Routine Supplies, Services, and Medical Equipment

Reimbursement Policy

Purpose

To provide clarification to facilities on routine supplies, services, and equipment not eligible for separate reimbursement.

Policy

Health Care providers (facilities, physicians, and other health care professionals) are responsible for accurately and timely: documenting, billing, and coding by following industry standard guidelines, including but not limited to AMA, CPT, HCPCS, CPT Assistant, Centers for Medicare & Medicaid Services (CMS) National Correct Coding Initiative (NCCI) Policy Manual, NCCI table edits and other CMS guidelines for appropriate claims review processing by Community Health Options.

"All services integral to accomplishing a procedure are considered bundled into that procedure and, therefore, are considered a component part of the comprehensive code. Many of these generic activities are common to virtually all procedures and, on other occasions, some are integral to only a certain group of procedures, but are still essential to accomplish these particular procedures. Accordingly, it is inappropriate to separately report these services based on standard medical and surgical principles" (CMS Claims Processing Manual, Chapter 12).

Inpatient "Routine Services" as defined by CMS Provider Reimbursement Manual, Chapter 22-Section 2202.6: "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" (CMS Provider Reimbursement Manual).

Claims that are reimbursed at a percent of charge, only charges for covered services are eligible for reimbursement. Items identified in this policy are charges not eligible for reimbursement. Except for the applicable copayment, Health Care providers may not bill Members for routine supplies, services, and medical equipment because their costs are packaged into the payment for the procedure/facility charge with which they are used.

Coding and Billing Guidelines

"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" (AMA[1]). Unspecified codes (e.g. 99070) and any use of "miscellaneous" charge items may not provide separate reimbursement.

Medical Equipment/Supply

Medical Equipment is any device that is used in the rendering of patient care to include: capital, minor, and other hardware (tools, machinery, and other equipment) that is owned (lease, rental, or purchase) by the Health Care facility or provider. Medical equipment, instruments, apparatuses, implements or items that are generally used for diagnostic or therapeutic purposes, for which are not implanted or incorporated into a body part, and that are used on more than one patient (that is, are reusable), are excluded from reimbursement. There is no separate reimbursement for medical equipment because payment for these types of devices are packaged in the procedure or facility charge respectively (Federal Register).

Capital equipment is equipment used to provide services to multiple patients and has an extended life. This equipment is considered a fixed asset of the health care facility and is not separately reimbursable.

Example list (not all-inclusive) of medical equipment not eligible for separate reimbursement:

- Cameras
- Cell Saver equipment and related supplies
- Defibrillator
- Fluoroscopy
- Lasers
- Machines (Anesthesia, Bladder Scan, Blood Pressure, Cautery, Humidifier, Ventilator, etc.)
- Monitors (Arterial, Cardiac, Fetal, Oximetry, Neurological, Capnography, etc.)
- Procedure specific instruments, tools, kits, trays, and carts
- Pumps (IV, Bio, PCA, etc.)
- Rental equipment
- Scopes and Microscopes
- Video equipment

Routine Supplies

Routine supplies are not separately reimbursed, and therefore are included in the general cost of the procedure or facility charge respectively. These items are generally available to all patients receiving services.

Example list (not all-inclusive) of routine supplies not separately reimbursed:

- Alcohol swabs/wipes
- Anesthesia – Local or Topical unless it is part of a regional nerve block
- Baby powder

- Bair Hugger Machine/Blankets
- Basin
- Band-aids
- Batteries
- Bedpan
- Blood pressure cuffs/Stethoscopes
- Breast pump
- Catheters, Canisters, Tubing, and Liners
- Cold and Hot packs
- Compression Sleeves, SCD Sleeves, and Ted Stockings
- Cotton balls, Qtips
- Diapers, Pads, Briefs
- Drapes, Bed Sheets, Covers, Blankets, Towels
- Dressing, Gauze, Tape, Sponges, etc.
- Guidewire, Introducers
- IV supplies
- OR items (saws, stapler, sutures, blades, scalpels, drills, mixing bowl, equipment covers, etc.)
- Oximeter
- Oxygen
- Personal Protective Equipment (PPE) – includes masks, gloves, surgical gown, face shields/hoods, etc.
- Personal care/convenience items (e.g. soap, toothpaste, razors, deodorant, socks, etc.)
- Positioning Aides, Pillows, and Wedges
- Syringes, Needles, Butterflies
- Solutions (saline, dextrose, lactated ringers, irrigation, etc.)
- Thermometers
- Urine culture kits
- Vascular Closure Devices
- Water bottle or pitcher
- X-ray Aprons and Shields
- Items used to obtain a specimen or complete a diagnostic or therapeutic procedure
- Items commonly available to patients (e.g. stock or bulk supply)

Supplies that may qualify for separate reimbursement are required to meet all the following criteria:

1. Medically necessary and provided at the direction of a physician
2. Use of the supply is specific to an individual patient and not reusable
3. Supply is not commonly used for all patients for a specific service
4. Supply is not commonly provided within a treatment area or unit (ICU/NICU, CCU, OR, PACU, etc.)
5. Supply is not part of basic stock items

Routine Nursing Services

Other routine services that are considered packaged into the payment for the procedure or facility charge are listed below (not all-inclusive):

- Normal Scope of Nursing services: "Administration of", IV insertions and flushes, respiratory treatment, nebulizer treatments, catheterization procedures, venipuncture, obtaining and monitoring patient vitals, specimen handling/collection, intubation/extubation, personal hygiene care, personal safety/quality care (e.g. turning of patient), and medical record documentation.
- Mixing, preparation, or dispensing of any medications (IV fluids, nutrition, etc.).
- Incremental Nursing Charges (revenue codes 230-239).

Other Disallowed Charges

- Admission Charges
- Anesthesia supplies when billed with Anesthesia Time Charges
- Bedside, Point of Care, Near Patient Testing (glucose, blood count, arterial blood gas, etc.)
- Blood storage, processing, thawing, administration, etc. (revenue codes 380, 390-392, and 399)
- Enteral/Parenteral Feeding Supplies (sets, tubes, bags, etc.)
- Isolation carts and supplies
- OR set-up, Preoperative Care, and Holding Charges
- Specialty beds and Mattress
- Stat Charges
- Ventilation management charges

References

American Medical Association (AMA). "Introduction – Instructions for Use of the CPT Codebook". Current Procedural Terminology (CPT). Chicago: AMA Press.

CMS Provider Reimbursement Manual, Determination of Cost of Services to Beneficiaries, Chapter 22, Section 2202.6: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929.html

CMS Regulations and Guidance, Transmittals: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/a02129.pdf

Federal Register, Health Care Financing Administration (HCFA), 65 FR 18433, Medical Devices Section: https://www.federalregister.gov/documents/2000/04/07/00-8215/office-of-inspector-general-medicare-program-prospective-payment-system-for-hospital-outpatient

Related Policies

Itemized Bill Submission
Outpatient & Professional Service Edits

Document Publication History

6/30/2022	Annual Review; added related policies section
4/26/2021	Expanded Routine Supply list, added Other Disallowed Charges section, redefined capital equipment, and incorporated previous definitions into the Policy section.
6/27/2019	Initial publication

This policy provides information on Community Health Options' claims adjudication processing guidelines. As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, adherence to plan policies and procedures, and claims editing logic. Community Health Options reserves the right to amend a payment policy at its discretion. Policies are enforced unless underpinning direction stated otherwise.