Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number:	RP-040		
Subject:	Facility Routine Supplies and Services		
Effective Date:	December 1, 2018	**End Date:**	
Issue Date:	May 30, 2025	**Revised Date:**	May 2025
Date Reviewed:	December 2024		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☐
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☐
Applicable Claim Type	**UB**	☒	**1500**	☐				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

This policy position applies to all commercial and/or Medicare Advantage lines of business as indicated above. Reimbursement policies are intended only to establish general guidelines for reimbursement under Highmark plans. The Plan retains the right to review and update its reimbursement policy guidelines at its sole discretion.

PURPOSE:

The intent of this policy is not to provide new guidance, rather to provide clarification to facilities on the most commonly billed routine medical/surgical supplies and services, which have been and continue to be, not eligible for separate reimbursement.

REIMBURSEMENT GUIDELINES:

Routine supplies and/or services are items or services that are used during the normal course of treatment and/or hospitalization and are integral for patients in a specific location. Examples include, but are not limited to surgery, treatment, therapy, or procedures.

Routine supplies are included in the general cost of the room where services are rendered. As such, these items are considered not eligible for separate reimbursement and are not eligible to be included in outlier calculations for additional reimbursement.

Facilities shall not be reimbursed or allowed to retain reimbursement for services considered to be non-reimbursable either through initial claim processing or audit/review functions. The following guidelines may assist hospital personnel in identifying items, supplies, and services that are not separately reimbursable.

General Routine Supplies

Note: This is not an all-inclusive list.

- Any supplies, items and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services in a specific location are considered routine services and not separately reimbursable in the inpatient and outpatient environments.
- Items and supplies that may be purchased over-the-counter are not separately reimbursable, excluding medications.
- Reusable items, supplies and equipment that are provided to patients during an inpatient or outpatient admission are not separately reimbursable.
- Reusable items, supplies and equipment that are provided to patients admitted to a given treatment area or unit, such as but not limited to: NICU, Burn Unit, PACU, or Medical/Surgical Unit, as well as all reusable items, supplies and equipment, such as but not limited to, pulse oximeter, blood pressure cuffs, or bedside table, are not separately reimbursable.
- Reusable items, supplies and equipment that are provided to patients receiving the same service are not separately reimbursable.
- Items/supplies used to obtain a specimen or complete a diagnostic or therapeutic procedure.

General Routine Services

Facility Personnel

Charges for Inpatient Services for Facility personnel are not separately reimbursable and the reimbursement for such is included in the room and board rate or procedure charges. Examples include, but are not limited to, ancillary personnel, lactation consultants, dietary consultants, overtime charges, transport fees, nursing functions (including IV or PICC line insertion at bedside), call back charges, nursing increments, therapy increments, and bedside respiratory and pulmonary function services. Outpatient Services for Facility personnel are also not separately reimbursable. Reimbursement is included in the reimbursement for the procedure or observation charge.

Service Areas

Including but not limited to, *cardiac, medical, surgical, pediatric, respiratory, burn, neonatal, neurological, rehabilitative, post-anesthesia/recovery, or trauma*, should be included in, but not limited to, the emergency room, basic room, or critical care area room daily charge.

Commonly Billed Routine Services That Are Not Separately Reimbursable

Note: These are examples and is not an all-inclusive list.

- Administration of blood or any blood product by nursing staff
- Charges for blood storage, transportation, processing and preparation, such as thawing, splitting, pooling, and irradiation
- Assisting physician or other licensed personnel in performing any type of procedure in the patient's room, treatment/procedure room, surgical suite, endoscopy suite, cardiac catheterization lab, or x-ray
- Cardiopulmonary resuscitation
- Changing of dressing, bandages and/or ostomy appliances

- Chest tube maintenance, dressing change, discontinuation
- Insert, discontinue, and/or maintain nasogastric tubes
- Intubation
- Maintenance and flushing of J-tubes; PEG tubes; and feeding tubes of any kind
- Monitoring and maintenance of peripheral or central intravenous lines and sites — to include site care, dressing changes, and flushes
- Monitoring of cardiac monitors; CVP (central venous pressure) lines; Swan-Ganz lines/pressure readings; arterial lines/readings; pulse oximeters; cardiac output; pulmonary arterial pressure
- Nursing care
- Point of Care (POC)/bedside testing/monitoring including but not limited to glucose monitoring, arterial blood gas, pulse oximetry, blood samples from either venous sticks or any type of central line catheter or PICC (peripherally inserted central catheter) line, urine specimens, stool specimens, arterial draws, sputum specimens, or any body fluid specimen
- Patient and family education and counseling
- Set up and/or take-down of: IV pumps, suctions, flow meters, heating or cooling pumps, over-bed frames, oxygen, feeding pumps, TPN, traction equipment, monitoring equipment
- Tracheostomy care and changing of cannulas
- Urinary catheterization
- Venipuncture
- Maintenance of oxygen administration equipment
- No separate charges will be reimbursed for callback, emergency, standby, urgent attention, ASAP, stat, or portable fees

Surgical/Operating/Procedure Room Time and Procedural Charges

The Operating Room (OR) charge will be based on a time or procedural basis. When time is the basis for the charge, it should be calculated from the time the patient enters the room until the patient leaves the room, as documented on the OR nurse's notes. The OR is defined as, but not limited to, surgical suites (major and minor), treatment rooms, endoscopy labs, cardiac catheterization labs, hybrid rooms, x-ray, pulmonary and cardiology procedural rooms. The operating room charges include facility personnel services, supplies, and equipment. Supplies, items and services that are necessary or otherwise integral to a surgery/procedure and/or the delivery of services are considered routine services and are not separately reimbursable.

Robotic Surgery

A robotic surgical system (S2900) is an add-on surgical technique commonly used in certain surgeries and listed separately from the primary procedure. Reimbursement for the use of a robotic system is considered by the Plan to be part of the primary procedure, therefore, the Plan will not separately reimburse procedure code S2900 and is not billable to the member. Please refer to Reimbursement Policy RP-029.

Examples below are not an all-inclusive list and are included in the surgical room and service charges.

- The use of the operating room
- The services of qualified professional/technical and facility personnel
- This is <u>not</u> an all-inclusive list: linen packs, instrument packs/trays/kits, packs, post-op dressing, equipment, and routine supplies such as sutures, gloves, dressings, sponges, prep kits, drapes, and surgical attire, tubing, connectors, trocars, drill bits, clips, catheters, cords, batteries, sheathes,

guide/glide wires, balloons, introducers, dilators, needles, pumps, arterial line, irrigation fluids, closure devices, staplers/staples all types, cement mixers, cement, putty, sealers, Surgicel-Absorber, anesthesia supplies (i.e. mask, stylet, ET tubes, blades, oxi-sensor, circuit breathing, circuit adult/pediatrics, gases, oxygen)

- Cardiac/neurological/anesthesia monitors and monitoring, solution warmers, crash carts, hemoconcentrators, Cardiopulmonary bypass equipment, room set-up of equipment and supplies, reusable instruments, wall suction equipment, Dinamap, or x-ray film
- Laparoscopes, bronchoscopes, endoscopes, and accessories
- Any supplies, items, equipment, and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services are considered routine and not separately reimbursable in the inpatient and outpatient environments

IV Sedation and Local Anesthesia

Charges for IV sedation and local anesthesia administered by the provider performing the procedure, and/or nursing personnel, is not separately reimbursable and is included as part of the OR time/procedure reimbursement.

Critical Care Units

The critical care daily room charge will include recovery service charges as well as the following:

Note: This is <u>not</u> an all-inclusive list:

- Continuous Renal Replacement Therapy (CRRT): The Plan will not separately reimburse for set-up/take down of therapy, any nursing services related to administration, and kits, filters, tubing, etc. necessary for administration of therapy
- Intensive care nursing charges
- Mechanical Ventilation: The Plan will not reimburse separately for equipment / tubing / nursing services / respiratory therapy services necessary for maintenance of mechanical ventilation. This includes but not limited to initial intubation, ween protocols, extubation sequences, or reintubation
- Extracorporeal membrane oxygenation (ECMO): Highmark will not reimburse separately for set up or take down of ECMO, professional services related to administration or daily management, kits, filters, or supplies for administration of ECMO

Telemetry

Telemetry charges in any telemetry unit is included in the reimbursement for the place of service. This includes, but is not limited to, ER, ICU, CCU, NICU, progressive care, step-down care, intermediate care, or post-critical care unit. Additional monitoring charges are not reimbursable.

Capital Equipment

Capital equipment is used to provide services to multiple patients and has an extended life. This equipment is considered a fixed asset of the facility and is not separately reimbursable. However, services provided with the use of this equipment, where specific codes exist and in accordance with correct coding and billing guidelines as previously mentioned, may be billed as appropriate, such as x-rays and dialysis. Unbundling of services such as pulse oximetry or fluoroscopy in the OR are not permitted or separately reimbursable.

Reimbursement for capital equipment will be included in the accommodation charge or facility fee in which the services were used and is not separately reimbursable. This applies to the hospital basic room and critical care area room, including, but not limited to *cardiac, medical, surgical, pediatric, respiratory, burn, neonate (level III and IV), neurological, rehabilitative, post-anesthesia or recovery, and/or trauma*, daily charge. The following list of equipment and/or services is considered to be capital equipment and are not separately reimbursable.

Note: This listing below is not considered all-inclusive and is not limited to these items.

- Anesthesia machines
- Monitors/machines (i.e., arterial pressure*, auto blood pressure, hemodynamic*, neurological, cardiac, oximetry, CO2) (*Inclusive of Critical Care room charge only)
- Beds (any kind), room furniture, over-bed tables, overhead frames, footboard
- Digital recording equipment
- Bed Scales
- Pumps (i.e., auto syringe, Gomco, heating/cooling, feeding, PCA, IV (any kind), Emerson)
- Blood warmers
- Scopes
- Nebulizers
- Traction equipment
- Crash cart
- Thermometers
- Wall suction
- Instruments
- Rental equipment
- Infant warmer
- Cameras

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

Correct coding and code definitions apply in all circumstances and to all provider types. Whenever a code is billed which includes another service, item, or supply, whether by code definition or by coding guidelines, the included service or supply is not eligible for separate reimbursement.

Facilities are responsible for accurately, completely, and legibly documenting the services provided. The facility or billing office shall submit claims for services rendered using valid HIPAA approved code sets. Claims are expected to be coded according to industry standard coding practices and guidelines, including but not limited to AMA, CPT, HCPCS, DRG guidelines, UB editor, CPT Assistant, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines.

RELATED POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-029: Surgical Techniques, Procedures and Related Services
- RP-035: Correct Coding Guidelines

- RP-042: Global Surgery and Subsequent Services
- RP-061: Implants and Implant Components

REFERENCES:

- Centers for Medicare and Medicaid Services (CMS); Provider Reimbursement Manual, Determination of Cost of Services to Beneficiaries, Chapter 22, Section 2202.6
- Medical Billing and Coding Certification website: Understanding Medical Bills
- UB-92 Editor
- U.S. Department of Health & Human Services website: Frequently asked questions about code set standards adopted under HIPAA
- National Archives and Records Administration, Federal Register; Title 42) Chapter IV) Subchapter B) Part 419) Subpart G) Section 419.66
- National Archives and Records Administration, Federal Register; Office of Inspector General; Medicare Program; Prospective Payment System for Hospital Outpatient Services, *pg. 18480*.
- National Archives and Records Administration, Federal Register; Medicare Program; Prospective Payment System for Hospital Outpatient Services: Revisions to Criteria to Define New or Innovative Medical Devices, Drugs, and Biologicals Eligible for Pass-Through Payments and Corrections to the Criteria for the Grandfather Provision for Certain Federally Qualified Health Centers, *pg. 47672.*
- National Archives and Records Administration, Federal Register; Medicare Program; Prospective Payment System for Hospital Outpatient Services: Revisions to Criteria to Define New or Innovative Medical Devices, Drugs, and Biologicals Eligible for Pass-Through Payments and Corrections to the Criteria for the Grandfather Provision for Certain Federally Qualified Health Centers, *pg. 67804.*
- National Archives and Records Administration, Federal Register; General and Plastic Surgery Devices; Reclassification of Blood Lancets, *pg. 11150.*
- AHA Coding Clinic for HCPCS, Third Quarter 2015; Volume 15; Number 3, *pg. 2*.

POLICY UPDATE HISTORY INFORMATION:

12 / 2018	Implementation
7 / 2019	Removed references to bulletins
11 / 2019	Added procedure code S2900
10 / 2020	Added reference section
11 / 2021	Added NY region applicable to the policy
1 / 2022	Added Delaware Medicare Advantage applicable to the policy
11 / 2022	Added items to supplies and capital equipment lists
12 / 2022	Added items to supplies and capital equipment lists
5 / 2025	Policy reformatted and rewritten

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-040		
Subject:	Facility Routine Supplies and Services		
Effective Date:	December 1, 2018	**End Date:**	
Issue Date:	January 3, 2022	**Revised Date:**	January 2022
Date Reviewed:	October 2021		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☒	**1500**	☐				

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Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

Supplies are typically grouped into routine and non-routine supply categories, from a billing and reimbursement perspective. The intent of this policy is not to provide new guidance, rather to provide clarification to facilities on the most commonly billed routine medical and surgical supplies, which have been and continue to be, not eligible for separate reimbursement.

Routine supplies are items used during the normal course of a surgery, treatment, therapy, procedure or service which are integral and necessary in order to perform. These items are typically defined as floor stock items that are used during the normal course of treatment and generally used for all patients in a specific area or location. Reusable supplies and equipment may also be considered routine.

REIMBURSEMENT GUIDELINES:

Routine supplies shall not be separately billed to The Plan or a patient. When billing for routine supplies, facilities are to include the routine supply charge into the charges of a procedure/service, the operating room charge, emergency room charge, recovery room charge, the accommodation charge or facility fee in which the services were used.

Correct coding and code definitions apply in all circumstances and to all provider types. Whenever a code is billed which includes another service, item or supply, whether by code definition or by coding guidelines, the included service or supply is not eligible for separate reimbursement.

Facilities are responsible for accurately, completely, and legibly documenting the services provided. The facility or billing office shall submit claims for services rendered using valid HIPAA approved code sets. Claims are expected to be coded according to industry standard coding practices and guidelines, including but not limited to AMA, CPT, HCPCS, DRG guidelines, UB editor, CPT Assistant, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines.

Facilities shall not be reimbursed or allowed to retain reimbursement for services considered to be non-reimbursable either through initial claim processing or audit functions. The following table is a listing of common supplies and/or services considered to be routine and are not separately reimbursable when billing A4649, L8699, S8301 and T5999. This listing is **not** considered all-inclusive and is **not** limited to these items.

Ablators	Forceps/Graspers	Saw blades
Adapters	Glucose monitor supplies	Scalpels
Anesthesia supplies	Grounding pads	Scissors
Anti-Fog	Hand pieces	Sealers
Argon Pads	Incentive spirometer	Shavers
Basins and baskets	Irrigation sets	Snares
Blood filters/warmers	Irrigation solutions	Specimen retriever
Blood pressure cuffs	IV catheters	Sponges
Bovie/Harmonic scalpel	IV Pumps	Staplers/Staples
Brushes	IV start kits	Suction equipment and supplies
Burs, Cutters	IV tubing admin set	Surgical kits/Trays
Cannulas	Ligature	Surgicel-Absorber
Catheters (Foley, IC)	Monitors	Sutures
Closure devices	Needles & insufflators	Temperature sensors
Cold Packs	Packs- Hot/Cold and Surgical	Tourniquets
Drapes	Pens/markers	Towels
Dressings/gauze	Per day or flat fee supplies	Traps
Drills	Personal items	Trocars
Duraprep	Probes	Tubing IV suction, equipment
Electrodes	Pumps	Other non-medical items
Extractors	Retrieval devices	

Medical Device And Standards For Billing HCPCS A4649 and L8699 with Revenue Codes 278 or 274

The Plan's reimbursement for code A4649 is intended for medical devices and shall not be used to report routine procedures and/or other routine/incidental medical supplies. Providers should only report code A4649, "Surgical Supply; Miscellaneous" when the medical device is not currently represented by a specific HCPCS Level II code. The Plan requires meaningful descriptions, which are to be available upon request for all items billed with a NOC Codes including A4649 and L8699 and will only accept assignments of Revenue Codes 278 or 274 (if applicable) in combination with HCPCS Codes A4649 and L8699.

CMS establishes temporary HCPCS level II codes (C-codes) for certain new drugs, biologicals, radiopharmaceuticals and medical devices. The Plan's definition of a medical device is consistent with the definition established by CMS and described in the Code of Federal Regulations (42 CFR 419.66). A medical device billed with A4649 must meet the following requirements to be considered for payment:

- The device is determined to be reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body part.
- The device is an integral and subordinate part of the service furnished, is used for one patient only, comes in contact with human tissue and is surgically implanted or inserted via introduction into the human body though a surgically created incision.
- The device must be of significant cost as defined by Medicare: "exceeding 25% of the APC payment"
- The device is **not** any of the following:

    - Equipment
    - An instrument
    - An apparatus
    - An implement
    - A routine or incidental supply such as a suture, staple, clip or surgical kit

Capital Equipment

Capital equipment is considered to be equipment used to provide services to multiple patients and has an extended life. This equipment is considered a fixed asset of the facility and is not separately reimbursable. However, services provided with the use of this equipment, where specific codes exist and in accordance with correct coding and billing guidelines as previous mentioned, may be billed as appropriate, such as x-rays and dialysis. Unbundling of services such as pulse oximetry or fluoroscopy in the OR are not permitted or separately reimbursable.

When billing for capital equipment, facilities should include the equipment charge into the charges of a accommodation charge or facility fee in which the services were used and not reported separately. The following table is a listing of equipment and/or services considered to be capital equipment and are not separately reimbursable. This listing is not considered all-inclusive and is not limited to these items.

Cardiac monitors	Cautery machines	Oximetry monitors
Scopes	Lasers	IV Pumps
Thermometers	Anesthesia machines	Cell Saver equipment
Instruments	Microscopes	Cameras
Rental equipment	Neurological Monitors	Automatic blood pressure machines and/or monitors

Note: A robotic surgical system (S2900) is an add-on surgical technique commonly used in certain surgeries and listed separately from the primary procedure. Reimbursement for the use of a robotic system is considered by the Plan to be part of the primary procedure, therefore, the Plan will not separately reimburse procedure code S2900 and is not billable to the member.

REFERENCES:

- CMS Provider Reimbursement Manual, Determination of Cost of Services to Beneficiaries, Chapter 22, Section 2202.6
  https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929

- Medical Billing and Coding Certification website: Understanding Medical Bills https://www.medicalbillingandcoding.org/health-insurance-guide/understanding-medical-bills/

- U.S. Department of Health & Human Services website: Frequently asked questions about code set standards adopted under HIPAA https://aspe.hhs.gov/report/frequently-asked-questions-about-code-set-standards-adopted-under-hipaa

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Date Reviewed:	July 2021		
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  https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929

- Medical Billing and Coding Certification website: Understanding Medical Bills https://www.medicalbillingandcoding.org/health-insurance-guide/understanding-medical-bills/

- U.S. Department of Health & Human Services website: Frequently asked questions about code set standards adopted under HIPAA https://aspe.hhs.gov/report/frequently-asked-questions-about-code-set-standards-adopted-under-hipaa

- National Archives and Records Administration, Federal Register; *Title 42 › Chapter IV › Subchapter B › Part 419 › Subpart G › Section 419.66* https://www.federalregister.gov/ https://www.ecfr.gov/cgi-bin/text-idx?node=pt42.3.419&rgn=div5#se42.3.419_166

- National Archives and Records Administration, Federal Register; Office of Inspector General; Medicare Program; Prospective Payment System for Hospital Outpatient Services, *pg. 18480*. https://www.federalregister.gov/documents/2000/04/07/00-8215/office-of-inspector-general-medicare-program-prospective-payment-system-for-hospital-outpatient

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- National Archives and Records Administration, Federal Register; General and Plastic Surgery Devices; Reclassification of Blood Lancets, *pg. 11150.* https://www.federalregister.gov/documents/2016/03/03/2016-04578/general-and-plastic-surgery-devices-reclassification-of-blood-lancets

POLICY UPDATE HISTORY INFORMATION:

12 / 2018	Implementation
07 / 2019	Removed references to bulletins
11 / 2019	Added procedure code S2900
10 / 2020	Added reference section
11 / 2021	Added NY region applicable to the policy

Highmark Reimbursement Policy Bulletin

HISTORY VERSIONS

Bulletin Number:	RP-040		
Subject:	Facility Routine Supplies and Services		
Effective Date:	December 1, 2018	**End Date:**	
Issue Date:	October 9, 2020	**Revised Date:**	October 2020
Date Reviewed:	September 2020		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV** ☒	**DE**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV** ☒		
Applicable Claim Type	**UB**	☒	**1500** ☐		

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this Policy.

PURPOSE:

Supplies are typically grouped into routine and non-routine supply categories, from a billing and reimbursement perspective. The intent of this policy is not to provide new guidance, rather to provide clarification to facilities on the most commonly billed routine medical and surgical supplies, which have been and continue to be, not eligible for separate reimbursement.

Routine supplies are items used during the normal course of a surgery, treatment, therapy, procedure or service which are integral and necessary in order to perform. These items are typically defined as floor stock items that are used during the normal course of treatment and generally used for all patients in a specific area or location. Reusable supplies and equipment may also be considered routine.

REIMBURSEMENT GUIDELINES:

Routine supplies shall not be separately billed to The Plan or a patient. When billing for routine supplies, facilities are to include the routine supply charge into the charges of a procedure/service, the operating room charge, emergency room charge, recovery room charge, the accommodation charge or facility fee in which the services were used.

Correct coding and code definitions apply in all circumstances and to all provider types. Whenever a code is billed which includes another service, item or supply, whether by code definition or by coding guidelines, the included service or supply is not eligible for separate reimbursement.

Facilities are responsible for accurately, completely, and legibly documenting the services provided. The facility or billing office shall submit claims for services rendered using valid HIPAA approved code sets. Claims are expected to be coded according to industry standard coding practices and guidelines, including but not limited to AMA, CPT, HCPCS, DRG guidelines, UB editor, CPT Assistant, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines.

Facilities shall not be reimbursed or allowed to retain reimbursement for services considered to be non-reimbursable either through initial claim processing or audit functions. The following table is a listing of common supplies and/or services considered to be routine and are not separately reimbursable when billing A4649, L8699, S8301 and T5999. This listing is **not** considered all-inclusive and is **not** limited to these items.

Ablators	Forceps/Graspers	Saw blades
Adapters	Glucose monitor supplies	Scalpels
Anesthesia supplies	Grounding pads	Scissors
Anti-Fog	Hand pieces	Sealers
Argon Pads	Incentive spirometer	Shavers
Basins and baskets	Irrigation sets	Snares
Blood filters/warmers	Irrigation solutions	Specimen retriever
Blood pressure cuffs	IV catheters	Sponges
Bovie/Harmonic scalpel	IV Pumps	Staplers/Staples
Brushes	IV start kits	Suction equipment and supplies
Burs, Cutters	IV tubing admin set	Surgical kits/Trays
Cannulas	Ligature	Surgicel-Absorber
Catheters (Foley, IC)	Monitors	Sutures
Closure devices	Needles & insufflators	Temperature sensors
Cold Packs	Packs- Hot/Cold and Surgical	Tourniquets
Drapes	Pens/markers	Towels
Dressings/gauze	Per day or flat fee supplies	Traps
Drills	Personal items	Trocars
Duraprep	Probes	Tubing IV suction, equipment
Electrodes	Pumps	Other non-medical items
Extractors	Retrieval devices	

Medical Device And Standards For Billing HCPCS A4649 and L8699 with Revenue Codes 278 or 274

The Plan's reimbursement for code A4649 is intended for medical devices and shall not be used to report routine procedures and/or other routine/incidental medical supplies. Providers should only report code A4649, "Surgical Supply; Miscellaneous" when the medical device is not currently represented by a specific HCPCS Level II code. The Plan requires meaningful descriptions, which are to be available upon request for all items billed with a NOC Codes including A4649 and L8699 and will only accept assignments of Revenue Codes 278 or 274 (if applicable) in combination with HCPCS Codes A4649 and L8699.

CMS establishes temporary HCPCS level II codes (C-codes) for certain new drugs, biologicals, radiopharmaceuticals and medical devices. The Plan's definition of a medical device is consistent with the definition established by CMS and described in the Code of Federal Regulations (42 CFR 419.66). A medical device billed with A4649 must meet the following requirements to be considered for payment:

- The device is determined to be reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body part.
- The device is an integral and subordinate part of the service furnished, is used for one patient only, comes in contact with human tissue and is surgically implanted or inserted via introduction into the human body though a surgically created incision.
- The device must be of significant cost as defined by Medicare: "exceeding 25% of the APC payment"
- The device is **not** any of the following:
    - Equipment
    - An instrument
    - An apparatus
    - An implement
    - A routine or incidental supply such as a suture, staple, clip or surgical kit

Capital Equipment

Capital equipment is considered to be equipment used to provide services to multiple patients and has an extended life. This equipment is considered a fixed asset of the facility and is not separately reimbursable. However, services provided with the use of this equipment, where specific codes exist and in accordance with correct coding and billing guidelines as previous mentioned, may be billed as appropriate, such as x-rays and dialysis. Unbundling of services such as pulse oximetry or fluoroscopy in the OR are not permitted or separately reimbursable.

When billing for capital equipment, facilities should include the equipment charge into the charges of a accommodation charge or facility fee in which the services were used and not reported separately. The following table is a listing of equipment and/or services considered to be capital equipment and are not separately reimbursable. This listing is not considered all-inclusive and is not limited to these items.

Cardiac monitors	Cautery machines	Oximetry monitors
Scopes	Lasers	IV Pumps
Thermometers	Anesthesia machines	Cell Saver equipment
Instruments	Microscopes	Cameras
Rental equipment	Neurological Monitors	Automatic blood pressure machines and/or monitors

Note: A robotic surgical system (S2900) is an add-on surgical technique commonly used in certain surgeries and listed separately from the primary procedure. Reimbursement for the use of a robotic system is considered by the Plan to be part of the primary procedure, therefore, the Plan will not separately reimburse procedure code S2900 and is not billable to the member.

REFERENCES:

- CMS Provider Reimbursement Manual, Determination of Cost of Services to Beneficiaries, Chapter 22, Section 2202.6
  https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929

- Medical Billing and Coding Certification website: Understanding Medical Bills https://www.medicalbillingandcoding.org/health-insurance-guide/understanding-medical-bills/

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POLICY UPDATE HISTORY INFORMATION:

12 / 2018	Implementation
07 / 2019	Removed references to bulletins
11 / 2019	Added procedure code S2900
10 / 2020	Added reference section

Highmark Reimbursement Policy Bulletin

HIGHMARK.

CLICK HERE FOR HISTORY VERSIONS

Bulletin Number:	RP-040		
Subject:	Facility Routine Supplies and Services		
Effective Date:	December 1, 2018	**End Date:**	
Issue Date:	December 9, 2019	**Revised Date:**	November 2019
Date Reviewed:	October 2019		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV** ☒	**DE**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV** ☒		
Applicable Claim Type	**UB**	☒	**1500** ☐		

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this Policy.

PURPOSE:

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Anti-Fog	Hand pieces	Scissors
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Blood filters/warmers	Irrigation sets	Shares
Blood pressure cuffs	Irrigation solutions	Specimen retriever
Bovie/Harmonic scalpel	IV catheters	Sponges
Brushes	IV Pumps	Staplers/Staples
Burs, Cutters	IV start kits	Suction equipment and supplies
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Closure devices	Monitors	Sutures
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Dressings/gauze	Pens/markers	Towels
Drills	Per day or flat fee supplies	Traps
Duraprep	Personal items	Trocars
Electrodes	Probes	Tubing IV suction, equipment
Extractors	Pumps	Other non-medical items

Medical Device And Standards For Billing HCPCS A4649 and L8699 with Revenue Codes 278 or 274

The Plan's reimbursement for code A4649 is intended for medical devices and shall not be used to report routine procedures and/or other routine/incidental medical supplies. Providers should only report code A4649, "Surgical Supply; Miscellaneous" when the medical device is not currently represented by a specific HCPCS Level II code. The Plan requires meaningful descriptions, which are to be available upon request for all items billed with a NOC Codes including A4649 and L8699 and will only accept assignments of Revenue Codes 278 or 274 (if applicable) in combination with HCPCS Codes A4649 and L8699.

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POLICY UPDATE HISTORY INFORMATION:

12 / 2018	Implementation
07 / 2019	Removed references to bulletins
11 / 2019	Added Procedure Code S2900

Highmark Reimbursement Policy Bulletin

HIGHMARK.

CLICK HERE FOR HISTORY VERSIONS

Bulletin Number:	RP-040		
Subject:	Facility Routine Supplies and Services		
Effective Date:	December 1, 2018	**End Date:**	
Issue Date:	July 26, 2019	**Revised Date:**	July 2019
Date Reviewed:	July 2019		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV** ☒	**DE**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV** ☒		
Applicable Claim Type	**UB**	☒	**1500** ☐		

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this Policy.

PURPOSE:

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Dressings/gauze	Pens/markers	Towels
Drills	Per day or flat fee supplies	Traps
Duraprep	Personal items	Trocars
Electrodes	Probes	Tubing IV suction, equipment
Extractors	Pumps	Other non-medical items

Medical Device And Standards For Billing HCPCS A4649 and L8699 with Revenue Codes 278 or 274

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POLICY UPDATE HISTORY INFORMATION:

12 / 2018	Implementation
07 / 2019	Removed references to bulletins

Highmark Reimbursement Policy Bulletin

Bulletin Number:	RP-040		
Subject:	Facility Routine Supplies and Services		
Effective Date:	December 1, 2018	**End Date:**	
Issue Date:	September 28, 2018	**Revised Date:**	
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV** ☒	**DE**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV** ☒		
Applicable Claim Type	**UB**	☒	**1500** ☐		

Reimbursement Policy designation of Facility application is respective to how the provider is contracted with The Plan. Provider contractual agreement terms in direct conflict with this Reimbursement Policy may supersede this Policy's direction and regional applicability.

Supplies are typically grouped into routine and non-routine supply categories, from a billing and reimbursement perspective. The intent of this policy is not to provide new guidance, rather to provide clarification to facilities on the most commonly billed routine medical and surgical supplies, which have been and continue to be, not eligible for separate reimbursement.

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CMS establishes temporary HCPCS level II codes (C-codes) for certain new drugs, biologicals, radiopharmaceuticals and medical devices. The Plan's definition of a medical device is consistent with the definition established by CMS and described in the Code of Federal Regulations (42 CFR 419.66). A medical device billed with A4649 must meet the following requirements to be considered for payment:

- The device is determined to be reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body part.

- The device is an integral and subordinate part of the service furnished, is used for one patient only, comes in contact with human tissue and is surgically implanted or inserted via introduction into the human body though a surgically created incision.
- The device must be of significant cost as defined by Medicare: "exceeding 25% of the APC payment"
- The device is **not** any of the following:
    - Equipment
    - An instrument
    - An apparatus
    - An implement
    - A routine or incidental supply such as a suture, staple, clip or surgical kit

Capital Equipment

Capital equipment is considered to be equipment used to provide services to multiple patients and has an extended life. This equipment is considered a fixed asset of the facility and is not separately reimbursable. However, services provided with the use of this equipment, where specific codes exist and in accordance with correct coding and billing guidelines as previous mentioned, may be billed as appropriate, such as x-rays and dialysis. Unbundling of services such as pulse oximetry or fluoroscopy in the OR are not permitted or separately reimbursable.

When billing for capital equipment, facilities should include the equipment charge into the charges of a procedure/service, the operating room charge, emergency room charge, recovery room charge, the accommodation charge or facility fee in which the services were used and not reported separately. The following table is a listing of equipment and/or services considered to be capital equipment and are not separately reimbursable. This listing is not considered all-inclusive and is not limited to these items.

Cardiac monitors	Cautery machines	Oximetry monitors
Scopes	Lasers	IV Pumps
Thermometers	Anesthesia machines	Cell Saver equipment
Instruments	Microscopes	Cameras
Rental equipment	Neurological Monitors	Automatic blood pressure machines and/or monitors

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

Refer to the following Highmark Provider Bulletins for additional information:

- HOSP 2005-008-W/ASC 2005-002-W
- HOSP 2003-008-W/ASC 2003-004-W