Reimbursement Policy

Facility Routine Supplies and Services

REIMBURSEMENT POLICY NUMBER: 43

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SCOPE AND APPLICATION 1
POLICY STATEMENT 2
CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) 10
BILLING AND CODING GUIDELINES 11
CROSS REFERENCES 13
REFERENCES 13
POLICY REVISION HISTORY 14

INSTRUCTIONS FOR USE: Company reimbursement policies serve as guidance for the administration of plan benefits, reimbursement methodologies, and acceptable billing practices, intended to help health care providers submit claims accurately in order to reduce delays and ensure more accurate claim adjudication. Reimbursement policies do not constitute a guarantee of coverage. They allow for the consistent application of our member contracts, provider contracts, clinical edits, and medical policies. In the event of a conflict between one of these documents and a reimbursement policy, these documents will take precedent over the reimbursement policy. If contracts and policies are silent, the Company may defer to guidance from the Centers for Medicare & Medicaid Services (CMS) when available and applicable. In addition to correct billing practices, in order to qualify for reimbursement, all services, items, and procedures must be covered member benefits and must also meet applicable authorization and medical necessity guidelines. Company reimbursement policies are reviewed annually. The Companies reserve the right to determine the application of reimbursement policies and make revisions to reimbursement policies at any time.

SCOPE AND APPLICATION

Provider Type:

☐ Professional Claims

☐ DMEPOS Suppliers

☐ All health care services billed on CMS 1500 forms

☐ All health care services billed on CMS 1500 forms, and when specified to those billed on UB04 forms

☒ Facilities

Plan Product:

☒ Commercial

☒ Medicare

☒ Medicaid/Oregon Health Plan (OHP)

SCOPE: Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as "Company" and collectively as "Companies").

☒ All health care services billed on UB04 forms (CMS 1450)

Plan participating and contracted facilities reimbursed on any of the following payment methodologies:

☒ DRG

☒ Modified DRG

☒ Percentage of billed charges/per diem

POLICY STATEMENT

NOTE: This policy applies to **inpatient and outpatient** hospital claims. The supplies and services addressed by this policy are considered part of the "room care" or accommodation charges, whether inpatient room and board ***or*** outpatient room settings (not an all-inclusive list, but examples of outpatient room settings include emergency room, procedure or operating room or surgical suite, endoscopy lab, cardiac catheter lab, post-anesthesia recovery room, etc.).

I. The following (A.-H.) facility supplies and services are considered **not separately reimbursable** because they are considered incidental to the facility charge:

A. Any supplies, items and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services in a specific location are considered routine services and not separately billable in the inpatient and outpatient environments. *(See Policy Guidelines below for examples of items, supplies and services that may be considered integral to the provision or delivery of another service.)*

B. Routine items or services included in the daily room and board charge for the level of care being provided**.** These items or services are considered included in the basic room or critical care area room (e.g., cardiac, medical, surgical, pediatric, respiratory, burn, neonate (level III and IV), neurological, rehabilitative, post-anesthesia recovery room, trauma, etc.) daily charge. The facility's charge for surgical suites and services shall include nursing personnel services, supplies, and equipment, included in the basic or critical care daily room charges. *(See Policy Guidelines below for examples of routine supplies and services.)*

C. Routine items or services included in the facility charge for the primary medical service being provided (e.g., surgical services and associated anesthesia services).

D. Items or services that are determined to be inappropriate or excessive.

E. Items or services that are determined to be duplicative**.**

F. Items or services that are wasted, broken, or destroyed.

G. Nursing care and/or treatment that is within the scope of normal nursing practice.

H. Assistance by hospital staff for any bedside procedures performed by physicians or other healthcare professionals regardless of patient location.

I. Transportation, including monitoring while being transported, within the facility.

II. The Plan will follow the Medicare Outpatient Prospective Payment System (OPPS) billing

methodology to ensure accurate reimbursement of outpatient services, supplies, procedures, and drugs. This includes, but is not limited to, adhering to status indicator reimbursement rules, such as HCPCS code assigned an OPPS status indicator "N" (items and services integral to the delivery of other procedures and services, their payment "packaged" into the payment for the other services and **not separately reimbursable**).

Note: see Policy Guidelines below for examples of facility items or services that are not separately reimbursable because they are incidental to the facility charge, as well as information regarding CMS OPPS status indicators.

POLICY GUIDELINES

Routine medical equipment and supplies are considered included in the reimbursement made for the procedure or facility charge. These items are generally available to all patients receiving services, so they are considered floor stock, with costs incorporated into the overall reimbursement of the procedure or facility charge.

While some services may be considered "bundled" based on an OPPS status indicator of "N" (see below for more information on OPPS status indicators), other routine supplies and services may be associated with certain revenue codes. The following lists offer examples of routine services that are not eligible for separate reimbursement. These are examples only, and thus, these lists are not meant to be interpreted as a comprehensive list.

NOTE: The ***inclusion of or reference to*** any revenue code does not mean all charges billed under that revenue code will always deny as a routine service. In contrast, the ***absence*** of a revenue code does not mean it is exempt from being considered a "routine supply or service."

ROUTINE SUPPLIES AND EQUIPMENT

Frequently associated revenue codes include, but may not be limited to: 260-269, 270, 279, 410, and 412.

- Admission, hygiene, and/or comfort kits
- Alcohol swabs
- Arterial blood gas kits
- Apnea monitors
- Baby powder
- Band Aids
- Basins
- Batteries
- Bedpans
- Bedding and linens (sheets, blankets, pillowcases, washcloths, and towels)
- Beds
- Betadine ointment/solutions
- Blood collection tubes
- Blood pressure cuffs/ monitors
- Breast feeding pumps/supplies
- CO2 monitors
- Commodes
- Compression garments or devices
- Contrast materials
- Cotton balls and cotton swabs
- Crash carts
- Deodorant

- Drapes
- Electrocardiogram (EKG) supplies
- Emesis basins
- Emerson pumps
- Gloves and gowns (used by patients or staff)
- Glucometers
- Feeding pumps
- Heating or cooling pads
- Heating or cooling pumps
- Humidifiers
- Ice packs
- Infant warmers
- Iodine scrub
- Irrigation solution and supplies
- IV arm boards
- IV pumps/poles, including drug delivery systems and supplies (e.g., tubing, infusion pump, syringes, flushes)
- Kleenex tissues
- Linens
- Lubricants and lotions
- Masks (used by patients or staff)
- Mattresses
- Mouth care kits, mouthwashes
- Nebulizers and related supplies
- Needles
- Nutrition support
- Oral swabs
- Oxygen masks
- Phototherapy lights
- Pillows
- Pulse oximetry probes
- Razors
- Restraints
- Sharps containers
- Skin cleansers, including alcohol, peroxide, and chlorohexidine antiseptic.
- Soap, shampoos, shaving creams
- Socks, slippers
- Syringes
- Stethoscopes
- Suction canisters and tubing
- Surgical trays and supplies
- Tape
- Telemetry equipment
- Therapeutic baths
- Thermometers
- Toilet paper
- Toilet seat lifts
- Tongue depressors
- Toothbrush, toothpaste
- Tubing, including feeding tubes
- Urinals
- Water pitchers
- X-ray film

SURGICAL SERVICES, EQUIPMENT, AND SUPPLIES

Frequently associated revenue codes include, but may not be limited to: 250, 270–279.

- Basin stands
- Bovie machines/pads/supplies
- Bronchoscopes
- Catheters, including urinary, cardiac, and vascular catheters
- Cords
- Closure supplies
- Compression garments or devices
- Crash carts
- Drapes
- Dressings, sterile gauze
- Endoscopes
- Fluoroscopy equipment
- Instruments
- Irrigation solutions
- IV kits
- Laparoscopes
- Lasers
- Lights and associated parts
- Limb holders
- Linens
- Monitoring Equipment/Supplies
- Needles
- Operating room set-ups of equipment and supplies
- Power equipment
- Robotic devices
- Room heating and monitoring equipment
- Perfusion equipment and services
- Screws/orthopedic hardware
- Sponges
- Staffing
- Staples and staplers

- Suction machines, canisters, tubing, and related supplies
- Sutures and suture related devices
- Surgeon's loops
- Surgical sealant
- Tables and table covers
- Ventilator or oxygen set-up and supplies
- Video equipment
- X-ray film

ANESTHESIA SERVICES, EQUIPMENT, AND SUPPLIES

Frequently associated revenue codes include, but may not be limited to: 250, 270–279.

- Airway supplies and airway humidifiers
- Anesthesia machines
- Anesthetic gases
- Arterial blood gasses
- Blood pressure monitors
- Blood warmers
- Breathing circuits
- Cardiac monitors and monitoring supplies
- CO2 monitors
- Disposable warming blankets
- Electrolytes
- Esophageal stethoscopes
- Extubation
- Gloves
- Instruments
- Intravascular catheters
- Intubation and intubation kits
- IV kits
- Laryngoscopes
- Linens
- Needles
- Positioning devices
- Positive pressure ventilation systems
- Pulse oximetry
- Restraints
- Saline slush machine
- Skin preparation
- Solution warmer
- Sterilization of equipment
- Stethoscopes
- Suction canisters, liners, and tubing
- Suction catheters
- Syringes and needles
- Thermometers
- Tongue blades
- Transport monitor
- Tubing
- Ventilation systems
- Warming lamps

RESPIRATORY THERAPY

Frequently associated revenue codes include, but may not be limited to: 0410 and 0412.

Services and Supplies

- Aerosol
- Airway supplies
- Ambu Bag
- Breathing circuit
- CO2 monitors
- Croupette
- Extubation
- Flow meter
- Humidifier
- Intermittent Mandatory Ventilation (IMV) circuit
- Incentive spirometry
- Intubation and intubation kits
- Intermittent Positive Pressure Breathing (IPPB)
- Isolettes
- Nasal cannula
- Nasal catheter
- Nursing care
- Oscillators
- Oxygen (and associated supplies)
- Oxygen masks
- Positive End Expiratory Pressure (PEEP)
- Respiratory technician time
- Tents or hoods
- T-piece
- Tubing
- Ultrasonic nebulizer

- Ventilation systems
- Ventilator related disposable supplies

Hourly/Daily Charges

- Hourly/daily charges for oxygen are not separately reimbursable from hourly/daily charges for ventilator support. This is considered duplicative (criterion. I.E. above).
- If more than one level of respiratory/ventilation support occurs on the same date of service, only the highest level of respiratory/ventilation support will be reimbursed. The lower level of support is considered duplicative (criterion I.E. above).

ROUTINE NURSING SERVICES

Frequently associated revenue codes include, but may not be limited to: 260, 300, 309, 361, 391, 460, 510, 761.

- Bathing of patients
- Blood draw and blood product administration
- Cardiopulmonary resuscitation
- Central line care
- Changing of linens and patient gowns
- Chest tube maintenance, dressing changes, discontinuation
- Dressing/bandage changes
- Enemas
- Incontinence treatments
- IV insertions, maintenance, or removals, including administration of fluids and medications
- Lactation consultations
- Medication administration
- Medical record documentation
- Monitoring and maintenance of peripheral or central IV lines and sites
- Nasogastric tube insertion, maintenance, removal
- Nebulizer treatments
- Neurologic status checks
- Obtaining of: blood sugars, blood samples (from either IV sticks, central lines, or PICCs), urine specimens, stool specimens, arterial draws, sputum specimens, or any body fluid specimen
- Obtaining and recording of patient assessments, including: vital signs, monitoring of cardiac monitors, pressure readings, pulse oximeters, and pulmonary arterial pressures
- Patient and family education/counseling
- RN first assists
- Telemetry monitoring
- Tracheostomy care
- Transporting, ambulating, transferring from bed or chair
- Urinary catheter insertions or removals
- Vaccine administration
- Wound care

ROOM AND BOARD CHARGE

According to the Centers for Medicare & Medicaid Services (CMS), "(i)npatient routine services in a hospital generally are those services included by the provider in a daily service charge--sometimes referred to as the 'room and board' charge."

ROUTINE OR ANCILLARY ITEMS OR SERVICES

Packaged Items and Services

Medicare Claims Processing Manual on Part B Hospital states, "Under the OPPS, packaged services are items and services that are considered to be an integral part of another service that is paid under the OPPS. No separate payment is made for packaged services, because the cost of these items and services is included in the APC payment for the service of which they are an integral part. For example, routine supplies, anesthesia, recovery room use, and most drugs are considered to be an integral part of a surgical procedure so payment for these items is packaged into the APC payment for the surgical procedure."[1]

Routine Supplies/Services

According to the Centers for Medicare & Medicaid Services (CMS):

> "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."[2]

These services are not separately billable Inpatient services per:

- Provider Reimbursement Manual – Part 1, Chapter 22, §2202.6[3]
- Medicare General Information, Eligibility, and Entitlement Manual
    - Chapter 1—General Overview, §60.4—Statutory Obligations of Practitioners and Other Persons[4]
    - Chapter 4—Physician Certification and Recertification of Services, §10—Certification and Recertification by Physicians for Hospital Services[5]
    - Chapter 4—Physician Certification and Recertification of Services, §20—Certification for Hospital Services Covered by the Supplementary Medical Insurance Program[6]
    - Chapter 5—Definitions, §20—Hospital Defined[7]

Ancillary Supplies/Services

Section 2202.8 of the Medicare Provider Reimbursement Manual states ancillary services in a hospital "include laboratory, radiology, drugs, delivery room (including maternity labor room), operating room (including postanesthesia and postoperative recovery rooms), and therapy services (physical, speech, occupational). Ancillary services may also include other special items and services for which charges are customarily made in addition to a routine service charge."

Section 2203 of the Medicare Provider Reimbursement Manual states:

> "The cost of those items and services specifically classified as routine in §2202.6 are always considered routine service costs, and the costs of those specifically classified as ancillary in §2202.8 are always considered ancillary service costs for purposes of Medicare reimbursement.

A separate ancillary charge for a particular item or service other than those listed as ancillary in §2202.8 is not recognized, and the cost of the item or service is not included in an ancillary cost center…"

The above referenced guideline will be used to determine if the supplies charged are reimbursable and will require a physician order.

Fluid Used to Administer Drugs

Medicare Claims Processing Manual on Part B Hospital states, "(h)ospitals are expected to report all drug administration CPT codes in a manner consistent with their descriptors, CPT instructions, and correct coding principles."[8]

CPT instructions in multiple locations, including the "Therapeutic, Prophylactic, and Diagnostic Injections and Infusions" section, and the "Chemotherapy and Other Highly Complex Biologic Agent Administration" section, state that fluid used to administer the drug(s) is considered incidental hydration and is not separately reportable."

If performed to facilitate the infusion or injection or hydration, the following services and items are also 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
5. Standard tubing, syringes, and supplies.

Payment for the above is included in the payment for the chemotherapy administration or non-chemotherapy injection and infusion service."[9]

Finally, CPT instructions for hydration, therapeutic, prophylactic, diagnostic injections and infusions, and chemotherapy also state that for ***facility*** reporting, claims should start with the initial code that is primary in the hierarchy of services. According to CPT instructions, chemotherapy services are primary to therapeutic, prophylactic, and diagnostic services, which are primary to hydration services. Infusions are primary to pushes, which are primary to injections. This hierarchy is to be followed by facilities and supersedes other parenthetical instructions for add-on codes that suggest an add-on of a higher hierarchical position may be reported in conjunction with a base code of a lower position (for example, the CPT manual states the hierarchy would not permit reporting 96376 with 96360, as 96376 is a higher order code. IV push is primary to hydration.)

If reporting multiple infusions of the same drug/substance on the same date of service, the initial code should be selected, and second and subsequent infusion(s) should be reported based on the individual time(s) of each additional infusion(s) of the same drug/substance using the appropriate add-on code.

Finally, CPT guidelines state that if reporting codes for which infusion time is a factor, use the actual time over which the infusion is administered. A ''keep open'' infusion of any type is not separately reported.

Self-Administered Drugs

For self-administered drugs for both inpatient and outpatient facility claims, see the following CMS references:

- Inpatient facility claims: Medicare Claims Processing Manual, Chapter 17 - Drugs and Biologicals, §10 – Payment Rules for Drugs and Biologicals
- Outpatient facility claims: Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services, §50.5 – Self-Administered Drugs and Biologicals

ROUTINE NURSING SERVICES

The costs of patient monitoring and nursing services are included in the facility's daily room and board charge or accommodation charges. A separate charge is not payable per Medicare Provider Reimbursement Manual Section 2202.6.[3] Examples of routine nursing services that are captured in the Room and Board rate include patients that receive from the floor nurse IV infusions and injections, blood administration, and nebulizer treatments.

Nursing care and treatment is included in the primary medical /surgical procedure charge and/or the room and board charge and thus, separate reimbursement is **not** made for nursing charges.

Revenue codes 0230-0239 are used to report Incremental Nursing charges, which are **extra** charges for nursing services rendered **above and beyond** normal nursing tasks and duties associated with the typical room and board or accommodation services for the unit in which the services were rendered. Therefore, reimbursement exceptions **may** be made for incremental nursing services in limited circumstances, if **all** of the following must be met:

- Item/service is ordered by a physician other qualified practitioner; **and,**
- Documentation submitted demonstrates that the provision of the supply/service is a significant increase in the nursing intensity provided beyond standard nursing services for that level of care; **and,**
- The item or service provided by the nurse is medically reasonable and necessary **and** a covered benefit for the individual member.

Routine nursing charges unbundled from standard room and board will not be reimbursed, and should **not** be reported using these revenue codes. If routine nursing charges are identified under revenue codes 0230-0239, the charges may be denied separate reimbursement.

DURABLE MEDICAL EQUIPMENT (DME)

According to the Medicare Claims Processing Manual, Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), "DME, prosthetic/orthotic devices (except customized

devices in a SNF), supplies and oxygen used during a Part A covered stay for hospital and skilled nursing facility (SNF) inpatients are included in the inpatient prospective payment system (PPS) and are not separately billable."[10]

Additionally, the MLN Facts Sheet on "Medicare DMEPOS Payments While Inpatient" states:

> "SSA Section 1861(n) limits Medicare Part B DME coverage to items used in the patient's home. Under 42 CFR Section 410.38, we [Medicare] doesn't pay DME separately to hospitals, CAHs, or skilled nursing facilities because the facility isn't a qualified home. The facility must provide all medically necessary DMEPOS during a Part A covered stay.
>
> We [Medicare] include all DMEPOS items during a Part A covered stay in the inpatient PPS rate and the facility can't separately bill them. The inpatient facility directly pays the supplier for provided items."[11]

CMS STATUS INDICATORS

The Plan applies status indicators as described in the Medicare Outpatient Prospective Payment System (OPPS) billing methodology to facilitate payment of items and services, including drugs and to ensure correct reimbursement of services, supplies procedures, and drugs.

> "An OPPS payment status indicator is assigned to every HCPCS code. The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule."[12]

Some examples of status indicators and their intent include the following (**not** an all-inclusive list):

- Services with status indicator **A** are paid under a fee schedule or payment system other than the OPPS.
- Services with status indicator **N** are paid under the OPPS, but their payment is packaged into payment for a separately paid service.
- Services with status indicator **T** are paid separately under OPPS but a multiple procedure payment reduction applies when two or more services with a status indicator of T are billed on the same date of service.

The full list of status indicators and their definitions is published in Addendum D1 of the OPPS/ASC proposed and final rules each year. The status indicator for each HCPCS code is shown in OPPS Addendum B.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

As of 11/3/2026, the following Centers for Medicare & Medicaid (CMS) guidelines and regulations were identified which address reimbursement for facility routine supplies and services:

- Medicare Benefit Policy Manual, Chapter 1—Inpatient Hospital Services Covered Under Part A, §40.0—Supplies, Appliances, and Equipment
- Medicare Benefit Policy Manual, Chapter 4—Part B Hospital, §230.2—Coding and Payment for Drug Administration
- Medicare Claims Processing Manual, Chapter 20—Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), §210—CWF Crossover Editing for DMEPOS Claims During an Inpatient Stay
- Medicare General Information, Eligibility, and Entitlement Manual
    - Chapter 1—General Overview, §60.4—Statutory Obligations of Practitioners and Other Persons
    - Chapter 4—Physician Certification and Recertification of Services, §10—Certification and Recertification by Physicians for Hospital Services
    - Chapter 4—Physician Certification and Recertification of Services, §20—Certification for Hospital Services Covered by the Supplementary Medical Insurance Program
    - Chapter 5—Definitions, §20—Hospital Defined
- Provider Reimbursement Manual – Part 1, Chapter 22, §2202.4, §2202.6, §2202.8, §2203
- MLN Matters® Number: MM8959. Implementing the Payment Policies Related to Patient Status from the CMS-1599-F
- MLN Matters® Number: SE1333. Temporary Instructions for Implementation of Final Rule 1599-F for Part A to Part B Billing of Denied Hospital Inpatient Claims
- Medicare Claims Processing Manual, Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)
- MLN Matters® Number: 1541573. Medicare DMEPOS Payments While Inpatient
- Medicare Claims Processing Manual, Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS), 10.4 – Packaging
- Medicare Claims Processing Manual, Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS), §10.1.1 - Payment Status Indicators
- Noridian web page for Revenue Codes
- Medicare Claims Processing Manual, Chapter 17 - Drugs and Biologicals, §10 – Payment Rules for Drugs and Biologicals
- Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services, §50.5 – Self-Administered Drugs and Biologicals

The above criteria and reimbursement methodologies are consistent with the CMS guidance and regulations regarding “routine” facility supplies and services.

BILLING AND CODING GUIDELINES

GENERAL

Revenue Codes

Hospital claims are frequently billed using revenue codes. Table 1 below includes examples of common revenue codes that may be used for routine supplies and services. Note this is not an all-inclusive list of revenue codes that may be used, nor is this an all-inclusive list of revenue codes to which the guidelines in this policy may be applied.[15]

Table 1: Common Revenue Codes

REVENUE CODES	
Revenue Code	**Description**
025X	Pharmacy
0250	General
026X	IV Therapy
0260	General
0261	Infusion pump
0262	Pharmacy services
0263	Drug/supply delivery
0264	Supplies
0269	Other
027X	Medical/Surgical Supplies and Devices
0270	General
0271	Nonsterile
0272	Sterile
0273	Take-home supplies
0274	Prosthetic/orthotic devices
0275	Pacemaker
0276	Intraocular lens
0277	Take-home oxygen
0278	Other implants
0279	Other supplies/devices
030X	Laboratory
0300	General
0309	Other
036X	Operating Room Services
0361	Minor surgery
039X	Administration, Processing and Storage for Blood and Blood Components

0391	Administration (e.g., transfusions)
041X	Respiratory Services
0410	General
0412	Inhalation services
046X	Pulmonary Function
0460	General
051X	Clinic
0510	General
076X	Specialty Services
0761	Treatment room

CROSS REFERENCES

None

The full Company portfolio of current Reimbursement Policies is available online and can be accessed here.

REFERENCES

1. Centers for Medicare & Medicaid Services (CMS). Medicare Claims Processing Manual, Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS), §10.4 - Packaging. Published 2003. Updated 2018. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c04.pdf. Accessed 12/8/2026.
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POLICY REVISION HISTORY

Date	Revision Summary
1/2023	Policy updated to new format
5/2023	Annual review
5/2024	Annual review
7/2024	Interim update; clarified “routine nursing services”
3/2025	Interim update; policy application includes both inpatient and outpatient claims, updated CPT Manual references, clarified appropriate use of incremental nursing revenue codes
4/18/2025	Interim update; clarified Plan use of OPPS status indicators
5/2025	Annual review
2/2026	Annual review; minor corrections

6/2026	Interim updates
11/4/2026	Interim update; add CMS references regarding self-administered drugs