Select Health

CODING/REIMBURSEMENT POLICY

INPATIENT/OUTPATIENT UNBUNDLING - FACILITY

Policy # 99
Implementation Date: 1/1/25
Review Dates:
Revision Dates:

Disclaimer:
1. Policies are subject to change without notice.
2. Policies outline coverage determinations for Select Health Commercial, Select Health Medicare (CMS), and Select Health Community Care (Medicaid) plans. Refer to the "Policy" section for more information.

Description

A claim review conducted on an itemized statement involves an examination of that statement and the associated medical records for unbundling of charges, not covered, and/or inappropriate charges whether the member's status is outpatient or inpatient.

Routine Services are those services included by the provider in a daily service charge. Routine services are composed of two components: 1) general routine services, and 2) special care units (SCU, CCU, ICU, and NICU). 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 applicable (CMS, Provider Reimbursement Manual, Part 1 Chapter 22, Determination of Cost of Services to Beneficiaries, 2202.6).

Unbundling can occur in two ways: 1) submission of revenue codes for payment of **routine** supplies/equipment/nursing care that are considered "bundled" and included in the payment of the room and board charges, and 2) submission of revenue codes for payment for individual parts of a procedure in addition to charges for the procedure itself (CMS, Medicaid National Correct Coding Initiative Policy Manual, Chapter 1).

COMMERCIAL PLAN POLICY AND CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)

Unbundled services are routine services, supplies, equipment, and items that are bundled into the reimbursement for the facility (e.g., daily room and board) or the associated surgery, procedure, therapy, treatment, or service and are not eligible for separate reimbursement or inclusion in the outlier calculation. Unbundled services identified on the claim or itemized bill will be denied and the claim adjusted accordingly. This policy applies to claims that include payment methodologies such as, but are not limited to, percentage of the billed charge or have an outlier payment applied, including the determination that an outlier threshold has been met. This policy does not apply to claim payments that are paid a DRG allowable without an outlier, per diems, case rates, or APC methodologies.

The following unbundled charges will be denied when reported by a facility.

A. General Policies

Select Health uses the following guidelines to identify services, supplies, equipment, and items that are bundled into the reimbursement for the facility/procedure and not separately reimbursable (not an all-inclusive list):

1. Any services, supplies, equipment, and items that are necessary or otherwise integral to the provision of a specific service and/or to the delivery of services in a specific location. (e.g. endoscopes used for a colonoscopy or EGD)
2. All items and supplies that may be purchased over the counter are not separately billable, excluding medications.
3. Any supply that is available to all patients admitted to a given treatment area or unit (i.e., NICU, Burn Unit, PACU, Medical/Surgical).
4. All reusable items, supplies, and equipment provided to all members admitted to a given treatment area or unit (i.e., NICU, Burn Unit, PACU, Medical/Surgical).
5. All reusable items, supplies and equipment that are provided to all members receiving the same service (i.e., an Ambu bag during resuscitation).
6. Items that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services (e.g., IV tubing, IV pumps).
7. Nursing services (e.g., IV injections and IV infusion administration) are included in the room and board charges.
8. The following services and items are included in the payment for the injection/infusion of any drug or fluid (e.g., chemotherapy, nonchemotherapy, hydration, TPN, enteral formula):
    - Use of local anesthesia
    - IV start
    - Access to indwelling IV, subcutaneous catheter or port
    - Flush at conclusion of infusion
    - Standard tubing, syringes, and supplies
9. Items used to obtain a specimen or complete a diagnostic or therapeutic procedure.
10. Kits that contain routine stock items, such as an IV start kit or urine catheter kit.
11. Anesthesia supplies when billed with an anesthesia time-based charge.
12. 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. Even though J1642 (Injection, heparin sodium, (heparin lock flush), per 10 units) describes heparin flushes, heparin flushes are not considered a “drug” and are not eligible for separate reimbursement under the fee schedule. 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.
13. Equipment

    Medical equipment or the use of this equipment is bundled in the procedure or facility charge and not separately reimbursable. Medical equipment includes any device that is generally used for diagnostic or therapeutic purposes, has an extended life or is considered a fixed asset of the provider or facility, and/or is used multiple times for multiple patients. Services provided with this 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 or fluoroscopy in the OR). 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).

    Examples of non-billable medical equipment include, but are not limited to: *(commonly associated revenue codes 260-269, 270, 279, 290, 320, 410, 412, 460)*

- Anesthesia machines
- Automatic blood pressure machines and/or monitors
- Bladder Scan equipment
- Cameras
- Cardiac monitors
- Cautery machines
- Cell Saver and related equipment and supplies
- Fluoroscopy in OR
- Instruments
- IV pumps
- Lasers
- Microscopes
- Neurological Monitors in OR
- Oximetry monitors
- Perfusion equipment and supplies in OR
- Procedure-specific Tool Kits/Instruments, whether rented, loaned, or purchased (e.g., orthopedic tools for joints, implants, spinal surgeries, etc.)
- Rental equipment
- Scopes
- Thermometers
- Ultrasound in OR

B. Inpatient Hospitals

Inpatient hospital care coverage includes:

- Semi-private rooms
- Meals
- General nursing
- Other hospital services and supplies

The following are general categories of inpatient facility charges that are not separately billable or reimbursable, including but not limited to:

1. Routine/Reusable Supplies

   Routine and /or reusable supplies are not separately reimbursable. They are used during the normal course of treatment and are considered necessary or otherwise integral to the provision of a specific service and/or to the delivery of services in a specific location. Routine supplies are considered floor stock and are generally available to all patients receiving the same service or admitted to a given treatment area or unit (e.g., NICU, Burn Unit, PACU, Medical/Surgical).

   Supplies that require a physician's order and are separately identifiable to a specific patient based on documentation in the medical record may qualify for separate reimbursement at the discretion of Select Health.

   Examples of routine supplies include, but are not limited to: *(commonly associated revenue codes 250, 270–279)* this is not an all-inclusive list of revenue codes*

   - Alcohol swabs/pads
   - Baby powder
   - Bandages/dressings (e.g., Band-Aids, 4X4, sponges) *Does not include wound vac supplies
   - Basin
   - Batteries
   - Bedpan, regular or fracture pan
   - Blood pressure cuff
   - Cotton balls, sterile or nonsterile
   - Diapers
   - Drapes

- Emesis basin
- Gloves/gowns/masks used by patients or staff
- Glucose test strips
- Heating pad
- Ice packs/hot packs
- Items and supplies that may be purchased over the counter (OTC)
- Items used to obtain a specimen or complete a diagnostic or therapeutic procedure (e.g., arterial blood gas kit, urine collection kits, mucus traps)
- IV arm boards
- IV catheters/start kits, tubing, extenders, stopcocks, and dressings
- Lemon glycerin swabs (flavored swabs)
- Lubricant Jelly
- Meal trays (including guest)
- Nutritional supplements (e.g., Ensure, Vivonex, Promed) *Does not include enteral formula
- Odor eliminator / Room deodorizer
- Oral swabs / Toothettes
- Oxygen
- Oxygen masks, cannulas, tubing
- Personal items (e.g., soap, toothpaste, deodorant, facial tissues, lotion, mouthwash (excluding chlorhexidine), razors, shampoo, shaving cream, socks/slippers, toilet paper)
- Pillows
- Preparation kits
- Restraints
- Sharps Containers
- Skin cleansing solutions (e.g., betadine, chlorhexidine)
- Solutions (e.g., saline, sterile water, IV flushes, irrigation, etc.)
- Syringes and needles
- Tape
- Thermometers
- Tubing (e.g., IV, blood, feeding)
- Urinal
- Wall suctioning supplies
- Water pitchers

Note: Items which do not appear on this list may or may not be eligible for separate reimbursement, depending upon whether they are considered routine supplies and other additional factors as determined by Select Health.

2. Components of Room and Board

Many basic services are included as components of room and board (revenue codes 0110 – 0174, 0200 – 0214) and not separately reimbursable. Components of room and board include, but are not limited to:

a. Nursing care

Routine nursing care/services performed by the primary bedside nurse (RN or LPN), certified nursing assistants, or technicians within the scope of their daily duties are bundled under the basic room daily charge and are not separately reimbursable. Examples of routine nursing care/services include, but are not limited to: (commonly associated revenue codes 260, 300, 309, 361, 391, 460, 510, 761)

- Admission assessment
- Monitoring of patients
- IV insertion, including lidocaine for IV insertion and saline flushes, assessments, infusion of fluids.
- Specialized IV-line placements (PICC line insertions, midline-catheter insertions, etc.)

- Medication administration
- Blood Administration (transfusions), including MTP (Massive Transfusion Protocol or IAT (Intraoperative Autologous Transfusion)
- TPN administration through a central line
- Any respiratory treatment (medications may be separately charged) including, but not limited to:
    - Sputum inductions, bronchial hygiene or airway clearance treatments
    - Incentive spirometry
    - Nebulizer treatment
    - Administration of mucolytics
    - Placement of masks for nebulized medications
- Urinary catheterization, dressing changes, tube feedings, bladder scans with or without PVR (post void residual)
- Point of care (POC) testing, such as urine dip stick, glucometer testing, mobile computer devices such as, but not limited to, those used for the analysis of blood gases, electrolytes, metabolites and urinary retention, and insertion of peripheral IV lines.
- Rectal inserts and related accessories will be denied as not reasonable and necessary because they do not meet the medical evidence requirements outlined in the Centers for Medicare & Medicaid Services (CMS) Program Integrity Manual. Per this policy they are considered misc. incontinence supplies and are not covered for any line of business. (CMS26)
- Assisting with bedside procedures performed by physicians or other qualified healthcare professionals.
- Pre-op holding for inpatient surgery
- Surgical prep for procedures
- Hemodynamic monitoring
- Incremental nursing care – (1:1, ICU/CCU setting, etc.)

b. Routine/Reusable Supplies and Floor stock

In addition to all the routine/reusable supplies listed above, items considered floor stock are not reimbursable. Floor stock includes, but is not limited to:

- Urine culture kits
- Alcohol wipes
- Cotton balls
- Thermometers
- Gloves
- Bedpans
- Patient gowns
- Sitz baths
- Breast pump
- Diapers
- Kits containing routine supplies such as alcohol wipes, cotton balls, etc.

c. All food and meals, including special diets, thickening agents, etc.

d. Other services typically provided to a member while an inpatient of a hospital.

3. <u>Lab/Pharmacy Services</u>

Examples of lab/pharmacy services which are not separately reimbursable include, but are not limited to:

a. Blood draws from capillary, arterial or vascular access devices regardless of practitioner performing the draw and regardless of whether arterial, venous, or capillary blood is drawn. Each blood draw or collection is part of the lab test and is not separately reimbursable. This includes, but is not limited to:

- Arterial lines

- Peripheral lines, short or midline
- Capillary blood collection with lancet or finger-stick devices
- Central lines:
    - Peripherally inserted (PICC)
    - Tunneled central venous catheter
    - Percutaneous non-tunneled
    - Implanted port

b. Pharmacy consultations for medication management or member education

c. Point of care (POC) testing, such as:

- Urine dip stick- CPT code 81001 and 81025
- Glucometer testing
- Mobile computer devices such as, but not limited to, those used for:
    - Analysis of blood gases
    - Electrolytes
    - Metabolites
    - Urinary retention
    - Insertion of peripheral IV lines
    - Etc.

4. Central Supply

- Telemetry batteries and leads
- Batteries for any equipment used during any procedure

5. Equipment

The following equipment and calibration of instrumentation is considered a required component of a specific level of care and is not separately reimbursable. See also Equipment, section A.2.

- Cardiac monitors (e.g., in an ICU setting (Med/Surg, CCU, NICU), Telemetry or Step-Down unit, OR, PACU/Recovery Room)
- Oximetry (e.g., in an ICU setting (Med/Surg, CCU, NICU), Telemetry or Step-Down unit, OR, PACU/Recovery Room)
- Arterial and Swan-Ganz monitors (e.g., in an ICU setting (Med/Surg, CCU, NICU), Telemetry or Step-Down unit, OR, PACU/Recovery Room)
- CO2 End Tidal Monitors, in-line or transcutaneous, or humidified air (e.g., in an ICU setting (Med/Surg, CCU, NICU), Telemetry or Step-Down unit, OR, PACU/Recovery Room)
- Fetal monitors (e.g., in a labor room setting)
- Transesophageal Echo (TEE) Monitors during Open Heart Surgery (TEE equipment is mandatory in the Open Heart Room, excluding NICU)
- Ventilator (e.g., OR, PACU/Recovery Room)
- Cell Saver equipment (e.g. OR)
- Neurological monitors (e.g., OR, ICU)
- Fluoroscopy in the OR
- Ultrasound guidance for any procedure

6. Respiratory Therapy

- Ventilator adjustments if performed by RN
- Ventilator System checks by respiratory therapist
- O2, CPAP, PEEP charges when the member is on ventilator support
- Ventilator weaning and extubation
- Member's own CPAP/BiPAP machine services
- Respiratory Assessment with treatments
- Oximetry Trending when done by routine monitor
- Endotracheal Suctioning when done with treatments or on ventilator
- Surfactant administration when done by the physician

- Point of care (POC) testing, such as urine dip stick, glucometer testing, mobile computer devices such as, but not limited to, those used for the analysis of blood gases, electrolytes, metabolites and urinary retention, and insertion of peripheral IV lines.

C. Specialty Unit/Critical Care Area

In addition to the routine medical/surgical supplies, equipment, and nursing services listed in the sections above, a Specialty Unit (e.g., Burn Unit) or Critical Care Area (e.g., Medical/Surgical ICU, NICU, PICU) daily charge includes supplies, equipment, and nursing services appropriate for that setting and not separately reimbursable. This includes, but is not limited to:

- All nursing care provided in this setting
- Respiratory Therapy Services
- Ventilatory Support and management
- Telemetry and related supplies
- Special warming/cooling blankets or beds
- Incubator/Isolette
- Heat lamp
- Resuscitation equipment (e.g., resuscitation masks, crash cart)
- Pressure bags
- Evaluations or social services required for the setting
- Post-operative surgical or procedural recovery services performed in the ICU setting (outside the PACU)

D. Non-intensive Specialty Unit Room

In addition to the routine medical/surgical supplies, equipment, and nursing services listed in the sections above, a non-intensive Specialty Unit Room (e.g., Progressive Care, Step Down Care, Psychiatric Care, and Chemical/Alcohol Dependency Care) daily charge includes supplies, equipment, and nursing services appropriate for that setting and not separately reimbursable. This includes, but is not limited to:

- Monitoring equipment/supplies of any kind; telemetry, any blood pressure cuff, crash cart, evaluations or social services required for the setting.
- All nursing care provided in this setting.

E. Surgical Rooms and Services

The facility's charge for surgical suites, major and minor treatment rooms, endoscopy labs, cardiac catheterization labs, X-ray, pulmonary and cardiology procedural rooms, and minor procedures performed at the bedside, includes all the routine supplies, equipment, and nursing services listed in the sections above. In addition, the following are examples of services and equipment considered bundled in the surgical room rate and not separately reimbursable. This includes, but is not limited to: *(commonly associated revenue codes 27X, 270-279, 300-370)*

- Air conditioning and filtration
- All reusable instruments charged separately (e.g., forceps/scissors)
- All services rendered by RN's, LPN's, scrub technicians, surgical assistants, orderlies, and aides
- Anesthesia equipment and monitors
- Anesthesia gases
- Any automated blood pressure/vital sign equipment (e.g., Dinamap)
- Anti-fog devices (FRED)
- Batteries for any equipment
- Cardiac monitors
- Cardiopulmonary bypass equipment
- Cautery Equipment (e.g., monopolar and bipolar electrosurgical/bovie)
- Cell Saver equipment and supplies
- CO2 monitors
- Crash carts
- Digital recording equipment and printouts

- Fracture tables
- Fluoroscopy in the OR
- Grounding pads
- Hemochron/supplies
- Hemoconcentrator
- Laparoscopes, bronchoscopes, endoscopes and accessories
- Lights, light handles, light cord, fiber optic
- Local anesthesia
- Microscopes
- Midas Rex (high speed pneumatic drill)
- Obtaining laboratory specimens (e.g., biopsies, tissue samples)
- Procedure-specific reusable tools/instruments (e.g., broaches, extractors, drill, drill bits, osteotomes, reamers, retractors)
- Power equipment
- Robotic surgical systems
- Room heating and monitoring equipment
- Room set-ups of equipment and supplies
- Saline infusion sonogram (SIS) equipment
- Saline slush machine
- Smoke Evacuators (e.g., Pneumoclear smoke evacuator)
- Solution warmer (warms IV fluid or solution used to warm scopes)
- Surgeons' loupes or other visual assisting devices
- Trocars
- Transport monitor (includes intra hospital transport)
- Video camera and tape
- Wall suction equipment
- Warming/cooling blankets (e.g., Bair Hugger)

Outpatient Surgical Rooms and Services

- When a procedure CPT code is billed, all usual and customary supplies/equipment required to complete the procedure are considered bundled into the procedure and are not separately reimbursable.
- *The operating room (OR) charge may be based on time or on a procedural basis. It Is inappropriate to include both a time based and procedural based OR fee.*
- *Anesthesia supplies are not separately reimbursable when billed with an anesthesia time-based charge.*

F. Emergency Room Charges

An Emergency Room Charge includes all nursing care, personnel, and routine disposable and/or reusable equipment, supplies and/or items appropriate for that setting. Emergency Room Charges that are not separately reimbursable include, but are not limited to:

- All nursing care provided in this setting
- IV start procedures
- Injections, fluids, and medications administered in the ER
- Fluid/medication administration fees
- Monitoring equipment/supplies of any kind (e.g., blood pressure cuff)
- Resuscitation equipment (e.g., crash cart, Ambu bag)
- Oxygen and supplies
- Evaluations or social services required for the setting
- Procedures performed in the ER by a nurse

G. Blood Processing/Storage

The below charge descriptions are considered included in the primary Blood Processing/Storage revenue code 390 or 392 and are not separately reimbursed:

- Blood product collection

- Cost of blood storage, blood monitoring, or blood delivery (e.g., transportation costs)
- Freezing
- Irradiating
- Leukocyte-reducing
- Pooling
- Retyping
- Safety testing (including but not limited to Hep C, Hep B, Viral and Bacterial testing, Blood Typing, Crossmatching, adverse reaction testing)
- Splitting
- Thawing blood products
  (CMS, Blood Transfusions. 110.7. Indications and Limitations of Coverage, B. Policy Governing Blood Transfusions)

H. **Imaging**

Imaging performed in the hospital setting includes all nursing care, personnel, and all routine disposable and/or reusable equipment, supplies and/or items necessary to complete the procedure. This includes, but is not limited to:

- 3D rendering is included in the primary imaging study and not separately reimbursable.
- Chest x-ray to confirm placement of central lines is included in the insertion procedure and not separately reimbursable.
- Contrast agents billed with an imaging procedure described as including contrast (e.g., CT abdomen with contrast, transesophageal echocardiography (TEE) with contrast) are not separately reimbursable.

I. **Implants** (commonly associated revenue codes 272-278)

The Food and Drug Administration (FDA) defines a medical implant as a device or tissue that is placed inside or on the surface of the body and is intended to remain there for a period of 30 days or more. To protect public health, the FDA may determine that devices placed for less than 30 days are also implants, such as implants which deliver medication, monitor body functions, or provide support to organs and tissues. Items considered implants include, but are not limited to:

- Stents
- Artificial joints
- Shunts
- Grafts
- Pins
- Plates
- Screws
- Anchors
- Radioactive seeds

<u>Wasted Implants</u>

Select Health follows CMS Program Memorandum A-02-129 for all wasted implants.

a. Wasted implants will be reimbursed in the following two situations:
   - When the implant has been inserted, and then removed. The reason for removal must be clearly documented in the operative report.
   - When the insertion was attempted, but unsuccessful. The reason for unsuccessful insertion must be documented in the operative report. F

b. Wasted implants will NOT be reimbursed in the following situations:
   - The implant has not been in contact with the member.
   - The implant was opened, contaminated, or the wrong size, but was not used.
   - The implant failed or was defective (the vendor/manufacturer is responsible for refund or replacement of item).

SELECT HEALTH MEDICARE (CMS)

Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, and InterQual criteria are not available, the Select Health Commercial policy applies. For the most up-to-date Medicare policies and coverage, please visit their search website http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp& or the manual website

SELECT HEALTH COMMUNITY CARE (MEDICAID)

Select Health Community Care policies typically align with State of Utah Medicaid policy, including use of InterQual. There may be situations where NCD/LCD criteria or Select Health commercial policies are used. For the most up-to-date Medicaid policies and coverage, please visit their website http://health.utah.gov/medicaid/manuals/directory.php or the Utah Medicaid code Look-Up tool

Sources

1. Centers for Medicare & Medicaid Services (CMS). (Revised 2024, January 1). Medicaid National Correct Coding Initiative Policy Manual Chapter 1 – General Correct Coding Policies. https://www.cms.gov/files/document/medicaid-ncci-policy-manual-2024-chapter-1.pdf
2. Centers for Medicare & Medicaid Services (CMS). Medicare Claims Processing Manual (Pub. 100-4), Chapter 12, Physicians/Non-Physician Practitioners
3. Centers for Medicare & Medicaid Services (CMS). Provider Reimbursement Manual, Determination of Cost of Services to Beneficiaries, Chapter 22, Section 2202.6
4. Centers for Medicare & Medicaid Services (CMS). Respiratory Care LCD- Noridian, L37293. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=37293
5. Centers for Medicare and Medicaid Services. “Inpatient hospital care.” Medicare.gov. Last accessed 8/22/2019. https://www.medicare.gov/coverage/inpatient-hospital-care
6. Centers for Medicare and Medicaid Services. “National Correct Coding Initiative Edits”, https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html
7. Centers for Medicare and Medicaid Services. “Program Memorandum A-02-129”, https://www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/a02129.pdf
8. Centers for Medicare and Medicaid Services. Benefit Policy Manual (Pub. 100-02). Chapter 1 - Inpatient Hospital Services Covered Under Part A, §20. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c01.pdf
9. Centers for Medicare and Medicaid Services. Provider Reimbursement Manual - Part 1. Chapter 22, Determination of Cost of Services To Beneficiaries, § 2203.
10. CMS, National Coverage Determination (NCD). Blood Transfusions. 110.7. Indications and Limitations of Coverage. B. Policy Governing Transfusions. www.cms.gov/medicare-coveragedatabase/view/ncd.aspx?ncdid=15
11. “Coding Standards – Levels of Use.” HCPCS Level II. *OptumInsight*.
12. Federal Register, Health Care Financing Administration (HCFA), 65 FR 18433, Medical Devices Section: https://www.federalregister.gov/documents/2000/04/07/00-8215/office-of-inspector-general-medicare-programprospective-payment-system-for-hospital-outpatient
13. Nurse Practice Act Rule, Utah. R156-31b. https://adminrules.utah.gov/public/rule/R156-31b/Current%20Rules?
14. Nurse Practice Act, Utah. Stat. § 58.31b. https://le.utah.gov/xcode/Title58/Chapter31b/58-31b.html
15. Nurse Practice Act. Standards and Scope of Practice. Montana, Oregon, Idaho & Washington State Board of Nursing.
16. “Nursing Care.” Washington State Legislature, Revised Code of Washington (RCW), Chapter 18.79. http://apps.leg.wa.gov/rcw/default.aspx?cite=18.79
17. U.S. Food and Drug Administration (FDA). “Implants and Prosthetics,” https://www.fda.gov/medical-devices/products-and-medical-procedures/implants-and-prosthetics

Disclaimer

This document is for informational purposes only and should not be relied on in the diagnosis and care of individual patients. Medical and Coding/Reimbursement policies do not constitute medical advice, plan preauthorization, certification, an explanation of benefits, or a contract. Members should consult with appropriate healthcare providers to obtain needed medical advice, care, and treatment. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the member’s individual benefit plan that is in effect at the time services are rendered.

The codes for treatments and procedures applicable to this policy are included for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Select Health® makes no representations and accepts no liability with respect to the content of any external information cited or relied upon in this policy. Select Health updates its Coverage Policies regularly, and reserves the right to amend these policies without notice to healthcare providers or Select Health members.

Members may contact Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions about this Coverage Policy may call Select Health Provider Relations at (801) 442-3692.