INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Outpatient Hospital and Ambulatory Surgical Center Services

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Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of April 1, 2016 Published: September 20, 2016	Semiannual update: • Clarified information in the *Rate Reduction* section • Added information regarding *from* and *through* dates and inpatient stays less than 24 hours to the *Outpatient Service within Three Days of an Inpatient Stay* section • Clarified, reorganized, and expanded information in the *Treatment Room Visits* section, including: – Specified that multiple visits on the same day are reimbursable only if for different types of treatment rooms – Identified infusions as stand-alone services, billed separately from the treatment room rate – Added information about orthotic and prosthetic codes reimbursed separately • Updated revenue codes in *Table 1 – Revenue Codes for Treatment Room Services*, *Table 2 – Revenue Codes for Add-On Services*, and *Table 3 – Revenue Codes for Stand-Alone Services* • Updated revenue code descriptions throughout the document	FSSA and HPE

Version	Date	Reason for Revisions	Completed By
1.2	Policies and procedures as of April 1, 2016 (*Core*MMIS updates as of February 13, 2017) Published: April 25, 2017	• Changed Web interChange references to Provider Healthcare Portal (Portal) • Added Portal options to the billing instructions • Added information about revenue codes in the *Introduction* section • Updated the *Reimbursement for Outpatient Hospital and ASC Services* section • Updated the *Rate Reduction* section • Updated the *Outpatient Surgeries* section • Updated the policies and billing guidelines in the *Treatment Room Visits* section	FSSA and HPE

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Outpatient Hospital and Ambulatory Surgical Center Services

Note:	*For policy information regarding coverage of outpatient hospital and ambulatory surgical center services, see the Medical Policy Manual at indianamedicaid.com.*

Introduction

Outpatient services are services provided in an acute care hospital, a psychiatric hospital, an ambulatory surgical center (ASC), or similar facility to individuals who are not registered as inpatients. Outpatient services include surgery, therapy, laboratory, radiology, chemotherapy, renal dialysis, clinic, treatment room, and emergency department care. The Indiana Health Coverage Programs (IHCP) covers outpatient services when such services are provided or prescribed by a physician, and when the services are medically necessary for the diagnosis or treatment of the member's condition. The member's medical condition, as described and documented in the medical record by the primary or attending physician, must justify the intensity of service provided.

This module contains general billing and reimbursement information for outpatient hospital and ASC services, as well as information specific to each of the four categories of service defined within the IHCP outpatient hospital prospective payment system:

- Outpatient surgeries
- Treatment room visits
- Add-on services
- Stand-alone services

For additional information about emergency room services, see also the *Emergency Services* module. For information about birthing centers, see the *Obstetrical and Gynecological Services* module. For information about comprehensive outpatient rehabilitation facility (CORF) services, see the *Therapy Services* module.

Revenue Codes on the *Code Sets* page at indianamedicaid.com provides a list of all revenue codes covered by the IHCP, as well as outpatient payment information for relevant codes.

Note:	*The IHCP developed the coverage policies, reimbursement policies, and billing requirements of the outpatient prospective payment system. The IHCP does not intend for these policies and requirements to mirror the policies and procedures of the Medicare program.*

Reimbursement for Outpatient Hospital and ASC Services

Outpatient pricing calculates a flat rate for emergency department treatment rooms and nonemergency department treatment rooms. Additionally, certain outpatient services are billed as add-ons and others are billed as stand-alone services.

Providers are reimbursed the lesser of their submitted charges or the Medicaid-allowed amount for all hospital services, except when the Hospital Assessment Fee (HAF) hospital adjustment factor has been applied. See the *Hospital Assessment Fee* module for more information.

Rate Reduction

Effective for dates of service from January 1, 2014, through June 30, 2017, the IHCP implemented a 3% reduction in reimbursement for inpatient and outpatient hospital services. The rate reduction is not applicable for state-operated psychiatric hospitals. Disproportionate share hospital (DSH) payments are not subject to the reimbursement reduction. The allowed amount for each detail line of outpatient and outpatient crossover claims is calculated using the current reimbursement methodology.

For HAF-participating hospitals, the 3% rate reduction applies only to clinical laboratory services. The allowed amount for each detail line of outpatient and outpatient crossover claims (excluding clinical laboratory services) is calculated using the current reimbursement methodology multiplied by the outpatient hospital adjustment factor of 2.7 %. Third-party liability (TPL) is subtracted from the total allowed amount of the claim. The hospital adjustment factors and corresponding dates are listed in the *Hospital Assessment Fee* module.

Coverage and Billing for Outpatient Services

IHCP fee-for-service outpatient claims can be submitted on the paper *UB-04* claim form or electronically, using the Provider Healthcare Portal institutional claim or the 837I transaction. See the *Claim Submission and Processing* module for general billing instructions.

Completed fee-for-service paper claim forms must be mailed to Hewlett Packard Enterprise at the following address for processing:

HPE Outpatient Claims
P.O. Box 7271
Indianapolis, IN 46207-7271

Managed care claims for Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise members must be billed to the appropriate managed care entity (MCE).

Note:	*The IHCP does not cover surgical or other invasive procedures to treat particular medical conditions when the practitioner performs the surgery or invasive procedure erroneously. The IHCP also does not cover services related to these noncovered procedures. All services provided in the operating room when an error occurs, and all related services provided during the same hospitalization in which the error occurred, are not covered. See the Provider Preventable Conditions section in the Surgical Services module for more information.*

Outpatient Service within Three Days of an Inpatient Stay

Outpatient services that occur within three days preceding an inpatient admission to the same facility for the same or related diagnosis are considered part of the corresponding inpatient admission. Providers are required to submit an *inpatient claim only* when the services, outpatient and inpatient, occur at their facility. Inpatient claims billed with outpatient charges for services rendered at the same facility within three days of admission should reflect the *from* and *through* dates of the inpatient stay, not the date the outpatient services were rendered.

> *Note: "Same or related diagnosis" refers to the primary diagnosis code and is based on the first three digits of the ICD code.*

If an outpatient claim is paid before the inpatient claim is submitted, the inpatient claim will be denied with an explanation of benefits (EOB) stating *Outpatient services performed three days prior to inpatient admission.* To resolve this denial, providers should void the outpatient claim in history, incorporate the outpatient services into the inpatient claim, and resubmit the corrected inpatient claim.

If an outpatient claim is submitted after the inpatient claim has been paid, the outpatient claim will be denied with an EOB indicating that the inpatient claim may be adjusted to reflect the outpatient services provided to the patient.

This policy is not applicable when the outpatient and inpatient services are provided by different facilities. Outpatient services provided within three days preceding a less-than-24-hour inpatient stay are billed as an outpatient service.

Inpatient Stays Less than 24 Hours

Providers should bill inpatient stays that are less than 24 hours as an outpatient service. For exceptions to this rule, see the *Inpatient Hospital Services* module for information about inpatient stays that are under 24 hours in duration.

Observation Billing

Observation services (including the use of a bed and periodic monitoring by a hospital's nursing staff) are reimbursable when they are furnished by a hospital on the hospital's premises and they are reasonable and necessary to evaluate the patient's condition or determine the need for possible admission to the hospital as an inpatient.

Providers can retain members for more than one 23-hour observation period when the member has not met criteria for admission but the treating physician believes that allowing the member to leave the facility would likely put the member at serious risk. This observation period can last *not more than three days or 72 hours and is billed as an outpatient claim*.

For all services rendered as outpatient procedures, and prior to admission, providers must bill with a date of service corresponding to the date the procedure was performed in fields 74 and 74a-e of the *UB-04* claim form or in the corresponding fields of the electronic claim.

Outpatient Surgeries

The IHCP reimburses an all-inclusive ASC rate for outpatient surgeries provided in a hospital or an ASC. This rate includes all services related to the surgery. See the *Surgical Services* module for more information about outpatient surgeries.

Treatment Room Visits

For purposes of the IHCP's outpatient prospective payment system, treatment rooms include emergency departments, clinics, cast rooms, labor and delivery rooms, and observation rooms. The IHCP allows multiple treatment room visits, of differing types, on the same day. Overutilization is subject to postpayment review.

The IHCP reimburses *emergency department services* for the treatment of ill and injured patients who require immediate, unscheduled medical or surgical care. The IHCP reimburses *clinic services* for diagnostic, preventative, curative, and rehabilitative services provided to ambulatory patients.

Treatment room services must be billed on the institutional claim (*UB-04* claim form or electronic equivalent) using the appropriate treatment room revenue code. Treatment room revenue codes are listed in Table 1.

Table 1 – Revenue Codes for Treatment Room Services

Revenue Code	Description
45X	Emergency room
483	Echocardiology
51X	Clinic
52X	Freestanding clinic
70X	Cast room
72X	Labor room/delivery
76X	Specialty services

Note: *When surgeries are performed in a treatment room, the appropriate surgical Current Procedural Terminology (CPT®[1]) code should accompany the treatment room revenue code, and reimbursement is based on the ASC methodology. (See the Surgical Services module for details.) Facilities should otherwise not use a surgical CPT code in addition to the treatment room revenue code.*

Under the fee-for-service reimbursement methodology, treatment room services are reimbursed at a flat rate that includes most drugs, injections, and supplies. The following policies and billing guidelines apply:

- Reimbursement for the administration of therapeutic or diagnostic injections, including vaccines, is included in the established rate for the treatment room in which the injection was administered (such as 450 – *Emergency room* or 510 – *Clinic*). Therefore, when providing other services in the treatment room setting, administration of the injection is not separately reimbursable. If, however, a patient receives *only* an injection service and no other service is provided, the provider is instructed to bill only revenue code 260 – *IV therapy – General* along with the administration code for the injection. For additional information about injections, see the *Injections, Vaccines, and Other Physician-Administered Drugs* module.
- The IHCP considers infusions to be a stand-alone service. When infusions are performed in conjunction with other services in a treatment room, providers may bill revenue code 260, along with the infusion administration procedure code, on a separate line from the treatment room revenue code. When performing only an infusion, providers may bill only revenue code 260 along with the administration code for the infusion.

[1] *CPT copyright 2016 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

- The IHCP allows separate reimbursement for specific orthotic and prosthetic codes when rendered in the outpatient setting. For a list of orthotic and prosthetic codes that can be billed with revenue code 274 for separate reimbursement when provided in conjunction with treatment room services, see *Revenue Codes Linked to Specific Procedure Codes* on the *Code Sets* page at indianamedicaid.com.

The IHCP allows certain add-on services, described in the *Add-On Services* section of this document, if they are billed in conjunction with a treatment room visit. All other add-on services are denied if billed in conjunction with a treatment room service.

Providers may bill stand-alone services in conjunction with treatment room services. Stand-alone services include therapies, dialysis, radiology, and laboratory services. See the *Stand-Alone Services* section of this document for details.

Add-On Services

The IHCP reimburses add-on services at a flat, statewide rate when billed with a stand-alone procedure. Table 2 lists revenue codes for add-on services.

Note: Add-on services are not allowed with any surgical revenue codes.

Table 2 – Revenue Codes for Add-On Services

Revenue Code	Description
250	Pharmacy – General
251	Generic drugs
252	Nongeneric drugs
255	Drugs incident to radiology
257	Nonprescription drugs
258	Intravenous (IV) solutions
259	Other pharmacy
270	Medical/surgical supplies and devices – General
271	Nonsterile supply
272	Sterile supply
273	Take-home supplies
275	Pacemaker
276	Intraocular lens (IOL)
277	Oxygen – Take home
278	Other implants
279	Other supplies/devices
290	Durable medical equipment (DME) (other than renal) – General
291	DME – Rental
292	Purchase of new DME
370	Anesthesia – General

Revenue Code	Description
383	Plasma
384	Platelets
386	Blood and blood components – Other components
387	Blood and blood components – Other derivatives (cryoprecipitates)
390	Administration, processing and storage for blood and blood components– General
391	Administration (e.g. transfusions)
621	Supplies incident to radiology
622	Supplies incident to other diagnostic services

Add-on services are separately reimbursable in conjunction with a stand-alone procedure. Certain add-on services are also separately reimbursable if billed in conjunction with a treatment room. These services are as follows:

- 255 – *Drugs incident to radiology*
- 258 – *IV solutions*
- 29X – *DME (other than renal)*
- 370 – *Anesthesia*
- 38X – *Blood and blood components*
- 39X – *Administration, processing and storage for blood and blood components*
- 62X – *Medical/surgical supplies*

All other add-on services are denied if billed in conjunction with a treatment room service. Add-on services are not separately reimbursable if provided on the same day as an outpatient surgery.

Stand-Alone Services

Stand-alone services include therapies, diagnostic testing, dialysis, laboratory services, and radiology procedures performed in an outpatient setting. Providers can bill stand-alone services separately or in conjunction with treatment room services. Stand-alone services are not separately reimbursable with outpatient surgeries if provided on the same day as the surgery.

The IHCP reimburses stand-alone services such as dialysis and physical, occupational, and speech therapies at an established flat statewide rate. Laboratory and radiology services are reimbursed at the lower of the charge submitted on the claim or the Fee Schedule amount. Providers must bill stand-alone services on the institutional claim (*UB-04* claim form or electronic equivalent).

The IHCP allows a maximum of *one unit of service, per revenue code, for each date of service*, except for revenue codes 274, 634, 635, 636, and all laboratory and radiology revenue codes. For revenue codes 274, 634, 635, and 636, and for laboratory and radiology revenue codes, multiple units of service are available for reimbursement. Table 3 lists the revenue codes for stand-alone services.

Table 3 – Revenue Codes for Stand-Alone Services

Revenue Code	Description
260	IV therapy – General
261	IV therapy – Infusion pump
274	Prosthetic/orthotic devices
28X	Oncology
30X	Laboratory
31X	Laboratory pathological
32X	Radiology – Diagnostic
33X	Radiology – Therapeutic and/or chemotherapy administration
34X	Nuclear medicine
35X	Computed tomographic (CT) scan
40X	Other imaging service
410	Respiratory services – General
412	Inhalation services
413	Hyperbaric oxygen therapy
419	Other respiratory services
42X	Physical therapy
43X	Occupational therapy
44X	Speech-language pathology
460	Pulmonary function – General
469	Other pulmonary function
47X	Audiology
480	Cardiology – General
481	Cardiac catheter laboratory
482	Stress test
489	Other cardiology
61X	Magnetic Resonance Technology (MRT)
634	Erythropoietin (EPO), less than 10,000 units
635	EPO, 10,000 units or more
636	Drugs requiring detailed coding
730	Electrocardiogram (EKG/ECG)
731	EKG/ECG – Holter monitor
732	EKG/ECG – Telemetry
739	Other EKG/ECG
740	Electroencephalogram (EEG) – General
750	Gastrointestinal services – General
780	Telemedicine – General

Revenue Code	Description
790	Extracoporeal shockwave therapy – General
820	Hemodialysis outpatient/home – General
821	Hemodialysis outpatient/home – Composite
823	Hemodialysis – Home equipment
825	Hemodialysis – Support services
829	Other outpatient hemodialysis
830	Peritoneal dialysis outpatient/home – General
831	Peritoneal dialysis outpatient/home – Composite
841	Continuous ambulatory peritoneal dialysis (CAPD) outpatient/home – Composite
851	Continuous cycling peritoneal dialysis (CCPD) outpatient/home – Composite
860	Magnetoencephalography (MEG) – General
861	MEG
881	Miscellaneous dialysis – Ultrafiltration
890	Donor bank – General
920	Other diagnostic services – General
921	Peripheral vascular lab
922	Electromyelogram
923	Pap smear
924	Allergy test
925	Pregnancy test
929	Other diagnostic services
940	Other therapeutic services – General
943	Cardiac rehabilitation

Stand-Alone Chemotherapy and Radiation Services

Bill all outpatient hospital chemotherapy and radiation treatment services on the institutional claim (*UB-04* claim form or electronic equivalent).

Chemotherapy services consist of four components: administration of chemotherapy agent, chemotherapy agent, IV solution and equipment, and treatment room services. Each of the four components is separately reimbursable when chemotherapy is administered using the following code combinations:

- **Administration of chemotherapy agent** – Bill using revenue codes 331, 332, or 335. The appropriate CPT chemotherapy codes are 96401 through 96549.
- **Chemotherapy agent** – Bill using revenue code 636 – *Drugs requiring detailed coding*, along with the appropriate Healthcare Common Procedure Coding System (HCPCS) code.
- **IV solution and equipment** – Bill using revenue code 258 for the IV solution and revenue code 261 for IV equipment.
- **Treatment room services** – Bill using revenue codes 45X, 483, 51X, 52X, or 76X.

Radiation treatment services consist of two components: administration of radiation treatment and treatment room services. Both components are separately reimbursable, using the following code combinations:

- **Administration of radiation treatment** – Bill using revenue codes 330, 333, or 339, along with the appropriate CPT radiation treatment code, 77261 through 77799.
- **Treatment room services** – Bill using revenue codes 45X, 483, 51X, 52X, or 76X.

> *Note: When chemotherapy and radiation treatment services are rendered on the same day, bill all applicable components to the IHCP.*