Payment Policy: Inpatient Only Procedure (Ambetter Only)

Reference Number: MP.PP.018
Product Types: Ambetter
Effective Date: 01/01/2013
Last Review Date: 04/2025

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
The Centers for Medicare and Medicaid Services (CMS) has determined that certain procedures should only be performed in an inpatient setting and therefore are not appropriate to be conducted in an outpatient facility setting. According to CMS,

> *"Inpatient only services are generally, but not always, surgical services that require inpatient care because of the nature of the procedure, the typical underlying physical condition of patients who require the service or the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged."*

Inpatient only procedures (IOP) are not payable under the Outpatient Prospective Payment System (OPPS). CMS designates IOP with an OPPS status indicator of "C" in the OPPS Addendum B. The published list can be viewed here: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates

Application
This policy applies to Ambetter.

Claims Reimbursement Edit
Code auditing software denies procedures that CMS determines should be performed in an inpatient only setting when billed in the outpatient setting.

State-specific rules, health plan contracts or health plan policies, may supersede this edit.

Rationale for Edit
Because of the invasive nature of certain procedures, the need for at least 24 hours of post-operative recovery time or monitoring before a patient can be safely discharged, or the underlying physical condition of the patient requiring surgery, CMS has determined that certain procedures are safest when performed in an inpatient setting.

Coding and Modifier Information
This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2025, American Medical Association. All rights reserved. CPT codes and CPT descriptions are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

The following codes are not subject to this policy and are reimbursed in outpatient settings for Ambetter health plans only:

CPT/HCPCS Code	Descriptor
22855	Removal of anterior instrumentation
00192	Anesthesia for procedures on facial bones or skull; radical surgery (including prognathism)
00846	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; radical hysterectomy
11005	Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; abdominal wall, with or without fascial closure
15757	Free skin flap with microvascular anastomosis
19361	Breast reconstruction; with latissimus dorsi flap
21343	Open treatment of depressed frontal sinus fracture
21620	Ostectomy of sternum, partial
22600	Arthrodesis, posterior or posterolateral technique, single interspace; cervical below C2 segment
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace, lumbar
22818	Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements); single or 2 segments
22846	Anterior instrumentation; 4 to 7 vertebral segments (List separately in addition to code for primary procedure)
22852	Removal of posterior segmental instrumentation
22855	Removal of anterior instrumentation
27036	Capsulectomy or capsulotomy, hip, with or without excision of heterotopic bone, with release of hip flexor muscles (ie, gluteus medius, gluteus minimus, tensor fascia latae, rectus femoris, sartorius, iliopsoas)
27075	Radical resection of tumor; wing of ilium, 1 pubic or ischial ramus or symphysis pubis
27134	Revision of total hip arthroplasty; both components, with or without autograft or allograft
27170	Bone graft, femoral head, neck, intertrochanteric or subtrochanteric area (includes obtaining bone graft)
27222	Closed treatment of acetabulum (hip socket) fracture(s); with manipulation, with or without skeletal traction
27470	Repair, nonunion or malunion, femur, distal to head and neck; without graft (eg, compression technique)
27472	Repair, nonunion or malunion, femur, distal to head and neck; with iliac or other autogenous bone graft (includes obtaining graft)

CPT/HCPCS Code	Descriptor
27486	Revision of total knee arthroplasty, with or without allograft; 1 component
27514	Open treatment of femoral fracture, distal end, medial or lateral condyle, includes internal fixation, when performed
27535	Open treatment of tibial fracture, proximal (plateau); unicondylar, includes internal fixation, when performed
27536	Open treatment of tibial fracture, proximal (plateau); bicondylar, with or without internal fixation
27703	Arthroplasty, ankle; revision, total ankle
27724	Repair of nonunion or malunion, tibia; with iliac or other autograft (includes obtaining graft)
33477	Transcatheter pulmonary valve implantation, percutaneous approach, including pre-stenting of the valve delivery site, when performed
33967	Insertion of intra-aortic balloon assist device, percutaneous
35301	Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision
37182	Insertion of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract formation/dilatation, stent placement and all associated imaging guidance and documentation)
37215	Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; with distal embolic protection
37618	Ligation, major artery (eg, post-traumatic, rupture); extremity
38724	Cervical lymphadenectomy (modified radical neck dissection)
39220	Resection of mediastinal tumor
42426	Excision of parotid tumor or parotid gland; total, with unilateral radical neck dissection
43279	Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed
43283	Laparoscopy, surgical, esophageal lengthening procedure (eg, Collis gastroplasty or wedge gastroplasty) (List separately in addition to code for primary procedure)
44005	Enterolysis (freeing of intestinal adhesion) (separate procedure)
44055	Correction of malrotation by lysis of duodenal bands and/or reduction of midgut volvulus (eg, Ladd procedure)
44110	Excision of 1 or more lesions of small or large intestine not requiring anastomosis, exteriorization, or fistulization; single enterotomy
44188	Laparoscopy, surgical, colostomy or skin level cecostomy
44204	Laparoscopy, surgical; colectomy, partial, with anastomosis
44602	Suture of small intestine (enterorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture; single perforation

CPT/HCPCS Code	Descriptor
44800	Excision of Meckel's diverticulum (diverticulectomy) or omphalomesenteric duct
44960	Appendectomy; for ruptured appendix with abscess or generalized peritonitis
45400	Laparoscopy, surgical; proctopexy (for prolapse)
47100	Biopsy of liver, wedge
47120	Hepatectomy, resection of liver; partial lobectomy
47380	Ablation, open, of 1 or more liver tumor(s); radiofrequency
47600	Cholecystectomy
48510	External drainage, pseudocyst of pancreas, open
49255	Omentectomy, epiploectomy, resection of omentum (separate procedure)
50040	Nephrostomy, nephrotomy with drainage
50060	Nephrolithotomy; removal of calculus
50405	Pyeloplasty (Foley Y-pyeloplasty), plastic operation on renal pelvis, with or without plastic operation on ureter, nephropexy, nephrostomy, pyelostomy, or ureteral splinting; complicated (congenital kidney abnormality, secondary pyeloplasty, solitary kidney, calycoplasty)
50545	Laparoscopy, surgical; radical nephrectomy (includes removal of Gerota's fascia and surrounding fatty tissue, removal of regional lymph nodes, and adrenalectomy)
51840	Anterior vesicourethropexy, or urethropexy (eg, Marshall-Marchetti-Krantz, Burch); simple
51900	Closure of vesicovaginal fistula, abdominal approach
53415	Urethroplasty, transpubic or perineal, 1-stage, for reconstruction or repair of prostatic or membranous urethra
54430	Corpora cavernosa-corpus spongiosum shunt (priapism operation), unilateral or bilateral
57280	Colpopexy, abdominal approach
57308	Closure of rectovaginal fistula; transperineal approach, with perineal body reconstruction, with or without levator plication
58140	Myomectomy, excision of fibroid tumor(s) of uterus, 1 to 4 intramural myoma(s) with total weight of 250 g or less and/or removal of surface myomas; abdominal approach
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)
58267	Vaginal hysterectomy, for uterus 250 g or less; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control

58548	Laparoscopy, surgical, with radical hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with removal of tube(s) and ovary(s), if performed
58700	Salpingectomy, complete or partial, unilateral or bilateral (separate procedure)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)
58740	Lysis of adhesions (salpingolysis, ovariolysis)
58750	Tubotubal anastomosis
58952	Resection (initial) of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy; with radical dissection for debulking (ie, radical excision or destruction, intra-abdominal or retroperitoneal tumors)
59120	Surgical treatment of ectopic pregnancy; tubal or ovarian, requiring salpingectomy and/or oophorectomy, abdominal or vaginal approach
60505	Parathyroidectomy or exploration of parathyroid(s); with mediastinal exploration, sternal split or transthoracic approach
60650	Laparoscopy, surgical, with adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal
61500	Craniectomy; with excision of tumor or other bone lesion of skull
61624	Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord)
62223	Creation of shunt; ventriculo-peritoneal, -pleural, other terminus
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), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, each additional segment (List separately in addition to code for primary procedure)
63707	Repair of dural/cerebrospinal fluid leak, not requiring laminectomy
63709	Repair of dural/cerebrospinal fluid leak or pseudomeningocele, with laminectomy
64760	Transection or avulsion of; vagus nerve (vagotomy), abdominal
G0341	Percutaneous islet cell transplant, includes portal vein catheterization and infusion
G0343	Laparotomy for islet cell transplant, includes portal vein catheterization and infusion

References

1. *Current Procedural Terminology (CPT®)*, 2025
2. *Centers for Medicare and Medicaid Services*, CMS Manual System and other CMS publications and services
3. *Centers for Medicare and Medicaid Services*, Hospital Outpatient PPS https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS

Revision History	
03/14/2017	Created Ambetter specific version of policy which excludes a list of codes.
5/31/2017	Corrected formatting and revised code list.
11/01/2019	Annual Review completed.
11/01/2020	Annual Review completed
11/30/2021	Annual Review completed; no major updates required
12/01/2022	Annual Review completed; no major updates required
04/01/2024	Completed annual review and revised code list
04/25/2025	Completed annual review, revised CPT descriptors according to current terminology, removed deleted codes 49203 and 49204

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to

recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.