**Title: Revenue Integrity - CDM - Supply Charging Policy**

**Policy:** Concord Hospital consistently evaluates supplies to determine if they are separately chargeable or not. Charges for routine supplies are packaged into the charges for the procedure or room charge. Non-routine supplies are separately charged. The decision of whether a supply is separately chargeable is *not* based on whether it will be reimbursed separately by Medicare.

Every supply provided by the hospital, will be captured in one of the following ways:

* Bundling the supply charge into general overhead
* Bundling the charge into an associated service, procedure, or item
* Separately charging the supply on a claim line item without a CPT/HCPCS code and a packaged revenue code
* Separately charging the supply on a claim line item with a CPT/HCPCS code
1. **Purpose:**

This document standardizes the determination of whether a supply is separately chargeable or not. It also provides guidance on how these items should be set up in the charge master.

1. **Abbreviations:**

CDM – Charge Description Master

CMS – Centers for Medicare and Medicaid Services

CPT – Current Procedural Terminology

DME – Durable Medical Equipment

FIM – Financial Item Master

HCPCS – Healthcare Common Procedure Coding System

MAC – Medicare Administrative Contractor

SIM – Service Item Master

1. **Definitions:**

Chargemaster – A database of all separately chargeable items, services, and supplies used in patient care and their associated prices. The charge master line item is made up of a department identifier, the charge item number (FIM and SIM), a description, a price, a HCPCS or CPT code, and a UB revenue code.

Durable Medical Equipment – Equipment that can withstand repeated use, is primarily used to service a medical purpose, is generally not useful to a person in absence of illness or injury, and is appropriate for use in the person’s home.

HCPCS – Codes maintained by the Center for Medicare and Medicaid Services (CMS). These codes describe services, procedures, durable medical equipment (DME), supplies, drugs, biologics, and radiopharmaceuticals. They are updated quarterly.

Implant – An implant is any type of material that is inserted or grafted onto the body. An implant may be human or animal tissue, inert material, or a radioactive substance. Implants of inert material are also referred to as implantable durable medical equipment. The implant may, but does not have to remain in the patient when the patient is discharged.

Orthotic Device – An orthopedic appliance or apparatus used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body.

Prosthetic Device – A device that replaces all or part of the function of a permanently inoperative or malfunctioning internal body organ.

Supply Items – Items used in the treatment of patients – such as trays, gowns, casting materials, and needles.

UB Revenue Code – A four digit code established by the National Uniform Billing Committee (NUBC) that categorizes a line item in the charge master. Examples: 0110 = Room & Board – Private; 0481 = Cardiac Cath Lab.

1. **Charging threshold:**

Concord Hospital will not charge separately for supply items if the charge (Cost x Markup) is less than $10.00. Concord Hospital considers supply items with a charge of less than $10.00 to be a routine supply.

1. **Pricing:**

Chargeable supply pricing is based on the current cost of the supply adjusted by established mark-up formulas. Supply charges that are hardcoded in STAR will be reviewed at least annually. In addition, the clinical department using the supply must notify the Manager of Revenue Integrity when the cost of the supply increases or decreases by more than 10% to allow for pricing updates. Manually priced supply items will be reviewed annually for coding accuracy.

For more information about pricing, see [Revenue Integrity - CDM - Pricing Policy](https://policyweb.crhc.org/docview/?docid=6534)

1. **Routine vs. non-routine**
	1. **Routine supplies**:
		1. **Definition:**

Routine supplies are not separately chargeable. They are items used during the normal course of treatment, and are directly related to 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 available to all patients in that specific area or location. Reusable supplies and equipment are also considered routine.

While, generally, items found in floor stock are considered routine, there may be some items stored in a general area in a department or on a nursing unit that are not considered routine. The amount or volume of the items typically must be measured or traceable to an individual patient for billing purposes. For example, IV fluids may be stored in bulk on a shelf in a stock room in order to be readily available when they are needed; however, these fluids require a physician’s order and are separately identifiable to a specific patient based on documentation in the medical record.

Supplies that are necessary or otherwise integral to a procedure or service are considered routine and not separately chargeable. The cost of these supplies will be included in the charge for the procedure or service. Integral means the supply is provided to all patients receiving the same service. Supplies that can vary based on the patient (e.g. age, sex, weight, diagnosis, medical needs) will not be considered routine.

* + 1. **Charge master set up for routine supplies:**

There is no charge master set up for routine supplies, because they are not separately chargeable. The cost of the supply should be included in the price of the separately chargeable therapy, treatment, room charge, procedure, or service.

* + 1. **Medicare reimbursement for routine supplies:**

There is no separate reimbursement for routine supplies, because they are not separately charged. Because the cost of the supply is included in the separately charged service, the supply cost will be considered when CMS sets rates for the separately reimbursed service.

* + 1. **Examples of routine supplies:**

**Figure 6.1. Examples of Routine Supplies (not an all-inclusive list)**

|  |  |  |
| --- | --- | --- |
| * Gowns/masks
* Towels
* Hypodermic needles
* Catheter anchors
* Lab supplies
* Suture boots
* Scalpels/blades
 | * IV tubing
* EKG electrodes
* Skin preps
* Personal care items
* Raytec/Lap sponges
* Kits/sets (without implants)
* TED Hose
 | * Bedpans/urinals
* Cautery cords
* Suction tubing/tips
* Oximeter probes
* Hypo/hyperthermia blankets
* Ambu bag
 |

* 1. **Non-routine supplies**
		1. **Definition:**

Non-routine supplies are also known as ancillary supplies. Non-routine supplies are separately chargeable. To be billed as non-routine, the item must be:

* Directly identifiable to a specific patient.
* Furnished at the direction of a physician because of specific medical need (excluding gowns, gloves, drapes, etc.) and must be documented in the patient’s medical record.
* Either non-reusable or represent a cost for each preparation.
* Types of non-routine supplies include implantable devices, prosthetic and orthotics (P&Os), and other supplies that do not meet the criteria of a routine supply.
	+ 1. **Charge master set up for non-routine supplies:**

Non-routine supplies are separately charged. Please note that even if a supply is assigned a HCPCS code, and separately *charged*, this doesn’t necessarily mean it will be separately *reimbursed*.

If the supply item is assigned a HCPCS code, the Revenue Integrity department will consult the Medicare OPPS Addendum B when determining how to set up the SIM for non-routine supplies.

The following items will be assigned a HCPCS code if one is available.

* Items designated with an “A” OPPS status indicator AND considered a non-implantable prosthetic or orthotic. Supply items considered prosthetics and orthotics can be identified with the presence of Category PO in the DMEPOS Fee Schedule.
* Items designated with an “N” (packaged items) OPPS status indicator
* Items designated with an “H” (pass-through devices) OPPS status indicator

If the item is assigned another status indicator, such as “A,” (excluding P&O), the supply is considered incident to a physician service and the HCPCS code should not be billed on the claim. Instead, the charge will be reported with the appropriate packaged revenue code. A list of packaged revenue codes can be found in the OPPS Final Rule.

* + 1. **Medicare reimbursement for non-routine supplies:**

Generally, Medicare bundles the payment for the supply into the payment for the separately chargeable service. For example, when the hospital charges for a hemodialysis catheter along with a charge for the insertion of the catheter, Medicare reimburses one sum for the insertion, and the supply reimbursement is bundled into that one payment.

Even though Medicare bundles the reimbursement for the supply, the charge data is used to set the rates for the separately reimbursed service, and therefore, Concord Hospital will charge separately for these non-routine supplies.

Medicare does pay separately for newly-approved devices. These devices are called transitional pass-through devices, and are paid separately for no less than two years and no more than three years.

* + 1. **Examples of non-routine supplies:**

**Figure 6.2. Examples of Non-Routine Supplies (not an all-inclusive list)**

|  |  |
| --- | --- |
| * Pacemaker/ ICD (implant)
* Neuro-stimulator (implant)
* Event recorder
* Hemodialysis catheter
 | * Knee mobilizer (P&O)
* Cervical collar (P&O)
* Braces (P&O)
* Kits/sets/trays (with implants)
 |

1. **Implanted Devices**
	1. **Definition**

Concord Hospital uses the NUBC definition of an implant: That which is implanted, such as a piece of tissue, a tooth, a pellet of medicine, or a tube or needle containing a radioactive substance, a graft, or an insert. Also included are liquid and solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed. An object or material partially or totally inserted or grafted into the body for prosthetic, therapeutic, diagnostic purposes.

* 1. **When an implant is separately chargeable**

Concord Hospital will charge separately for implants meeting the NUBC requirements.

The NUBC requires the following two steps to be used when determining if an item meets the implantable device definition:

* First: CMS states what is not a device – A device is not a material or supply furnished incident to a service (e.g. a surgical staple, a suture, customized surgical kit or clip, other than a radiologic site marker). If the item passes the first step then review the second step.
* Second: Determine if the device meets the NUBC definition below:

*“That which is implanted, such as a piece of tissue, a tooth, a pellet of medicine, or a tube or needle containing radioactive substance, a graft, or an insert. Also included are liquid and solid plastic materials used to augment tissues or to fill in area traumatically or surgically removed. An object or material partially or totally inserted or grafted into the body for prosthetic, therapeutic, or diagnostic purposes.*

Items meeting the two above criteria will be charged separately using the appropriate implant revenue code, and a HCPCS, if available.

* 1. **Charge master set up for implants**

Implants meeting the above NUBC requirements are separately charged. Please note that even if a supply is assigned a HCPCS code, and separately *charged*, this doesn’t necessarily mean it will be separately *reimbursed*.

The Revenue Integrity department will consult the Medicare OPPS Addendum B when determining how to set up the SIM for implants.

The following items will be assigned a HCPCS code if one is available.

* Items designated with an “N” (packaged items) OPPS status indicator
* Items designated with an “H” (pass-through devices) OPPS status indicator

If the item is assigned another status indicator, such as “A,” (excluding P&O), the supply is considered incident to a physician service and the HCPCS code should not be billed on the claim. Instead, the charge will be reported without a HCPCS and the appropriate packaged revenue code. A list of packaged revenue codes can be found in the OPPS Final Rule.

* 1. **Medicare reimbursement for implants**

Generally, Medicare bundles the payment for the implant into the payment for the separately chargeable service. For example, when the hospital charges for an implantable cardioverter-defibrillator along with a charge for the insertion of the cardioverter-defibrillator, Medicare reimburses one sum for the insertion, and the implant reimbursement is bundled into that one payment.

Even though Medicare bundles the reimbursement for the supply, the charge data is used to set the rates for the separately reimbursed service, and therefore, Concord Hospital will charge separately for these non-routine supplies.

Medicare does pay separately for recent FDA-approved devices. These devices are called transitional pass-through devices, and are paid separately for no less than two years and no more than three years.

* 1. **Wasted Implants**

Concord Hospital will follow the guidance in CMS Program Memorandum A-02-129, for all wasted implants.

***Wasted implants may be billed in the following two situations:***

* When the implant has been inserted, and then removed. The reason for removal must be clearly documented in the operative report.
* When the insertion was attempted, but unsuccessful. The reason for unsuccessful insertion must be documented in the operative report.

***Wasted implants may not be billed in the following situations:***

* The implant has not been in contact with the patient.
* The implant was opened, contaminated, or the wrong size, but was not used.
* The implant failed or was defective. In this case, we will not bill the implant, but contact the vendor/manufacturer for a refund or replacement.
	1. **Examples of implants:**

**Figure 7.1. Examples of Implants (not an all-inclusive list)**

|  |  |  |
| --- | --- | --- |
| * Stents
* Artificial joints
* Shunts
 | * Grafts
* Pins
* Plates
 | * Screws
* Anchors
* Radioactive seeds
 |

1. **Capital Equipment**
	1. **Equipment** - Equipment, whether purchased or rented, should not be charged separately. The equipment costs are captured via depreciation or rental cost in the Medicare cost report. When a hospital agrees to provide a service, it is the hospital’s responsibility to have the appropriate and required equipment available for providing the service. If the hospital has to rent a piece of equipment in order to provide the service, this is considered a cost of doing business. These items are included in the cost of the procedure and not separately billable, with the exception of some Durable Medical Equipment (see section 9).
	2. **Disposable supplies** - Disposable supplies associated with capital equipment may be separately chargeable (see the proceeding sections to determine whether the item is separately chargeable or will be included in the procedure cost).
2. **Durable Medical Equipment (DME)**
	1. **Definition:**

Durable Medical Equipment is defined as equipment that can withstand repeated use, is primarily used to service a medical purpose, is generally not useful to a person in absence of illness or injury, and is appropriate for use in a person’s home.

Most items traditionally considered DME can only be billed by DME facilities. Concord Hospital is not licensed as a DME facility, and therefore cannot bill to the DME MAC per Medicare DME billing regulations. However, the following three items have been granted an exemption to these regulations and can be billed by hospitals:

* **Implanted DME**, such as pacemakers and replacement joints. Concord Hospital charges for implantable DME when it meets the NUBC definition of an implant and Medicare coverage requirements. See section 7
* **Surgical dressings** – Concord Hospital doesn’t charge separately for surgical dressings. The costs for these items are included in hospital overhead.
* **Prosthetics and orthotics** – Concord Hospital charges for prosthetics and orthotics when they meet Medicare’s coverage requirements. See section 9.2.
	1. **Prosthetics and Orthotics:**
		1. **Coverage:** Medicare covers prosthetic and orthotic devices only when these items are used as permanent replacements for malfunctioning or missing organs or as supportive orthopedic appliances. Medicare doesn’t cover these devices when used to deliver a routine service. For example, Foley catheters and urinary drainage bags are routinely used in hospitals; however, they would only be considered prosthetic if used as a urinary replacement device for a permanently incontinent patient.
		2. **Charging:** The chargemaster has been updated with prosthetic and orthotic DME items that Concord Hospital can bill for per the DME billing guidelines. If you need to charge a DME item that is not in the charge master, email the Revenue Integrity Coordinator and s/he will advise whether the item is chargeable or not.
	2. **Chargemaster Setup for Durable Medical Equipment**

The Revenue Integrity department will consult the Medicare OPPS Addendum B when determining how to set up the SIM for DME.

The following items will be assigned a HCPCS code if one is available.

* Items designated with an “A” OPPS status indicator AND is considered a non-implantable prosthetic or orthotic. Supply items considered prosthetics and orthotics can be identified with the presence of Category PO in the DMEPOS Fee Schedule.
* Items designated with an “N” (packaged items) OPPS status indicator
* Items designated with an “H” (pass-through devices) OPPS status indicator

If the item is assigned another status indicator, such as “A,” (excluding P&O), the supply is considered incident to a physician service and the HCPCS code should not be billed on the claim. Instead, the charge will be reported without a HCPCS and the appropriate packaged revenue code. A list of packaged revenue codes can be found in the OPPS Final Rule.

1. **Kits, Trays, Packs, and Sets**

Kits, trays, packs, and sets will be carefully reviewed by the clinical department and Revenue Integrity for inclusion of routine items that should not be separately charged. Additionally, if the kit contains individual items that are separately considered non-routine, those items should be charged separately.

If the kit is determined to be chargeable, and does not have a HCPCS code, then it can be billed under the appropriate packaged revenue code without a HCPCS code.

1. **Parenteral and Enteral Nutrition Services**
	1. **PEG Tubes** – Percutaneous Endoscopic Gastrostomy (PEG) tubes are considered implants and should be reported without a HCPCS under revenue code 278. There are B HCPCS codes for these items, but these codes cannot be reported by facilities.
	2. **Enteral nutrition (EN) and total parenteral nutrition (TPN) –** Typically, only DME providers can bill for enteral and parenteral nutritional supplements.
2. **References:**

Medicare Claims Processing Manual (PUB. 100-04), Chapter 4, Section 10, Subsection 10.4: Packaging

Medicare Claims Processing Manual (PUB. 100-04), Chapter 20, Section 10, Section 10.1.2: Prosthetic Devices – Coverage Definition

Medicare Benefit Policy Manual (PUB. 100-02), Chapter 14, Section 10: Coverage of Medical Devices

1. **Related Documents:**

[Revenue Integrity - CDM - CDM Maintenance](https://policyweb.crhc.org/docview/?docid=2753)

[Revenue Integrity - CDM - Pricing Policy](https://policyweb.crhc.org/docview/?docid=6534)

1. **Authorizing Document:**

N/A

1. **Associated Committees:**

Charge master Committee

**Appendix A: Decision Tree for Routine vs Non-Routine Supplies**

|  |  |  |
| --- | --- | --- |
| Is it medically necessary and furnished at the direction of a physician?  | **No** | **Routine** |
|  **Yes** |  |  |
| Is it separately identifiable to an individual patient?  | **No** | **Routine** |
|  **Yes** |  |  |
| Is it disposable and used only on one patient and then thrown away? OR does it meet the definition of Durable Medical Equipment?  | **No** | **Routine** |
|  **Yes** |  |  |
| Is this a bulk supply item that is open for use to the general patient population?  | **Yes** | **Routine** |
|  **No** |  |  |
| Is this a food supplement or part of a dietary plan?  | **Yes** | **Routine** |
|  **No** |  |  |
| **Non-Routine** |  |  |  |