



## REIMBURSEMENT POLICY STATEMENT OHIO MEDICAID

Policy Name		Policy Number	Effective Date
Inpatient Services – Less Than 24 Hours		PY-0960	03/01/2020
Policy Type			
Medical	Administrative	Pharmacy	<b>REIMBURSEMENT</b>

Reimbursement Policy Statement: Reimbursement Policies prepared by CSMG Co. and its affiliates (including CareSource) are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and 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. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

CSMG Co. and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

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## A. Subject

### Inpatient Services – Less Than 24 Hours

## B. Background

Reimbursement policies are designed to assist you when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and their office staff are encouraged to use self-service channels to verify member's eligibility.

## C. Definitions

- **Inpatient:** Defined by OAC – “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.”
- **Outpatient services:** Defined by OAC – 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. 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 5160-4-01 of the Administrative Code.
- **Inpatient services:** Defined by OAC – Services which are ordinarily furnished in a hospital 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 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.
- **Transfer** - A patient is said to be "transferred" when he or she:
  - Is moved from one eligible hospital's inpatient or outpatient department, as described in rule 5160-2-01 of the Administrative Code, to another eligible hospital's inpatient or outpatient department, including state psychiatric facilities.
  - Is moved from an eligible hospital to the same hospital's distinct part psychiatric unit.
  - Is moved to an eligible hospital from the same hospital's distinct part psychiatric unit.

## D. Policy

- I. For all inpatient services billed to CareSource that do not meet the definition of an inpatient service as defined in this policy will be denied, with the exception of the



exclusions outlined below. Hospitals may resubmit denied claims for the services provided to the patient on the date of admission as an outpatient claim.

- II. Inpatient services are defined as:
  - A. 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.
  - B. Emergency room services are covered as an inpatient service when a patient is admitted from the emergency room.
  - C. Observation services rendered to the member 3 days preceding an inpatient stay should be included in the inpatient stay.
  - D. Exclusions to inpatient services that will be paid as a DRG are:
    - 1. The member dies,
    - 2. The member is transferred to another inpatient unit within the hospital,
    - 3. The member is transferred to another hospital, or
    - 4. The member is transferred to a state psychiatric facility.
  - E. If member leaves “Against Medical Advice” (AMA) **AND** the member does not stay beyond midnight of the day of admission, the inpatient claim will be denied. The claim may be resubmitted as an outpatient.

#### E. Conditions of Coverage

Reimbursement is dependent on, but not limited to, billing based on correct coding guidelines. Prior authorization of the inpatient services is not a guarantee of payment.

#### F. Related Policies/Rules

#### G. Review/Revision History

	DATE	ACTION
<b>Date Issued</b>		
<b>Date Revised</b>		
<b>Date Effective</b>	03/01/2020	
<b>Date Archived</b>	02/02/2021	

#### H. References

1. Hospital Billing Guidelines - [medicaid.ohio.gov](https://medicaid.ohio.gov). (2018, July 1). Retrieved October 3, 2019, from <https://medicaid.ohio.gov>
2. Ohio Administration Code Chapter 5160-2 Hospital Services. (n.d.). Retrieved October 3, 2019, from <http://codes.ohio.gov>
3. Ohio Administration Code Chapter 5160-2 Hospital Services. (n.d.). Retrieved October 3, 2019, from <http://codes.ohio.gov>

**The Reimbursement Policy Statement detailed above has received due consideration as defined in the Reimbursement Policy Statement Policy and is approved.**