
**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 |
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| 1.0 | Policies and procedures as of October 1, 2015<br>Published: February 25, 2016 | New document | FSSA and HPE |
| 1.1 | Policies and procedures as of April 1, 2016<br>Published: September 20, 2016 | Scheduled update | FSSA and HPE |
| 1.2 | Policies and procedures as of April 1, 2016<br>(*Core*MMIS updates as of February 13, 2017)<br>Published: April 25, 2017 | *Core*MMIS update | FSSA and HPE |
| 2.0 | Policies and procedures as of July 1, 2017<br>Published: September 26, 2017 | Scheduled update:<br>• Edited and reorganized text throughout for clarity<br>• Changed Hewlett Packard Enterprise references to DXC<br>• Updated the *through* date in the *Rate Reduction* section<br>• Updated the *Outpatient Service Within Three Days of an Inpatient Stay* section, including clarifying dates entered on the claim<br>• Updated *Table 1 – Revenue Codes for Treatment Room Services*, including adding revenue code 710<br>• Updated *Table 2 – Revenue Codes for Add-On Services*, including adding revenue code 294<br>• Updated *Table 3 – Revenue Codes for Stand-Alone Services*, including:<br>– Added revenue codes 262, 263, 264, and 530<br>– Removed end-dated codes | FSSA and DXC |

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# Outpatient Hospital and Ambulatory Surgical Center Services

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| *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), a clinic, or other treatment room setting (such as an emergency room) to individuals who are not registered as inpatients. Outpatient services include surgery, therapy, laboratory, radiology, chemotherapy, and renal dialysis.

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.

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| *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 reimbursed separately as add-ons or 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*

For dates of service from January 1, 2014, through June 30, 2019, 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. Third party liability (TPL) is subtracted from the total allowed amount of the claim.

For HAF-participating hospitals, the 3% rate reduction applies only to clinical laboratory services. For all other services performed at a HAF-participating hospital, the allowed amount for each detail line of outpatient and outpatient crossover claims is calculated using the current reimbursement methodology multiplied by the outpatient hospital adjustment factor of 2.7%. 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 DXC Technology at the following address for processing:

**DXC 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).

## *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.

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

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. However, for all services on the inpatient claim, including services rendered as outpatient procedures prior to admission, providers must enter the date that the procedure was actually performed in fields 74 and 74a–e of the *UB-04* claim form (or in the corresponding fields of the electronic claim).

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 in duration as an outpatient service. See the *Inpatient Hospital Services* module for exceptions to this rule.

### *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*.

Observation services rendered as outpatient procedures but occurring within 72 hours of an admission must be billed as an inpatient claim, as described in the *Outpatient Service within Three Days of an Inpatient Stay* section.

## 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.

> *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.*

# Treatment Room Visits

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

The IHCP reimburses *emergency room 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 |
|---|---|
| 450 | Emergency room – General |
| 451 | Emergency room –Emergency Medical Treatment and Labor Act (EMTALA) emergency medical screening services |
| 456 | Emergency room – Urgent care |
| 459 | Other emergency room |
| 483 | Echocardiology |
| 51X | Clinic |
| 520 | Freestanding clinic – General |
| 521 | Clinic visit by member to rural health clinic (RHC)/federally qualified health center (FQHC) |
| 523 | Freestanding clinic – Family practice clinic |
| 529 | Other freestanding clinic |
| 70X | Cast room |
| 710 | Recovery room |
| 720 | Labor room/delivery – General |
| 721 | Labor room/delivery – Labor |
| 724 | Birthing center |
| 760 | Specialty services – General |
| 761 | Treatment room |
| 762 | Observation hours |

*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.*

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

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.

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.

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 procedure code for the administration of 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 procedure code for the administration of the infusion, 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 procedure code for the administration of the infusion.
- The IHCP allows separate reimbursement for specific orthotic and prosthetic devices when provided in conjunction with treatment room services and billed with revenue code 274 – *Orthotic/prosthetic devices*.

For lists of procedure codes that can billed with revenue codes 260 and 274, see *Revenue Codes Linked to Specific Procedure Codes* on the *Code Sets* page at indianamedicaid.com.

# 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.* |
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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 |

| Revenue Code | Description |
|---|---|
| 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 |
| 294* | DME (other than renal) – Supplies/drugs for DME |
| 370* | Anesthesia – General |
| 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 |
| *Note: Revenue codes marked with an asterisk (*) are separately reimbursable if billed in conjunction with a treatment room revenue code.* | |

Add-on services are separately reimbursable in conjunction with a stand-alone procedure. In addition, some add-on services (indicated by an asterisk in Table 2) are also separately reimbursable if billed in conjunction with a treatment room revenue code. 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 |
| 262 | IV therapy/pharmacy services |
| 263 | IV therapy/drug/supply delivery |
| 264 | IV therapy/supplies |
| 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 |
| 41X | Respiratory services |
| 42X | Physical therapy |
| 43X | Occupational therapy |
| 44X | Speech-language pathology |
| 46X | Pulmonary function |
| 47X | Audiology |
| 480 | Cardiology – General |
| 481 | Cardiac catheter laboratory |
| 482 | Stress test |
| 489 | Other cardiology |
| 530 | Osteopathic Services – General |
| 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 |
| 73X | Electrocardiogram (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 |
| 92X | Other diagnostic services |
| 940 | Other therapeutic services – General |
| 943 | Cardiac rehabilitation |

## Stand-Alone Chemotherapy and Radiation Services

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

Chemotherapy services consist of five components that are separately reimbursable when billed as follows:

- **Administration of chemotherapy agent** – Bill using revenue codes 331, 332, or 335, along with the appropriate chemotherapy CPT codes (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** – Bill using revenue code 258.
- **IV equipment** – Bill using revenue code 261.
- **Treatment room services** – Bill using revenue codes 45X, 483, 51X, 52X, or 76X.

Radiation treatment services consist of two components that are separately reimbursable when billed as follows:

- **Administration of radiation treatment** – Bill using revenue codes 330, 333, or 339, along with the appropriate radiation treatment CPT 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.*