

Commercial Reimbursement Policy

Subject: **Drugs and Devices Requiring Procedures – Facility**

Policy Number: **C-26001**

Policy Section: **Facility**

Last Approval Date: **01/28/2026**

Effective Date: **07/01/2026**

Policy

The health plan will allow reimbursement for drug and devices billed with a supporting procedure on the same claim for outpatient facility providers, unless provider, state, or federal contracts and/or requirements indicate otherwise. If a drug or device is submitted without the supporting procedure, reimbursement will not be allowed.

The health plan requires a supporting procedure for drugs and devices, which is based on CMS Outpatient Code Edits (OCE).

Related Coding

Standard correct coding applies.

Definitions

General Reimbursement Policy Definitions

Related Policies and Materials

Code and Clinical Editing – Professional and Facility

Implants – Facility

Outpatient Facility Revenue Code Billing Requirements – Facility

Pharmaceutical Waste – Professional and Facility

References and Research Materials

This policy has been developed through consideration of the following:

- American Academy of Professional Coders
- CMS
- Outpatient Code Edits (OCE)

Policy History

01/28/2026	Initial approval 01/28/2026 and effective 07/01/2026
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Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's benefit plan. The determination that a service, procedure, or item is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must also meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

Ensure that you use proper billing and submission guidelines, including 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 medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Use of Reimbursement Policy

This policy is subject to federal and state laws, to the extent applicable, as well as the terms, conditions, and limitations of a member's benefits on the date of service. Reimbursement Policy is constantly evolving, and we reserve the right to review and update these policies periodically.

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