CareSource

ADMINISTRATIVE POLICY STATEMENT
Nevada Marketplace

Policy Name & Number	Date Effective
Inpatient Services Allowed in the Outpatient Setting-NV MP-AD-1541	11/01/2026
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statements contain supplemental information regarding standard benefit administration and coverage details. Administrative Policy Statements do not guarantee an authorization or payment of services. The Member's plan contract (e.g., Evidence of Coverage, Member Handbook) contains specific terms and conditions, including limitations, exclusions, benefit maximums, eligibility, and other relevant conditions of coverage. Except as otherwise required by law, if there is a conflict between the Administrative Policy Statement and the plan contract and/or provider agreement, then the plan contract and/or provider agreement will be the controlling document. Reasonable discretion may be used in interpreting and applying this Policy Statement to services provided in a particular case, and the policy may be modified at any time. Policy Statements may be superseded by federal and state laws and regulations, as applicable. In the case of a discrepancy between the Policy Statement's effective date and any applicable legal or regulatory requirement, the law or regulation will govern.

Coverage for mental health and substance use disorder (MH/SUD) benefits are provided at the same level as coverage for medical and surgical (M/S) benefits, as required by the Mental Health Parity and Addiction Equity Act (MHPAEA). MH/SUD benefits are not subject to limits or requirements that are more restrictive than those that apply to M/S benefits.

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A. Subject

Inpatient Services Allowed in the Outpatient Setting

B. Background

The Centers for Medicare and Medicaid Services (CMS) develops and maintains fee schedules which outline the fee maximums used to reimburse physicians and/or other providers. CMS periodically updates the payment rates for Medicare services paid under the outpatient prospective payment system (OPPS) and those paid under the ambulatory surgical center (ASC) payment system. Within the OPPS is an inpatient-only (IPO) list which has defined the list of services that Medicare will only pay for when performed in the inpatient setting. These services, while on the IPO list, do not have reimbursement rates for the outpatient setting. The IPO list is routinely revised as technology improves and techniques and risk factors change.

Since the IPO list is based on the Medicare population, which is distinct from the Marketplace population in health risk factors, there are services and procedures on the IPO list that can be appropriately performed in the outpatient setting for Marketplace members. When these medically necessary services are performed in an outpatient setting, the services are reimbursed at an adjusted rate from the inpatient setting, due to the differences in the setting and care provided. This policy outlines the process CareSource uses to determine the outpatient reimbursement for these services.

C. Definitions

- **Inpatient** – Relating to a patient admitted to a hospital, skilled nursing facility, inpatient hospice, long term acute care, respite care, or inpatient rehabilitation facility.
- **Prior Authorization (PA)** – A required review of a service, treatment, or admission for a benefit coverage determination, which must be obtained prior to the service, treatment, or admission start date, pursuant to the terms of this Plan.
- **Outpatient** – Relating to a patient who has not been admitted to a hospital, skilled nursing facility, or inpatient rehabilitation facility.

D. Policy

I. Coverage may be dependent on medical necessity review. Refer to the PA Lookup Tool to determine if prior authorization is required.

II. CareSource may reimburse services designated by CMS as inpatient-only when performed in the outpatient setting. For services and procedures deemed appropriate to perform in an outpatient setting, CareSource uses the following to determine an outpatient reimbursement rate for the entire claim:

A. The procedure code designated as an Inpatient Only code from the OPPS fee schedule file is assigned a corresponding diagnosis-related group (DRG), published by CMS.
B. The base rate is multiplied by the specific case mix index (CMI) assigned to the DRG.
C. This value is then multiplied by the average wage index for the provider state.

D. A 40% reduction to the value is performed to account for outpatient site of service.

E. Conditions of Coverage
NA

F. Related Policies/Rules
NA

G. Review/Revision History

	DATE	ACTION
Date Issued	05/21/2025	New Policy, approved at Committee.
Date Revised	08/12/2026	Review: updated references, approved at Committee.
Date Effective	11/01/2026	
Date Archived		

H. References

1. FY 2026 IPPS Final Rule Home Page. Centers for Medicare and Medicaid Services. Updated June 17, 2026. Accessed June 19, 2026. www.cms.gov
2. FY 2027 IPPS Proposed Rule Home Page. Centers for Medicare and Medicaid Services. Updated June 2, 2026. Accessed June 19, 2026. www.cms.gov
3. Hospital outpatient PPS. Centers for Medicare and Medicaid Services. Updated March 10, 2026. Accessed June 19, 2026. www.cms.gov
4. Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2026 Rates, 88 Fed. Reg. 58,640 (2025).
5. Hospital Price Transparency, 45 C.F.R. §§ 180.10-.110 (2025).
6. *Provider Manual: Marketplace Plan*. CareSource; 2026. Accessed June 19, 2026. www.caresource.com