Ohio Administrative Code

Rule 5160-2-02 General provisions: hospital services.

Effective: January 1, 2022

For purposes of Chapter 5160-2 of the Administrative Code, the following definitions apply, unless the context clearly indicates otherwise:

(A) "Diagnosis related groups (DRGs)" - A patient classification system that reflects clinically cohesive groupings of services that consume similar amounts of hospital resources in an inpatient setting. The groupings used to assign cases to a DRG for claims payment and the grouping logic used to develop relative weights for DRG's are described in rule 5160-2-65 of the Administrative Code.

(B) "Discharged" - A patient who:

(1) Is formally released from a hospital;

(2) Dies while hospitalized;

(3) Is discharged within the same hospital from an acute care bed and admitted to a bed in an inpatient psychiatric facility or is discharged within the same hospital from a bed in an inpatient psychiatric facility to an acute care bed. Rule 5160-2-65 of the Administrative Code explains the payment methodology for these types of a discharges; or

(4) Signs himself or herself out against medical advice (AMA).

(C) "Enhanced Ambulatory Patient Groups (EAPGs)" - A group of outpatient procedures, encounters, or ancillary services, which reflect similar patient characteristics and resource utilization and which incorporate the use of "International Classification of Diseases" diagnosis codes, current procedural terminology (CPT) code set and healthcare common procedure coding system (HCPCS) procedure codes. .

(D) "Hospital" - has the same meaning as in rule 5160-2-01 of the Administrative Code.

(E) "Inpatient" - A patient who is admitted to a hospital based upon the written orders of a practitioner of physician services as described in paragraph (L) of this rule and whose inpatient stay continues beyond midnight of the day of admission.

(F) "Inpatient psychiatric facility" or "Distinct part psychiatric unit" - A hospital or an unit of a hospital that focuses on the treatment of the behavioral health needs of a patient and is excluded from the medicare inpatient prospective payment system in accordance with 42 C.F.R. 412.25 effective as of October 1, 2020.

(G) "Inpatient services" - Services which are ordinarily furnished in a hospital for the care and treatment of patients. 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 a practitioner of physician services as defined in paragraph (L) of this rule. Emergency room services are covered as an inpatient service when a patient is admitted from the emergency room.

Outpatient services provided within three calendar days prior to the date of admission in hospitals will be covered as inpatient services. This provision applies when the patient recieves all of the services, including emergency room and observation services, at the same hospital. The following exceptions apply:

(1) When a patient's medicaid coverage changes payer sources (fee-for-service or managed care) on the date of the inpatient admission, all outpatient services provided within three calendar days prior to the inpatient admission will be submitted to the payer source responsible for those dates of service. The inpatient claim will be submitted to the payer source in effect on the date of admission.

(2) When a patient is admitted under the inpatient hospital services program (IHSP) benefit plan, all outpatient services provided by either the same hospital or different hospital, prior to the inpatient admission will not be included on the inpatient claim, with the exception of any outpatient services provided on the date of admission which will be included on the inpatient hospital claim if provided at the same facility as the inpatient admission.

(3) When outpatient behavioral health services as described in rule 5160-2-76 of the Administrative Code are provided, any outpatient behavioral health services provided within three calendar days prior to the inpatient admission will be submitted on an outpatient claim.

(H) "Medically necessary services" - Services as defined in rule 5160-1-01 of the Administrative Code.

(I) "Observation services" - Those services furnished in an outpatient hospital setting, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate a patient's condition or determine the need for possible admission to the hospital as an inpatient.

(J) "Outpatient" - A patient who is not admitted as an inpatient 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," the "American Osteopathic Association", or is certified under 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 an inpatient psychiatric facility within the same hospital, to another hospital, or to a state psychiatric facility.

(K) "Outpatient services" - Diagnostic, therapeutic, rehabilitative, or palliative treatment or services furnished by or under the direction of a practitioner of physician services which are furnished to a patient by a hospital. Outpatient services do not include direct-care services provided by a practitioner of physician services as defined in paragraph (L) of this rule.

(L) "Practitioner of physician services" - Are physicians, podiatrists, dentists, clinical nurse specialists, certified nurse-midwives, certified nurse practitioners or physician assistants.

(M) "Principal diagnosis" - The diagnosis established after study to be chiefly responsible for causing the patient's admission to the hospital.

(N) "Readmission" - An admission to the same institution within thirty days of discharge for

hospitals paid under the Ohio department of medicaid's prospective payment system, as described in rule 5160-2-65 of the Administrative Code.

(O) "Transfer" - A patient who:

(1) Is moved from one eligible hospital's, inpatient or outpatient department to another eligible hospital's inpatient or outpatient department, including state psychiatric facilities;

(2) Is moved from an eligible hospital to the same hospital's inpatient psychiatric facility; or

(3) Is moved to an eligible hospital from the same hospital's inpatient psychiatric facility.