Payment Policy: Unbundling Adjustments on Clean Claim Reviews

Reference Number: CC.PI.10
Product Types: ALL
Effective Date: 09/2022
Last Review Date: 07/2024

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
This policy provides clarification on the facility billed charges that will be evaluated for unbundling as a part of the clean claim review process. The purpose of this policy is to define the requirements for the proper application of the unbundling adjustments identified by clean claim reviews.

POLICY:
It is the policy of the Company to comply with provisions set forth in federal guidelines and the contract with the state in which they operate and meets or exceeds all requirements and timeframes outlined in the contract. To comply with these provisions, the Company has the fiduciary obligation to review facility charges prior to payment to help assure that such charges are free of potential defects or improprieties. The Company is also obligated to ensure compliance with applicable billing standards.

One element of the clean claim reviews is determining if a supply item should be considered routine (not separately payable) or non-routine (separately payable). This "Unbundling" evaluation calls attention to line items that appear to have been billed in error.

"Implant" is defined as an object, device or material that is inserted surgically, or embedded via surgical or nonsurgical means, or grafted into the body and remains in the body either indefinitely for prosthetic and/or therapeutic purposes or remains in the body for a temporary or provisional period of time for diagnostic and/or therapeutic purposes.

Section 2202.6 of the CMS Provider Reimbursement Manual specifically states "Routine Services – Inpatient routine services in a hospital or skilled nursing facility are those services included by the provider in a daily service charges—sometimes referred to as the 'room and board' charges…Included in 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."

To ensure the Company only pays for those supply and service charges that are considered "non-routine," and not an integral component of underlying room and/or procedure charges, the Company has put into effect the following procedure:

Application
Institutional providers

PROCEDURE:

1. The supply or service must be medically necessary, reasonable for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

2. The supply or service must be furnished at the direction of a physician (by distinct physician order).

3. Supplies that are generally available to all patients billed at the same underlying room and board acuity level and/or ordinarily furnished to patients during the course of a procedure, even though the equipment is rented by the hospital are not separately payable. The cost of these supply items is already included in the underlying charge for the room or procedure in which the services are delivered.

4. Supplies, items, pharmaceuticals, and services that are necessary or otherwise integral to the provision of a specific underlying service and/or the delivery of such underlying service(s) are not separately payable.

5. Items and supplies that may be purchased over the counter are not separately payable.

6. Supply fees billed daily or one time, which are unidentified and unsupported by medical records or documentation are not reimbursable.

7. Blood and blood product administration services are not separately reimbursable on inpatient Claims. Thawing/Pooling fees are not separately reimbursable.

8. Pharmacy charges will include the cost of the drugs prescribed by the physician. Medications furnished to patients shall not include an additional separate charge for administration of drugs, the cost of materials necessary for the preparation and administration of drugs, and the services rendered by registered pharmacists and other pharmacy personnel.

9. Advancements in laboratory testing technology allow a facility to obtain a wide variety of values/results from a single underlying blood sample and analysis. The costs incurred to analyze and obtain results from a blood sample will be reimbursed for each blood sample analysis performed. Multiple charges for results obtained from the same underlying blood sample analysis are not separately reimbursed.

10. Charges for the operating room includes the use of the operating room, the services of qualified professional and technical personnel, linen packs, basic instrument packs, basic packs, dressings, equipment, routine supplies such as sutures, gloves, dressings, sponges, prep kits, drapes, and surgical attire. Charges for instrument trays for any procedure are included in the cost of the procedure and are not separately reimbursable. The operating room charge shall include the cost of robotic technology and is not eligible for separate reimbursement.

11. Charges for reusable items, supplies and equipment are not separately payable, as the use of such reusable items, supplies and equipment does not result in an incremental cost

12. All charges are otherwise subject to review for confirmation that the amount billed for such supplies and services both reasonably and consistently relates back to its underlying (direct and indirect) costs.

Examples of supplies and equipment that are not separately reimbursable include, but are not limited to:

- Admission kits
- Anesthesia supplies, including pharmaceuticals/gases when billed with anesthesia time charges
- Any Linen
- Bedpans/Urinals
- Beds/Mattresses
- Bili light
- Bladder scans
- Blood pressure cuffs and monitors
- Breast milk/storage
- Capital equipment
- Cardiac monitors
- Catheters (routine)
- Cotton balls
- CPR
- CRRT
- Dialysis supplies
- Diapers
- Disposable blood pressure cuffs
- Disposable towels
- Drapes
- Dressing change trays/packs/kits
- Dressings/Gauze/Sponges
- Education/training
- Enteral/Parenteral feeding supplies (tubing, bags, sets, etc.)
- Experimental services
- Facility personnel charges (lactation consultants, dietary consultants, transport fees, professional therapy functions (physical, occupational, and speech), etc.)
- Foley/Straight catheters
- Garter Belts
- Gloves/Gowns/Drapes/Covers/Blankets
- Handling fees
- Heat light/Heating pad
- Ice packs/Water bottles
- Injections (vaccine administration)
- Internal transports
- Intubation/extubation
- Investigational items
- Irrigation solutions

- Isolation supplies
- Isolettes
- IV infusions/IV push
- IV line flushes and solutions
- IV or PICC line insertions
- IV supplies (administration kits, arm boards, bottles, bags, catheters, pumps, tubing, extensions, angiocaths, sheaths, stat-locks, blood tubing, start kits, pressure bags, adapters, caps, plugs, fluid warmers, sets, transducers, etc.)
- IV solutions used to dilute medications
- Kerlix/Tegaderm/OpSite/Telfa
- Kits/Packs
- Lotion
- Masks (including oxygen, CPAP, nasal cannulas/prongs, etc.)
- Meal trays
- Medication preparation
- Monitoring (cardiac output, central venous pressure (CVP) lines, pulse oximetry, TCM, blood pressure monitoring, capnography, end tidal CO2, neurological status checks, pulmonary arterial pressure, Swanz-ganz lines/pressure readings, routine telemetry
- Monitoring supplies (electrodes, cables, wires, etc.)
- Nutritional supplements/additives
- Odor eliminator/Room deodorizer
- Operating room equipment (saws, skin staplers, staples & staple removers, sutures, scalpels, blades etc.)
- Operating Room Supplies (gowns, instrument trays, surgical packs, etc.)
- Oral care kits and/or swabs (lemon glycerine swabs, flavored swabs, mouth care kits, toothettes, toothbrush, etc.)
- Oximeter sensors/probes/covers
- Oxygen unless utilized as an exclusive form of respiratory therapy
- Oxygen sensors
- Pacing cables/wires/probes
- Patient transport
- Perfusion supplies when billed with perfusionist time charges
- Personal convenience items
- Point of Care monitoring and testing (bedside glucose, oximetry, fecal occult blood, etc.)
- Portable charges
- Preparation kits
- Preparation or Set-up Charges
- Pressure/Pump transducers
- Razors
- Rental Fees
- Replacement batteries
- Restraints
- Resuscitation
- Reusable items
- Routine nursing services
- RT assessment

- Saline Solutions
- SCD Sleeves/Compression sleeves/Ted hose
- Separate nursing charges
- Sharps containers
- Shaving cream
- Skin cleansers/preps
- Skin temperature probes
- Slippers
- Soap
- Socks
- Specialty beds
- Specimen collection devices, containers, and fees (venipuncture, phlebotomy, heel stick, etc.)
- Sputum induction/Sputum trap
- Stat charges
- Stockings
- Suction supplies (canisters, tubing, tips, catheters, liners, etc.)
- Syringes/Needles/Lancets/Butterflies
- Tape
- Televisions
- Thermometers/Temperature probes
- Toilet tissue
- Tongue depressors
- Traction equipment
- Transducer kits/packs
- Tracheostomy care/Changing of cannulas
- Underpads
- Urometers/Leg Bags/Tubing
- Video Systems
- Wall suction
- Wipes (baby, cleansing, etc.)

References

CC.PI.04 Clean Claim Reviews

CC.PI.06 Cost to Charge Adjustments on Clean Claim Reviews

Revision History	
September 2022	New Policy Document
September 2023	Annual Review
July 2024	Annual Review
September 2024	Format Updated to HP Requirement
September 2024	Posted

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

 Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.