



Facility Routine Supplies and Services

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NOTICE

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Blue KC reserves the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to: <https://providers.bluekc.com/ContactUs/PaymentPolicies>.

PROVIDER/ENTITY IMPACTED

<input checked="" type="checkbox"/> PROFESSIONAL	<input checked="" type="checkbox"/> FACILITY	<input type="checkbox"/> DME	<input type="checkbox"/> AMBULATORY SURGERY	<input checked="" type="checkbox"/> LAB	<input type="checkbox"/> OTHER
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LINES OF BUSINESS IMPACTED

<input checked="" type="checkbox"/> COMMERCIAL	<input checked="" type="checkbox"/> BLUE MEDICARE ADVANTAGE	<input checked="" type="checkbox"/> ACA QHP¹	<input checked="" type="checkbox"/> SMALL GROUP ACA	<input checked="" type="checkbox"/> JAA²	<input checked="" type="checkbox"/> FEP³	<input type="checkbox"/> DENTAL
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¹ ACA QHP: Affordable Care Act Qualified Health Plan for Individual/Family ² JAA: Joint Administrative Account ³ FEP: Federal Employee Program

Disclaimer

Blue KC has developed Provider Payment Policies to provide guidance on payment methodologies as they pertain to submitted claims. These policies are written following industry standard recommendations from sources such as:

- Current Procedural Terminology
- Centers for Medicare and Medicaid
- American Medical Association
- National Correct Coding Initiative
- Other professional organizations and societies

Coverage of any service is determined by date of service, a member's eligibility and benefit limits for the service or services rendered, all terms of the Provider Service Agreement, and other standards of coding rules and guidelines.

Final payment is subject to the application of claims adjudication and edits common to the industry.

For confirmation of which services may be eligible for coverage and description of when medical services are considered medically necessary, not medically necessary, or investigational, please contact:

- Blue KC Provider Hotline for Commercial lines of Business 816-395-3929
- Affordable Care Act Provider Hotline 866-859-3822
- Blue Medicare Advantage Provider Hotline 866-508-7140

In the event of a conflict between any policies, the Member's coverage document will govern.

Description/Application

This policy is being published to provide greater transparency into our process regarding items associated with certain inpatient and outpatient stays that aren't considered separately reimbursable. These items are already

included within the room and board reimbursement or the reimbursement for an underlying procedure, as applicable.

In addition, Blue KC does follow the 3-day payment rule on outpatient services that are considered medically related to an inpatient stay. Under the 3-day payment window, a hospital (or an entity that is wholly owned or wholly operated by the hospital) must include on the claim for a beneficiary's inpatient stay, the diagnoses, procedures, and charges for all outpatient diagnostic services and admission-related outpatient nondiagnostic services provided during the payment window.

All services other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the same date of the inpatient admission are deemed related to the admission and are not separately reimbursed.

Policy

Routine services encompass regular room/observation room costs, dietary and nursing services, minor medical and surgical supplies, medical and psychiatric social services, and the use of certain equipment and facilities without a separate charge. While services not considered routine (or "ancillary") may be considered for reimbursement, routine aspects of such ancillary services will not be separately reimbursed.

Routine services are incorporated into the reimbursement for the room and board charge (which can include both standard hospital rooms and special care units such as the CCU or ICU), facility charge, or ancillary service charge, as appropriate for the location where the services are provided. There is no separate reimbursement for bundled separately billed routine services.

Routine medical equipment and supplies are not eligible for separate reimbursement as they are included in the reimbursement for the procedure or facility charge. These items, which are generally available to all patients receiving services, are considered floor stock, and are incorporated into the overall reimbursement of the procedure or facility charge. Therefore, routine supplies are not separately reimbursable.

The following guidelines may assist facility personnel in identifying items, supplies, and services that are not reimbursed separately. This is not an all-inclusive list.

- 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 in the inpatient and outpatient environments. (Radiopharmaceuticals will be reimbursed separately for Medicare Advantage lines of business)
- All items and supplies that may be purchased over the counter
- All reusable items, supplies and equipment that are provided to all patients during an inpatient or outpatient admission
- All reusable items, supplies, and equipment that are provided to all patients admitted to a given treatment area or unit

Facility Routine Supplies and Services

Medical Equipment/Supplies

This includes, but is not limited to, items associated with revenue codes 260-269, 270, 279, 410, and 412

Intravenous (IV) Therapy, IV Infusion Pump, IV Pharmacy Services	Sterile Supplies (Surgical Instruments, Biopsy Forceps, Implanted Medical Devices)
Non-Sterile Supplies (Stethoscopes, Bandages, Diagnostic Kits, Medical Instruments)	Perfusion Equipment and Supplies
Machines (Anesthesia, Bladder Scanner, Blood Pressure, Humidifier, CPAP)	Pumps (IV, Bio, syringe, blood warmer, suction, feeding, PCA)
Beds, Commodes, Scales, Overhead Frame	Fetal Monitors

Medical/Surgical Supplies

This includes, but is not limited to, items associated with revenue codes 250, 270–279

Alcohol Swabs/Pads/Baby Powder	Basin
Bandages/Dressings	Mouth Care Kits
Batteries	Oxygen and Supplies (Masks, Cannula, Tubing)
Bedpans	Breast Pumps
Cold/Hot Packs	Reusable Equipment or Items
Head Lights or Pads	Thermometers
IV solutions	IV Saline and/or Heparin Flushes
Tubing, (IV, Blood)	Items used for specimens' collection (arterial blood gas kit, urine collection kits, mucus traps)

Nursing Care/Services, carried out by primary bedside nurses (RN and/or LPN), respiratory therapists, certified nursing assistants, perfusionists or other technicians as part of their daily responsibilities, are included in the reimbursement for the room and board charge and are not eligible for separate reimbursement.

Nursing Services

This includes, but is not limited to, items associated with revenue codes 260, 300, 309, 361, 391, 460, 510, 761

Administration of Blood or any Blood Product	Administration/Application of any Medication, Chemotherapy, and/or IV Fluids
Assisting Physician in Performing any Procedure	Medical Record Documentation
Accessing Indwelling IV Catheter	Preparing and Dispensing Medication
Monitoring (Cardiac Monitors, Vital Signs)	Fluid Specimen Collection
Personal Hygiene	Point of Care Testing (Glucose, Urine Dip, ABG)
Respiratory Treatments	Incremental Nursing Care
Insertion, removal, maintenance of Nasogastric Tubes	IV Hydration
Maintenance or Flushing of Tubing	Tracheostomy Care
Urinary Catheterization	Venipuncture (Venous or Arterial)
IV and PICC line insertions	IV transfusions

Facility Routine Supplies and Services

In addition to the above-listed services, personal and supply items, and equipment, if post-operative surgical or procedural recovery services are performed in any critical care room setting other than the Pre- and Post-Anesthesia Recovery Room, the critical care daily room charges will cover service charges.

This coverage extends to surgical suites (both major and minor), treatment rooms, endoscopy labs, cardiac cath labs, X-ray facilities, pulmonary and cardiology procedural rooms. Reimbursement of the hospital's charge for surgical suites and services includes the entire range of nursing personnel services, supplies, and equipment, as already included in the basic or critical care daily room charges. Additionally, the following services and equipment will be incorporated into the surgical rooms and service charge reimbursement.

Surgical Rooms

This includes, but is not limited to, items associated with revenue codes 270-279, 300-370

Anesthesia Equipment, Monitors and Gases	Robotic Assisted Techniques
Intubation/Extubation	Drill bits, Saws, Blades, etc.
Blood Pressure/Vital Sign Equipment	Batteries for any Equipment
Cardiac Monitors	Saline Infusion, slush machine,
Cardiopulmonary Bypass Equipment	CO2 Monitors
Surgeons' Loupes or Visual Assisting Devices	Surgical Cultures
Grounding Pads	Hemochron Supplies
Laparoscopes, Bronchoscopes, Endoscopes, Fluoroscopies/C-arm, and Additional Accessories	Local Anesthesia
Laboratory Specimen Collection	Video Camera Equipment

Reimbursement for recovery room services (time or flat fee) includes all used and or available services, equipment, monitoring, nursing care that is necessary for the patient's welfare and safety during his/her confinement. This includes, but is not limited to EKG monitoring, Dinamap, pulse oximeter, injection fees, nursing, nursing time, nursing supervision, equipment, and supplies (whether disposable or reusable), intermittent compression devices, defibrillator, and oxygen. Separate reimbursement for these services will not be made.

Ventilator management (CPT 94002, 94003) will be allowed once per day by either a physician, an advanced practice provider, or respiratory therapist

Examples of Ventilator or CPAP components that are not separately reimbursed.

This includes, but is not limited to, items associated with revenue codes 410, 412, 419, 460

System Set Up, System Checks, Circuit Change	Respiratory assessment
Tracheostomy, Supplies and Care	Carbon Dioxide end tidal system setup and/or monitoring
O2, CPAP, PEEP changes	Endotracheal suctioning, weaning, extubating,

The following information is for all settings, included but not limited to outpatient, inpatient, ambulatory surgery centers, and residential care

General Policies for all Settings

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. Even though J1642 (Injection, heparin sodium, (heparin lock flush), per ten 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 hospital 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.

Blood Draws

Blood draws are considered a part of a lab service and are not reimbursed separately. This includes:

- Venipuncture
- Finger, heel, and ear sticks

Supplies, Materials, Supplements, Remedies, etc.

Correct coding guidelines require that the most specific, comprehensive code available be selected to report services or items billed. Blue KC accepts HCPCS codes for processing. Therefore, 99070 is rarely the most specific code available 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. When billing an unlisted code, medical records will be reviewed prior to claim adjudication.

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 will not be separately reimbursed.

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) is not separately reimbursable.

Facility Routine Supplies and Services

Examples of non-reimbursable capital equipment:

- Cardiac monitor
- 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

Coding

CPT/HCPCS	Definition
N/A	

References and Resources

Medicare Reimbursement Manual – Part 1, Chapter 22, Determination of Cost of Services to Beneficiaries, 2202.6 Routine Services
American Medical Association, Current Procedural terminology and association publications and services
Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets
CMS, National Correct Coding Initiative Policy Manual for Medicare & Medicaid

Related Documents

Blue KC Payment Policy POL-PP-194 Implants – Inpatient Facility
Blue KC Payment Policy POL-PP-254 Codes Inclusive to Imaging Services

Revision History

Version	Date	Summary of Revisions
001	09/01/2018	Initial version
002	09/1/2019	Annual review- No changes were made
003	09/01/2020	Annual review, no changes were made

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004	05/13/2021	Blood draws are considered to be a part of the lab service and are not separately reimbursed.
05	9/1/2021	Annual Review, no changes were made
06	9/1/2022	Annual Review, added "When billing an unlisted code, medical records will be reviewed prior to claim adjudication.
07	9/1/2023	Annual review, added to policy "This policy applies to all lines of business, including, but not limited to, Commercial, Medicare Advantage, Federal Employee Program, and ACA."
08	3/12/2024	Removed blood drawn from capillary, arterial, or vascular access devices from being considered part of lab fee.
09	9/1/2024	Annual Review, no changes were made.
10	3/7/2025	Removed "low osmolar" from Contrast material for inpatient or outpatient radiology procedures
11	3/12/2025	Clarification added on ventilator management being included in facility charges as it is considered an integral part of the overall care provided to a patient requiring mechanical ventilation
12	4/1/2026	Update - Ventilator management (CPT 94002, 94003) will be allowed once per day by when submitted by a physician, advanced practice provider, or respiratory therapist