

	Reimbursement Policy Manual		Policy #:	RPM043
Policy Title:	Hospital Routine Supplies and Services			
Section:	Facility-Specific	Subsection:	None	
Scope:	This policy applies to the following Medical (including Pharmacy/Vision) plans:			
Companies:	<input checked="" type="checkbox"/> All Companies: Moda Partners, Inc. and its subsidiaries & affiliates <input type="checkbox"/> Moda Health Plan <input type="checkbox"/> Moda Assurance Company <input type="checkbox"/> Summit Health Plan <input type="checkbox"/> Eastern Oregon Coordinated Care Organization (EOCCO) <input type="checkbox"/> OHSU Health IDS			
Types of Business:	<input checked="" type="checkbox"/> All Types <input type="checkbox"/> Commercial Group <input type="checkbox"/> Commercial Individual <input type="checkbox"/> Commercial Marketplace/Exchange <input type="checkbox"/> Commercial Self-funded <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare Advantage <input type="checkbox"/> Short Term <input type="checkbox"/> Other: _____			
States:	<input checked="" type="checkbox"/> All States <input type="checkbox"/> Alaska <input type="checkbox"/> Idaho <input type="checkbox"/> Oregon <input type="checkbox"/> Texas <input type="checkbox"/> Washington			
Claim forms:	<input type="checkbox"/> CMS1500 <input checked="" type="checkbox"/> CMS1450/UB (or the electronic equivalent or successor forms)			
Date:	<input checked="" type="checkbox"/> All dates <input type="checkbox"/> Specific date(s): _____ <input type="checkbox"/> Date of Service; For Facilities: <input type="checkbox"/> n/a <input type="checkbox"/> Facility admission <input type="checkbox"/> Facility discharge <input type="checkbox"/> Date of processing			
Provider Contract Status:	<input checked="" type="checkbox"/> Contracted directly, any/all networks <input checked="" type="checkbox"/> Contracted with a secondary network <input checked="" type="checkbox"/> Out of Network			
Originally Effective:	10/12/2009	Initially Published:	11/12/2015	
Last Updated:	7/12/2023	Last Reviewed:	7/12/2023	
Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No				
Last Update Effective Date for Texas:		7/12/2023		

Reimbursement Guidelines

Correct coding and code definitions apply in all circumstances and to all provider types. Whenever a code is billed which includes another service or supply, whether by code definition or by coding guidelines, the included service or supply is not eligible for separate reimbursement.

A. General Policies for All Settings

1. Flushes, Diluents, Saline, Sterile Water, etc.

Per CPT and CMS⁶ guidelines, heparin flushes, saline flushes, IV flushes of any type, and solutions used to dilute or administer substances, drugs, or medications are included in the administration service (see note below for inpatient setting). These items are considered supplies and are not eligible for separate reimbursement. Even though J1642 (Injection, heparin sodium, (heparin lock flush), per 10 units) describes heparin flushes, heparin flushes are not considered a “drug” and are not eligible for separate reimbursement under the fee schedule or provider contract provisions for drugs.

This applies to all provider types in all settings. In most cases payment for these supplies is included in the administration charge which is reportable with a CPT or HCPCS code. In the

Inpatient setting, the administration service is included in the room charge or facility fee, and reimbursement for these supplies is included in the reimbursement for the eligible services.

Please note:

- Denials for solutions used to dilute or administer substances will be applied to all hospital claim reviews for all claims with admission dates of service 2/1/2016 and following.
- For inpatient settings flushes and diluents are included either in the drug charge itself or the drug administration service which is included in room and board nursing care and not separately billable.

2. 99070 for Reporting Supplies, Materials, Supplements, Remedies, etc.

Correct coding guidelines require that the most specific, comprehensive code available be selected to report services or items billed. (AMA¹, OptumInsight²) Moda Health accepts HCPCS codes for processing. Therefore, 99070 is never the most specific code available to use to report a supply, drug, tray, or material provided over and above those usually included in a service rendered. Any HCPCS Level II code in the HCPCS book is more specific than 99070. The HCPCS book also includes a wide variety of more specific unlisted codes that should be used in place of 99070 when the billing office cannot identify a listed HCPCS code to describe the supply or material being billed.

3. Capital Equipment

Capital equipment is used in the provision of services to multiple patients and has an extended life. This equipment is considered a fixed asset of the facility. This equipment or the use of that equipment may not be separately billed.

Where specific procedure codes exist, the services provided with that equipment may be billed as appropriate (e.g., x-rays, dialysis) and in accordance with correct coding and billing guidelines (e.g., no unbundling of oximetry checks, or fluoroscopy in the OR). If specific procedure codes do not exist, in most cases the services provided by that equipment are included in a larger, related service, and are not eligible for separate reimbursement (e.g., thermometer).

“Equipment used multiple times for multiple patients (should be part of facility charge)” and is not separately billable or reimbursable. (Administar¹⁴)

Examples of non-billable capital equipment: (Administar¹⁵)

- Cardiac monitors
- Cautery machines
- Oximetry monitors
- Scopes
- Lasers
- IV pumps
- Thermometers
- Automatic blood pressure machines and/or monitors
- Anesthesia machines
- Cell Saver equipment

- Instruments
- Microscopes
- Cameras
- Rental equipment
- Neurological Monitors in OR
- Perfusion equipment and supplies in OR
- Bladder Scan equipment
- Fluroscopy and/or Ultrasound in OR
- Cell Saver and related equipment and supplies
- Procedure-specific Tool Kits/Instruments, whether rented, loaned, or purchased (e.g., orthopedic tools for joints, implants, spinal surgeries, etc.)

B. For Inpatient Hospitals

Facilities will not be reimbursed nor allowed to retain reimbursement for services considered to be non-reimbursable. The following are general categories and lists of examples of inpatient facility charges that are not separately billable or reimbursable, including but not limited to:

1. Routine Supplies

Routine supplies are not separately billable and are items that are included in the general cost of the room where services are being rendered or the reimbursement for the associated surgery or primary procedure. These items, if identified on a claim or itemized bill, are not eligible for separate reimbursement, and are not eligible to be included in outlier calculations for additional reimbursement.

Routine supplies should not be billed in the non-covered charge column on the UB-04. The costs for the routine supplies are covered, because they are factored into the setting or procedure charge. Although they are covered, they are not billed separately. (OptumInsight¹⁷)

Examples of routine supply items not separately billable are as follows (list is not all-inclusive): (OptumInsight¹⁷)

- Personal convenience supply items
- Gowns used by staff
- Gloves used by staff
- Masks used by staff
- Oxygen when not specifically used by the patient
- Items ordinarily used for or on most patients in that area or department
- Thermometers
- Patient gowns
- Items commonly available to patients in a particular setting (e.g., stock or bulk supply)
- Equipment commonly available to patients in a particular setting or ordinarily furnished to patients during the course of a procedure, whether hospital-owned or rented, and supplies used in conjunction with this equipment
- Oxygen masks and oxygen supplies
- Drapes

- Preparation kits
- Any linen
- Syringes
- Saline solutions
- Irrigation solutions
- Reusable items
- Cardiac monitors
- Oximeters
- IV pumps
- IV tubing
- Blood pressure monitors and/or cuffs
- Thermometers
- Ice bags or packs
- Heat light or heating pad
- Wall suction
- Admission, hygiene, and/or comfort kits or items (Administar¹⁵, BCKS¹⁸)
- Restraints (Administar¹⁵)
- Reusable equipment and items (Administar¹⁵, BCKS¹⁸, Administar¹⁹)
- Items used to obtain a specimen or complete a diagnostic or therapeutic procedure (DeWald¹⁶)
- All items and supplies that may be purchased over-the-counter are not separately billable (Noridian¹²)

Items which do not appear on this list *may or may not* be eligible for separate reimbursement, depending upon whether they are considered routine supplies and other additional factors.

2. Components of Room and Board

Many basic services are included as components of room and board charges (revenue codes 0110 – 0174, 0200 – 0214). Moda Health considers components of room and board charges as not separately reimbursable. Facilities will not be reimbursed nor allowed to retain reimbursement for services considered to be not separately reimbursable.

a. Nursing care

Nursing care and treatment that are within the scope of normal nursing practice including, but not limited to:

- Admission assessment
- Monitoring of patients
- IV insertion, including lidocaine for IV insertion and saline flushes, assessments, infusion of fluids.
- Specialized IV line placements (PICC line insertions, midline-catheter insertions, etc.)
- Medication administration (CMS^{24, 25})
- Blood Administration (transfusions), including MTP (Massive Transfusion Protocol or IAT (Intraoperative Autologous Transfusion)
- TPN administration through a central line
- Any respiratory treatment (medications may be separately charged) including, but not limited to:

- Sputum inductions, bronchial hygiene or airway clearance treatments
- Incentive spirometry
- Nebulizer treatment
- Administration of mucolytics
- Placement of masks for nebulized medications
- Urinary catheterization, dressing changes, tube feedings, bladder scans with or without PVR (post void residual)
- Point of care (POC) testing, such as urine dip stick, glucometry testing, mobile computer devices such as, but not limited to, those used for the analysis of blood gases, electrolytes, metabolites and urinary retention, and insertion of peripheral IV lines.
- Rectal inserts and related accessories will be denied as not reasonable and necessary because they do not meet the medical evidence requirements outlined in the Centers for Medicare & Medicaid Services (CMS) Program Integrity Manual. Per this policy they are considered misc. incontinence supplies and are not covered for any line of business. (CMS²⁶)
- Assisting with bedside procedures performed by physicians or other qualified healthcare professionals.
- Pre-op holding for inpatient surgery
- Surgical prep for procedures
- Hemodynamic monitoring
- Incremental nursing care – (1:1, ICU/CCU setting, etc.)
- Infant/Newborn Nursery Room Related Charges
 - Newborn car seat testing
 - Newborn hearing screening

b. Floor stock (routine supplies)

- Urine culture kits
- Alcohol wipes
- Cotton balls
- Thermometers
- Gloves
- Bedpans
- Patient gowns
- Sitz baths
- Breast pump
- Diapers
- Kits containing routine supplies such as alcohol wipes, cotton balls, etc.

c. All food and meals (CMS²³), including special diets, thickening agents, etc.

d. Other services typically provided to a patient while an inpatient of a hospital.

3. Lab/Pharmacy Services

- Blood draws from capillary, arterial or vascular access devices regardless of practitioner performing the draw and regardless of whether arterial, venous or capillary blood is drawn. Each blood draw or collection is part of the lab test and is not separately reimbursable. This may include, but not limited to:
 - Arterial lines
 - Peripheral lines, short or midline
 - Capillary blood collection with lancet or finger-stick devices
 - Central lines:
 - Peripherally inserted (PICC)
 - Tunneled central venous catheter
 - Percutaneous non-tunneled
 - Implanted port
- Pharmacy consultations for medication management or patient education
- Low Osmolar Contrast material for inpatient or outpatient radiology procedures
- Point of care (POC) testing, such as:
 - urine dip stick
 - Glucometry testing
 - Mobile computer devices such as, but not limited to, those used for:
 - Analysis of blood gases
 - Electrolytes
 - Metabolites
 - Urinary retention
 - Insertion of peripheral IV lines
 - Etc.

4. Central Supply

- Telemetry batteries, leads
- Batteries for any equipment used during any procedures

5. Equipment

A required component of a specific level of care and the calibration of instrumentation. See also Capital Equipment, section A.3.

- Cardiac monitors (e.g., in an NICU setting, ICU/CCU, Telemetry or Step-Down, OR and Recovery Room, etc.)
- Oximetry (e.g., in an NICU setting, ICU/CCU, OR, Recovery Room, Emergency Department, etc.)
- Arterial and Swan-Ganz monitors (e.g., in an NICU setting, ICU/CCU, OR, Recovery Room, etc.)
- CO2 End Tidal Monitors, in-line or transcutaneous, or humidified air (e.g., for patients on ventilator, in the OR, etc.)
- Fetal monitors (e.g., in a labor room setting, etc.)
- Transesophageal Echo (TEE) Monitors during Open Heart Surgery (TEE equipment is mandatory in the Open Heart Room, excluding NICU)
- Ventilator (e.g., in OR, Recovery Room, etc.)
- Cell Saver equipment (e.g., in OR, etc.)
- Neurological monitors (e.g., in OR, ICU, etc.)

- Ultrasound guidance for procedures

6. Respiratory Therapy

- Ventilator adjustments if performed by RN
- Ventilator System checks by respiratory therapist
- O2, CPAP, PEEP charges when patient is on ventilator support
- Ventilator weaning and extubation
- Patient's own CPAP/BiPAP machine services
- Respiratory Assessment with treatments
- Oximetry Trending when done by routine monitor
- Endotracheal Suctioning when done with treatments or on ventilator
- Surfactant administration when done by the physician
- Point of care (POC) testing, such as urine dip stick, glucometry testing, mobile computer devices such as, but not limited to, those used for the analysis of blood gases, electrolytes, metabolites and urinary retention, and insertion of peripheral IV lines.

7. Blood Processing/Storage

- a. The following revenue codes are used to report blood processing/storage:

- 0390 – Blood Processing/Storage; General
- 0392 -- Blood Processing/Storage; Processing and Storage

NOTE: We do not accept revenue code 0399 – Blood Processing/Storage; Other. (Moda^E) Charges submitted under 0399 will be denied to provider responsibility.

- b. The below charge descriptions are considered included in the primary Blood Processing/Storage revenue code 390 or 392 and are not separately reimbursed: (CMS²⁷)

- Blood product collection
- Safety testing (Including but not limited to Hep C, Hep B, HIV, Viral and Bacterial testing, Blood Typing, Crossmatching, adverse reaction testing)
- Retyping
- Pooling
- Irradiating
- Leukocyte-reducing
- Freezing
- Thawing blood products
- Cost of blood delivery (e.g., transportation costs)
- Cost of blood monitoring
- Cost of blood storage
- Splitting

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation		Definition
AMA	=	American Medical Association
BiPAP	=	Bilevel Positive Airway Pressure
CCI	=	Correct Coding Initiative (see "NCCI")
CCU	=	Coronary Care Unit, or Critical Care Unit
CMS	=	Centers for Medicare and Medicaid Services
CPAP	=	Continuous Positive Airway Pressure
CPT	=	Current Procedural Terminology
DME	=	Durable Medical Equipment
DRG	=	Diagnosis Related Group (also known as/see also MS DRG)
HCPCS	=	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	=	Health Insurance Portability and Accountability Act
IAT	=	Intraoperative Autologous Transfusion
ICU	=	Intensive Care Unit
IV	=	Intravenous
MS DRG	=	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
MTP	=	Massive Transfusion Protocol
NAS	=	Noridian Administrative Services
NCCI	=	National Correct Coding Initiative (aka "CCI")
NICU	=	Neonatal Intensive Care Unit
NOC	=	Not otherwise classified
NOS	=	Not otherwise specified
O2	=	Oxygen
OR	=	Operating room
PEEP	=	Positive end-expiratory pressure
PICC	=	Peripherally inserted central catheter
POC	=	Point of care
RPM	=	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)

Acronym or Abbreviation		Definition
TEE	=	Transesophageal Echo
TPN	=	Total Parenteral Nutrition
UB	=	Uniform Bill

Procedure codes (CPT & HCPCS):

There are multiple codes which apply to supplies and implants, but this policy refers to all current codes in effect each year.

HCPCS Level II code set includes a vast number of codes describing a wide variety of medical and surgical supplies, as well as implants, durable medical equipment, prosthetics, orthotics, and other items. It is impossible to list all relevant supply codes here; *any code lists offered are not all-inclusive*. This policy refers to all current codes in effect each year.

Possible non-specific supply codes include:

Code	Code Description
99070	Supplies and materials (except spectacles), provided by the physician over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided) (Note: Effective for dates of service 04/01/2015 and following, 99070 is no longer considered valid by Moda Health)
A4335	Incontinence supply; miscellaneous
A4421	Ostomy supply; miscellaneous
A4641	Radiopharmaceutical, diagnostic, not otherwise classified
A4649	Surgical supply; miscellaneous
A4913	Miscellaneous dialysis supplies, not otherwise specified
A4913	Miscellaneous dialysis supplies, not otherwise specified
A9150	Nonprescription drugs
A9152	Single vitamin/mineral/trace element, oral, per dose, not otherwise specified
A9153	Multiple vitamins, with or without minerals and trace elements, oral, per dose, not otherwise specified
A9279	Monitoring feature/device, stand-alone or integrated, any type, includes all accessories, components and electronics, not otherwise classified
A9280	Alert or alarm device, not otherwise classified
A9698	Nonradioactive contrast imaging material, not otherwise classified, per study
A9699	Radiopharmaceutical, therapeutic, not otherwise classified
A9900	Miscellaneous DME supply, accessory, and/or service component of another HCPCS code
A9999	Miscellaneous DME supply or accessory, not otherwise specified
C2698	Brachytherapy source, stranded, not otherwise specified, per source

Code	Code Description
C2699	Brachytherapy source, nonstranded, not otherwise specified, per source
E1399	Durable medical equipment, miscellaneous
E1699	Dialysis equipment, not otherwise specified
J3490	Unclassified drugs
J7599	Immunosuppressive drug, not otherwise classified
J7699	NOC drugs, inhalation solution administered through DME
J7799	NOC drugs, other than inhalation drugs, administered through DME
J8498	Antiemetic drug, rectal/suppository, not otherwise specified
J8499	Prescription drug, oral, nonchemotherapeutic, NOS
J8597	Antiemetic drug, oral, not otherwise specified
J9999	Not otherwise classified, antineoplastic drugs
Q0505	Miscellaneous supply or accessory for use with ventricular assist device
Q4050	Cast supplies, for unlisted types and materials of casts
Q4051	Splint supplies, miscellaneous (includes thermoplastics, strapping, fasteners, padding and other supplies)
Q4082	Drug or biological, not otherwise classified, Part B drug competitive acquisition program (CAP)
S0590	Integral lens service, miscellaneous services reported separately
S8189	Tracheostomy supply, not otherwise classified
S8301	Infection control supplies, not otherwise specified
T1999	Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in "remarks"
V2199	Not otherwise classified, single vision lens
V2799	Vision service, miscellaneous
V5298	Hearing aid, not otherwise classified
V5299	Hearing service, miscellaneous

Some supply codes related to injection and infusion administration:

Code	Code Description
J1642	heparin lock flush), per 10 units
A4216	Sterile water, saline and/or dextrose, diluent/flush, 10 ml
A4218	Sterile saline or water, metered dose dispenser, 10 ml

Coding Guidelines & Sources - (Key quotes, not all-inclusive)

When coding for services or supplies, the most specific and comprehensive code available is to be selected to report the service or item. Select the code which accurately identifies the service performed or the item supplied. Do not select a CPT or HCPCS code which merely approximates the service provided. If

no such specific code exists, then report the service or item using the appropriate unlisted procedure or service code.” (AMA¹)

The same procedure or supply item may be described by both a CPT (Level I HCPCS) code and a HCPCS (Level II HCPCS) code. When this occurs, there are rules to follow to determine which code is correct to use to report the service or supply.

- When both a CPT and a HCPCS Level II code have virtually identical descriptions for a procedure, service, or item, the CPT code should be used. (OptumInsight²)
- If the descriptions are not identical, (e.g. the CPT code description is generic, whereas the HCPCS Level II code is more specific), the Level II code should be used. (OptumInsight²)
- The exception to this rule is if the more specific HCPCS Level II code is in a grouping of codes that is designated for use by a specific government agency or program which does not apply to this member’s claim. (For example, H-codes and T-codes are developed specifically for state Medicaid Agencies.)

Units of service must be reported correctly. “Each HCPCS/CPT code has a defined unit of service for reporting purposes. [The billing office] should not report units of service for a HCPCS/CPT code using a criterion that differs from the code’s defined unit of service.” (CMS¹¹)

“Medicare inpatient hospital care coverage includes:

- Semi-private rooms
- Meals
- General nursing
- Drugs as part of your inpatient treatment
- Other hospital services and supplies” (CMS²³)

“Note: ... You pay for a private room unless it's medically necessary.” (CMS²³)

“If performed to facilitate the infusion or injection or hydration, the following services and items are included and are not separately billable:

- a. Use of local anesthesia;
- b. IV start;
- c. Access to indwelling IV, subcutaneous catheter or port;
- d. Flush at conclusion of infusion; and
- e. Standard tubing, syringes and supplies.” (AMA²¹)

“The overview guidelines define and list the services that are included and, therefore, not separately reported, including local anesthesia; the IV start, establishment of access to and indwelling IV, subcutaneous catheter or port; the flush at conclusion of infusion, administration supplies, including standard tubing, and syringes, and the preparation of chemotherapy agents.” (AMA²²)

“If performed to facilitate the infusion or injection or hydration, the following services and items are included and are not separately billable:

1. Use of local anesthesia;
2. IV start;
3. Access to indwelling IV, subcutaneous catheter or port;
4. Flush at conclusion of infusion; and
5. Standard tubing, syringes and supplies.

Payment for the above is included in the payment for the chemotherapy administration or non-chemotherapy injection and infusion service.” (CMS⁶)

Routine-Not Separately Billable Items: Routine supplies are defined as those items which are included in the general cost of the room where the service is being delivered, i.e., patient room, operating room, cast room, etc., or as part of the procedure performed. These items are generally made available to a patient receiving service in that particular setting. Supplies defined as routine are not separately billable from the room or procedure charge as ancillary services. Their costs are reimbursed on the cost report as part of the overall/procedure costs. (Administar¹⁵)

“Q₁₉: Is it possible to publish a list of routine supplies that are non-billable for hospitals?

A₁₉: Yes we can publish an article.

The following is the article posted. (Noridian¹²)

“The provider should review the instructions furnished by The Centers for Medicare & Medicaid Services located in the Provider Reimbursement Manual and the Medicare Benefit Policy Manual. The following guidelines may assist hospital personnel in identifying items, supplies and services that are not separately billable. This is not an all-inclusive list of instructions.

1. Any supplies, items, and services that are necessary or otherwise integral to the provision of a specific service and/or to the delivery of services in a specific location are considered routine services and not separately billable in the inpatient and outpatient environments
2. All items and supplies that may be purchased over-the-counter are not separately billable
3. All reusable items, supplies and equipment that are provided to all patients during an in or outpatient admission are not separately billable.
4. All reusable items, supplies, and equipment that are provided to all patients admitted to a given treatment area or unit (i.e. NICU, Burn Unit, PACU, Medical/Surgical) are not separately billable.
5. All reusable items, supplies and equipment that are provided to all patients receiving the same service (i.e., an Ambu bag during resuscitation) are not separately billable.

While the Medicare program cannot dictate to a provider what its charges or charge structure may be, the program may determine whether or not the charges are allowable for use in apportioning costs under the program.” (Noridian¹²)

“Routine supplies are items used during the normal course of treatment, which are directly related to and/or integral to the performance of separately payable therapy, treatments, procedures, or services. These supplies are customarily used during the course of treatment and are normally found in the floor stock, which are generally used by all patients in that specific area/or location. Reusable supplies and equipment may also be considered routine. Routine supplies should not be separately billed to a patient or a payer. When charging for routine supplies, hospitals have an option to include the charge in the charge of the procedure/service, the accommodation charge, the operating room charge, or capture it on the hospital Cost Report.” (Nave/MedAssets⁷)

“QUESTION: Can we charge for rental equipment (e.g. specialty beds)?

ANSWER:

Equipment charges, whether purchased or rented, should not be billed separately. The equipment is captured via depreciation or rental cost overall on the cost report.” (Nave/MedAssets⁷)

“Routine supplies should not be separately billed to a patient or a payor.” (Nave/MedAssets⁷)

“Items that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services (ie: IV tubing, IV pumps) are not considered separately billable. Also nursing services (ie: IV injections and IV infusion administration), are included in the room and board charges.” (CMS^{24, 25})

“2202.6 Routine Services.--Inpatient routine services in a hospital or skilled nursing facility generally are those services included in by the provider in a daily service charge--sometimes referred to as the "room and board" charge. Routine services are composed of two board components; (1) general routine services, and (2) special care units (SCU's), including coronary care units (CCU's) and intensive care Units (ICU's). Included in routine services are the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made.

In recognition of the extraordinary care furnished to intensive care, coronary care, and other special care hospital inpatients, the costs of routine services furnished in these units are separately determined. If the unit does not meet the definition of a special care unit (see § 2202.7), then the cost of such service cannot be included in a separate cost center, but must be included in the general routine service cost center.” (CMS³)

“2202.8 Ancillary Services.--Ancillary services in a hospital or SNF include laboratory, radiology, drugs, delivery room (including maternity labor room), operating room (including postanesthesia and postoperative recovery rooms), and therapy services (physical, speech, occupational). Ancillary services may also include other special items and services for which charges are customarily made in addition to a routine service charge.” (CMS³)

2203 PROVIDER CHARGE STRUCTURE AS BASIS FOR APPORTIONMENT -- ...Costs of routine services are determined based on the consideration that all patients in each separate area are receiving similar services.... The cost of those items and services specifically classified as routine in §2202.6 are always considered routine service costs... A separate ancillary charge for a particular item or service other than those listed as ancillary in §2202.8 is not recognized, and the cost of the item or service is not included in an ancillary cost center, where the common or established practice of providers of the same class (hospital or SNF) in the same State is to include the item or service in the routine service charge....” (CMS³)

2208.3 Determining Cost of Inpatient Ancillary Services Covered Under Part B for Medicare Beneficiaries in Hospitals and Skilled Nursing Facilities with All-Inclusive Rate or No-Charge Structure.-- ... Where the cost of a particular ancillary service is not considered sufficiently significant to treat as a separate cost center, it may be included as a part of routine services. As such, it would be allocated on the basis of an average cost per inpatient day.” (CMS³)

“Under the OPPS, packaged services are items and services that are considered to be an integral part of another service that is paid under the OPPS. No separate payment is made for packaged services, because the cost of these items and services is included in the APC payment for the service of which they are an integral part. For example, routine supplies, anesthesia, recovery room use, and most drugs are considered to be an integral part of a surgical procedure so payment for these items is packaged into the APC payment for the surgical procedure.” (CMS⁹)

“4.2.1 - Examples of Medicare Fraud

Fraud may take such forms as...Unbundling or “exploding” charges. ... Examples of cost report fraud include ... Including costs of non-covered services, supplies, or equipment in allowable costs.” (CMS²⁶)

“Processing and storage costs may include blood product collection, safety testing, retyping, pooling, irradiating, leukocyte-reducing, freezing, and thawing blood products, along with the costs of blood delivery, monitoring, and storage. In general, such categories of processing costs are not patient-specific. There are specific blood HCPCS codes for blood products that have been processed in varying ways, and these codes are intended to make payment for the variable resource costs of blood products that have been processed differently.” (CMS²⁷)

Cross References

- A. “[Moda Health Reimbursement Policy Overview](#).” Moda Health Reimbursement Policy Manual, RPM001.
- B. “[Medical, Surgical, and Routine Supplies](#).” Moda Health Reimbursement Policy Manual, RPM021.
- C. “[Facility Guidelines, General Overview](#).” Moda Health Reimbursement Policy Manual, RPM065.
- D. “[Facility DRG Validation](#).” Moda Health Reimbursement Policy Manual, RPM069.
- E. “[Revenue Codes Ending in "9" \("Other" Categories\)](#).” Moda Health Reimbursement Policy Manual, RPM042.

References & Resources

1. American Medical Association. “Introduction - Instructions for Use of the CPT Codebook.” *Current Procedural Terminology (CPT)*. Chicago: AMA Press.
2. “Coding Standards – Levels of Use.” *HCPCS Level II*. OptumInsight.
3. CMS. “Determination Of Cost Of Services To Beneficiaries.” *Medicare Provider Reimbursement Manual* (Pub. 15-1). Chapter 22.
<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929.html>
4. “Standards and Scope of Practice for the Licensed Practical Nurse and Registered Nurse.” Oregon State Board of Nursing, Nurse Practice Act.
https://public.health.oregon.gov/HealthyPeopleFamilies/Youth/HealthSchool/SchoolBasedHealthCenters/Documents/Training1108_NursePracticeAct.pdf
5. “Nursing Care.” Washington State Legislature, Revised Code of Washington (RCW), Chapter 18.79.
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Background Information

Surgical and medical supplies are used in the course of services performed/care provided by physicians and other professional providers in the inpatient hospital or outpatient hospital.

Many supply items have HCPCS codes. Some HCPCS for supply items may even have RVU values on the CMS Physician Fee Schedule. Despite this, supply items are included in the allowable amount calculation for the primary service or facility fee for which they were used and are not eligible for separate reimbursement, with limited exceptions which will be addressed later in this policy. Billing of both services provided and the associated supplies used must follow correct coding and billing guidelines. This document is provided to clarify Moda Health's policy on reimbursement for routine supplies provided during the course of treatment.

In the Inpatient Hospital setting, routine medical and/or surgical supplies are not separately billable on the hospital claim. Routine supplies include items normally found in floor stock, items customarily used in the course of treatment, items considered incident to a physician service (e.g., status indicator A), reusable supplies, equipment (whether hospital-owned or rented), and items directly related to and/or integral to the performance of services reported elsewhere on the claim. "Routine supplies should not be separately billed to a patient or a payor." (Nave/MedAssets⁷)

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member’s medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member’s medical benefit plan, the member’s medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider’s agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Policy History

Date	Summary of Update
7/12/2023	Clarification/Annual Review: Nursery room bundled charges added for clarification. Section B.7 added. Coding Guidelines: 1 entry added. Cross References: 3 entries added. Hyperlinks added. References & Resources: 1 entry added.
7/13/2022	Formatting & Clarification/Update: Change to new header. Acronym table: 2 entries added. Coding Guidelines & Sources: 6 additional CMS quotes added. References & Resources: item # 9 determined to be duplicate to # 10 with a typo, so deleted. All footnotes for # 10 – 27 renumbered accordingly. The section for item # 27 (now 26) was determined to no longer exist. Updated to different chapter & section which is applicable. Policy History section: Added. Entries prior to 2022 omitted (in archive storage).
11/12/2015	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
10/12/2009	Original Effective Date (with or without formal documentation). Policy based on correct coding guidelines and CMS policy for Hospital Routine Supplies and Services.