Reimbursement Policy

Title: Itemized Bill Review	
Policy Number: RP04	**Applies to:** ☒ Commercial
Effective Date: 12/1/2025	☒ Level Funded
Last Updated:	☒ Medicare Advantage ☐ Medicaid

Disclaimer

These coding and reimbursement policies serve as a guide to assist providers in accurate claims submissions and to outline the basis for reimbursement. The determination that a service, procedure, item, etc., is covered under a member's benefit plan is not a determination that the provider will be reimbursed. Services and items must also meet Quartz provider and billing guidelines appropriate to the procedure and diagnosis.

Providers must follow proper billing and submission guidelines including the use of industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the clinical documentation.

Quartz coding and reimbursement policies apply to both participating and non-participating providers and facilities unless a specific exception is stated in the policy.

If proper coding/billing guidelines or current reimbursement policies are not followed, Quartz may:

- Reject or deny the claim
- Recover and/or recoup claim payment
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

Quartz utilizes claim editing software to assess coding and billing accuracy on claims.

From time to time, Quartz may, in its sole discretion, revise these policies. When there is an update, Quartz will publish the most current policy to Quartz's Provider Manual.

Policy

This reimbursement policy applies to Inpatient and Outpatient facility charges submitted on the CMS-1450 (UB-04) Health Insurance Claim Form or its electronic equivalent for the Quartz Commercial, Level Funded, and Medicare Advantage lines of business. Quartz, or its designated review entity, applies CMS guidelines and established industry sources to determine routine services, supplies, and equipment/items included within the primary room and board charge, facility charge, or other services and to address unbundled or non-separately reimbursable charges.

Quartz, or its designated review entity, reserves the right to review any claim, including those submitted by contracted and non-contracted providers, and may request medical records and/or itemized bills at any time for auditing or review purposes. Quartz may adjust reimbursement based on payment integrity findings identified through these reviews.

Quartz incorporates CMS's Provider Reimbursement Manual definition of "routine services". Routine services include regular room or observation room costs, dietary and nursing services, minor medical and surgical supplies, medical and psychiatric social services, and the use of certain equipment without a separate charge. Routine services and ancillary services will not be separately reimbursed.

Routine services are incorporated into the reimbursement for the room and board charge (which can include both standard hospital rooms and special care units such as the CCU or ICU), facility charge, or ancillary service charge, as appropriate for the location where the services are provided. There is no separate reimbursement for bundled, separately billed routine services.

This includes, but is not limited to, items and supplies associated with revenue codes 250, 260-269, 270-279, 410, and 412

- Intravenous (IV) Therapy, IV Infusion Pump, IV Pharmacy Services
- Non-Sterile Supplies (Stethoscopes, Bandages, Diagnostic Kits, Medical Instruments)
- Machines (Anesthesia, Bladder Scanner, Blood Pressure, Humidifier, CPAP)
- Machines (Anesthesia, Bladder Scanner, Blood Pressure, Humidifier, CPAP)
- Beds, Commodes, Scales, Overhead Frame
- Alcohol Swabs/Pads/Baby Powder
- Bandages/Dressings
- Batteries
- Bedpans
- Cold/Hot Packs
- Heat Lights or Pads
- IV Solutions
- Tubing (IV, Blood)
- Sterile Supplies (Surgical Instruments, Biopsy Forceps, Implanted Medical Devices)
- Perfusion Equipment and Supplies
- Machines (Anesthesia, Bladder Scanner, Blood Pressure, Humidifier, CPAP)
- Pumps (IV, Bio, syringe, blood warmer, suction, feeding, PCA)
- Fetal Monitors
- Basin
- Mouth Care Kits
- Oxygen and Supplies (Masks, Cannula, Tubing)
- Breast Pumps
- Reusable Equipment or Items
- Thermometers
- IV Saline and/or Heparin Flushes
- Items used for specimens' collection (arterial blood gas kit, urine collection kits, mucus traps)

Services, carried out by bedside nurses (RN and/or LPN), respiratory therapists, certified nursing assistants, perfusionists, or other technicians as part of their daily scope and responsibilities, are included in the reimbursement for the room and board charge and will not receive separate reimbursement.

This includes, but is not limited to, services associated with revenue codes 260, 300, 309, 361, 391, 460, 510, 761

- Administration of Blood or any Blood Product
- Assisting Physician in Performing any Procedure
- Accessing Indwelling IV Catheter
- Monitoring (Cardiac Monitors, Vital Signs)
- Personal Hygiene
- Respiratory Treatments
- Insertion, removal, maintenance of Nasogastric Tubes
- Maintenance or Flushing of Tubing
- Urinary Catheterization
- IV and PICC line insertions
- Administration/Application of any Medication, Chemotherapy, and/or IV Fluids
- Medical Record Documentation
- Preparing and Dispensing Medication
- Fluid Specimen Collection
- Point of Care Testing (Glucose, Urine Dip, ABG)

- Incremental Nursing Care
- IV Hydration
- Tracheostomy Care
- Venipuncture (Venous or Arterial)
- IV transfusions

Charges for the management of a ventilator or CPAP, owned by the facility, will be considered for reimbursement for one (1) unit per day. Certain services ancillary to ventilator or CPAP usage are separately reimbursable; however, there are components within these services that are routine and integral to the delivery and are not separately reimbursed.

This includes, but is not limited to, items and/or services associated with revenue codes 410, 412, 419, 460

- System Set Up, System Checks, Circuit Change
- Tracheostomy, Supplies and Care
- O2, CPAP, PEEP changes
- Respiratory assessment
- Carbon Dioxide end tidal system setup and/or monitoring
- Endotracheal suctioning, weaning, extubating

When post-operative surgical or procedural recovery takes place in a critical care setting outside of the designated pre- or post-anesthesia recovery areas, the hospital's critical care daily room rate will be considered inclusive of those service charges. This applies to recovery occurring in major or minor surgical suites, treatment rooms, endoscopy units, cardiac catheterization labs, radiology rooms, and pulmonary or cardiology procedure areas. Payment for the hospital's surgical suite charges is intended to cover all associated nursing services, supplies, and equipment, as these are already accounted for within the basic or critical care daily room rates. The following services and equipment are also included as part of the surgical room and procedural service reimbursement.

This includes, but is not limited to, items and/or services associated with revenue codes 270-279, 300-370

- Anesthesia Equipment, Monitors, and Gases
- Intubation/Extubation
- Blood Pressure/Vital Sign Equipment
- Cardiac Monitors
- Cardiopulmonary Bypass Equipment
- Surgeons' Loupes or visual Assisting Devices
- Grounding Pads
- Laparoscopes, Bronchoscopes, Endoscopes, Fluoroscopies/C-arm, and Additional Accessories
- Laboratory Specimen Collection
- Robotic Assisted Techniques
- Drill bits, Saws, Blades, etc.
- Batteries for any Equipment
- Saline Infusion, slush machine
- CO2 Monitors
- Surgical Cultures
- Hemochron Supplies
- Local Anesthesia
- Video Camera Equipment

Related Policies

General Coding Guidelines

Resources

Centers for Medicare and Medicaid Services (CMS)
Official UB-04 Data Specifications Manual

Compliance

Quartz conducts post-payment reviews and audits to ensure policy compliance. Misuse of codes, modifiers, or exceeding service limits may lead to provider education, recoupment, or other corrective action. Providers must submit supporting documentation, if requested, as part of claim review processes.

Document History		
12/1/2025	Document created	Payment Integrity Department