moda HEALTH	Reimbursement Policy Manual	Policy #:	RPM021
Policy Title:	**Medical, Surgical, and Routine Supplies (including but not limited to 99070)**		
Section:	Administrative	Subsection:	None

Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:

Companies:	☒ All Companies: Moda Partners, Inc. and its subsidiaries & affiliates ☐ Moda Health Plan ☐ Moda Assurance Company ☐ Summit Health Plan ☐ Eastern Oregon Coordinated Care Organization (EOCCO) ☐ OHSU Health IDS
Types of Business:	☒ All Types ☐ Commercial Group ☐ Commercial Individual ☐ Commercial Marketplace/Exchange ☐ Commercial Self-funded ☐ Medicaid ☐ Medicare Advantage ☐ Short Term ☐ Other: _____
States:	☒ All States ☐ Alaska ☐ Idaho ☐ Oregon ☐ Texas ☐ Washington
Claim forms:	☒ CMS1500 ☒ CMS1450/UB (or the electronic equivalent or successor forms)
Date:	☒ All dates ☐ Specific date(s): _____ ☐ Date of Service; For Facilities: ☐ n/a ☐ Facility admission ☐ Facility discharge ☐ Date of processing
Provider Contract Status:	☒ Contracted directly, any/all networks ☒ Contracted with a secondary network ☒ Out of Network

Originally Effective:	1/1/2002	Initially Published:	12/10/2014
Last Updated:	11/3/2022	Last Reviewed:	11/9/2022
Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No			
Last Update Effective Date for Texas:	11/9/2022		

Reimbursement Guidelines

A. General Policy Statement

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.

(Please also refer to the "Coding Guidelines & Sources" section and "Procedure Code Definitions" table, listed later in this document.)

B. General Policies for All Settings

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

Per CPT and CMS 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. These items are considered supplies and are not eligible for separate reimbursement. (AMA[4,5], CMS[3]) Despite the fact that J1642 (Injection, heparin sodium,

(heparin lock flush), per 10 units) describes an item (flush) containing the drug heparin, heparin flushes are not considered a "drug" but rather a "supply" and heparin flushes 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.

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

For HCFA1500 claims with dates of service 04/01/2015 and following, CPT code 99070 will be denied to provider write-off with an explanation code mapped to Claim Adjustment Reason Code 189 (Not otherwise classified or "unlisted" procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service.). There is always a procedure code more specific than 99070 available to be used.

Correct coding guidelines require that the most specific, comprehensive code available be selected to report services or items billed. (AMA[1], Optum360/CMS[2]) We accept 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. The use of more specific HCPCS Level II procedure codes helps to ensure more accurate determination of benefits and processing of the claim.

It is important to note that not all HCPCS codes will be eligible for covered benefits under the member's contract, and if covered, not all HCPCS codes will be eligible for separate reimbursement.

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 provider, clinic, or 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). 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. (AdminaStar[14])

Examples of non-billable capital equipment: (AdminaStar[15])

- Cardiac monitors
- Cautery machines
- Oximetry monitors
- Scopes
- Lasers
- IV pumps
- Thermometers
- Automatic blood pressure machines and/or monitors
- Anesthesia machines
- Instruments
- Microscopes
- Cameras
- Rental equipment

C. For Professional Services

1. Supplies and Services Included in the Practice Expense Allowance

The Centers for Medicare and Medicaid Services (CMS) establishes and determines a relative value unit (RVU) for procedure codes and publishes this information on the Medicare Physician Fee Schedule Database (MPFSDB). Since 2002, the practice expense portion of the RVU includes medical and surgical supplies and equipment commonly furnished and that are a usual part of the surgical or medical procedures. (CMS[16]) Additional charges for routine supplies and/or equipment used for a surgical procedure or during an office visit or office procedure are not appropriate and not eligible for separate reimbursement, regardless of the method used to bill for them (individual HCPCS codes, 99070, a separate line item with modifier SU attached, etc.). Payment is included in the reimbursement for the primary procedure code.

The practice expense portion of the RVU includes such items as:

- Medical and/or surgical supplies
  - Surgical trays (e.g., A4550, and other HCPCS codes)
  - Syringes, needles, biopsy needles, local anesthetic, saline irrigation or flush supplies, etc.
  - Dressings, gloves, IV catheters and supplies, etc.
  - Other specific supplies needed for each procedure
- Wages for nonphysician clinical and nonclinical staff
- Building space and building utilities expenses
- Equipment expenses
  - EKG monitor, oximetry monitor, BP cuff/monitor, otoscope, thermometer, etc.
  - Lab and/or x-ray equipment
  - Other specific equipment needed for each procedure
- Office supplies and office equipment
- Furniture in treatment rooms, front office, lobby, etc.

2. Separately Reporting Additional Supplies and Materials

   In those cases when supplies and materials are provided which the provider feels are clearly over and above those usually included with the office visit or other services rendered and require separate reporting on the claim:
   - CPT code 99070 *should not be used* to bill for those supplies and materials. For claims processed with dates of service 04/01/2015 and following, 99070 will be denied to provider write-off.
   - Bill supplies and materials with HCPCS Level II codes to ensure that the most specific code available is billed, and to enable accurate claims processing.
   - Unlisted codes need to be submitted accompanied by a clear and specific description for the item or service being billed.

3. Separate Reimbursement for Additional Supplies and Materials

   The supplies and materials billed with a HCPCS Level II code may or may not be eligible for benefits under the member's contract, and if covered the supplies and materials may or may not be eligible for separate reimbursement.

   Procedure codes designated with status indicator B (Bundled code) and/or P (Bundled/Excluded codes) on the Medicare Physician Fee Schedule Database (MPFSDB) are not eligible for separate reimbursement. In the definition of these status indicators, CMS has indicated reimbursement for these codes is bundled into the allowance (RVU) for the physician service with which it is associated or connected ("incident to").

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation		Definition
AMA	=	American Medical Association
ASC	=	Ambulatory Surgery Center
BP	=	Blood Pressure
CCI	=	Correct Coding Initiative (see "NCCI")
CMS	=	Centers for Medicare and Medicaid Services
CPT	=	Current Procedural Terminology
DRG	=	Diagnosis Related Group (also known as/see also MS DRG)
EKG	=	Electrocardiogram
HCPCS	=	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	=	Health Insurance Portability and Accountability Act
MPFSDB	=	Medicare Physician Fee Schedule Database

Acronym or Abbreviation		Definition
MS DRG	=	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
NCCI	=	National Correct Coding Initiative (aka "CCI")
RPM	=	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
RVU	=	Relative Value Unit
UB	=	Uniform Bill

Procedure codes (CPT & HCPCS):

There are multiple codes for various supplies and implants but this policy refers to all current codes in effect at the time of the date of service.

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 at the time of the date of service.

The HCPCS Level II code set also includes a variety of non-specific codes which are still more specific than CPT code 99070. 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, 99070 is no longer considered valid for claims processing)
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

Code	Code Description
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
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
L8499	Unlisted procedure for miscellaneous prosthetic services
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

Some codes related to vitamins, supplements, and herbal remedies dispensed by Naturopaths or other professional providers:

Code	Code Description
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

Modifier Definitions:

Modifier	Modifier Description & Definition
Modifier SU	Procedure performed in physician's office (to denote use of facility and equipment)

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. (AMA[1])

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. (Optum360/CMS[2])
- 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. (Optum360/CMS[2])
- 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." (CMS[13])

"Therapeutic, prophylactic, and diagnostic injections and infusions, (excluding chemotherapy)

A therapeutic, prophylactic, or diagnostic IV infusion or injection, other than hydration, is for the administration of substances/drugs. The fluid used to administer the drug(s) is incidental hydration and is not separately payable.

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 nonchemotherapy injection and infusion service." (CMS[3])

"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" (AMA[4,5])

Cross References

A. "Moda Health Reimbursement Policy Overview." Moda Health Reimbursement Policy Manual, RPM001.

B. "Hospital Routine Supplies and Services." Moda Health Reimbursement Policy Manual, RPM043.

C. "Modifier SU - Procedure Performed in Physician's Office (Facility and equipment)." Moda Health Reimbursement Policy Manual, RPM070.

D. "Additional Practice Expense Items During a Public Health Emergency (PHE) – CPT 99072." Moda Health Reimbursement Policy Manual, RPM074.

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.* Optum360.

3. CMS. "Payment for Codes for Chemotherapy Administration and Nonchemotherapy Injections and Infusions." *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 30.5, C.

4. American Medical Association. "Reporting Drug Administrations [sic] Services for 2006." *CPT Assistant.* Chicago: AMA Press, November 2005, p. 1.

5. American Medical Association. "Hydration, Therapeutic, Prophylactic, Diagnostic Injections and Infusions, and Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration." *Current Procedural Terminology (CPT) 2014, Professional Edition.* Chicago: AMA Press, pp. 591-592.

6. CMS. *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 20.4.4.

7. Dummit, Laura A. *The Basics: Relative Value Units (RVUs)*. National Health Policy Forum. Washington, DC: The George Washington University, February 12, 2009.

8. CMS. *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 17 – Drugs and Biologicals, § 20.1.3, 20.3, 80.5, 80.6.

9. Wright, Suart. *Office of Inspector General (OIG) Memorandum Report: Payment for Drugs Under the Hospital Outpatient Prospective Payment System (OPPS)*. Washington D.C.: Office of Inspector General (OIG), October 22, 2010.

10. Kirschenbaum, Bonnie, MS, FASHP, FCSHP. *Quirks In the Reimbursement (It's hard to get paid if you don't know the rules)*. Oncology Issues, July/August 2010.

11. CMS. *National Correct Coding Initiative Policy Manual*. Chapter 11 Medicine, § B Therapeutic or Diagnostic Infusions/Injections and Immunizations & § N Chemotherapy Administration.

12. CMS. *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 30.5.

13. CMS. *National Correct Coding Initiative Policy Manual*. Chapter 1 General Correct Coding Policies, §A, "Introduction".

14. AdminaStar Federal Bulletins: 95-05-02 and 95-10-12.

15. AdminaStar Supplies Guidelines. AdminaStar Medicare FI. February 18, 2012: September 6, 2013. http://www.docstoc.com/docs/113740447/Download-File43 .

16. "2002 Changes and Corrections." Medicare Part B News, Issue # 194, page 24.

Background Information

Surgical and medical supplies are used in the course of services performed/care provided by physicians and other professional providers in the office or clinic setting, or inpatient hospital, outpatient hospital, ambulatory surgery center (ASC), and multiple other outpatient settings.

Many supply items have HCPCS codes. Some HCPCS for supply items may even have RVU values on the CMS Physician Fee Schedule. Despite this, supplies used in conjunction with care provided in physician's office/clinic or other outpatient setting generally may not be separately reported and are not eligible for separate reimbursement based on industry standard guidelines. The procedure codes for professional services include reimbursement for the supply items needed to perform those services. As of January 1, 2002, the practice expense portion of the RVU includes an allowance for medical and surgical supplies and equipment needed to perform the surgical or medical procedures. (CMS[16])

Billing of both the services provided and the associated supplies used must follow correct coding and billing guidelines. This document is provided to clarify our policy on reimbursement for routine supplies provided during the course of treatment.

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
11/9/2022	Formatting/Update: Change to new header; includes Idaho. Converted section A. General Policy Statement into outline format. Acronym Table added. Cross References: Hyperlinks added. Policy History section: Added. Entries prior to 2022 omitted (in archive storage).
12/10/2014	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
1/1/2022	Original Effective Date (with or without formal documentation). Policy based on CMS policy, procedure codes definitions, and correct coding guidelines.