Ohio Administrative Code

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

Effective: January 1, 2016

(A) 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 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 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.

Effective for inpatient admissions that begin on or after January 1, 2016, outpatient services, as described in paragraph (B)(4) of this rule, provided within three calendar days prior to the date of admission in hospitals described in rule 5160-2-01 of the Administrative Code, will be covered as inpatient services. This includes emergency room and observation services.

(3) "Outpatient" - A patient who is not an inpatient as defined in paragraph (B) 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," the "American Osteopathic Association" and/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 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 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 5160-4-01 of the Administrative Code.

(5) "Diagnostic related groups (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 5160-2-65 of the Administrative Code. The groupings used to assign cases to a DRG for claims payment are identified in rule 5160-2-65 of the Administrative Code.

(6) "Distinct Part Psychiatric unit " is a distinct part recognized by medicare.

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

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

(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 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.

(c) Is moved to an eligible hospital from the same hospital's distinct part psychiatric unit.

(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.

(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 as described in paragraph (B) (6) of this rule or is discharged within the same hospital, from a bed in a distinct part psychiatric unit to an acute care bed. Rule 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).

(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.