Introduction

The proper categorization of supplies has become a difficult issue in light of both payment system changes and with the increase in compliance rules and regulations in all areas of health care payment. The following has been developed to assist in the development of proper billing policies and procedures in this area. The supply issues addressed here do not include non-implantable DME (Durable Medical Equipment) or any other types of equipment that might be construed to be supply items. These should be cross-referenced in other applicable policies and procedures.

Additionally, the special APC Transitional Pass-Through items that commenced with the implementation of APCs are also not explicitly addressed in this position paper. These transitional items are addressed in a separate position paper and which also involves setting of prices and preferential fee schedules. This issue of the ‘Medicare Charging Rule’ is also addressed in a separate position paper.

Thus the discussion provided herein pertains primarily to Revenue Center Codes\(^2\) (RCCs) 270, 271 and 272. There are additional RCCs for supplies that should be used before the 270, 271, 272 sequence is considered. (Note: RCC=270 is scheduled to be discontinued by Medicare. Replace with RCC=271 or 272 or other RCCs as appropriated.)

Historical Background

In the next section of this position paper Section 2203.2 of the Medicare Provider Reimbursement Manual is discussed. This entry forms the basis of proper billing for supply items. One of the first\(^3\) Fiscal Intermediaries to take this section and extrapolate the contents was AdminaStar Federal in their Part A Bulletin, #95-10-12 issued on October 17, 1995. Over the years other FIs have followed suit and Medicare auditors from the FIs have developed internal audit standards in this area as well. Whether their interpretations of these rules are correct or incorrect can be questioned. It is difficult to obtain these internal

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1 The Apex Medical Center is a fictitious hospital that is used, along with other entities and fictitious persons, in Dr. Abbey's workshops, books and articles.
2 We will use RCC as an acronym for either Revenue Code or Revenue Center Code. We will also use the 3-digit form even though the 4-digit form is more correct.
3 There may be other FIs that have also issued bulletins in this area.
auditing guidelines and thus their guidelines must be gleaned from the results of audits.

During unrelated audits, such as pharmacy, there have been indications of potential problems. While the auditors did not look specifically at supply charges, they did note incidentally that the saw the surgical tray charges and indicated that if they were auditing for those charges that the surgical tray line items bills would not be acceptable.

CMS has also starting using the key phrase, “integral part”, more frequently in Federal Register entries for supplies and drugs. The idea is that if the given supply item is integral to the procedure, that is, the supply item is always used for the procedure, then the supply item is not only packaged but should not be separately billed. The charge (cost) for the item should be rolled-up into the charge for the associated procedures. Likewise, drugs that are an integral part of a procedure should be treated as are supplies that are packaged and not separately billable. For instance, see November 1, 2002, Federal Register (APC Update entry), pages 66746 and 66767, for the use of the “integral part” language.

Even more recently, CMS has provided guidance concerning the equivalent phrases, “not separately billed” and “not separately reported”. The use of this phrase has arisen since the AMA has started using this type of phraseology relative to conscious sedation and also along with the new injections codes introduced in CY2006. Currently, it appears that CMS is telling us that to “not separately bill” means that you can have a line-item in the chargemaster with a charge so long as there is no associated CPT/HCPCS code with the line item appearing on the claim form.

Note: If this guidance appears to be counter-intuitive, it is! If one is ‘billing’ for something, it is reasonable to interpret that there would be a line-item on the detailed statement for that item. However, CMS seems to be reaching for a distinction that is based in the APC payment system in that any of these ‘line-items’ will be separately payable only if there is a CPT or HCPCS code attached. There really seems to be confusion between ‘billing’ and ‘payment’ issues.

It is clear that over the past decade, the whole issue of billing for supplies and the associated development of Charge Masters, that the supply issue is a major compliance issue which, when audits occur, can result in

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4 CMS has indicated that this does NOT mean that drugs should be classified as supply items, only that the integral part concept applies as does this concept with supply items.
5 We will separate CPT and HCPCS since these seem to be more recognized as separate code sets under HIPAA TSC (Transaction Standard/Standard Code Set) Rule as opposed to the older HCPCS Level I and Level II.
6 See CMS Q&A Document provided with new injection codes. Q&A #6 is provided as an endnote for this Position Paper.
7 In theory, CMS can’t really tell hospitals how to bill. See 42 USC § 1395.
It would also seem that the guidance provided by CMS and/or associated Medicare Administrative Contractors (e.g., the FIs) has not always been completely consistent. As is often the case with the Medicare Program, hospitals and other providers are left to their own devices in formulating policies and procedures, which for this paper involve the chargemaster.

Non-Covered Items – As will be discussed below, there are a number of items that are considered to be ‘non-covered’ items. This is due primarily to a lack of medical necessity. An example category is ‘convenience’ items such as slippers, talcum, toothpaste, etc. These non-covered items can still be billed (assuming they are used) they just have to appear on the UB-92 as non-covered. Due to the nature of most of these items (i.e., being inexpensive), hospitals generally include them as a part of the overhead and don’t bill them separately at all. While this is technically incorrect, it does not appear to have drawn any unusual attention from auditors primarily due to the low cost of these items. What does draw immediate attention is the converse, i.e. billing for convenience items as ordinary ancillary supplies. However, care should be taken to distinguish between non-covered (but still billable) and non-billable items.

Non-Billable Items – Non-billable supply items are those that do not qualify as ancillary or billable under the rules discussed below. While these items cannot be billed (i.e., they should not appear as a line item on the Charge Master), they can still be charged. The charges for these items must be rolled up or bundled into the charges for the procedure, room and/or other services being provided. For instance, the routine supplies associated with a given surgical procedure cannot be separately billed, but the cost for these supplies can be rolled into the surgical time charge and/or charge for the given surgical procedure.

Payment System Changes – A part of the driving force behind the changes in billing for supplies lies with the shift in payment methodologies. Over the past two decades there has been a significant movement from cost-based payment methodologies now to prospective payment and further to managed-care contracting. In a cost-based reimbursement environment it is critical to bill for each and every item being used. Thus Charge Masters have been set up to include every conceivable item with a separate charge and line-item for billing purposes.

With the advent of prospective payment systems such as DRGs (FFY 1984) and APCs starting August 1, 2000, there is a great deal of bundling including supplies. Under APCs all supplies are bundled with the exception of some special transitional pass-through items. Even these items will be separately billable and payable only for a relatively short period of time. It is anticipated that the separate payment for these supply items will be phased out by 2004.
Thus under a system like APCs, there is little incentive to generate long detailed statements of multiple supply items that are not going to be paid separately anyway.

**Detailed Statement A Part Of The Claim** – Note that for auditing purposes the detailed statement is considered to be a part of the claim even though it is not filed. It is this additional consideration that brings the whole Charge Master issue for supply categorization into sharper focus.

**Physician Supplies** – With the implementation of Physician Payment Reform through RBRVS (Resource Based Relative Value System) in 1992, the number of supplies for which physician can bill was eliminated to just a handful. There are a very few supplies such as casting supplies and certain Urological supplies that can be billed by physicians. For a current complete listing, see the current RBRVS Federal Register that is generally published early in November of each year.

**Key Factors For Determining If A Supply Item Is Billable**

The *Medicare Provider Reimbursement Manual* states that the given item must meet the following criteria:

- a. Be directly identifiable to a specific patient,
- b. Be furnished as the direction of a physician because of specific medical needs,
- c. Be either not reusable or represent a cost for each preparation.

Each of these three criteria has separate implications and the FIs (Fiscal Intermediaries) and their associated auditors have interpreted these criteria when applying them to given situations.

**Supply Definition** – The third criteria makes it very clear that any supply items are to be disposable. Reusable items are classified, generally, as some form of equipment that also should not be billed or billed as a special type of item such as DME. (See Historical Background above.) In very limited cases, such as recondition catheters under FDA approval, some items can be charged as supplies when they are reused.⁸

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⁸ This raises the issue of how to bill for a catheter that may have a useful life of three uses after reconditioning. A reasonable approach is to take the cost plus reconditioning costs and pro-rate this over the expected life of the item.
Medical Necessity – An additional issue is that of medical necessity. Any supply that is used must be medically necessary and documented as such.

Convenience Supply Items – One of the key criteria is that of being medically necessary, that is, furnished at the direction of a physician because of specific medical needs. There are a number of supply items that are certainly consumed, but they are not medically necessary for specific medical needs. Examples of these items are slippers, toothpaste, mouth wash, powder, skin lotion and the like. These are non-covered items which can be billed, but not to the Medicare program! If these items are to appear on the Charge Master and the detailed statements, then they must appear as non-covered charges on the UB-92. The most typical approach for these items is to simply not bill for them at all. Instead they are simply treated as overhead items.

Stock/Bulk Supply Items – In order to be a billable supply item, the given item must not be a stock or bulk item in the billed setting and the amount or volume used must be measured or traceable to the individual patient. This comes from the first criteria above, “Be directly identifiable to a specific patient”. Most typically these items are not specifically delineated for use. Examples are: pads, drapes, cotton balls, tongue depressors, wipes, bedpans, urinals, gauze, prep kits, syringes, pillows, towels, bed linens, diapers, irrigation solutions, etc. There have been extensive discussions as to whether this includes IV solutions. Some hospitals, in given patient care setting, simply stock IV solutions for use as necessary. The question then becomes whether the individual units used are documented. If they are documented, then it appears that they can be billed.

Routine Supply Items – The Medicare auditors have extended some of these concepts into the fact that if a given supply item is a ‘routine’ or ‘integral part’ of a procedure or if the supply item is ‘typically’ used for all patients in a given setting, then they are not separately billable. For instance, in surgery scalpels blades are almost always used. Thus they are considered to be a ‘routine’ or ‘integral part’ of the surgery. This interpretation appears to come from the ‘identification to a specific patient’ although this appears to be a weak interpretation.

Never-the-less, it appears that it is safest to eliminate any supplies that are regularly or routinely used in a given settings. In the surgical suites this includes many common supplies. It is thus the unusual, non-routine and generally expensive supplies that become separately billable. (See Ancillary Supply discussion below).

While the application of the ‘routine’ or ‘integral part’ concepts is problematic, with the types of payment systems generally bundling supplies, for compliance purposes it is generally best to over bundle supply items as opposed to breaking too many items out on the Charge Master.
**Take-Home Supply Items** – Take-home supplies, as with self-administrable drugs, are non-covered items under Medicare and must be categorized under a separate Revenue Center Code, RCC=273.

**Ancillary Supply Items** – The phrase ‘Ancillary Supply’ represents those supplies that are separately billable and should thus appear on the Charge Master and as line-items on the detailed statements. This phrase appears to be first used in the AdminaStar Bulletin reference above. The questions posed in this bulletin are:

a. Is the item medically necessary and furnished at the direction of a physician?

b. Is the item used specifically for or on the patient?

c. Is the item not ordinarily used for or on most patients or was the volume or quantity used for or on the patient significantly greater than normally used for or on most patients in the billed setting?

d. Is the item not basically as stock (bulk) supply in the billed setting and is the amount of volume used typically measured or traceable to the individual patient for billing purposes?

e. Can the item be billed under another revenue center code that more appropriately describes it (e.g., telemetry, radiology supplies, other diagnostic supplies, surgical dressings, pacemakers, Intraocular lenses, prosthetic and orthotic devices)?

Each of these questions tends to eliminate and/or identify supplies that are ‘routine’. Item a., eliminate convenience items since they are not medically necessary. Item b., includes items such as gown, gloves, masks and the like since they are worn by workers and not, per se, used for or on the patient. Item c., addresses the whole issue of ‘routine’ or ‘integral part’. This area is the most unclear. Identifying items that are not ordinarily used for or on most patients in a given setting is difficult. Item d., addresses ‘overhead’ items. This includes a wide range of generally inexpensive supplies such as steri-strips, gauze, cotton balls, etc. Part e. stresses how important it is to classify a supply to any other category before categorizing it to the RCC=270/271/272 categories.

Other RCCs of interest are:

- RCC=273, Take-Home Supplies,
- RCC=274 – Prosthetic/Orthotics,
- RCC=275 – Pacemakers,
- RCC=276 – IOLs,
- RCC=278 – Other Implants,
- RCC=279 – Other Supplies,
RCC=29X – DME,
RCC=621 – Incident to Radiology Supplies,
RCC=622 – Incident to Diagnostic Supplies,
RCC=623 – Surgical Dressings,
RCC=624 – Investigation Devices.

**Low Cost Supplies**

One of the easiest ways to eliminate many of the supplies that are considered to be routine or stock items is to simply set a lower limit on the cost of a supply before it can be considered for placement on the Charge Master. While the lower limit varies between hospitals, a typical dollar amount is $10.00. This means that if a supply cost $10.00 or less, then it is automatically considered to be an overhead item and it is not separately billed. There can be exceptions to this if there is a large quantity of inexpensive items used in certain circumstances.

**Surgical Trays**

The subject of billing for supply trays based upon the discussion above requires careful analysis and the end result of the analysis is that surgical trays should not be billed per se.

First, any and all items on the surgical tray must be disposable. Thus any reusable items or equipment must be excluded from the tray.

Second, there must be a formal exception mechanism so that if any item(s) on the tray are NOT used, then the billing must be adjusted. Even if the items are disposed and not used on another patient, they cannot be billed since they are not medically necessary.

Third, given the fact that a given supply item is on a tray indicates that it is recognized as being routinely necessary for the performance of the procedure. Thus one has to conclude that it is a routine supply used with the procedure, otherwise it would not be identified to be on a given tray.

This same situation can be extended to surgical preference cards. If it is known in advance what supplies are to be used with a given procedure, then these supplies can to some degree be determined to be ‘routine’ and ‘integral to the procedure’. Obviously, surgical preference cards are by physician so that there are going to be variations. However, most of the variations will be with the more expensive and ‘non-routine’ supplies that are separately billable. In mathematical terms the set of all preference cards for a given procedure by various surgeons can be considered. The intersection or all of the common...
items on each of these preference cards for the given surgery would then be considered to be ‘routine’ or an ‘integral’ part of the procedure.

The basic conclusion is that surgical trays can be billable only under the most unusual of circumstances. There are instances, one of which noted above, where Medicare auditors have indicated that surgical trays are not billable and that the individual items should be listed and billed if they are truly ancillary supplies.

**Supply Kits/Packs**

Supply kits are typically disposable supplies that are used in conjunction with a specific device or piece of equipment. Based upon the discussion above, it appears that these are billable items. They are medically necessary (assuming the use of the equipment is medically necessary), they are specific to the patient, used on the patient, specific to the procedure and certainly are ordered by a physician.

**Limited Use Reusable Items**

There are a very few items, generally catheters, that can be re-conditioned and used for a limited number of times (typically not more than three times). The re-conditioning process must be FDA approved. These can still be billed out as supplies (which by definition are to be disposable). The typical approach is to take the cost plus re-conditioning costs and divide by the number of anticipated uses. This cost can then be translated into an appropriate charge using the hospital’s cost-to-charge ratio (CCR).

**Other Implants – Revenue Code 278**

Some fee-for-service third party payers will pay for supply items classified under RCC=278 but will not pay, or pay a lesser percentage, for supply items categorized under RCCs such as 271 and 272. Thus, for proper reimbursement, supply items that are implantable must be appropriately classified under RCC=278. This generally includes screws, rods, plates and a host of orthopedic supply items.

**CMS C-Codes**

C-Codes are Level II HCPCS. These codes generally describe expensive supply items that are often classified as implantable DME. However, most of these
items are inserted into the body, used and withdrawn. Due consideration should be given to using RCC=278.

From time to time, C-Codes can fall into three different categories:

1. Pass-Through Payment Items,
2. Special Payment Items, and
3. Required Items Although Status Indicator “N”.

As far as coding and billing are concerned, if the given C-Code generates a separate payment (see items 1. and 2. above) then these codes should certainly be billed. In theory, Status Indicator “N” items are packaged, no separate payment is generated and billing is optional. However, CMS has determined that some hospitals do not charge correctly for these items even on a bundled basis. Thus CMS is requiring the use of certain C-Codes in conjunction with specific procedures. (For instance, see Tables 19 and 20 in the November 15, 2004 Federal Register along with updated lists from CMS). It is anticipated that the table of required C-Codes will be expanded in the future, thus charge master coordinators will be making quarterly changes in this area for some time to come.

Special Supply/Implantable Items

There are a number of special types of items that have their own revenue codes such as pacemaker (RCC=275) and intra-ocular lenses (RCC=276). These items are generally easy to recognize and categorize.

Conclusion

The whole compliance issue of properly categorizing supply items on the hospital’s Charge Master is an ongoing and evolving issue generally fueled by CMS. Care must be taken to monitor various Transmittal, Q&A Publications and Federal Register entries, particularly those involve the APC Payment System for hospital outpatient services. There are no truly clearly cut answers in this area. Most hospitals tend to take a relatively conservative approach by bundling certain supply items to avoid any possible compliance issues.

Endnote

The following is from Q&A #6 as issued by CMS relative to the new (CY2006) injection codes and the language within CPT indicating certain items not to be billed or reported separately.

Q6. In section 230.2.B.of Chapter 4 of the Medicare Claims Processing Manual under the heading “Included Services,” as revised by Transmittal 785, hospitals
are instructed that certain specified services, such as use of local anesthesia, IV starts, etc., when performed to facilitate an infusion or injection, are not separately “billable”. Does this mean that hospitals cannot report charges for the services that are listed?

A6. Hospitals should either package charges for the items listed as “Included Services” into the charge for the service with which the items are associated or report charges for these items under revenue code lines without HCPCS codes. This instruction just means that the charges for the "Included Services" are not reported separately using other HCPCS codes on the claim. For example, when initiating an intravenous drug infusion and then billing for the total hours of infusion, a hospital should not also bill CPT code 36000 for the insertion of the intravenous catheter necessary for the intravenous infusion.

Additional References

See the monthly “Medical Reimbursement Newsletter” published by Abbey & Abbey, Consultants, Inc. A series of articles discussing the ‘Integral Part’ concept was provided in the following issues:

2. Integral-Part – Part 2 – November, 2005, pages 63-65;
3. Integral-Part – Part 3 – December, 2005, pages 69-71; and