CENTENE Corporation

Payment Policy: Inpatient Only Procedure (Ambetter Only)

Reference Number: MP.PP.018
Product Types: Ambetter
Effective Date: 01/01/2013
Last Review Date: 07/17/2017

Coding Implications

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview

The Centers for Medicare and Medicaid Services (CMS) has determined that certain procedures should only be performed in an inpatient setting and therefore, are not appropriate to be conducted in an outpatient facility setting. According to CMS,

> ***Inpatient only services are generally, but not always, surgical services that require inpatient care because of the nature of the procedure, the typical underlying physical condition of patients who require the service or the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged.***

Inpatient only procedures (IOP) are not payable under the Outpatient Prospective Payment System (OPPS). CMS designates IOP with an OPPS status indicator of "C" in the OPPS Addendum B. For the most current list, see https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html?DLSort=2&DLEntries=10&DLPage=1&DLSortDir=descending

Application

Ambetter Health Plans will reimburse certain procedures currently designated by CMS as *Inpatient Only* procedures as payable when performed in the outpatient setting. The complete procedure code list which may be billed in the outpatient setting is defined in the *Coding and Modifier Information* section below. Any procedure not listed is considered a CMS *Inpatient Only* procedure and is subject to the CMS *Inpatient Only* payment rules.

Reimbursement

Claims Reimbursement Edit

The Health Plan's clinical code auditing software will deny procedures that CMS determines should be performed in an inpatient only setting (with the exception of the excluded codes provided below) when billed in the outpatient setting.

Rationale for Edit

Because of the invasive nature of certain procedures, the need for at least 24 hours of post-operative recovery time or monitoring before a patient can be safely discharged, or the underlying physical condition of the patient requiring surgery, CMS has determined that certain procedures are safest when performed in an inpatient setting.

Coding and Modifier Information

This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2016, American Medical Association. All rights reserved. CPT codes and CPT descriptions are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

The following codes are excluded from the "inpatient only list", are not subject to the Inpatient Only rules and will be reimbursed in an outpatient setting. Procedures removed from the "inpatient only" list may be appropriately furnished in either the inpatient or outpatient settings and such procedures continue to be payable when furnished in the inpatient setting.

CPT/HCPCS Code	Descriptor
22855	Remove spine fixation device
00192	Anesth facial bone surgery
00670	Anesth spine cord surgery
00846	Anesth hysterectomy
00944	Anesth vaginal hysterectomy
01214	Anesth hip arthroplasty
11005	Debride abdom wall
15757	Free skin flap microvasc
19260	Removal of chest wall lesion
19307	Mast mod rad
19361	Breast reconstr w/lat flap
21343	Open tx dprsd front sinus fx
21365	Opn tx complx malar fx
21422	Treat mouth roof fracture
21620	Partial removal of sternum – THIS COULD BE WOUND CLOSURE, SOFT TISSUE, DEBRIDEMENT ONLY
21899	Neck/chest surgery procedure
22600	Neck spine fusion
22630	Lumbar spine fusion
22633	Lumbar spine fusion combined
22818	Kyphectomy 1-2 segments
22846	Insert spine fixation device
22852	Remove spine fixation device
22855	Remove spine fixation device
22856	Cerv artific diskectomy
23472	Reconstruct shoulder joint
24999	Upper arm/elbow surgery

CPT/HCPCS Code	Descriptor
26989	Hand/finger surgery
27036	Excision of hip joint/muscle
27075	Resect hip tumor
27130	Total hip arthroplasty
27134	Revise hip joint replacement
27170	Repair/graft femur head/neck
27222	Treat hip socket fracture
27447	Total knee arthroplasty
27470	Repair of thigh
27472	Repair/graft of thigh
27486	Revise/replace knee joint
27514	Treatment of thigh fracture
27535	Treat knee fracture
27536	Treat knee fracture
27599	Leg surgery procedure
27703	Reconstruction ankle joint
27724	Repair/graft of tibia
29999	Arthroscopy of joint
30999	Nasal surgery procedure
33477	Implant tcat pulm vlv perq
33967	Insert i-aort 3recut device
35301	Rechanneling of artery
37182	Insert hepatic shunt (tips)
37215	Transcath stent cca w/eps
37618	Ligation of extremity artery
37799	Vascular surgery procedure
38724	Removal of lymph nodes neck
39220	Resect mediastinal tumor
42426	Excise parotid gland/lesion
43279	Lap myotomy heller
43282	Lap paraesoph her rpr w/mesh
43283	Lap esoph lengthening
43774	Lap rmvl gastr adj all parts
44005	Freeing of bowel adhesion
44055	Correct malrotation of bowel
44110	Excise intestine lesion(s)
44188	Lap colostomy
44204	Laparo partial colectomy
44602	Suture small intestine
44799	Unlisted px small intestine

CPT/HCPCS Code	Descriptor
44800	Excision of bowel pouch
44960	Appendectomy
44970	Laparoscopy appendectomy
45400	Laparoscopic proc
46999	Anus surgery procedure
47100	Wedge biopsy of liver
47120	Partial removal of liver
47379	Laparoscope procedure liver
47380	Open ablate liver tumor rf
47600	Removal of gallbladder
48510	Drain pancreatic pseudocyst
49203	Exc abd tum 5 cm or less
49204	Exc abd tum over 5 cm
49255	Removal of omentum
49329	Laparo proc abdm/per/oment
49659	Laparo proc hernia repair
50040	Drainage of kidney
50060	Removal of kidney stone
50405	Revision of kidney/ureter
50545	Laparo radical nephrectomy
51840	Attach bladder/urethra
51900	Repair bladder/vagina lesion
53415	Reconstruction of urethra
54430	Revision of penis
55866	Laparo radical prostatectomy
57280	Suspension of vagina
57308	Fistula repair transperine
58140	Myomectomy abdom method
58150	Total hysterectomy
58180	Partial hysterectomy
58267	Vag hyst w/urinary repair
58548	Lap radical hyst
58700	Removal of fallopian tube
58720	Removal of ovary/tube(s)
58740	Adhesiolysis tube ovary
58750	Repair oviduct
58952	Resect ovarian malignancy
59120	Treat ectopic pregnancy
60271	Removal of thyroid
60505	Explore parathyroid glands

CPT/HCPCS Code	Descriptor
60650	Laparoscopy adrenalectomy
61500	Removal of skull lesion
61624	Transcath occlusion cns
62223	Establish brain cavity shunt
63048	Remove spinal lamina add-on
63057	Decompress spine cord add-on
63081	Remove vert body dcmprn crvl
63082	Remove vertebral body add-on
63267	Excise intrspinl lesion lmbr
63707	Repair spinal fluid leakage
63709	Repair spinal fluid leakage
64760	Incision of vagus nerve
64911	Neurorraphy w/vein autograft
64999	Nervous system surgery
66999	Eye surgery procedure
75952	Endovasc repair abdom aorta
G0341	Percutaneous islet celltrans
G0343	Laparotomy islet cell transp

Procedure Codes Which Will Be Denied When Billed in an Outpatient Setting

Please see the following link for inpatient only procedures which are not allowed in an outpatient setting: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html?DLSort=2&DLEntries=10&DLPage=1&DLSortDir=descending

References

1. *Current Procedural Terminology (CPT®)*, 2016
2. *Centers for Medicare and Medicaid Services*, CMS Manual System and other CMS publications and services

3. Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services – https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html.

Revision History	
03/14/2017	Created an Ambetter specific version of the Inpatient Only policy which excludes a list of codes.
05/31/2017	Corrected formatting and revised code list.
07/17/2017	Removed Duplicate Codes
07/19/2017	Fixed the link in Reimbursement section, added clarifying language to coding section to adequately describe the list of codes excluded from "inpatient only" rules.

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.

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