INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Outpatient Facility Services

LIBRARY REFERENCE NUMBER: PROMOD00041
PUBLISHED: OCTOBER 29, 2020
POLICIES AND PROCEDURES AS OF AUGUST 1, 2020
VERSION: 5.0

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	Scheduled update	FSSA and HPE
1.2	Policies and procedures as of April 1, 2016 (*Core*MMIS updates as of February 13, 2017) Published: April 25, 2017	*Core*MMIS update	FSSA and HPE
2.0	Policies and procedures as of July 1, 2017 Published: September 26, 2017	Scheduled update	FSSA and DXC
3.0	Policies and procedures as of May 1, 2018 Published: July 31, 2018	Scheduled update	FSSA and DXC
4.0	Policies and procedures as of August 1, 2019 Published: October 15, 2019	Scheduled update	FSSA and DXC
5.0	Policies and procedures as of August 1, 2020 Published: October 29, 2020	Scheduled update: • Edited text as needed for clarity • Changed references for revenue code payment information from the *Revenue Codes* code document to the Outpatient Fee Schedule • Added reference to the Outpatient Fee Schedule in the *Introduction* section • In the *Rate Reduction* section, added that the reduction does not apply to UPL payments • Updated the *Billing for Outpatient Facility Services* section • Updated the *Treatment Room Visits* section with billing limit on treatment room revenue code families	FSSA and Gainwell

Table of Contents

> *Note: The information in this module applies to Indiana Health Coverage Programs (IHCP) services provided under the **fee-for-service (FFS)** delivery system. For information about services provided through the **managed care** delivery system – including Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise services – providers must contact the member's managed care entity (MCE) or refer to the MCE provider manual. MCE contact information is included in the IHCP Quick Reference Guide available at in.gov/medicaid/providers.*
>
> *For updates to information in this module, see IHCP Banner Pages and Bulletins at in.gov/medicaid/providers.*

Introduction

Outpatient facility services are services provided by an acute care hospital, a psychiatric hospital, an ambulatory surgical center (ASC), or other treatment room setting (including certain types of clinics[1]) to individuals who are registered as patients with the facility but not admitted as inpatients.

> *Note: If providers not employed by the facility take a tissue sample, blood sample, or specimen and send it to the facility for tests, the service is classified as a **nonpatient** (rather than an **outpatient**) facility service because the patient did not directly receive the service from the facility.*

The Indiana Health Coverage Programs (IHCP) covers outpatient facility 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. To find out if a particular code is covered for outpatient claims, and whether prior authorization is required, see the Outpatient Fee Schedule, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.

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

- Outpatient surgeries
- Treatment room visits
- Add-on services (including certain drugs, supplies, and medical equipment)
- Stand-alone services (including therapy, renal dialysis, laboratory, radiology, and chemotherapy)

For additional information about emergency room services, see the *Emergency Services* module. For information about birthing centers, see the *Obstetrical and Gynecological Services* module. For details about outpatient billing for end-stage renal disease (ESRD) services, *see the Renal Dialysis Services* module.

[1] *Freestanding renal dialysis clinics (provider specialty 300) and birthing centers (provider specialty 088) bill as outpatient facilities. All **other** IHCP-enrolled clinics bill on the professional or dental claim.*

Comprehensive outpatient rehabilitation facilities (CORFs) also bill the IHCP on the professional claim; see the Therapy Services module for details.

> *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 Facility Services

Outpatient facility pricing calculates a flat rate for emergency department treatment rooms and nonemergency department treatment rooms. Additionally, certain outpatient facility services are reimbursed separately as add-ons or as stand-alone services. For a list of revenue codes reimbursed by the IHCP, as well as outpatient payment information for relevant codes, see the Revenue Codes tab of the Outpatient Fee Schedule, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.

The Outpatient Fee Schedule also lists rates for outpatient procedure codes, and includes ASC pricing indicators when applicable. The ASC rates associated with ASC pricing indicators are listed in the ASC Code/Rate table, also accessible from the *IHCP Fee Schedules* page.

Providers are reimbursed the lesser of their submitted charges or the Medicaid-allowed amount for applicable outpatient facility 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, 2021, the IHCP implemented a 3% reduction in reimbursement for inpatient and outpatient hospital services. The allowed amount for each detail line of outpatient and outpatient crossover claims is calculated using the current reimbursement methodology. The reduction is applied at the detail level. Third-party liability (TPL) is subtracted from the total allowed amount of the claim.

The rate reduction is not applicable for state-operated psychiatric hospitals. Additionally, disproportionate share hospital (DSH) payments and upper payment limit (UPL) payments are not subject to the reimbursement reduction.

For outpatient claims from 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. The hospital adjustment factors and corresponding dates are listed in the *Hospital Assessment Fee* module.

Billing for Outpatient Facility Services

IHCP fee-for-service outpatient claims must be submitted on an institutional claim (*UB-04* claim form, IHCP Provider Healthcare Portal institutional claim, or 837I electronic transaction). See the *Claim Submission and Processing* module for general billing instructions.

If submitting the claim on a *UB-04* claim form, see the *IHCP Quick Reference Guide* for the mailing address for fee-for-service outpatient claims.

Outpatient Service within 3 Days before an Inpatient Stay

Outpatient services rendered within 3 days preceding an inpatient admission to the same facility for the same or related diagnosis are considered part of the corresponding inpatient admission.

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

In this situation, the outpatient services will not be reimbursed separately from the inpatient claim:

- If an outpatient claim is submitted for the services and is paid before the inpatient claim is submitted, the inpatient claim will be denied with explanation of benefits (EOB) 6515 – *Inpatient services performed three days after outpatient DOS [date of service]*. 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 EOB6516 – *Outpatient services performed three days prior to inpatient admission*. This EOB indicates that the inpatient claim may be adjusted to reflect the outpatient services provided to the patient.

Inpatient claims billed with outpatient charges for services rendered at the same facility within 3 days before an 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 service-detail fields of the electronic claim).

Providers are required to submit an inpatient claim only when both the outpatient and inpatient services occur at their facility. This policy is not applicable when the outpatient and inpatient services are provided by different facilities.

Outpatient services provided within 3 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 3 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 3 Days before 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, with the exception of certain durable medical equipment (DME) implanted during the surgery. For a list of items that are separately reimbursable for the outpatient surgery, see the *Implantable DME Separately Reimbursable in the Outpatient Setting* table in *Surgical Services Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers. The facility provider should submit claims for these items, and only these items, on the professional claim (*CMS-1500* claim form or electronic equivalent) for separate reimbursement in addition to the institutional claim.

See the *Surgical Services* module for more information about outpatient surgery billing and reimbursement.

> *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 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.

To confirm whether a revenue code is considered a treatment room revenue code, see the Revenue Codes tab on the Outpatient Fee Schedule, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.

> *Note: When surgeries are performed in a treatment room, the appropriate surgical Current Procedural Terminology (CPT®[2]) 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.*

Effective September 25, 2019, the IHCP does not reimburse more than one treatment room revenue code within the same family (see Table 1) billed for the same date of service and by the same provider, on the same or different claims. If a provider does submit a claim that does not follow this reimbursement policy, the claim will deny for explanation of benefits (EOB) 6392 – *Treatment room revenue codes in the same family are limited to one revenue code per date of service, same provider*.

[2] *CPT copyright 2020 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

Table 1 – Families of Treatment Room Revenue Codes with Reimbursement Limit Applied

Revenue Code Family	General Description
450, 451, 456, 459, 480–483, 489	Emergency Room (450, 451, 456, 459), Cardiology (480–483, 489)
510–517, 519–521, 523, 529	Clinic (510–517, 519), Freestanding clinic (520–521, 523, 529)
700, 710, 720, 721, 724, 760–762	Cast Room (700), Recovery Room (710), Labor Room/Delivery (720, 721, 724), Specialty Services (760–762)
900, 907, 914–916, 918	Behavioral Health Treatments

Providers may bill stand-alone services in conjunction with treatment room services. Stand-alone services include services such as therapies, dialysis, radiology, and laboratory. 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:

- **Administration of injections** – Reimbursement for the administration of therapeutic or diagnostic injections, including vaccines, is incorporated in the established rate for the treatment room in which the injection was administered (such as 450 – *Emergency room* or 510 – *Clinic*). Therefore:
  - When other services besides the injection are provided in the treatment room setting, administration of the injection is not separately reimbursable.
  - If a patient receives ***only*** an injection service in the treatment room, 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. No treatment room revenue code should be billed.

  For more information about injection administration and billing, see the *Injections, Vaccines, and Other Physician-Administered Drugs* module.

- **Infusions** – The IHCP considers infusions to be a stand-alone service. Therefore:
  - 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 detail 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. No treatment room revenue code should be billed.

- **Orthotic and prosthetic devices** – The IHCP allows separate reimbursement for certain designated orthotic and prosthetic devices when provided in conjunction with treatment room services and billed with revenue code 274 – *Orthotic/prosthetic devices*.

- **Drugs** – The IHCP allows separate reimbursement for certain designated drugs when provided in conjunction with treatment room services and billed with revenue code 636 – *Drugs Requiring Detailed Coding*.

For procedure codes that can billed with revenue codes 260, 274, and 636 for separate reimbursement in addition to the treatment room rate, see *Revenue Codes with Special Procedure Code Linkages*, accessible from the *Code Sets* page at in.gov/medicaid/providers. For information about special procedure code linkages for revenue code 724 – *Birthing center*, see the *Obstetrical and Gynecological Services* module.

> *Note: Although revenue code 451 (Emergency room – Emergency Medical Treatment and Labor Act (EMTALA) emergency medical screening services) is sometimes classified as a treatment room code, it is more accurately described as a "triage" code, used for screening costs when a patient presents in the ER for a nonemergency condition. When revenue code 451 is billed, all other lines on the claim for that date of service will be denied.*

Add-On Services

The IHCP reimburses add-on services at a flat, statewide rate when billed with a stand-alone procedure. In addition, some add-on services are also separately reimbursable if billed in conjunction with a treatment room revenue code. Add-on services are not separately reimbursable if provided on the same day as an outpatient surgery. Each add-on revenue code is restricted to one unit per provider per date of service.

The Revenue Codes tab on the Outpatient Fee Schedule indicates which revenue codes are used for add-on services and whether the add-on revenue code is separately reimbursable from a treatment room code. The Outpatient Fee Schedule is accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.

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. Certain stand-alone revenue codes are restricted to one unit per provider per date of service.

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.

The Revenue Codes tab on the Outpatient Fee Schedule indicates which revenue codes are used for stand-alone services and whether the stand-alone revenue code is restricted to one unit per date of service. The Outpatient Fee Schedule is accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.

Stand-Alone Chemotherapy and Radiation Services

Providers should bill all outpatient facility 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. Preparation of chemotherapy agents is included in the service for administration of the agent.
- **IV solution** – Bill using revenue code 258.
- **IV equipment** – Bill using revenue code 261. No reimbursement will be made for other revenue codes associated with supplies.
- **Treatment room services** – Bill using revenue codes 45X, 48X, 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, 48X, 51X, 52X, or 76X.

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