Medical, Surgical, and Routine Supplies (including but not limited to 99070)

Last Updated: 5/14/2025 **Last Reviewed: 5/14/2025** **Originally Effective: 1/1/2002**

Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No

If yes, Texas Last Update Effective Date: n/a **Policy #: RPM021**

Scope

Companies: Moda Partners, Inc. and its subsidiaries & affiliates (All) **Provider Contract Status:** Any

Claim Forms: CMS1500 & CMS1450 (paper and electronic versions) **Claim Dates:** All

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 "Resources" 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. [3, 4, 5] 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 1500 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. [1, 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. [14]
   Examples of non-billable capital equipment: [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.[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: [17, 18, 19]
   - 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").

Definitions

Acronyms

Acronym	Definition
AMA	American Medical Association
BP	Blood Pressure
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
EKG	Electrocardiogram
HCPCS	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
MPFSDB	Medicare Physician Fee Schedule Database (see also PFS)
NUCC	National Uniform Claim Committee
PFS	Physician Fee Schedule (see also MPFSDB)
RPM	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
RBRVU	Resource-based Relative Value Unit (see also RVU)
RVU	Relative Value Unit (see also RBRVU)

Definition of Terms

Term	Definition
1500 Claim Form	The basic paper claim form prescribed by many payers for claims submitted by physicians, other providers, and suppliers, and in some cases, for ambulance services. Also known as the CMS 1500 claim form; formerly known as the HCFA 1500 claim form. There are now electronic equivalents to the 1500 claim form. [20]
Capital Equipment	Equipment which has an extended life and is used in providing care and services to multiple patients.
Practice Expense	The costs associated with the direct and indirect practice resources associated with operating an office and furnishing medical services. Includes rent/mortgage, utilities, office supplies, clinical equipment and supplies, staffing expenses, etc. Practice expense is one component of the RVU assigned to a procedure code on the Medicare Physician Fee Schedule.
Relative Value Units (RVUs)	Resource-based relative value units (RVUs) comprise the core of the Medicare Physician Fee Schedule (MPFS). CMS publishes quarterly updates to the MPFS on the CMS website. Each CPT or HCPCS code on the MPFS has an assigned RVU unit Total Value. Either the Non-Facility Total value or Facility Total value is used for pricing, depending upon the place of service. For more information about RVUs, see items listed in Resources.[12. 26, 27, 28, 29, 30, 31] <u>RVUs and Fee Allowances</u> The RBRVU and fee allowance for services represent the average work effort and practice expenses required to provide a service. For any given procedure code, there could typically be a range of work effort or practice expense required to provide the service.[31] For any given procedure code, there could typically be a range of work effort or practice expense required to provide the service. Thus, the payment for a service should be increased only under very unusual circumstances based upon review of medical records and other documentation. [32, 33]

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 for our plans)
A4335	Incontinence supply; miscellaneous
A4421	Ostomy supply; miscellaneous
A4641	Radiopharmaceutical, diagnostic, not otherwise classified

Code	Code Description
A4649	Surgical supply; miscellaneous
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
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)

Related Policies

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.

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.
17. CMS. "Improving Practice Expense Data & Methods Town Hall – June 16, 2021 Meeting Materials - Presentation Slides." Centers for Medicare & Medicaid Services (CMS). Last updated June 16, 2021; Last accessed: April 24, 2024. https://www.cms.gov/regulations-and-guidance/guidance/transmittals/2017downloads/test.pdf .
18. CMS. "Supplies." *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 20.4.4.
19. CMS. "Method for Computing Fee Schedule Amount, Formula." *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 20.1.A.
20. NUCC. "1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12, Version 12.0." National Uniform Claim Committee (NUCC) and the American Medical Association (AMA). Last updated July 2024; Last accessed April 8, 2025. https://www.nucc.org/images/stories/PDF/1500_claim_form_instruction_manual_2024_07-v12.pdf .
21. CMS. "Medicare Physicians Fee Schedule (MPFS)." *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 20.
22. CMS. "Method for Computing Fee Schedule Amount." *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 20.1.
23. CMS. "Relative Value Units (RVUs)." *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 20.2.
24. CMS. "Bundled Services/Supplies." *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 20.3.
25. RAND Corporation. "Overview of the MPFS." Improving Practice Expense Data & Methods Town Hall – June 16, 2021 Read Ahead Materials, pp. 2-3. Last updated June 16, 2021; Last accessed January 26, 2022. Improving Data and Methods Related to Indirect Practice Expense in the Medicare Physician Fee Schedule: Read-ahead materials for the virtual Town Hall (cms.gov) .
26. Burgette, Lane F., et al. "Practice Expense Data Collection and Methodology: Phase II Final Report." Santa Monica, CA: RAND Corporation, 2021. Last accessed October 4, 2022. https://www.rand.org/pubs/research_reports/RRA1181-1.html .
27. CMS. "Supplies." *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 20.4.
28. CMS. "Payment Due to Unusual Circumstances (Modifiers "-22" and "-52")." *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 20.4.6.

Policy History

Reminder: 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 current information by going to: https://www.modahealth.com/medical/policies_reimburse.shtml

Date	Summary of Update
5/14/2025	Definitions of Terms added. Resources updated. Formatting updates. No policy changes.
6/12/2024	Formatting updated. Footnotes & Sources added. No policy changes.
11/9/2022	Idaho added to Scope. Formatting updated. No policy changes. Policy History section added; entries prior to 2022 omitted (in archive storage).
12/10/2014	Policy document 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.