ADMINISTRATIVE POLICY STATEMENT
Michigan Marketplace

Policy Name & Number	Date Effective
Inpatient Services Allowed in the Outpatient Setting-MI MP-AD-1450	01/01/2025
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statement prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy 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 Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Administrative Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Administrative Policy Statement. If there is a conflict between the Administrative Policy Statement 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.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

Table of Contents

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** – 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 Prior Authorization Lookup Tool to determine if prior authorization is required for a service prior to performing it.

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 that is designated as an Inpatient Only code from the OPPS fee schedule 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	07/17/2024	New market, approved at Committee
Date Revised		
Date Effective	01/01/2025	
Date Archived		

H. References

1. FY 2024 IPPS final rule home page. Centers for Medicare and Medicaid Services. Updated March 5, 2024. Accessed July 15, 2024. www.cms.gov
2. Hospital outpatient PPS. Centers for Medicare and Medicaid Services. Updated July 12, 2024. Accessed July 15, 2024. www.cms.gov
3. Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2024 Rates, 88 Fed. Reg. 58,640 (2023).
4. Hospital Price Transparency, 45 C.F.R. §§ 180.10-.110 (2024).
5. *Provider Manual: Marketplace Plan*. CareSource; 2024. Accessed July 15, 2024. www.caresource.com