REIMBURSEMENT POLICY STATEMENT
INDIANA MEDICAID

Policy Name		Policy Number	Effective Date
Inpatient Services - Less Than 24 Hours		PY-0961	01/01/2020
Policy Type			
Medical	Administrative	Pharmacy	**REIMBURSEMENT**

Reimbursement Policy Statement: Reimbursement Policies prepared by CSMG Co. and its affiliates (including CareSource) are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

CSMG Co. and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

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A. Subject

Inpatient Services – Less Than 24 Hours

B. Background

Reimbursement policies are designed to assist you when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and their office staff are encouraged to use self-service channels to verify member's eligibility.

C. Definitions

- **Inpatient Services**: Services provided while the member is registered as an inpatient in an acute care or psychiatric hospital for 24 hours or more
- **Outpatient Services**: Services provided by an acute care hospital, a psychiatric hospital, an ambulatory surgical center, a clinic, or other treatment room setting to members who are registered with the facility but are not registered as an inpatient.

D. Policy

I. For all inpatient services billed to CareSource that do not meet the definition of an inpatient service as defined in this policy will be denied, with the exception of the exclusions outlined below. Hospitals may resubmit denied claims for the services provided to the patient on the date of admission as an outpatient claim.

II. Inpatient services are defined as:
   A. All covered services provided to patients during the course of their inpatient stay, whether furnished directly by the hospital or under arrangement, except for direct-care services provided by physicians, podiatrists, and dentists.
   B. Emergency room services are covered as an inpatient service when a patient is admitted from the emergency room.

III. Exclusions to inpatient services are:
   A. Expiration within one day of birth when the following criteria is met:
      1. Claim must be submitted with patient status code of 20 – Expired (died)
      2. Members date of birth matches the admit date on the claim
   B. Inpatient Only Codes that are defined below in the table in the Conditions of Coverage section of this policy

E. Conditions of Coverage

Reimbursement is dependent on, but not limited to, billing based on correct coding guidelines. Prior authorization of the inpatient services is not a guarantee of payment.

This code table is a subset of the procedure codes from the Medicare Inpatient-Only (IPO) list that the Indiana Health Coverage Programs has determined to be billable as inpatient procedures even when the member is in the hospital for less than 24 hours.

CPT Code	Description
00604	Anesthesia for procedures on cervical spine and cord; procedures with patient in the sitting position
00670	Anesthesia for extensive spine and spinal cord procedures (eg, spinal instrumentation or vascular procedures)
00802	Anesthesia for procedures on lower anterior abdominal wall; panniculectomy
00865	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; radical prostatectomy (suprapubic, retropubic)
00944	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); vaginal hysterectomy
01404	Anesthesia for open or surgical arthroscopic procedures on knee joint; disarticulation at knee
20661	Application of halo, including removal; cranial
21347	Open treatment of nasomaxillary complex fracture (Lefort II type); requiring multiple open approaches
22595	Arthrodesis, posterior technique, atlas-axis (C1-C2) with bone graft and/or internal fixation
22600	Arthrodesis, posterior technique, cervical below C2 segment, local bone or bone allograft
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar
22632	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (list separately in addition to code for primary procedure)
22846	Anterior instrumentation; 4 to 7 vertebral segments (list separately in addition to code for primary procedure)
22850	Removal of posterior nonsegmental instrumentation (eg, Harrington rod)
22852	Removal of posterior segmental instrumentation
22855	Removal of anterior instrumentation
23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement [eg, total shoulder])
27268	Closed treatment of femoral fracture, proximal end, head; with manipulation
27280	Arthrodesis, sacroiliac joint (including obtaining graft)
27445	Arthroplasty, knee, total; prosthetic (eg, Walldius type)
27535	Open treatment of tibial fracture, proximal (plateau); unicondylar, includes internal fixation, when performed
31725	Catheter aspiration (separate procedure); tracheobronchial with fiberscope, bedside
35400	Angioscopy (non-coronary vessels or grafts) during therapeutic intervention (list separately in addition to code for primary procedure)
35741	Exploration; popliteal artery
38724	Cervical lymphadenectomy (modified radical neck dissection)
50040	Nephrostomy, nephrotomy with drainage
59120	Surgical treatment of ectopic pregnancy; tubal or ovarian, requiring salpingectomy and/or oophorectomy, abdominal or vaginal approach)
63081	Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment
63082	Vertebral corpectomy (vertebral body resection), cervical, each additional segment

F. Related Policies/Rules

G. Review/Revision History

	DATE	ACTION
Date Issued		
Date Revised		
Date Effective	1/1/2020	
Date Archived		

H. References

1. “Indiana Health Coverage Programs.” Indiana Health Coverage Programs - Provider Code Sets - Inpatient Hospital Service Codes, http://provider.indianamedicaid.com

The Reimbursement Policy Statement detailed above has received due consideration as defined in the Reimbursement Policy Statement Policy and is approved.

IN-P-0961 *Date Issues 11/1/2019* *OMPP Approved 01/01/2020*