Medicare Chargeable Items List

The determination regarding whether a service, supply or equipment is chargeable is based upon:

- The Kansas Fiscal Intermediary's (FI) interpretation and application of existing Medicare laws and regulations or CMS manuals and other instructions regarding coverage, charging and billing.

- Absent specific regulatory or CMS guidance, a provider survey to determine the common or established classification of an item or service as routine and not separately chargeable or separately chargeable as an ancillary item wherein 40% or more of responding providers made a separate ancillary charge for a particular item or service.

  Some items on the chargeable items list were based upon surveys conducted by the Kansas Hospital Association. Survey results were reviewed by a committee of hospital representatives and the Kansas Fiscal Intermediary.

  The first survey to determine "common and established" charging practices in Kansas was performed in 1997. In December 1998, the FI published M-K Letter 99-1 containing the results of the survey. A second survey was performed in 2006.

  This list is not all-inclusive.

The authoritative source for reliance on a survey to determine charging practices by hospitals in the state of Kansas is the following citation from the Provider Reimbursement Manual (PRM) 15-1, Chapter 22, Section 2203 Provider Charge Structure as Basis for Apportionment.[1]

The authoritative sources for classifying a service, supply or equipment as routine or ancillary are PRM 15-1, Section 2202.6 Routine Services and Section 2202.8 Ancillary Services.[1]. **(Note: CMS responded to the Kansas FI, on August 24, 2006, and is in agreement with this source. Nursing services to patients in the routine rooms are part of the routine room and board charge.)**

In addition, the Kansas Fiscal Intermediary has determined that the provisions of PRM 2203.2, Ancillary Services in SNFs, apply to hospitals, as well as to SNFs. Charges for items and services meet the requirements for recognition as ancillary charges if they are:

- o Direct identifiable services to individual patients, and
- o Not generally furnished to most patients, and
- o One of the following:
  -Not reusable, e.g., artificial limbs and organs, braces, intravenous fluids or solutions, oxygen (including medications), disposable catheters;
  -Represent a cost for each preparation, e.g., catheters and related equipment, colostomy bags, drainage equipment, trays and tubing.

[1] Provider Reimbursement Manual sections are reproduced after the chargeable items list.

Equipment permanently stored or housed in a room or ancillary department is not usually separately chargeable.

ICU/CCU areas must house specific equipment. This equipment is not charged in addition to the ICU/CCU daily rate. SEE PRM 15.1 Chapter 22

Operating room equipment is not separately chargeable. These items should be bundled into the procedure or room charge. (For example, anesthesia machines, operating room table, monitors, etc.)

Chargeable Items List

Survey responses: Items in which a separate charge was made by less than 40% of the hospitals responding to the 1997 or the 2006 survey were usually determined to be non-chargeable except when the FI determined that the item was chargeable based upon Medicare regulations or CMS guidance.

The list that follows is divided into four sections

- **Supply/Equipment**
- **Procedure Descriptions**
- **Routine Administrative Items/ Services**
- **Patient Convenience Items – Admission/Hygiene/Comfort**.

Supply/Equipment Description	Survey Results	Charge Separately? Y- Yes N- No	Comments
Abduction pillows	>40%	Y	Determined from 1997 survey
Ace wraps	> 40%	Y	
Adaptive device	< 40%	N	Determined from 1997 survey
Anesthesia machine	< 40%	N	Charges for equipment should be included in the overall charge for the operating room.
Apligraft (wound care)	> 40%	Y	
Aqua machine	< 40%	N	
Bair Hugger blankets	< 40%	N	Determined from 1997 survey
Bandages	> 40%	Y	Must be documented in the record
Band-aids	< 40%	N	
Bed alarms	< 40%	N	
Bed pans	< 40%	N	
Bed rails	< 40%	N	Determined from 1997 survey
Bed scale	< 40%	N	Determined from 1997 survey

Supply/Equipment Description	Survey Results	Charge Separately? Y- Yes N- No	Comments
Beds, specialty	< 40%	N	Also, see *Mattresses, specialty*
Bilirubin light	> 40%	Y	Determined from 1997 survey
Biopatch (antimicrobial dressing)	> 40%	Y	
Bladder scanner	< 40%	N	The charge for the equipment should be included in the charge for the test.
Blades, sterile	> 40%	Y	
Blood filters	> 40%	Y	
Blue Pads, blankets, linens	< 40%	N	Determined from 1997 survey
Breast pump	> 40%	Y	Breast pumps provided to a patient, which are subsequently taken home with the patient, are considered a patient convenience item. They should be billed to the patient under revenue code 990.
C-Arm	< 40%	N	Determined from 1997 survey
Calculi strainer	> 40%	Y	
Cameras/Video equipment	< 40%	N	Determined from 1997 survey
Canes	N/A	N	Determined in 1997 survey- Classified as a covered supply but considered routine, no separate charge can be made.
Casting supplies	> 40%	Y	
Catheters and supplies (i.e. Foley, straight)	> 40%	Y	
Cell saver, auto transfusion, and supplies	> 40%	Y	
CLC 2000 Positive Pressure Connector for PICC	> 40%	Y	
Coban (self-adherent wrap)	> 40%	Y	
Compression boots	> 40%	Y	

Supply/Equipment Description	Survey Results	Charge Separately? Y- Yes N- No	Comments
Crash cart (Code Blue) supplies	> 40%	Y	
Crutches – **inpatient**	See comments	N	Determined in 1997 survey- Classified as a covered supply but considered routine, no separate charge can be made.
Crutches – **outpatient**	> 40%	See Comments	These can be billed only under DME benefits when provided to a patient for take home use. The facility must be a DME provider and must bill to the DME regional carrier.
Daily aspirator rental	< 40%	N	Determined from 1997 survey
Defibrillator	> 40%	See Comments	Defibrillators permanently housed or stored in a room or ancillary department are not separately chargeable.
Dermabond	> 40%	Y	
Diapers, adult	< 40%	N	
Diapers, baby	< 40%	N	
Dilatation balloons	> 40%	Y	
Drapes, covers	< 40%	N	
Dressing (i.e. Tegaderm, Xeroform)	> 40%	Y	
Electrodes-Physical Therapy	See Comments	N	"When used in physical therapy the electrodes should be bundled into the modality provided. The cost of supplies (e.g., theraband, hand putty, electrodes) used in furnishing covered therapy care is included in the payment for the HCPCS codes billed by the physical therapist, and are, therefore, not separately billable." Per CMS manual 100-2 Chapter 15, Section 230.
Electrodes, all other	> 40%	Y	
Enema bag, soap suds, disposable bag	> 40%	Y	
Face shields for administration of oxygen	> 40%	Y	
Feeding bag (plum enteral)	> 40%	Y	

Supply/Equipment Description	Survey Results	Charge Separately? Y- Yes N- No	Comments
Feeding tubes and sets	> 40%	Y	
Filter, leukocyte removal	> 40%	Y	
First step and therapulse (Overlay)	See comments	Y	1997 survey. (See mattress, specialty)
Flexible Stockaide	< 40%	N	Determined from 1997 survey
Foot cradle	N/A	N	Determined in 1997 survey- Classified as a covered supply but considered routine, no separate charge can be made.
Foley catheter and catheter supplies	> 40%	Y	
Gamma graft (irradiated human skin)	> 40%	Y	
Gastric band	> 40%	Y	
Gloves in ancillary departments	< 40%	N	
Gloves in patient room	< 40%	N	
Glucometers	< 40%	N	
Glucometer supplies	< 40%	See Comments	Per the FI, these supplies are separately chargeable.
GOMCO	> 40%	Y	Determined from 1997 survey
Gown, isolation Inpatient	< 40%	N	
Gowns, disposable	< 40%	N	
Heat light	> 40%	Y	Determined from 1997 survey
Heating pads	>40%	Y	Determined from 1997 survey
Hot and cold packs	< 40%	See Comments	Per FI, a separate charge for the packs can be made, except when provided in Physical Therapy.
Hyperinflation bag	> 40%	Y	
Ice packs, First Ice	> 40%	See Comments	Per FI, a separate charge for the packs can be made, except when provided in Physical Therapy.

Supply/Equipment Description	Survey Results	Charge Separately? Y- Yes N- No	Comments
ID band or bracelet	< 40%	N	Determined from 1997 survey
Immobilizers	> 40%	Y	
Implantable pumps	> 40%	Y	
Incubator	< 40%	N	Determined from 1997 survey
IV catheter	> 40%	Y	
IV Extension set	> 40%	Y	
IV pumps	> 40%	Y	
IV supplies	> 40%	Y	
IV tubing	> 40%	Y	
K-pad	> 40%	Y	
K-wire	> 40%	Y	
Kinetic machine	< 40%	N	Determined from 1997 survey
Lap sponge	> 40%	Y	
Leads & guides for ICD and pacemakers	> 40%	Y	
Leg lifter	< 40%	N	Determined from 1997 survey
Lifter	See comments	N	Per F/I 1997 survey- This item is not covered and a separate charge cannot be made to Medicare.
Limb holder	See comments	N	Per F/I 1997 survey- This item is not covered and a separate charge cannot be made to Medicare.
Masks	See comments	N	Per F/I- this item is classified as a covered supply but considered routine, no separate charge can be made.
Mattresses, disposable (eggcrate)	< 40%	N	
Mattresses, specialty	> 40%	See Comments	Per FI, a separate charge can be made for specialty mattresses under revenue code 27X, if ordered by physician. See MK 99-1, dated 12-31-98. *(See also Mattresses, disposable)*
Moisturizer, nasal - **inpatient**	See Comments	Y	Self-administered drugs dispensed to an inpatient are covered and chargeable.

Supply/Equipment Description	Survey Results	Charge Separately? Y- Yes N- No	Comments
Moisturizer, nasal – **outpatient**	See Comments	N	If provided to an outpatient, this is considered self-administered and not covered
Monitor, Bispectral Index (BIS)	< 40%	N	
Monitor, blood pressure	< 40%	N	
Monitor, cardiac/heart	> 40%	See Comments	Exception: A separate charge can be made if the equipment is portable AND there is dedicated personnel monitoring the equipment. If the above criteria are not met, the equipment charge should be part of the room charge. Equipment permanently stored or housed in a room or ancillary department is not separately chargeable. See Provider Reimbursement Manual 15-1 Chapter 22.
Monitor, dynamap	< 40%	N	
Monitor, fetal	> 40%	Y	
Nasal cannula	> 40%	Y	
Nebulizer	>40%	Y	Determined from 1997 survey
Nursing shield	> 40%	Y	
Ointment (protective barrier) - **inpatient**	See Comments	Y	Must be ordered and documented in patient record
Ointment (protective barrier) – **outpatient**	See Comments	N	Ointment is considered self administered EXCEPT when provided in connection with wound care or an invasive procedure.
Oxygen	> 40%	Y	
Oxygen hood	> 40%	Y	
Oxygen tubing and supplies, face shield	> 40%	Y	
Pads, aqua	> 40%	Y	
Pads, incontinence	< 40%	N	
Pads, sanitary	> 40%	Y	
Pain pumps	> 40%	Y	

Supply/Equipment Description	Survey Results	Charge Separately? Y- Yes N- No	Comments
PCA pumps	> 40%	Y	
Peak Flow Meters	> 40%	Y	
PICC line supplies (includes CLC 2000)	> 40%	Y	
Posey belt	< 40%	N	Determined from 1997 survey
Reacher	< 40%	N	Determined from 1997 survey
Restraints (arm, leg, limb, etc.)	< 40%	N	Determined from 1997 survey
Scalpels	> 40%	Y	
Screws, plates for orthopedic patients	> 40%	Y	
Scrotal support	> 40%	Y	
Shave prep kit	< 40%	N	
Shoe horn	< 40%	N	Determined from 1997 survey
Silver nitrate sticks	> 40%	Y	
Sitz bath, portable	> 40%	Y	Determined from 1997 survey
Slings and wraps	> 40%	Y	
Specimen cups, traps	< 40%	N	
Specimen hat	< 40%	N	
Sponge, long handle or others used in OR	< 40%	N	Determined from 1997 survey
Statlocks (to secure IV lines, PICC, etc)	< 40%	N	
Stitz marker	< 40%	N	
Suction catheter	>40%	Y	
Suction machine	< 40%	N	

Supply/Equipment Description	Survey Results	Charge Separately? Y- Yes N- No	Comments
Suction tips	> 40%	Y	
Supplemental nutrition (Ensure, Vivonex, Citrotin, Jevity)	< 40%	N	Determined in 1997 survey. Additional note: The FDA classifies these items as food, therefore a separate charge cannot be made. Items classified as drugs can be charged separately.
Swab sticks	< 40%	N	
Syringes	< 40%	N	
Tattoo ink for Endo	< 40%	N	
Ted hose	> 40%	Y	
Telemetry	> 40%	See Comments	See *Monitor, cardiac/heart*
Telfa, steri-strips	> 40%	Y	
Theraband	See Comment	N	Theraband should be bundled into the treatment provided. "The cost of supplies (e.g., theraband, hand putty, electrodes) used in furnishing covered therapy care is included in the payment for the HCPCS codes billed by the physical therapist, and are, therefore, not separately billable." Reference CMS manual 100-2 Chapter 15, Section 230.
Thermometer, all types	< 40%	N	Determined from 1997 survey
Toilet seat lifter, elevator	< 40%	N	Determined from 1997 survey
Transfer belt	< 40%	N	Determined from 1997 survey
Trapeze (bed treatment)	< 40%	N	
Unna boots	> 40%	Y	
Urine dipsticks done by nursing	< 40%	N	
Vaporizer	> 40%	Y	Determined from 1997 survey

Supply/Equipment Description	Survey Results	Charge Separately? Y- Yes N- No	Comments
Ventricular Assist Device, electric or pneumatic	> 40%	Y	
Video equipment in surgery	< 40%	N	Equipment permanently stored or housed in a room or ancillary department is not separately chargeable
Walkers - inpatient	See Comments	N	Per F/I 1997 survey- This item is not covered and a separate charge cannot be made to Medicare.
Walkers - outpatient	See comments	See comments	These can be billed only under DME benefits when provided to a patient for take home use. The facility must be a DME provider and must bill to the DME regional carrier.
Wheelchairs - inpatient	See comments	N	Per F/I 1997 survey- This item is not covered and a separate charge cannot be made to Medicare
Wheelchairs - outpatient	See comments	See comments	These can be billed only under DME benefits when provided to a patient for take home use. The facility must be a DME provider and must bill to the DME regional carrier.
Warming blankets	< 40%	N	
Wipes (adult wash cloths)	< 40%	N	
Wound vac	> 40%	Y	
Wound vac supplies	> 40%	Y	
X-ray copies when sent with patient	< 40%	N	

Procedure Descriptions	Survey Results	Charge Separately? Y- Yes N- No	Comments
Catheter care - inpatient	See Comments	N	Considered part of routine nursing services
Catheter care – outpatient	See Comments	Y	Nursing time and room costs are billed under the appropriate HCPCS code that represents the service performed
Fluoroscopy in the OR	> 40%	Y	
IV flush, IV care, IV administration - inpatient	See Comment	N	A procedural charge for an IV flush and /or administration cannot be billed separately. This is considered a routine cost. However, the materials and supplies used for the IV flush and administration can be charged separately.
IV flush - **outpatient**	See Comment	N	The materials and supplies used for the IV flush can be charged separately. A procedure charge for an IV flush cannot be made. Exception: When the patient presents to the facility for the sole purpose of flushing a port, line, or catheter, a separate charge can be made, if IV drugs were not administered.
Lab call back	< 40%	See Comments	Per FI, this is an administrative expense; no separate charge can be made.
Labor induction	> 40%	See Comments	The labor and delivery room charge includes induction.
Newborn nursing observation	< 40%	N	Determined from 1997 survey
Oximetry	> 40%	Y	Must be ordered and medically necessary.
Oxygen setup or administration	> 40%	See Comments	This is a service that can be done by nursing staff. If a hospital chooses to have RT perform the service, this does not make it billable. A separate charge should not be made.
Point of Care Testing	< 40%	N	
Prep time for bone marrow aspirations	< 40%	N	
Radiology call back	< 40%	N	
Respiratory treatments by nursing staff – **inpatient**	See comments	N	This is considered a routine cost, and a separte charge cannot be made.
Specimen handling and processing fees	> 40%	See Comment	Per FI, this is an administrative expense; no separate charge can be made

Procedure Descriptions	Survey Results	Charge Separately? Y- Yes N- No	Comments
Stat charges or call back charges	<40%	N	Determined from 1997 survey
Tracheostomy Care or suction - inpatient	< 40%	N	When provided by nursing, this is a routine service. When provided by RT, it is billable. Determined from 1997 survey
Tracheostomy Care or suction - outpatient	> 40%	Y	
Transfusion reaction investigation charges	< 40%	N	

Routine Administrative Items/ Services	Survey Results	Charge Separately? Y- Yes N- No	Comments
Additional personnel	< 40%	N	Determined from 1997 survey
Additive fees	< 40%	N	Determined from 1997 survey
After hours personnel	< 40%	N	Determined from 1997 survey
Bedside x-ray charge	< 40%	N	Determined from 1997 survey
Educational or training materials or books	< 40%	N	Determined from 1997 survey
Emergency charge for x-ray	< 40%	N	Determined from 1997 survey
Management consultations	< 40%	N	Determined from 1997 survey
Medical social services	< 40%	N	Determined from 1997 survey
Oxygen transport fees	< 40%	N	Determined from 1997 survey
Oxygen stand by	< 40%	N	Determined from 1997 survey
Pharmacist analysis fees or profile fees	< 40%	N	Determined from 1997 survey
Social services/Discharge planning	< 40%	N	Determined from 1997 survey
Special diet trays	< 40%	N	Determined from 1997 survey
Supplemental nutrition (Ensure, Vivonex, Citrotin, Jevity)	< 40%	N	The FDA classifies these items as food. Therefore a separate charge cannot be made. Items classified as drugs can be charged separately. Determined from 1997 survey

Patient Convenience Items – Admission/ Hygiene/Comfort	Survey Results	Charge Separately? Y- Yes N- No	Comments
Admission kits	< 40%	See comments	If a separate charge is made, the charge must be billed to the patient under revenue code 990. If no separate charge is made, it is considered a routine cost.
Baby bath	See Comment	See Comment	Non-covered item. If a separate charge is made, the charge must be billed to the patient under revenue code 990.
Baby wipes	See Comment	N	Per F/I in 1997 survey, Covered supply but considered routine and no separate charge can be made.
Carafes	See Comment	N	Per F/I in 1997 survey, Covered supply but considered routine and no separate charge can be made.
Comb/brushes	See Comment	See Comment	If a separate charge is made, the charge must be billed to the patient under revenue code 990.
Cool wipes	See Comment	See Comment	If a separate charge is made, the charge must be billed to the patient under revenue code 990.
Cosmetics	See Comment	See Comment	If a separate charge is made, the charge must be billed to the patient under revenue code 990.
Cot charges	See Comment	See Comment	If a separate charge is made, the charge must be billed to the patient under revenue code 990.
Dental cup	See Comment	See Comment	If a separate charge is made, the charge must be billed to the patient under revenue code 990.
Deodorant	See Comment	See Comment	If a separate charge is made, the charge must be billed to the patient under revenue code 990.
Hand/body lotion and cream	See Comment	See Comment	If a separate charge is made, the charge must be billed to the patient under revenue code 990.
Lip balm	See Comment	See Comment	If a separate charge is made, the charge must be billed to the patient under revenue code 990.
Mouth moisturizer	See Comment	N	Per F/I in 1997 survey, Covered supply but considered routine and no separate charge can be made.
Mouth wash	See Comment	See Comment	If a separate charge is made, the charge must be billed to the patient under revenue code 990.
Personal belonging bag	See Comment	See Comment	If a separate charge is made, the charge must be billed to the patient under revenue code 990.
Pitchers	See Comment	N	Per F/I in 1997 survey, Covered supply but considered routine and no separate charge can be made.
Powder	See Comment	See Comment	If a separate charge is made, the charge must be billed to the patient under revenue code 990.

Patient Convenience Items – Admission/ Hygiene/Comfort	Survey Results	Charge Separately? Y- Yes N- No	Comments
Shampoo	See Comment	See Comment	If a separate charge is made, the charge must be billed to the patient under revenue code 990.
Shaving cream	See Comment	See Comment	If a separate charge is made, the charge must be billed to the patient under revenue code 990.
Slippers, house shoes	See Comment	See Comment	If a separate charge is made, the charge must be billed to the patient under revenue code 990.
Soaps	See Comment	See Comment	If a separate charge is made, the charge must be billed to the patient under revenue code 990.
Tissue, Kleenex	See Comment	See Comment	If a separate charge is made, the charge must be billed to the patient under revenue code 990.
Toothbrush	See Comment	See Comment	If a separate charge is made, the charge must be billed to the patient under revenue code 990.
Toothettes	See Comment	N	Per F/I in 1997 survey, Covered supply but considered routine and no separate charge can be made.
Toothpaste	See Comment	See Comment	If a separate charge is made, the charge must be billed to the patient under revenue code 990.

2202.4 CHARGES

Charges refer to the regular rates established by the provider for services rendered to both beneficiaries and to other paying patients. Charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient. All patients' charges used in the development of apportionment ratios should be recorded at the gross value; i.e., charges before the application of allowances and discounts deductions.

2202.6 ROUTINE SERVICES

Inpatient routine services in a hospital or skilled nursing facility generally are those services included in by the provider in a daily service charge—sometimes referred to as the "room and board" charge. Routine services are composed of two board components; (l) general routine services, and (2) special care units (SCU's), including coronary care units (CCU's) and intensive care Units (ICU's). 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.

2202.8 ANCILLARY SERVICES

Ancillary services in a hospital or SNF include laboratory, radiology, drugs, delivery room (including maternity labor room), operating room (including post anesthesia 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. (See §2203.1 and §2203.2 for further discussion of ancillary services in an SNF.)

2203. PROVIDER CHARGE STRUCTURE AS BASIS FOR APPORTIONMENT

To assure that Medicare's share of the provider's costs equitably reflects the costs of services received by Medicare beneficiaries, the intermediary, in determining reasonable cost reimbursement, evaluates the charging practice of the provider to ascertain whether it results in an equitable basis for apportioning costs. So that its charges may be allowable for use in apportioning costs under the program, each facility should have an established charge structure which is applied uniformly to each patient as services are furnished to the patient and which is reasonably and consistently related to the cost of providing the services. While the Medicare program cannot dictate to a provider what its charges or charge structure may be, the program may determine whether or not the charges are allowable for use in apportioning costs under the program. Hospitals that have subproviders and hospital-based SNFs must also maintain uniform charges across all payer categories, as well as like charges for like services across each provider setting, in order to properly apportion costs. If like charges for like services are not maintained across provider settings, the cost report must not combine charges when calculating cost-to-charge ratios but must

report separately, by department, costs and charges for the hospital, subprovider, and skilled nursing facility. An exception to this requirement is if the provider has the ability to gross-up charges described in §2314.B.

In determining reimbursement for the costs of routine services, providers do not use charges but use patient days for apportionment purposes in a skilled nursing facility (to the extent certified) or in a hospital (with separate computation for each separate care unit). Costs of routine services are determined based on the consideration that all patients in each separate area are receiving similar services.

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, where the common or established practice of providers of the same class (hospital or SNF) in the same State is to include the item or service in the routine service charge. Where there is no common or established classification of an item or service as routine or ancillary among providers of the same class in the same State, a provider's customary charging practice is recognized so long as it is consistently followed for all patients and does not result in an inequitable apportionment of cost to the program. Ancillary charges for items or services furnished Medicare beneficiaries, including those enumerated in §2202.8, are not recognized by the program if separate charges are not also recorded by the provider for all non-Medicare patients receiving these same items or services directly from the provider.

2203.1 ROUTINE SERVICES IN SNFs

Hospitals and most SNFs differ historically in their charging practices and method of providing services. It is common in nursing homes and other posthospital care facilities, of which SNFs provide the higher level of care, for certain supplies and services to be furnished or purchased for some patients directly by their families or third parties, while the institution furnishes them to other patients and charges for them. In addition, customary charges may not be recorded, as they are for Medicare beneficiaries, for patients for whom other third-party payers reimburse the SNF a flat rate. Such practices may significantly distort allocations in determining departmental costs. To reduce the potential impact of unusual or inconsistent charging practices, the following types of items and services, in addition to room, dietary, medical social services, and psychiatric social services, are always considered routine in an SNF for purposes of Medicare cost apportionment, even if customarily considered ancillary by an SNF:

- All general nursing services, including administration of oxygen and related medications (see §2203.2 for inhalation therapy by an inhalation therapist), handfeeding, incontinency care, tray service, enemas, etc.

- Items which are furnished routinely and relatively uniformly to all patients, e.g., patient gowns, paper tissues, water pitchers, basins, bed pans, deodorants, mouthwashes.

o Items stocked at nursing stations or on the floor in gross supply and distributed or utilized individually in small quantities, e.g., alcohol, applicators, cotton balls, bandaids, antacid, aspirin (and other nonlegend drugs ordinarily kept on hand), suppositories, tongue depressors.

o Items which are utilized by individual patients but which are reusable and expected to be available in an institution providing an SNF level of care, e.g., ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, other durable medical equipment (DME) which does not meet the criteria for ancillary services in SNFs under §2203.2 and the requirements for recognition of ancillary charges under §2203. The criteria in §2203.2 explicitly state that items and services may be considered ancillary if they are identifiable items and services tailored to an individual patient's specific medical needs, are furnished at the direction of a physician, and are either not reusable or represent a cost for each preparation. Accordingly, those items of DME which do not meet both the criteria of §2203.2 and the requirements of §2203 for recognition of ancillary charges must be classified as routine. Examples of DME which may qualify as ancillary items are respirators and air fluidized beds.

o Special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet, even if written as a prescription item by a physician, because these supplements have been classified by the Food and Drug Administration as a food rather than a drug.

EXCEPTION: To facilitate accurate and equitable cost apportionment within a single hospital-SNF complex where both components have customarily followed a uniform charging practice, the same classification of items and services as routine or ancillary may continue to be used by a participating hospital-based SNF as is used by the related hospital for Medicare reimbursement purposes.

2203.2 ANCILLARY SERVICES IN SNFs

Items and services (other than the types classified as routine services in §2203.1) may be considered ancillary in an SNF if charges for them meet the requirements of §2203 for recognition of ancillary charges and if they are:

o Direct identifiable services to individual patients, and

o Not generally furnished to most patients, and

o One of the following:

- Not reusable, e.g., artificial limbs and organs, braces, intravenous fluids or solutions, oxygen (including medications), disposable catheters;

- Represent a cost for each preparation, e.g., catheters and related equipment, colostomy bags, drainage equipment, trays and tubing;

- Complex medical equipment, e.g., ventilators; or

- Support surfaces. The support surfaces which are classified as ancillary are those listed under the Durable Medical Equipment Regional Carrier's (DMERC) level 2 and level 3 support surfaces categories. For example, support surfaces which qualify under DMERC's level 2 support surface criteria are low air loss mattress replacement and overlay systems. An example of support surfaces which qualify under DMERC's level 3 support surface criteria is air fluidized therapy.

NOTE: Items listed in the DMERC level 1 support surface criteria do not qualify for this category because they are inexpensive and common enough to be considered routine services in all cases.

The use of an operating room and the provision of inhalation therapy services by an inhalation therapist are reimbursable skilled nursing facility services only when furnished to the SNF by a hospital with which the SNF has a transfer agreement.

2314 B. “GROSSING UP” METHOD

"Grossing up" of charges means applying the provider's standard charge structure to the non-Medicare patient services. Charges so determined should be added to charges for services to Medicare patients and used to apportion costs in accordance with the apportionment method the provider is required to use under the program.