TO BE RESCINDED

**5160-2-07.1 Hospital services subject to and excluded from DRG prospective payment.**

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

Effective:

Five Year Review (FYR) Dates: 2/8/2018

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Certification

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Date

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| Promulgated Under: | 119.03 |
| Statutory Authority: | 5164.02 |
| Rule Amplifies: | 5162.03, 5164.02 |
| Prior Effective Dates: | 10-1-84; 7-29-85; 7-3-86; 10-19-87; 7-1-89; 1-1-91; 9-3-91 (Emer.); 11-10-91; 7-1-92; 4-1-93; 8-1-93; 2-1-00; 8-1-02; 6-1-04 |