Select Health

CODING/REIMBURSEMENT POLICY

OPPS (HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM) AND ASC (AMBULATORY SURGICAL CENTER) SERVICES ONLY COVERED INPATIENT

Policy # CR-84

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Review Dates:
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Disclaimer:
1. Policies are subject to change without notice.
2. Policies outline coverage determinations for Select Health Commercial, Select Health Medicare (CMS), and Select Health Community Care (Medicaid) plans. Refer to the "Policy" section for more information.

Description

Increasingly providers and patients are searching for alternative methods to perform invasive procedures such as total joint replacement of the knee or hip or spinal fusion with instrumentation. In some circumstances these procedures are being offered in an outpatient setting. Though this may appear attractive as it portrayed at reducing costs, several questions related to safety and patient outcomes have not been answered to establish this site of service. Questions also remain as to whether the outcomes of the procedures in this setting are at least as good and as durable as when done in an inpatient setting.

COMMERCIAL PLAN POLICY AND CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)

Select Health covers the following procedures as listed in Appendix A (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html) **only when performed as inpatient procedures. (Select Health allows inpatient anesthesia when billed with outpatient procedures in the outpatient setting).** No place of service edits are applicable when an inpatient-only code is billed in another place of service.

Performance of these procedures in alternative outpatient, office, or ambulatory surgical center settings is considered investigational/experimental, as the safety and efficacy of performing the procedures in these settings is not established.

Those procedures not listed may be covered in either inpatient or outpatient settings.

SELECT HEALTH MEDICARE (CMS)

Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, and InterQual criteria are not available, the Select Health Commercial policy applies. For the most up-to-date Medicare policies and coverage, please visit their search website http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp& or the manual website

SELECT HEALTH COMMUNITY CARE (MEDICAID)

Select Health Community Care policies typically align with State of Utah Medicaid policy, including use of InterQual. There may be situations where NCD/LCD criteria or Select Health

commercial policies are used. For the most up-to-date Medicaid policies and coverage, please visit their website http://health.utah.gov/medicaid/manuals/directory.php or the Utah Medicaid code Look-Up tool

Summary of Medical Information

CMS (Centers for Medicare and Medicaid Services) assigns each CPT procedure code a status indicator to indicate the coverage/non-coverage of the service. Some of these status indicators are used to define services which are only covered when done in an inpatient setting. Services designated with a C5 status indicator in the ASC Fee Schedule or designated with a status C in the OPPS fee schedule are designated as inpatient only procedures.

Status indicator C5 – Inpatient surgical procedure under OPPS; no payment made.

Status indicator C – Inpatient only procedure; procedure not paid under OPPS.

The services identified by these status indicators is also referred to as the inpatient-only list. These services are generally surgical services and there are over 1700 of these codes. Some of the more common services we see are total knee replacements and some fracture repairs. Medicare will not pay for these services when done outside of the inpatient setting. Services included on this list are determined based on several things including the nature of the procedure, the underlying physical condition of the patient, or the need for at least 24 hours of postoperative recovery time or monitoring before the patient can/should be discharged safely.

Sources

1. Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCs Release and Code Sets.
2. Current Procedural Terminology (CPT®), (2016) – American Medical Association.
3. Retrieved from https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1613-FC.html?DLPage=1&DLSort=2&DLSortDir=descending