

Routine Supplies, Services, and Medical Equipment

Reimbursement Policy

Definitions

1. Inpatient “Routine Services” as defined by Centers for Medicare & Medicaid Services (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” (CMS1).
2. CMS stipulates that supplies and drugs that are clearly integral to a treatment or procedure, insofar that the treatment or procedure could not be performed without them, are considered packaged and inclusive to the payment for that procedure or treatment (CMS2).

Policy

Health Care providers (facilities, physicians and other health care professionals) are responsible for accurately and timely: documenting, billing, and coding by following CMS billing guidelines for appropriate claims review processing by Community Health Options.

Except for the applicable copayment or cost-sharing, 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” (AMA1). 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).

In addition, Healthcare Financial Management Association (HFMA) provides additional caution of billing medical equipment. “It is not allowable to bill for either the replacement cost of equipment or operating equipment. Equipment is considered by the Health Care Financing Administration (HCFA) to be capital

equipment under the heading of ‘major medical, surgical or rehabilitation equipment.’ As such, the replacement cost is reimbursed as a capital pass thru on the Medicare cost report. To bill for this equipment would result in a minimum of double reimbursement and even more, depending on the total amount billed over the life of the equipment. This would be considered, at a minimum, abuse of the Medicare program and potentially fraudulent” (HFMA.org).

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

- Monitors (Arterial, Cardiac, Fetal, Oximetry, Neurological, etc.)
- Machines (Anesthesia, Bladder Scan, Blood Pressure, Cautery, Humidifier, Ventilator, etc.)
- Pumps (IV, Bio, etc.)
- Vascular Closure Devices
- Scopes and Microscopes
- Cameras
- Cell Saver equipment and related supplies
- Instruments, Tools, Tool Kits/Trays
- Lasers

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 considered floor stock and are generally available to all patients receiving services.

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

- Alcohol swabs/wipes
- Baby powder
- Basin
- Band-aids
- Batteries
- Bedpan
- Breast pump
- Cold and Hot packs
- Cotton balls
- Diapers
- Drapes
- Gloves
- Linen (gowns, bed sheets, etc.)
- Masks
- Oxygen
- Personal care/convenience items (e.g., soap, toothpaste, razors, deodorant, socks, etc.)
- Syringes and Needles
- Solutions (saline, irrigation, etc.)
- Thermometers
- Tubing (IV, Blood, etc.)
- Urine culture kits
- Water pitcher
- 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 ordinarily used for all patients for a specific service
4. Supply is not part of basic stock items

Other Routine 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, 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.)

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>

Document Publication History

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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.