Health Alliance™

Policy & Procedure

Policy Name:	Medical Policy: Inpatient vs Outpatient Surgery Guidelines	Policy #:	MP-312

Policy Information

Owner Department:	Medical UM & Systems Department
Owner:	Assigned Medical Director
Electronic Signature/Date:	Krystal Revai (06/29/2023), Lori Slaughter (06/28/2023)

If there is a discrepancy between a medical policy and a patient's policy or plan document/summary plan description, the policy or plan document/summary plan descriptions provisions and limitations will govern the determination of benefits.

Purpose of the Policy

To establish criteria for coverage of procedures as inpatient or outpatient.

Statement of the Policy

To apply objective and evidence-based criteria when determining the medical appropriateness of health care services.

NOTE: Please refer to plan documents for prior authorization necessity/status.

Interpretations

1.1 The InterQual procedure guidelines are used as a reference for coverage of procedures as inpatient or outpatient for commercial members. For Medicare Advantage members, use the Medicare link in step 1.2.

1.2 However, if no guidance is given in InterQual in relation to inpatient or outpatient coverage for a commercial member, then refer to the Medicare spreadsheet (Ref. 1); listing procedures by CPT code for procedures that Health Alliance will cover on an inpatient basis. All other codes will be covered as outpatient.

- **CMS Elimination of Inpatient Only List:**
  - In this rule, we are finalizing our proposal to eliminate the Inpatient Only (IPO) list over a three-year transitional period, beginning with the removal of approximately 300 primarily musculoskeletal-related services, with the list completely phased out by CY 2024. This will make these procedures eligible to be paid by Medicare in the hospital outpatient setting when outpatient care is appropriate, as well as maintain our ability to pay for these services in the hospital inpatient setting when inpatient care is appropriate, as determined by the physician.

1.3 If the procedure in question is not addressed by either reference in section 1 or section 2, the medical director would make a determination of appropriate inpatient or outpatient coverage.

CPT Codes

Providers are required to indicate the diagnosis and procedure codes when requesting review of coverage.

References

1. Medicare link : CMS-1772-FC | CMS (From here, click on link 2023 NFRM OPPS Addenda, accept licensing agreement, when file downloads open it and look for & click on Addendum E – Final HCPCS Codes that Would be Paid Only as Inpatient Procedures for 2023.

History

Created Date:	07/05/17
Effective Date:	07/05/17
Next Review Date:	06/29/2024
Revision Date:	06/19/18 – MDC-Revision to update Medicare link.
	06/18/19 – MDC-Annual review, no changes, link to CY 2019 updated.
	05/19/20 – MDC-Annual review, no changes, CY 2020 IPO list updated.
	04/20/21 – MDC-Annual review, name changed, link to updated table.
	05/17/22 – MDC-Annual review, link updated to current year.
	11/01/22 – D. Hasler-Updated Ref 1 link and instructions.
	05/15/23 – MDC-Annual review, Medicare link updated, no changes.