) "Total medicaid inpatient payments" for each hospital means the amount paid by the medicaid program for services rendered to eligible medicaid patients, excluding supplemental payments, as reported on the medicaid cost report, as specified in paragraph (B) of this rule.

(5) "Total medicaid inpatient discharges" means for each state hospital the number of discharges from the facility for medicaid patients, as reported on the medicaid cost report, as specified in paragraph (B) of this rule.

(6) "Total medicaid inpatient charges" means for each state hospital the charges for covered medicaid inpatient services rendered, as reported on the medicaid cost report, as specified in paragraph (B) of this rule.

(7) "Medicare inpatient payments for hospitals exempt from medicare diagnosis related group (DRG) payments and Medicare inpatient payments for subproviders" means the inpatient payment amount as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(8) "Medicare inpatient DRG payments" means the DRG payment amount as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(9) "Medicare inpatient outlier payments" means the outlier payment amount as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(10) "Medicare inpatient indirect medical education" means the indirect medical education adjustment amount as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(11) "Medicare inpatient disproportionate share payments" means the inpatient disproportionate share adjustment amount as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(12) "Medicare inpatient hospital capital payments" means the payment for inpatient program capital as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(13) "Medicare inpatient direct medical education" means the direct graduate medical education payment amount as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(14) "Medicare inpatient hospital payments - other" means the sum of net organ acquisition cost, cost of teaching physicians, routine service other pass through costs, and ancillary service other pass through costs, as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(15) "Total medicare inpatient charges" means the amount of inpatient charges for each hospital and subprovider, as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(16) "Cost based hospitals" means hospitals excluded from the DRG prospective payment system, as specified in rule 5101:3-2-07.1 of the Administrative Code.

(B) Source data for calculations.

The calculations described in this rule will be based on cost reporting data described in rule 5101:3-2-23 of the Administrative Code, which reflects the most recent completed interim settled medicaid cost report for all hospitals, and the medicare cost report for the corresponding cost reporting period.

(C) Calculation of available inpatient payment gap for state hospitals that are not free-standing psychiatric hospitals.

(1) For each state hospital, calculate the total medicare inpatient payment by adding the amounts described in paragraphs (A)(7) to (A)(14) of this rule. For available inpatient payment gap calculations for payment periods ending in calendar year 2002, reduce medicare indirect medical education payments described in paragraph (A)(10) of this rule by 15.4 per cent prior to calculating the total medicare inpatient payment.

(2) For each state hospital, calculate the medicare payment to charge ratio by dividing the amount calculated in paragraph (C)(1) of this rule by the total medicare inpatient charges as described in paragraph (A)(15) of this rule.

(3) For each state hospital, calculate the total estimated medicare inpatient payment for medicaid inpatient discharges by multiplying the amount calculated in paragraph (C)(2) of this rule by the total medicaid inpatient charges as described in paragraph (A)(6) of this rule.

(4) For each state hospital, calculate the available inpatient payment gap by taking total estimated medicare inpatient payments for medicaid inpatient discharges as calculated in paragraph (C)(3) of this rule and subtracting actual total medicaid inpatient payments as described in paragraph (A)(4) of this rule. For each cost based hospital, as defined in paragraph (A)(16) of this rule, the available inpatient gap equals zero.

(5) For each state hospital that has an available inpatient payment gap greater than zero resulting from the calculations in paragraph (C)(4) of this rule, calculate the available per discharge supplemental inpatient hospital payment amount by dividing the amount in paragraph (C)(4) of this rule by the amount in paragraph (A)(5) of this rule.

(D) Calculation of available inpatient payment gap for state psychiatric hospitals (SPH) subject to medicaid prospective payment as described in Chapter 5101:3-2 of the Administrative Code and excluded from prospective payment under medicare, 42 C.F.R. 412.23(a) in effect as of October 1, 2003.

(1) For each SPH described in this paragraph, "medicaid inpatient costs" means medicaid inpatient costs as reported on the medicaid cost report, as specified in paragraph (B) of this rule.

(2) For each SPH described in this paragraph, "medicaid inpatient payments" means medicaid inpatient payments as reported on the medicaid cost report, as specified in paragraph (B) of this rule.

(3) For each SPH described in this paragraph, "medicaid discharges" means medicaid discharges as reported on the medicaid cost report, as specified in paragraph (B) of this rule.

(4) For each SPH described in this paragraph, calculate the available inpatient payment gap by subtracting the amount in paragraph (D)(2) of this rule from the amount in paragraph (D)(1) of this rule.

(5) For each SPH described in this paragraph that has an available inpatient payment gap greater than zero resulting from the calculations in paragraph (D)(4) of this rule, calculate the available per discharge supplemental inpatient hospital payment amount by dividing the amount in paragraph (D)(4) of this rule by the amount in paragraph (D)(3) of this rule.

(E) For the first supplemental upper payment limit program year, the resulting per discharge supplemental payment amount calculated in paragraphs (C) and (D) of this rule will be in effect from April 1, 2002 through December 31, 2002. For each supplemental upper payment limit program year after calendar year 2002, the resulting per discharge supplemental payment amount calculated in paragraphs (C) and (D) of this rule will be in effect from the first day of January through the thirty-first day of December of each year.

(F) Payment of supplemental inpatient hospital upper limit payments.

(1) In January and July of each year after April 1, 2002, the department will notify state hospitals of the available per discharge supplemental inpatient hospital payment amount as described in paragraph (C)(5) or (D)(6) of this rule, the number of actual medicaid inpatient discharges paid for through the department's medicaid management information system (MMIS) for each state hospital in the six months prior to the month of notification, and the maximum allowable supplemental payment that the state hospital is eligible to receive for the prior six months. The maximum allowable supplemental payment amount is the product of the actual number of medicaid discharges paid during the prior six months and the available per discharge supplemental inpatient hospital payment amount as described in paragraph (C)(5) or (D)(6) of this rule, subject to the limitations described in paragraph (F)(2~~3~~) of this rule. The first six-month supplemental upper limit payment will be prorated from April 1, 2002 to the end of the six-month period from which the actual medicaid inpatient discharges were obtained.

~~(2) State hospitals electing to receive supplemental inpatient hospital payments must notify the department within fourteen days of the date of the notice described in paragraph (F)(1) of this rule of their intent to participate. State hospitals that elect to participate and have notified the department of that intent shall provide an intergovernmental transfer, via electronic funds transfer, up to but not to exceed an amount that equals the maximum allowable supplemental payment amount as described in paragraph (F)(1) of this rule multiplied by [1-(federal medical assistance percentage)] by no later than thirty days from the date of the notice described in paragraph (F)(1) of this rule. Failure to submit the intergovernmental transfer by this deadline will preclude the hospital from receiving the supplemental payment for the six month payment period.~~

~~(3)~~(2) The total supplemental inpatient hospital payments funds that will be paid to each state hospital by ~~electing to receive supplemental inpatient hospital payments from~~ the department shall be the amount calculated ~~supplied by each hospital~~ in paragraph (F)(~~2~~1) of this rule~~, divided by [1-(federal medical assistance percentage)]~~. If the total of the funds that will be paid to all state hospitals ~~electing to participate~~ exceeds the aggregate upper payment limit for all state hospitals calculated each supplemental inpatient upper limit payment program year as described in paragraphs (C) and (D) of this rule, then the amount paid to each state hospital ~~electing to participate~~ will be limited to its proportion of the aggregate upper payment limit. The department may request adjustments to the amounts ~~transferred from and~~ paid to state hospitals ~~electing to participate~~ for the six month time period.

(G) The total supplemental inpatient hospital payments funds that will be paid to each state hospital ~~electing to receive supplemental inpatient hospital payments from~~ by the department as described in paragraph (F)(2~~3~~) of this rule will be included in the calculation of disproportionate share limits as described in rules 5101:3-2-07.5 and 5101:3-2-10 of the Administrative Code.

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R.C. 119.032 review dates: 04/01/2014

Certification: CERTIFIED ELECTRONICALLY

Date: 03/29/2010

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.021, Section 309.30.17 of Am. Sub. H.B. 1 of the 128th G.A.

Prior Effective Dates: 7/22/02, 9/1/03, 4/1/09

5160-2-52 Supplemental Inpatient Hospital Payments for Private Hospitals

Formerly **5101:3-2-52 Supplemental Inpatient Hospital Payments for Private Hospitals**

HHTL 3352-10-04

Effective Date: April 8, 2010

This rule sets forth the methodology used to determine the supplemental inpatient hospital payments to private hospitals required by Section 309.30.17 of Amended Substitute House Bill 1 of the 128th General Assembly.

(A) Definitions.

(1) "Private hospital" means an Ohio hospital, other than a public hospital as defined in rule 5101:3-2-50 or a state hospital as defined in 5101:3-2-51 or a children's hospital as defined in rule 5101:3-2-53 of the Administrative Code, which is subject to prospective payment as described in rule 5101:3-2-07.1 of the Administrative Code.

(2) "Available inpatient payment gap" means the difference between what is estimated using the methodology described in paragraph (C) of this rule that medicare would have paid for medicaid consumers and actual medicaid payments made in accordance with Chapter 5101:3-2 of the Administrative Code.

(3) "Total medicaid inpatient payments" for each hospital means the amount paid by the medicaid program for services rendered to eligible medicaid patients, excluding supplemental payments, as reported on the medicaid cost report, as specified in paragraph (B) of this rule.

(4) "Total medicaid inpatient discharges" means for each hospital the number of discharges from the facility for medicaid patients, as reported on the medicaid cost report, as specified in paragraph (B) of this rule.

(5) "Total medicaid inpatient charges" means for each hospital the charges for covered medicaid inpatient services rendered, as reported on the medicaid cost report, as specified in paragraph (B) of this rule.

(6) "Medicare inpatient payments for hospitals exempt from medicare diagnosis related group (DRG) payments and medicare inpatient payments for subproviders" means the inpatient payment amount as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(7) "Medicare inpatient DRG payments" means the DRG payment amount as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(8) "Medicare inpatient outlier payments" means the outlier payment amount as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(9) "Medicare inpatient indirect medical education" means the indirect medical education adjustment amount as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(10) "Medicare inpatient disproportionate share payments" means the inpatient disproportionate share adjustment amount as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(11) "Medicare inpatient hospital capital payments" means the payment for inpatient program capital as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(12) "Medicare inpatient direct medical education" means the direct graduate medical education payment amount as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(13) "Medicare inpatient hospital payments - other" means the sum of net organ acquisition cost, cost of teaching physicians, routine service other pass through costs, and ancillary service other

pass through costs, as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(14) "Total medicare inpatient charges" means the amount of inpatient charges for each hospital and subprovider, as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(15) "Total medicaid days" means for each private hospital the number of days reported from the facility for medicaid fee-for-service patients, as reported on the medicaid cost report, as specified in paragraph (B) of this rule.

(16) "Program year" means the twelve month period beginning on the first day of January and ending on the thirty first day of December.

(B) Source data for calculations.

Unless otherwise specified, the calculations described in this rule will be based on cost reporting data described in rule 5101:3-2-23 of the Administrative Code that reflects the most recent completed interim settled medicaid cost report for the hospitals, and the medicare cost report for the corresponding cost reporting period.

(C) Calculation of available inpatient payment gap for private hospitals and private children's hospitals as defined in rule 5101:3-2-53.

(1) Calculation of available inpatient payment gap for private and private children's hospitals that are not free-standing private psychiatric hospitals.

(a) For each private and private children's hospital, calculate the total medicare inpatient payment by adding the amounts described in paragraphs (A)(6) to (A)(13) of this rule.

(b) For each private and private children's hospital, calculate the medicare payment-to-charge ratio by dividing the amount calculated in paragraph (C)(1)(a) of this rule by the total medicare inpatient charges as described in paragraph (A)(14) of this rule.

(c) For each private and private children's hospital, calculate the total estimated medicare inpatient payment for medicaid inpatient discharges by multiplying the amount calculated in paragraph (C)(1)(b) of this rule by the total medicaid inpatient charges as described in paragraph (A)(5) of this rule.

(d) For each private and private children's hospital, calculate the available inpatient payment gap by taking total estimated medicare inpatient payments for medicaid inpatient discharges as calculated in paragraph (C)(1)(c) of this rule and subtracting actual total medicaid inpatient payments as described in paragraph (A)(3) of this rule.

(e) For each private and private children's hospital that has an available inpatient payment gap greater than zero resulting from the calculations in paragraph (C)(1)(d) of this rule, calculate the available per discharge supplemental inpatient hospital payment amount by dividing the amount in paragraph (C)(1)(d) of this rule by the amount in paragraph (A)(4) of this rule.

(2) Calculation of available inpatient payment gap for freestanding private psychiatric hospitals (PPH) subject to medicaid prospective payment as described in rule 5101:3-2-07.8 of the Administrative Code and excluded from prospective payment under medicare, 42 C.F.R. 412.23(a) in effect as of October 1, 2003.

(a) For each PPH described in this paragraph, "medicaid inpatient costs" means medicaid inpatient costs as reported on the medicaid cost report, as specified in paragraph (B) of this rule.

(b) For each PPH described in this paragraph, "medicaid inpatient payments" means medicaid inpatient payments as reported on the medicaid cost report, as specified in paragraph (B) of this rule.

(c) For each PPH described in this paragraph, "medicaid discharges" means medicaid discharges as reported on the medicaid cost report, as specified in paragraph (B) of this rule.

(d) For each PPH described in this paragraph, calculate the available inpatient payment gap by subtracting the amount in paragraph (C)(2)(b) of this rule from the amount in paragraph (C)(2)(a) of this rule.

(e) For each PPH described in this paragraph that has an available inpatient payment gap greater than zero resulting from the calculations in paragraph(C)(2)(d) of this rule, calculate the available per discharge supplemental inpatient hospital payment amount by dividing the amount in paragraph (C)(2)(d) of this rule by the amount in paragraph (C)(2)(c) of this rule.

(3) For all private and private children's hospitals, sum the amounts calculated in paragraphs (C)(1)(d) and (C)(2)(d) of this rule. This is the aggregate inpatient upper limit for all private and private children's hospitals.

(4) The available inpatient gap for private and private children's hospitals calculated in paragraphs (C)(1)(a) to (C)(2)(e) of this rule is the same as the inpatient gap calculated in paragraphs (C)(1)(a) to (C)(2)(e) of rule 5101:3-2-53 of the Ohio Administrative Code. The total available inpatient gap for private and private children's hospitals is the amount described in paragraph (C)(3) of this rule.

(D) For each supplemental payment made after the effective date of this rule, the resulting upper payment limit calculated in paragraph (C) of this rule will be in effect from the first day of January through the thirty-first day of December for each supplemental payment program year.

(E) Payment of supplemental inpatient hospital upper limit payments to private hospitals.

Supplemental inpatient hospital upper limit payments to private hospitals shall be made as follows:

(1) In July of each year after the effective date of the medicaid state plan amendment implementing this payment program, the department will calculate for each eligible private hospital a supplemental inpatient hospital payment amount by multiplying the ratio of each private hospital's total medicaid fee-for-service days derived from actual medicaid inpatient discharges paid for through the department's medicaid management information system (MMIS) in the state fiscal year that ends prior to the month of payment, to the total medicaid fee-for-service days from all private hospitals derived from actual inpatient discharges paid for through the department's MMIS in the state fiscal year that ends prior to the month of payment, but not earlier than the effective date of the state plan amendment, by the aggregate upper payment limit for all private and private children's hospitals calculated each supplemental inpatient upper limit payment program year as described in paragraph (C) of this rule less the amounts expended for the private children's hospitals in rule 5101:3-2-53 of the Administrative Code for the same payment period.

(2) If the total of the funds that will be paid to all private hospitals exceeds the aggregate upper payment limit for all private hospitals calculated each supplemental inpatient upper limit payment program year as described in paragraph (C) of this rule, then the amount paid to each private hospital will be limited to each hospital's proportion of the aggregate upper payment limit.

(3) For each fiscal year the supplemental upper limit payment for private hospitals paid under this rule and private children's hospitals paid under 5101:3-2-53 of the Administrative Code will not exceed the limits specified in 42 C.F.R 447.272.

(F) All medicaid payments including payments made under this rule are subject to the limitations described in rule 5101:3-2-24 of the Administrative Code.

(G) The total funds that will be paid to each private hospital will be included in the calculation of disproportionate share limits as described in rules 5101:3-2-07.5 and 5101:3-2-10 of the Administrative Code.

Effective: 04/08/2010

R.C. 119.032 review dates: 04/01/2015

Certification: CERTIFIED ELECTRONICALLY

Date: 03/29/2010

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.021, Section 309.30.17 of Am. Sub. H.B. 1 of the 128th G.A.

5160-2-53 Supplemental Inpatient Hospital Payments for Children's Hospitals

Formerly **5101:3-2-53 Supplemental Inpatient Hospital Payments for Children's Hospitals**

HHTL 3352-10-04

Effective Date: April 8, 2010

Most Current Prior Effective Date: **April 18, 2008**

This rule sets forth the methodology used to determine the supplemental inpatient hospital payments to children's hospitals required by Section ~~309.30.13~~ 309.30.15 of Amended Substitute House Bill ~~119~~ 1 of the ~~127th~~ 128th General Assembly.

(A) Definitions.

(1) "Childrens hospital", for the purpose of this rule, means an Ohio hospital as defined in section 3702.51 of the Revised Code that is owned and operated by a private entity and is subject to prospective payment as described in rule 5101:3-2-07.1 of the Administrative Code.

(2) "Private hospital" means an Ohio hospital other than as defined in rules 5101:3-2-50 and 5101:3-2-51 of the Administrative Code.

(3) "Available inpatient payment gap" means the difference between what is estimated using the methodology described in paragraphs (C) and (D) of this rule that medicare would have paid for medicaid consumers and actual medicaid payments made in accordance with Chapter 5101:3-2 of the Administrative Code.

(4) "Total medicaid inpatient payments" for each hospital means the amount paid by the medicaid program for services rendered to eligible medicaid patients, excluding supplemental payments, as reported on the medicaid cost report, as specified in paragraph (B) of this rule.

(5) "Total medicaid inpatient discharges" means for each hospital the number of discharges from the facility for medicaid patients, as reported on the medicaid cost report, as specified in paragraph (B) of this rule.

(6) "Total medicaid inpatient charges" means for each hospital the charges for covered medicaid inpatient services rendered, as reported on the medicaid cost report, as specified in paragraph (B) of this rule.

(7) "Medicare inpatient payments for hospitals exempt from medicare ~~diagnostic~~ diagnosis related ~~groups~~group (DRG) payments and medicare inpatient payments for subproviders" means the inpatient payment amount as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(8) "Medicare inpatient DRG payments" means the DRG payment amount as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(9) "Medicare inpatient outlier payments" means the outlier payment amount as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(10) "Medicare inpatient indirect medical education" means the indirect medical education adjustment amount as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(11) "Medicare inpatient disproportionate share payments" means the inpatient disproportionate share adjustment amount as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(12) "Medicare inpatient hospital capital payments" means~~"~~ the payment for inpatient program capital as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(13) "Medicare inpatient direct medical education" means the direct graduate medical education payment amount as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(14) "Medicare inpatient hospital payments - other" means the sum of net organ acquisition cost, cost of teaching physicians, routine service other pass through costs, and ancillary service other pass through costs, as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(15) "Total medicare inpatient charges" means the amount of inpatient charges for each hospital and subprovider, as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(16) "Total medicaid days" means for each children's hospital the number of days reported from the facility for medicaid fee-for-service patients, as reported on the medicaid cost report, as specified in paragraph (B) of this rule.

(17) "Program year" means the twelve-month period beginning on the first day of January and ending on the thirty-first day of December.

(18) "Medicaid inpatient cost-to-charge ratio" means the historic medicaid inpatient cost-to-charge ratio applicable to a hospital as described in paragraph (B)(2) of rule 5101:3-2-22 of the Administrative Code.

(B) Source data for calculations.

Unless otherwise specified, the calculations described in this rule will be based on cost reporting data described in rule 5101:3-2-23 of the Administrative Code that reflects the most recent completed interim settled medicaid cost report for all hospitals, and the medicare cost report for the corresponding cost reporting period.

(C) Calculation of available inpatient payment gap for private hospitals.

(1) Calculation of available inpatient payment gap for private hospitals that are not free-standing psychiatric hospitals.

(a) For each private hospital, calculate the total medicare inpatient payment by adding the amounts described in paragraphs (A)(7) to (A)(14) of this rule.

(b) For each private hospital, calculate the medicare payment-to-charge ratio by dividing the amount calculated in paragraph (C)(1)(a) of this rule by the total medicare inpatient charges as described in paragraph (A)(15) of this rule.

(c) For each private hospital, calculate the total estimated medicare inpatient payment for medicaid inpatient discharges by multiplying the amount calculated in paragraph (C)(1)(b) of this rule by the total medicaid inpatient charges as described in paragraph (A)(6) of this rule.

(d) For each private hospital, calculate the available inpatient payment gap by taking total estimated medicare inpatient payments for medicaid inpatient discharges as calculated in paragraph (C)(1)(c) of this rule and subtracting actual total medicaid inpatient payments as described in paragraph (A)(4) of this rule.

(e) For each private hospital that has an available inpatient payment gap greater than zero resulting from the calculations in paragraph (C)(1)(d) of this rule, calculate the available per discharge supplemental inpatient hospital payment amount by dividing the amount in paragraph (C)(1)(d) of this rule by the amount in paragraph (A)(5) of this rule.

(2) Calculation of available inpatient payment gap for private psychiatric hospitals (PPH) subject to medicaid prospective payment as described in rule 5101:3-2-07.8 of the Administrative Code and excluded from prospective payment under medicare, 42 C.F.R. 412.23(a) in effect as of October 1, 2003.

(a) For each PPH described in this paragraph, "medicaid inpatient costs" means medicaid inpatient costs as reported on the medicaid cost report, as specified in paragraph (B) of this rule.

(b) For each PPH described in this paragraph, "medicaid inpatient payments" means medicaid inpatient payments as reported on the medicaid cost report, as specified in paragraph (B) of this rule.

(c) For each PPH described in this paragraph, "medicaid discharges" means medicaid discharges as reported on the medicaid cost report, as specified in paragraph (B) of this rule.

(d) For each PPH described in this paragraph, calculate the available inpatient payment gap by subtracting the amount in paragraph (C)(2)(b) of this rule from the amount in paragraph (C)(2)(a) of this rule.

(e) For each PPH described in this paragraph that has an available inpatient payment gap greater than zero resulting from the calculations in paragraph(C)(2)(d) of this rule, calculate the available per discharge supplemental inpatient hospital payment amount by dividing the amount in paragraph (C)(2)(d) of this rule by the amount in paragraph (C)(2)(c) of this rule.

(3) For all private hospitals, sum the amounts calculated in paragraphs (C)(1)(d) and (C)(2)(d) of this rule. This is the aggregate inpatient upper limit for all private hospitals.

~~(1) For each private hospital, calculate the total medicare inpatient payment by adding the amounts described in paragraphs (A)(7) to (A)(14) of this rule.~~

~~(2) For each private hospital, calculate the medicare payment-to-charge ratio by dividing the amount calculated in paragraph (C)(1) of this rule by the total medicare inpatient charges as described in paragraph (A)(15) of this rule.~~

~~(3) For each private hospital, calculate the total estimated medicare inpatient payment for medicaid inpatient discharges by multiplying the amount calculated in paragraph (C)(2) of this rule by the total medicaid inpatient charges as described in paragraph (A)(6) of this rule.~~

~~(4) For each private hospital, calculate the available inpatient payment gap by taking total estimated medicare inpatient payments for medicaid inpatient discharges as calculated in paragraph (C)(3) of this rule and subtracting actual total medicaid inpatient payments as described in paragraph (A)(4) of this rule.~~

~~(5) For all private hospitals, sum the amounts calculated in paragraph (C)(3) of this rule. This is the aggregate inpatient upper limit for all private hospitals.~~

~~(6) For all private hospitals, the sum of the amounts calculated in paragraph (C)(4) of this rule, is the aggregate inpatient upper limit payment gap for all private hospitals~~

(D) For each supplemental payment made after the effective date of this rule, the resulting upper payment limit calculated in paragraph (C) of this rule will be in effect from the first day of January through the thirty-first day of December for each supplemental payment program year.

(E) Notwithstanding paragraph (C)(5) of rule 5101:3-2-07.9 of the Administrative Code and except as provided in paragraph (F) of this rule, the director of the Ohio department of job and family services (ODJFS) shall pay a children's hospital that meets the criteria in paragraphs (E)(1) and (E)(2) of rule 5101:3-2-07.9 of the Administrative Code, for each cost outlier claim made in fiscal years ~~2008 and 2009~~ 2010 and 2011, an amount that is the product of the hospital's allowable charges and the hospital's medicaid inpatient cost-to-charge ratio. These payments shall be made as supplemental inpatient outlier payments as follows:

(1) In July of each year after the effective date of the medicaid state plan amendment implementing this payment program, the director shall calculate for each eligible children's hospital the difference between the total amount the director would have paid according to the methodology in paragraph (E) of this rule for such claims for services incurred during the prior state fiscal year using the same cost-to-charge ratio as the ratio used to calculate cost outlier payments in accordance with rule 5101:3-2-07.9 of the Administrative Code for services incurred during that time period and the total amount the director paid according to the methodology in paragraph

(A)(6) or (C)(5) of rule 5101:3-2-07.9 of the Administrative Code, as the applicable paragraph existed on June 30, 2007, for such claims as reflected in actual medicaid inpatient claims paid through the department's medicaid management information system (MMIS) in the prior state fiscal year.

(2) If the sum of the amounts calculated in paragraph (E)(1) of this rule for all eligible children's hospitals is less than or equal to the available amount for each fiscal year as provided in Section ~~309.30.13~~ 309.30.15 of Amended Substitute House Bill ~~119~~ 1 of the ~~127th~~ 128th General Assembly, then the supplemental inpatient outlier payment for each children's hospital shall be the amount calculated in paragraph (E)(1) of this rule. Otherwise, the supplemental inpatient outlier payment for each children's hospital shall be the amount calculated in paragraph (F) of this rule.

(F) The director shall cease paying a children's hospital for a cost outlier claim under the methodology in paragraph (E) of this rule and revert to paying the hospital for such a claim according to methodology in paragraph (A)(6) or (C)(5) of rule 5101:3-2-07.9 of the Administrative Code, as applicable, when the difference between the total amount the director would pay according to the methodology in paragraph (E) of this rule for such claims and the total amount the director paid according to the methodology in paragraph (A)(6) or (C)(5) of rule 5101:3-2-07.9 of the Administrative Code, as the applicable paragraph existed on June 30, 2007, for such claims, exceeds the available amount for each fiscal year as provided in Section ~~309.30.13~~309.30.15 of Amended Substitute House Bill ~~119~~1 of the ~~127th~~ 128th General Assembly. If the sum of the amounts calculated in paragraph (E)(1) of this rule for all eligible children's hospitals is greater than the available amount for each fiscal year as provided in Section ~~309.30.13~~309.30.15 of Amended Substitute House Bill ~~119~~1 of the ~~127th~~ 128th General Assembly, then the supplemental inpatient outlier payment for each children's hospital shall be the amount calculated as follows:

(1) For each eligible children's hospital, the director shall calculate the ratio equal to the amount described in paragraph (E)(1) of this rule for each children's hospital divided by the sum of the amount described in paragraph (E)(1) of this rule for all children's hospitals. For children's hospitals that did not have an outlier claim paid in that period, this figure shall be zero.

(2) The supplemental inpatient outlier payment for each children's hospital shall be the product of the ratio described in paragraph (F)(1) of this rule multiplied by the available amount for each fiscal year as provided in Section ~~309.30.13~~ 309.30.15 of Amended Substitute House Bill ~~119~~1 of the ~~127th~~ 128th General Assembly.

(G) If the total funds that would be paid to all children's hospitals under paragraph (E) or (F) of this rule exceeds the aggregate inpatient upper limit payment gap for all private hospitals as described in paragraphs (C) and (D) of this rule, then the amount paid to each children's hospital will be the product of the ratio of the amount described in paragraph (F)(1) of this rule multiplied ~~times~~by the aggregate inpatient upper limit payment gap for all private hospitals as described in paragraphs (C) and (D) of this rule.

(H) The director shall make supplemental inpatient hospital upper limit payments to children's hospitals if the difference between the total amount the director has paid according to the methodology in paragraph (E) of this rule for cost outlier claims and the total amount the director would have paid according to the methodology in paragraph (A)(6) or (C)(5) of rule 5101:3-2-07.9 of the Administrative Code for such claims, as the applicable paragraph existed on June 30, 2007, does not require the expenditure of the available amount for each fiscal year as provided in Section ~~309.30.13~~ 309.30.15 of Amended Substitute House Bill ~~119~~1 of the ~~127th~~ 128th General Assembly. If the supplemental outlier payments specified in paragraph (E) of this rule do not require the expenditure of the available amount for each fiscal year as provided in Section ~~309.30.13~~ 309.30.15 of Amended Substitute House Bill ~~119~~ 1 of the ~~127th~~ 128th General Assembly, and are less than the aggregate inpatient upper limit payment gap for all private hospitals as calculated for each supplemental payment program year as described in paragraphs (C) and (D) of this rule then supplemental inpatient hospital upper limit payments to children's hospitals shall be made as follows:

(1) In July of each year after the effective date of the medicaid state plan amendment implementing this payment program, the department will calculate for each eligible children's hospital a supplemental inpatient hospital payment amount by multiplying the ratio of each children's hospitals' total medicaid fee-for-service days derived from actual medicaid inpatient discharges paid for through the department's medicaid management information system (MMIS) in the state fiscal year prior to the month of payment, to the total medicaid fee-for-service days from all children's hospitals derived from actual inpatient discharges paid for through the department's MMIS in the state fiscal year prior to the month of payment, by the difference between the available amount for each fiscal year as provided in Section ~~309.30.13~~ 309.30.15 of Amended Substitute House Bill ~~119~~ 1 of the ~~127th~~ 128th General Assembly minus the supplemental payments made pursuant to paragraph (E) of this rule, subject to the limitation described in paragraph (H)(2) of this rule.

(2) If the total funds that would be paid to all children's hospitals under paragraph (H)(1) exceeds the aggregate upper payment limit gap for all private hospitals as calculated for each supplemental inpatient upper limit payment program year as described in paragraphs (C) and (D) of this rule, then the amount paid to each children's hospital will be limited to its proportion, as determined by the ratios described in paragraph (H)(1) of this rule, of the difference between the aggregate upper payment limit gap minus the supplemental payments made pursuant to paragraph (E) of this rule.

(I) All medicaid payments including payments made under this rule are subject to the limitations described in rule 5101:3-2-24 of the Administrative Code.

(J) The total funds that will be paid to each children's hospital will be included in the calculation of disproportionate share limits as described in rule 5101:3-2-07.5 of the Administrative Code.

Effective: 04/08/2010

R.C. 119.032 review dates: 11/30/2009 and 04/01/2015

Certification: CERTIFIED ELECTRONICALLY

Date: 03/29/2010

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.021, Section 309.30.15 of Am. Sub. H.B. 1 of the 128th G.A.

Prior Effective Dates: 11/24/05, 4/18/08

5160-2-54 Supplemental Outpatient Hospital Upper Limit Payments for Private, Public Non State-Owned, and Public State-Owned Hospitals

Formerly **5101:3-2-54 Supplemental Outpatient Hospital Upper Limit Payments for Private, Public Non State-Owned, and Public State-Owned Hospitals**

HHTL 3352-10-04

Effective Date: April 8, 2010

This rule sets forth the methodology used to determine the supplemental outpatient payments to each class of hospitals required by Section 309.30.17 of Amended Substitute House Bill 1 of the 128th General Assembly.

(A) Definitions

(1) Classification of hospitals: For the purpose of determining upper limit tests for hospitals and making upper limit payments to hospitals, hospitals are grouped into the following three hospital classes, non state-owned public hospitals, state- owned public hospitals and private hospitals.

(2) "Hospital" means an Ohio hospital other than a children's hospital as defined in rule 5101:3-2-53 of the Administrative Code and is subject to prospective payment as described in rule 5101:3-2-07.1 of the Administrative Code.

(3) "Available outpatient payment gap" means the difference between what is estimated using the methodology described in paragraphs (C) of this rule that medicare would have paid for medicaid consumers and actual medicaid payments made in accordance with Chapter 5101:3-2 of the Administrative Code.

(4) "Total medicaid outpatient payments" for each hospital means the amount paid by the medicaid program for services rendered to eligible medicaid patients, excluding supplemental payments, as reported on the medicaid cost report, as specified in paragraph (B) of this rule.

(5) "Total medicaid outpatient visits" means for each hospital the number of outpatient visits to the facility for medicaid patients, as reported on the medicaid cost report, as specified in paragraph (B) of this rule.

(6) "Medicare Outpatient Charges - Critical Access Hospital" - means for each critical access hospital, the amount of outpatient charges, as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(7) "Medicare Outpatient Charges - PPS Hospital" means for each PPS hospital and sub provider, the amount of outpatient charges, as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(8) "Medicare Outpatient Charges - PPS Hospital (Non-PPS Charges)" means for each PPS hospital and sub provider the amount of outpatient non PPS charges, as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(9) "Total medicare outpatient charges" means the sum of paragraphs (A)(6) to (A)(8) of this rule.

(10) "Total medicaid outpatient charges" means for each hospital the charges for covered medicaid outpatient services rendered, as reported on the medicaid cost report, as specified in paragraph (B) of this rule.

(11) "Medicare Outpatient Payments - Critical Access Hospital" - the payment for outpatient hospital services for critical access hospitals as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(12) "Medicare Outpatient Payments - PPS Hospital" - the payment for outpatient hospital services for PPS hospitals as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(13) "Medicare Outpatient Direct MedEd Payments" - the payment for outpatient direct medical education for each PPS hospital as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(14) "Medicare Outpatient Payments - PPS Hospital (Sub provider 1)" - means for each sub provider 1, as reported on the medicare cost report, the amount of outpatient payments, as specified in paragraph (B) of this rule.

(15) "Medicare Outpatient Payments - PPS Hospital (Sub provider 2)" - means for each sub provider 2, the amount of outpatient payments, as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(16) "Total medicare outpatient payments" means the sum of paragraphs (A)(11) to (A)(15) of this rule.

(17) "Program year" means the twelve month period beginning on the first day of January and ending on the thirty first day of December.

(B) Source data for calculations.

Unless otherwise specified, the calculations described in this rule will be based on cost reporting data described in rule 5101:3-2-23 of the Administrative Code that reflects the most recent completed interim settled medicaid cost report for the hospitals, and the medicare cost report for the corresponding cost reporting period.

(C) Calculation of available outpatient payment gap for all hospitals as defined in paragraph (A) (2) of this rule.

(1) For each hospital, calculate the total medicare outpatient payment by taking the amounts described in paragraph (A)(16) of this rule.

(2) For each hospital, calculate the medicare outpatient payment-to-charge ratio by dividing the amount calculated in paragraph (C)(1) of this rule by the total medicare outpatient charges as described in paragraph (A)(9) of this rule.

(3) For each hospital, calculate the total estimated medicare outpatient payment for medicaid outpatient visits by multiplying the amount calculated in paragraph (C)(2) of this rule by the total medicaid outpatient charges as described in paragraph (A)(10) of this rule.

(4) For each hospital, calculate the available outpatient payment gap by taking total estimated medicare outpatient payments for medicaid outpatient visits as calculated in paragraph (C)(3) of this rule and subtracting actual total medicaid outpatient payments as described in paragraph (A)(4) of this rule.

(5) For each hospital that has an available outpatient payment gap greater than zero resulting from the calculations in paragraph (C)(4) of this rule, calculate the available per visit supplemental outpatient hospital payment amount by dividing the amount in paragraph (C)(4) of this rule by the amount in paragraph (A)(5) of this rule.

(6) For all hospitals in each hospital class, sum the amounts calculated in paragraph (C)(4) of this rule. This is the aggregate outpatient upper limit for all hospitals in each hospital class.

(D) For each supplemental payment made after the effective date of this rule, the resulting upper payment limit calculated in paragraph (C) of this rule will be in effect from the first day of January through the thirty-first day of December for each supplemental payment program year.

(E) Payment of supplemental outpatient hospital upper limit payments to hospitals in each hospital class.

Supplemental outpatient hospital upper limit payments to hospitals shall be made as follows:

(1) In July of each year after the effective date of the medicaid state plan amendment implementing this payment program, the department will calculate for each eligible hospital in each hospital class a supplemental outpatient hospital payment amount by multiplying the aggregate outpatient upper limit gap in each hospital class as calculated in (C)(6) by the ratio of each

hospital's total medicaid fee-for-service outpatient visits to the the total number of medicaid fee-for-service outpatient visits for all hospitals in that class derived from actual outpatient visits paid for through the department's medicaid management information system (MMIS) in the state fiscal year that ends prior to the month of payment but not earlier than the effective date of the state plan amendment.

(2) If the total of the funds that will be paid to all hospitals in a class exceeds the aggregate upper payment limit for the class calculated each supplemental outpatient upper limit payment program year as described in paragraph (C) of this rule, then the amount paid to each hospital in the class will be limited to each hospital's proportion of the aggregate upper payment limit for that class.

(3) For each fiscal year the supplemental upper limit payment for private, public non state-owned, and public state-owned hospitals will not exceed the limits specified in 42 C.F.R 447.321.

(F) All medicaid payments including payments made under this rule are subject to the limitations described in rule 5101:3-2-24 of the Administrative Code.

(G) The total funds that will be paid to each hospital will be included in the calculation of disproportionate share limits as described in rules 5101:3-2-07.5 and 5101:3-2-10 of the Administrative Code.

Effective: 04/08/2010

R.C. 119.032 review dates: 04/01/2015

Certification: CERTIFIED ELECTRONICALLY

Date: 03/29/2010

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.021, Section 309.30.17 of Am. Sub. H.B. 1 of the 128th G.A.

5160-2-65 Inpatient Hospital Reimbursement

Formerly **5101:3-2-65 Inpatient Hospital Reimbursement**

HHTL 3352-14-03

Effective Date: March 27, 2014

Most Current Prior Effective Date: **January 1, 2014 (Emergency)**

Effective for dates of discharge on or after July 1, 2013, hospitals defined as eligible providers of hospital services in rule ~~5101:3-2-01~~5160-2-01 of the Administrative Code and not defined in paragraph (A) of this rule are subject to the all patient refined diagnosis related groups (APR-DRG) and prospective payment methodology utilized by the Ohio department of medicaid as described in this rule.

Unless otherwise referenced in this rule, rules ~~5101:3-2-07.1~~5160-2-07.1, ~~5101:3-2-07.3~~5160-2-07.3, ~~5101:3-2-07.4~~5160-2-07.4, ~~5101:3-2-07.8~~5160-2-07.8, ~~5101:3-2-07.9~~5160-2-07.9 and ~~5101:3-2-07.11~~5160-2-07.11 of the Administrative Code apply only to inpatient hospital claims for discharges occurring on or before June 30, 2013.

(A) Excluded hospitals. Services provided by the following institutions are not subject to the APR-DRG reimbursement system:

(1) "Freestanding rehabilitation hospitals" excluded from medicare prospective payment in accordance with 42 CFR 412.23(b) effective October 1, 2003;

(2) "Freestanding long-term hospitals" excluded from medicare prospective payment in accordance with 42 CFR 412.23(e) effective October 1, 2003;

(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) Cancer hospitals as defined in rule ~~5101:3-2-07.2~~5160-2-07.2 of the Administrative Code for discharges on and after July 1, 1992.

(B) Hospital peer groups. For purposes of setting rates and making payments under the APR-DRG prospective payment system, the department classifies all hospitals not defined in paragraph (A) of this rule into one of the mutually exclusive peer groups defined in this paragraph.

(1) Teaching hospitals as defined in rule ~~5101:3-2-07.2~~5160-2-07.2 of the Administrative Code that are located in Ohio.

(2) Teaching hospitals as defined in rule ~~5101:3-2-07.2~~ 5160-2-07.2 of the Administrative Code that are not located in Ohio.

(3) Children's hospitals as defined in rule ~~5101:3-2-07.2~~5160-2-07.2 of the Administrative Code that are located in Ohio.

(4) Children's hospitals as defined in rule ~~5101:3-2-07.2~~5160-2-07.2 of the Administrative Code that are not located in Ohio.

(5) Rural referral center hospitals as defined in rule ~~5101:3-2-07.2~~5160-2-07.2 of the Administrative Code that are located in Ohio.

(6) Metropolitan statistical area (MSA) hospitals as defined in rule ~~5101:3-2-07.2~~5160-2-07.2 of the Administrative Code that are located in Ohio.

(7) Non-MSA hospitals as defined in rule ~~5101:3-2-07.2~~5160-2-07.2 of the Administrative Code that are located in Ohio.

(8) Hospitals that are not located in Ohio that are not classified in paragraph (B)(2) or (B)(4) of this rule.

(C) Classification procedures are as described in rule ~~5101:3-2-07.2~~5160:2-07.2 of the Administrative Code.

(D) DRG/severity of illness assignment.

(1) Each discharge on or after July 1, 2013 is assigned a DRG and one of four severity of illness (SOI) factors based upon the date of discharge.

(2) If a claim submitted by a hospital is deemed ungroupable because it does not contain valid values for one or more of the variables required by the APR-DRG grouper, then the claim will be denied payment by the department.

(E) Payment formula.

(1) The formula used in the APR-DRG prospective payment system effective for dates of discharge on or after July 1, 2013 is as follows: total payment, rounded to the nearest whole penny, equals (a) base payment plus (b) capital allowance plus (c) medical education allowance (if hospital is eligible) plus (d) outlier payment (if applicable) plus (e) other payments for organ transplants where;

(a) Base payment equals the hospital base rate as described in paragraph (H) of this rule multiplied by the corresponding relative weight for the DRG/SOI as described in paragraph (I) of this rule.

(b) Capital allowance equals the per case add-on as described in paragraph (K) of this rule.

(c) Medical education allowance equals the per case add-on, case mix adjusted, as described in paragraph (L) of this rule.

(d) Outlier payment equals the eligible outlier costs multiplied by the outlier payment percentage as described in paragraph (J) of this rule.

(e) Other payments for transplant related services as described in paragraph (M) of this rule.

(F) Payments under the prospective payment system are made on the basis of a prospectively determined rate as provided in this rule. No year-end retrospective adjustment is made for prospective payment except as provided in rule ~~5101:3-2-24~~5160-2-24 of the Administrative Code. Except as provided in rules ~~5101:3-2-24~~5160-2-24, ~~5101:3-2-07.13~~5160-2-07.13, and ~~5101:3-2-42~~5160-2-40 of the Administrative Code, a hospital may keep the difference between its prospective payment rate and costs incurred in furnishing inpatient services and is at risk for costs which exceed the prospective payment amounts.

(G) Sources for inputs in the payment formula.

(1) The dataset used as inputs in the payment formula and determination of relative weights established for discharges on or after July 1, 2013 consists of:

(a) Inpatient hospital claims with dates of discharge from October 1, 2008 through September 30, 2010;

(b) Cost reports submitted by hospitals to the department on its medicaid cost report for the hospital years that end in state fiscal years 2009 (JFS 02930 rev. 4/2009), 2010 (JFS 02930 rev. 4/2010) and 2011 (JFS 02930 rev. 4/2011); and

(c) Inflation factors computed for Ohio by a nationally-recognized research firm that computes similar factors for the medicare program.

(2) The inflation factors were used to apply an inflationary value to the total cost computed for each case inflating it to September 30, 2013.

(H) Computation of hospital base rate.

(1) Except as described in paragraph (H)(4) of this rule, the base rate for each Ohio children's hospital is equal to:

(a) Ninety-nine and five hundredths per cent of the total inflated costs for the cases assigned to a children's hospital divided by the number of cases assigned to the children's hospital; divided by

(b) The peer group case mix score as calculated in paragraph (H)(3) of this rule.

(2) Except as described in paragraph (H)(4) of this rule, the base rate for hospitals in Ohio peer groups other than Ohio children's hospitals is equal to:

(a) Sixty-four and five hundredths per cent of the total inflated costs for the cases assigned to a peer group; divided by the number of cases in the peer group; divided by

(b) The peer group case mix score as calculated in paragraph (H)(3) of this rule.

(c) For dates of service on or after January 1, 2014, the amount will be equal to ninety-five per cent of the amount calculated in paragraph (H)(2)(a) and (H)(2)(b) of this rule.

(3) The peer group case mix score is equal to:

(a) The sum of the relative weight values across all cases assigned to a peer group; divided by

(b) The number of cases in the peer group.

(4) For non-Ohio hospital peer groups, the peer group base rate is equal to the value assigned to the peer group effective January 1, 2013. For dates of service on or after January 1, 2014, the amount will be equal to ninety-five per cent of the base rate in effect on January 1, 2013.

(5) Peer group risk corridors.

Effective for discharges on or after July 1, 2013 and on or before June 30, 2016, the department will apply the following:

(a) If a hospital is in a non-MSA peer group, in the rural referral center peer group, or is in a MSA peer group but has a medicare designation as a critical access hospital, then the hospital's base rate is equal to the greater of:

(i) The peer group base rate; or

(ii) Seventy per cent of the computed costs of the hospital's cases.

(b) If a hospital is in a MSA peer group and is not a medicare designated critical access hospital, then the hospital's base rate is equal to:

(i) The peer group base calculated in paragraph (H)(2) of this rule, if the peer group base rate does not result in more than a three per cent reduction or gain in payments compared to the DRG prospective payment system in effect prior to July 1, 2013; or

(ii) A hospital-specific base rate established to ensure the new peer group base rate does not result in more than a three per cent reduction or gain in payments compared to the prior DRG prospective payment system.

(iii) For discharges on or after July 1, 2014 the risk corridor shall be adjusted to be no more than a five per cent reduction or gain.

(iv) For discharges on or after July 1, 2015 the risk corridor shall be adjusted to be no more than an eight per cent reduction or gain.

(c) If the hospital is in the teaching hospital peer group, then the hospital's base rate is equal to:

(i) The peer group base rate unless it was found that the new peer group base rate would result in a reduction or more than a three per cent gain in payments from the prior DRG prospective payment system; or

(ii) A hospital-specific base rate established to ensure that the new peer group base rate does not result in a reduction or more than a three per cent gain in payments compared to the prior DRG prospective payment system.

(d) If the hospital is in a children's hospital peer group, then the hospital's base rate is equal to:

(i) The hospital base rate calculated in paragraph (H)(1) of this rule, if the base rate does not result in more than a five per cent reduction or gain in payments compared to the prior DRG prospective payment system; or

(ii) A hospital-specific base rate established to ensure the new peer group base rate does not result in more than a five per cent reduction or gain in payments compared to the prior DRG prospective payment system.

(e) If the hospital is a psychiatric hospital owned and operated by the state of Ohio, regardless of peer group, then the hospital's base rate is equal to;

(i) The hospital base rate calculated in paragraph (H)(1) of this rule, if the peer group base rate does not result in a reduction in payments compared to the prior DRG prospective payment system; or

(ii) A hospital-specific base rate established to ensure the new peer group base rate does not result in a reduction.

(I) Computation of relative weights. The relative weight is equal to:

(1) The average inflated cost per case within the DRG/SOI; divided by

(2) The average inflated cost per case across all DRG/SOIs.

(J) Computation of outlier payments.

(1) If a discharge is eligible for an outlier payment, then the payment is equal to ninety-five per cent of the value of eligible outlier costs. For dates of service on or after January 1, 2014, the payment will be equal to ninety per cent of the value of eligible outlier costs.

(2) Eligible outlier costs are equal to the cost of the case minus an outlier threshold.

(a) When discharges are submitted for payment by hospitals, the cost of the case is computed as the product of covered billed charges and a hospital-specific medicaid inpatient cost-to-charge ratio as described in rule ~~5101:3-2-22~~5160-2-22 of the Administrative Code.

(b) The outlier threshold is equal to the base payment as described in paragraph (E)(1)(a) of this rule plus a fixed outlier threshold as described in paragraph (J)(2)(c) of this rule.

(c) The fixed outlier threshold varies and can be either DRG specific or peer group specific. The fixed outlier threshold for neonate and tracheostomy DRGs is forty-two thousand nine hundred dollars. The fixed outlier threshold for DRGs other than neonate and tracheostomy DRGs billed by hospitals in a children's peer group or the teaching peer group is fifty-four thousand four hundred dollars. The fixed outlier threshold for cases other than neonate and tracheostomy billed by hospitals among other peer groups is sixty-eight thousand dollars.

(3) For any claim that qualifies for an outlier payment, the final claim payment shall be limited to the lessor of covered billed charges or the total payment calculated in paragraph (E)(1) of this rule.

(K) Computation of capital payments.

(1) For Ohio hospitals, a capital allowance will be paid as described in rule ~~5101:3-2-07.6~~5160-2-07.6 of the Administrative Code.

(2) For non-Ohio hospitals a capital allowance will be paid as described in rule ~~5101:3-2-07.6~~5160-2-07.6 of the Administrative Code.

(3) Hospitals serving recipients enrolled in a medicaid managed care plan shall be paid a capital allowance that it is determined based on a hospital's medicaid managed care service experience as published by the department. Non-Ohio hospitals shall be paid a capital allowance using the published statewide average managed care capital rate.

(L) Computation of medical education payments.

For Ohio hospitals that have an approved medical education program as defined in rule ~~5101:3-2-07.7~~5160-2-07.7 of the Administrative Code, an education allowance amount is added. The medical education allowance amount is described in rule ~~5101:3-2-07.7~~5160-2-07.7 of the Administrative Code adjusted to ensure payment neutrality for medical education with the adoption of the APR-DRG payment system described in this rule. For dates of service on or after January 1, 2014, the medical education payments for all hospitals except Ohio children's hospitals will be equal to ninety-five per cent of the amount described in this paragraph.

(1) If a hospital had modeled medical education payments that were less than the medical education payments received for the same discharges upon initial payment, then the hospital's medical education allowance was adjusted upward so that, when multiplied by the new relative weights, the payments yielded payment neutrality on the medical education payment component alone.

(2) If a hospital had modeled medical education payments that were more than the medical education payments received for the same discharges upon initial payment, then no adjustment was made to the medical education allowance rate for the hospital.

(M) Other payments for transplant related services.

(1) Reimbursement for all organ transplant services, except for kidney transplants, 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.

(2) Reimbursement for bone marrow transplant and hematopoietic stem cell transplant is contingent upon review and the recommendation by the "Ohio Hematopoietic Stem Cell Transplant Consortium" based on criteria established by Ohio experts in the field of bone marrow transplant and authorization from the department. Reimbursement is further contingent upon:

(a) Membership in the "Ohio Hematopoietic Stem Cell Transplant Consortium"; or

(b) Compliance with the performance standards described in agency 3701 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.

(3) Organ acquisition and transportation costs for heart, heart/lung, liver, pancreas, single/double lung, and liver/small bowel transplant services will be reimbursed at one hundred per cent of billed charges.

(4) For harvesting costs for bone marrow transplant services, the prospective payment amount will be either:

(a) The DRG amount as described in this rule if the donor is a medicaid recipient or if the bone marrow transplant is autologous.

(b) The product of the covered billed charges times the hospital-specific, medicaid inpatient cost-to-charge ratio as described in rule ~~5101:3-2-22~~5160-2-22 of the Administrative Code, if the donor is not a medicaid recipient.

(N) Other payment policies.

(1) In accordance with rule ~~5101:3-2-03~~5160-2-03 of the Administrative Code, no coverage is available for days of inpatient care which occur solely for the provision of rehabilitation services related to a chemical dependency.

(2) A claim for inpatient services qualifies for interim payment on the thirtieth day of a consecutive inpatient stay and at thirty-day intervals thereafter. Under interim payment, hospitals will be paid on a percentage basis of charges. The percentage will represent the hospital-specific medicaid inpatient cost-to-charge ratio as described in rule ~~5101:3-2-22~~5160-2-22 of the Administrative Code. For those hospitals which are not required to file a cost report under the provisions of rule

~~5101:3-2-23~~5160-2-23 of the Administrative Code, the statewide average medicaid inpatient cost-to-charge ratio as described in rule ~~5101:3-2-22~~5160-2-22 of the Administrative Code will be used. Interim payments are made as a credit against final payment of the final discharge bill. Amounts of difference between interim payment made and the prospective payment described in paragraph (A) of this rule for the final discharge will be reconciled when the final discharge bill is processed.

(3) Payments for transfers as defined in rule ~~5101:3-2-02~~5160-2-02 of the Administrative Code are subject to the following provisions. If a hospital paid under the prospective payment system transfers an inpatient to another hospital or receives an inpatient from another hospital and that transfer is appropriate as defined in rule ~~5101:3-2-07.13~~5160-2-07.13 of the Administrative Code, then each hospital is paid a per diem rate for each day of the patient's stay in that hospital, plus capital, medical education and outlier allowances, as applicable, not to exceed, for nonoutlier cases, the final prospective payment rate that would have been paid for the appropriate DRG/SOI as described in paragraph (E) of this rule. When a patient is transferred, the department's payment is based on the DRG/SOI under which the patient was treated at each hospital.

The per diem rate is determined by dividing the product of the hospital's base rate multiplied by the DRG/SOI relative weight as described in this rule by the statewide average length of stay calculated for the specific DRG/SOI into which the case falls.

For inpatient services provided to patients who are discharged, within the same hospital, from an acute care bed and admitted to a bed in a psychiatric unit distinct part, payment will be made based on the DRG representing services provided in the acute care section and the services provided in the psychiatric unit distinct part.

(4) In instances when a recipient's eligibility begins after the date of admission to the hospital or is terminated during the course of a hospitalization, payment will be made on a per diem basis as described in paragraph (N)(3) of this rule plus the allowance for capital, medical education and outliers, as applicable.

(5) Readmissions are defined in rule ~~5101:3-2-02~~5160-2-02 of the Administrative Code. A readmission within one calendar day of discharge, to the same institution, is considered to be one discharge for payment purposes so that one DRG payment is made. If two claims are submitted, the second claim processed will be rejected. In order to receive payment for the entire period of hospitalization, the hospital will need to submit an adjustment claim reflecting services and charges for the entire hospitalization.

(6) In the case of deliveries, the department requires hospitals to submit separate claims based respectively on the mother's individual eligibility and the child's individual eligibility.

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Billing Instructions

Hospital Billing Instructions

Hospital Appendix

JFS 02930 Hospital Cost Report

JFS 02930, Hospital Cost Report State Fiscal Year 2001 Certification By Officer Of Hospital form

SFY 2001 Outpatient Billing Code Allocation

SFY 2001 Inpatient Billing Code Allocation

Hospital Cost Report Schedules and Instructions

JFS 02930, SYF 2001 Medicaid Cost Report, General INSTRUCTIONS

JFS 02930, SCHEDULE A, Reconciliation Of Patient Revenues

INSTRUCTIONS for Schedule A, Miscellaneous Revenues

JFS 02930, SCHEDULE B, Total Facility Cost Distribution

INSTRUCTIONS for Schedule B, Cost Distribution

JFS 02930, SCHEDULES C and C-1, Calculation Of Routine Costs and Discharge Statistics

INSTRUCTIONS for Schedule C, Calculation Of Routine Costs and Discharge Statistics

JFS 02930, SCHEDULE D, Title XIX Cost Calculations

INSTRUCTIONS for Schedule D, Title XIX Cost Calculations

JFS 02930, SCHEDULE D-1, Title V Cost Calculations

INSTRUCTIONS for Schedule D-1, Title V Cost Calculations

JFS 02930, SCHEDULE E, Miscellaneous Cost and Payment Information

INSTRUCTIONS for Schedule E, Utilization Review Costs and Medical Education Costs

JFS 02930, SCHEDULE F, Hospital Care Assurance Uncompensated Care (Sections I,II, and III)

INSTRUCTIONS for Schedule F, Hospital Care Assurance Uncompensated Care (Sections I,II)

JFS 02930, SCHEDULE G, Title XIX Capital Related Cost Reimbursement

INSTRUCTIONS for Schedule G, Title XIX Capital Related Cost Reimbursement

JFS 02930, SCHEDULE H, Settlement Summary

INSTRUCTIONS for Schedule H, Settlement Summary

JFS 02930, SCHEDULE I, Title XIX H.M.O. Cost Calculations

INSTRUCTIONS for Schedule I, Title XIX H.M.O. Cost Calculations

Prospective Data Review 2001 Hospital Care Assurance Program - Final Summary Report

Prospective Data Review 2001 Hospital Care Assurance Program - Final Summary

Relative Weights For Discharges On Or After January 1, 2002

Relative Weights For Discharges On or After January 1, 2002

Medicaid Handbook Transmittal Letters (MHTLs)

MHTL 3334-09-02 (Discontinuing the Disability Medical Assistance (DMA) Program and the Rescission of Ohio Administrative Code (OAC) Rule 5101:3-23-01)

Medicaid Handbook Transmittal Letter (MHTL) No. 3334-09-02 is maintained in the General Information e-book.

Medical Assistance Letters

MAL 569 (Changes to the Medicaid Preferred Drug List Effective October 1, 2010)

Medical Assistance Letter Letter No 569 is maintained in the Pharmacy Services e-book.

MAL 561 (Announcement of Changes to Coverage of Prescription Drugs and Certain Medical Supplies)

Medical Assistance Letter No 561 is maintained in the Pharmacy Services e-book.

MAL 522 (August 14, 2007 - Guidance on the Implementation of Employee Education about False Claims Recovery as provided in MAL 516)

Medical Assistance Letter No 522 is maintained in the General Information e-book.

MAL 516 (November 9, 2006 - Employee Education About False Claims Recovery)

Medical Assistance Letter No 516 is maintained in the General Information e-book.

MAL 473 (September 2, 2004 - Pharmacy Program Initiatives: Clinical Utilization Edits and Preferred Drug List Implementation)

Medical Assistance Letter No 473 is maintained in the Pharmacy Services e-book.

MAL 460 (December 18, 2003 - Consumer Co-Payments for Prescription Medication Requiring Prior Authorization)

Medical Assistance Letter No 460 is maintained in the Pharmacy Services e-book.

MAL 456 (September 15, 2003 - Preferred Drug List (PDL) Information)

Medical Assistance Letter No 456 is maintained in the Pharmacy Services e-book.