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:	December 19, 2022	**Revised Date:**	December 2022
Date Reviewed:	August 2022		
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.

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 are included in the general cost of the room where services are rendered. These items are considered floor stock and are generally available to all patients receiving services. As such, these items are considered non-billable for separate reimbursement and are not eligible to be included in outlier calculations for additional reimbursement. 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. Examples are provided throughout this policy. The UB-92 Editor uses the following guide to determine if an item can be separately billed. You must be able to answer “yes” to the following questions:

- *Is the supply medically necessary and furnished at the direction of a physician (i.e., not personal convenience items such as slippers, powders, lotions, etc.)?*
- *Is the supply used for a specific patient (excluding gowns, gloves, and masks used by staff)?*
- *Is the supply not ordinarily used for or on most patients (excluding blood pressure cuffs, thermometers and patient gowns)?*
- *Is the supply not basically a stock (bulk) supply (excluding drapes, pads, cotton balls, urinals, bedpans, bed linen and gauze)?*

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 guidelines may assist hospital personnel in identifying items, supplies, and services that are not separately billable. 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 billable in the inpatient and outpatient environments.
- All items and supplies that may be purchased over-the-counter are not separately billable, **excluding medications**.
- All reusable items, supplies and equipment that are provided to all patients during an inpatient or outpatient admission are not separately billable.
- All reusable items, supplies and equipment, such as pulse oximeter, blood pressure cuffs, bedside table, etc., that are provided to all patients admitted to a given treatment area or units are not separately billable.
- All reusable items, supplies and equipment that are provided to all patients receiving the same service are not separately billable.
- Items used to obtain a specimen or complete a diagnostic or therapeutic procedure.

The following are services that should be included in the basic room or critical care area room *(cardiac, medical, surgical, pediatric, respiratory, burn, neonate (level III and IV), neurological, rehabilitative, post-anesthesia or recover, and trauma)* daily charge.

- Administration of blood or any blood product by nursing staff (does not include tubing, blood bank preparation, etc.)
- Administration or application of any medicine, chemotherapy, and/or intravenous fluids
- Assisting patient onto bedpan, bedside commode, or into bathroom
- Assisting physician or other licensed personnel in performing any type of procedure in the patient's room, treatment room, surgical suite, endoscopy suite, cardiac catheterization lab; or x-ray
- Bathing of patients
- Body preparation of deceased patients
- Cardiopulmonary resuscitation
- Changing of dressing, bandages and/or ostomy appliances
- Changing of linens and patient gowns
- Chest tube maintenance, dressing change, discontinuation
- Enemas
- Enterostomal services
- Feeding of patients
- Incontinent care
- Insert, discontinue, and/or maintain nasogastric tubes
- Intubation
- Maintenance and flushing of J-tubes; PEG tubes; and feeding tubes of any kind

- Management or participation in cardiopulmonary arrest event. Obtaining and recording of blood pressure, temperature, respiration, pulse, pulse oximetry
- Medical record documentation
- 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
- Neurological status checks
- Nursing care
- Obtaining and recording of blood pressure, temperature, respiration, pulse, pulse oximetry
- Obtaining of: finger-stick blood sugars; 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
- Oral care
- Patient and family education and counseling
- Preoperative care
- 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
- Start and/or discontinue intravenous lines
- Suctioning or lavaging of patients
- Tracheostomy care and changing of cannulas
- Transporting, ambulating, range of motion, transfers to and from bed or chair
- Turning and weighing patients
- Urinary catheterization
- Venipuncture

Ancillary Personnel Providing Nursing or Technical Services include but are not limited to the following:

- Bedside Glucose monitoring, i.e. Accucheck
- Maintenance of oxygen administration equipment
- Mixing, preparation, or dispensing of any medications, IV fluids, total parenteral nutrition (TPN), or tube feedings
- No separate charges will be allowed for callback, emergency, standby, urgent attention, ASAP, stat, or portable fees
- Single determination or continuous pulse oximetry monitoring

Surgical Room and Services

HCPCS/CPT/ICD 10 PCS codes include all services usually performed as part of the procedure as a standard of medical/surgical practice. A provider/supplier shall not separately report these services simply because HCPCS/CPT/ICD 10 PCS codes exist for them. This includes surgical suites, major and minor, treatment rooms, endoscopy labs, cardiac cath labs, X-ray, pulmonary and cardiology procedural rooms that are integral to the surgical service. The hospital's charge for surgical suites and services shall include the entire above listed nursing personnel services, supplies, and equipment (as included in the basic or critical care daily room charges). Further, any supplies, items and services that are necessary or otherwise integral to a surgery and/or the delivery of services are considered routine services and not separately billable in the inpatient and outpatient environments. In addition, while this is not intended to be an all-

inclusive list, the following services and equipment will be included in the surgical rooms and service charges:

Air conditioning / filtration	Laparoscopes, bronchoscopes, endoscopes and accessories
All reusable instruments charged separately	Lights; light handles; light cord, fiber optic microscopes
All services rendered by RN's, LPN's, scrub technicians, surgical assistants, orderlies, and aides	Monopolar and bipolar electrosurgical / bovie or cautery equipment
Anesthesia equipment and monitors	Midas Rex
Any automated blood pressure equipment	Obtaining laboratory specimens
Cardiac monitors	Power equipment
Cardiopulmonary bypass equipment	Room heating and monitoring equipment
C02 monitors	Room set-ups of equipment and supplies
Crash carts	Saline slush machine
Digital recording equipment and printouts	Solution warmer
Dinamap	Surgeons' loupes / visual assisting devices
Fracture tables	Transport monitor
Grounding pads	Video camera and tape
Hemochron	Wall suction equipment
Hemoconcentrator	X-ray film

Critical Care Units

In addition to services listed elsewhere in this policy, personal and supply items, and equipment, if post-operative surgical or procedural recovery services are performed in any critical care room setting (other than the Post-anesthesia Recovery Room), the critical care daily room charge will include recovery service charges as well as the following:

- Continuous Renal Replacement Therapy (CCRT): 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, or 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. These costs would be included in the bundled payment that is associated with the procedure.

Telemetry

For any basic care room billed at higher than the providers posted base room rate, or any room identified as a post-critical care, progressive care, intermediate care, or step-down care, wherein the patient is

monitored by telemetry, telemetry will be considered included in the higher room rate. Charges for medically necessary mobile telemetry units will be allowed unless services are rendered in one of the settings described in the preceding sentence.

Example of Basic Care Rooms: labor & delivery, newborn nursery, levels I and II, pediatric, medical, surgical, rehabilitative, oncology, orthopedic, neurological and urological.

General Routine Services

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	Ice packs	Rasp
Adapters	Incentive spirometer	Reamers/Tunnelers
Admission hygiene kits	Irrigation sets	Retrieval devices
Alcohol swabs	Irrigation solutions	Retractors
Anesthesia supplies	IV arm boards	Saw blades
Anti-fog	IV catheters	Saline solutions
Argon pads	IV pumps	Scalpels
Arterial blood gas kits	IV start kits	Scissors
Baby powder	IV tubing admin set	Sequential stockings
Band-aids	Kleenex tissues	Sealers
Basins and baskets	Knot pusher	Shampoo
Bed pans (all types)	K wires	Sharp containers
Bone Tap	Laparoscopic and robotic tools	Shavers
Blood filters/warmers	Ligature	Shaving cream
Blood tubes	Lotion	Skin cleansing liquid
Blood pressure cuffs	Lubricant Jelly	Sleeve-sequential compression
Bovie/harmonic scalpel	Masks for patients or staff	Snares
Brushes	Meal trays	Socks/slippers
Burs, cutters	Measuring pitcher	Soap
Cannulas	Mid-stream urine kits	Sphincterome
Catheters (Foley, IC)	Microdebrider	Extremity stabilizer
Cement mixers	Mouth care kits	Specimen retriever
Cements	Mouthwash	Sponges
Closure devices	Monitors	Staplers/Staples
Comfort kits	Needles & insufflators	Suction equipment and supplies
Cotton balls (all types)	Odor eliminator /deodorizer	Surgical kits/trays
Cold Packs	Oral swabs	Surgicel-Absorber
Deodorant	Oxygen masks	Suture systems
Dilators	Oxygen	Sutures/suture shuttles/passers
Dissectors	Pads/Padding	Syringes

Drapes	Preparation kits	Tape
Dressings/gauze	Pillows	Temperature sensors
Drills	Radiation protection shields	Thermometers
Duraprep	Razors	Tissue/bone collector
Electrodes	Restraints	Toilet tissue
Emesis Basin	Reusable sheets, draw sheets	Tongue depressors
Extractors	Reusable blankets, washcloths	Toothettes, oral swabs
Eye retractors	Reusable pillowcases	Toothbrush
Eye tension rings	Pastes	Toothpaste
Flavored glycerin swabs	Packs- hot/cold and surgical	Tourniquets
Forceps/graspers	Pens/markers	Towels (any type)
Funnels	Per day or flat fee supplies	Trap Sputum
Gels	Personal items	Traps
Gloves for patients or staff	Pill camera	Trocars
Glucose monitor supplies	Power pick	Tubing IV suction, equipment
Gowns for patients or staff	Cold therapy units	Urinal
Grounding pads	Probes	Wax
Hand pieces	Putty	Water pitcher
Heat light or heating pad	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.

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 hospital basic room and critical care area room *(cardiac, medical, surgical, pediatric, respiratory, burn, neonate (level III and IV), neurological, rehabilitative, post-anesthesia or recover, and trauma)* daily charge. 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.

Ambu bag	Defibrillator and paddles	Overhead frames
Anesthesia machines	Digital recording equipment	Over-bed tables
Aqua pad monitor	Dinamap	Oximetry monitors
Arterial pressure monitors*	Emerson pumps	Oxisensors (any kind)
Auto syringe pump	Fans	PCA pump
Auto thermometers	Feeding pumps	Penlight or other flashlight
Auto blood pressure machines	Flow meters	Pill pulverizer
Auto blood pressure monitors	Footboard	Pressure bags
Bed scales	Glucometers	Pressure infusion equipment
Beds (any kind)	Gomco pumps	Radiant warmer
Bedside commodes	Guest beds	Rental equipment
Blood pressure cuffs	Heating or cooling pumps	Room furniture
Blood warmers	Hemodynamic monitors*	Scopes
Bone Mills/grinders	Humidifiers	Sitz baths
Cardiac monitors	Infant warmer	Stethoscopes
Cameras	Instruments	Telephone
Cautery machines	IV pumps (any kind)	Television
Cell Saver equipment	Lasers	Thermometers
C02 monitors	Microscopes	Traction equipment
Crash cart	Neurological Monitors	Transport isolette
	Nebulizers	Wall suction (any kind)

* Inclusive of Critical Care room charge only.

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.

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.

REFERENCES:

- 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

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:	November 1, 2022	**Revised Date:**	November 2022
Date Reviewed:	July 2022		
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.

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	Glucose monitor supplies	Rasp
Adapters	Grounding pads	Reamers/Tunnelers
Anesthesia supplies	Hand pieces	Retrieval devices
Anti-Fog	Incentive spirometer	Retractors
Argon Pads	Irrigation sets	Saw blades
Basins and baskets	Irrigation solutions	Scalpels
Bone Tap	IV catheters	Scissors
Blood filters/warmers	IV Pumps	Sequential Stockings
Blood pressure cuffs	IV start kits	Sealers
Bovie/Harmonic scalpel	IV tubing admin set	Shavers
Brushes	Knot Pusher	Sleeve-sequential compression
Burs, Cutters	K wires	Snares
Cannulas	Laparoscopic and Robotic Tools	Sphincterome
Catheters (Foley, IC)	Ligature	Extremity Stabilizer
Cement Mixers	Microdebrider	Specimen retriever
Cements	Monitors	Sponges
Closure devices	Needles & insufflators	Staplers/Staples
Cold Packs	Oxygen	Suction equipment and supplies
Dilators	Pads/Padding	Surgical kits/Trays
Dissectors	Radiation Protection Shields	Surgicel-Absorber
Drapes	Pastes	Suture Systems
Dressings/gauze	Packs- Hot/Cold and Surgical	Sutures/Suture Shuttles/Passers
Drills	Pens/markers	Temperature sensors
Duraprep	Per day or flat fee supplies	Tissue/Bone Collector
Electrodes	Personal items	Tourniquets
Extractors	Pill Camera	Towels
Eye Retractors	Power Pick	Traps
Eye Tension Rings	Cold Therapy Units	Trocars
Forceps/Graspers	Probes	Tubing IV suction, equipment
Funnels	Putty	Wax
Gels	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.

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.

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

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
- Medical Billing and Coding Certification website: Understanding Medical Bills
- 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

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**	☐				

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.

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

- 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

- 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.* https://www.federalregister.gov/documents/2000/08/03/00-19668/medicare-program-prospective-payment-system-for-hospital-outpatient-services-revisions-to-criteria

- 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.* https://www.federalregister.gov/documents/2000/08/03/00-19668/medicare-program-prospective-payment-system-for-hospital-outpatient-services-revisions-to-criteria

- 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
1 / 2022	Added Delaware Medicare Advantage applicable to the policy

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:	November 1, 2021	**Revised Date:**	July 2021
Date Reviewed:	July 2021		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☐	**NY** ☒
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/

- 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

- 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.* https://www.federalregister.gov/documents/2000/08/03/00-19668/medicare-program-prospective-payment-system-for-hospital-outpatient-services-revisions-to-criteria

- 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.* https://www.federalregister.gov/documents/2000/08/03/00-19668/medicare-program-prospective-payment-system-for-hospital-outpatient-services-revisions-to-criteria

- 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/

- 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

- 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.* https://www.federalregister.gov/documents/2000/08/03/00-19668/medicare-program-prospective-payment-system-for-hospital-outpatient-services-revisions-to-criteria

- 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.* https://www.federalregister.gov/documents/2000/08/03/00-19668/medicare-program-prospective-payment-system-for-hospital-outpatient-services-revisions-to-criteria

- 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

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:

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	Retrieval devices
Adapters	Glucose monitor supplies	Saw blades
Anesthesia supplies	Grounding pads	Scalpels
Anti-Fog	Hand pieces	Scissors
Argon Pads	Incentive spirometer	Sealers
Basins and baskets	Introducers	Shavers
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
Cannulas	IV tubing admin set	Surgical kits/Trays
Catheters (Foley, IC)	Ligature	Surgicel-Absorber
Closure devices	Monitors	Sutures
Cold Packs	Needles & insufflators	Temperature sensors
Drapes	Packs- Hot/Cold and Surgical	Tourniquets
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.

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.

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:

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	Retrieval devices
Adapters	Glucose monitor supplies	Saw blades
Anesthesia supplies	Grounding pads	Scalpels
Anti-Fog	Hand pieces	Scissors
Argon Pads	Incentive spirometer	Sealers
Basins and baskets	Introducers	Shavers
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
Cannulas	IV tubing admin set	Surgical kits/Trays
Catheters (Foley, IC)	Ligature	Surgicel-Absorber
Closure devices	Monitors	Sutures
Cold Packs	Needles & insufflators	Temperature sensors
Drapes	Packs- Hot/Cold and Surgical	Tourniquets
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.

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

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.

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	Retrieval devices
Adapters	Glucose monitor supplies	Saw blades
Anesthesia supplies	Grounding pads	Scalpels
Anti-Fog	Hand pieces	Scissors
Argon Pads	Incentive spirometer	Sealers
Basins and baskets	Introducers	Shavers
Blood filters/warmers	Irrigation sets	Snares
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
Cannulas	IV tubing admin set	Surgical kits/Trays
Catheters (Foley, IC)	Ligature	Surgicel-Absorber
Closure devices	Monitors	Sutures
Cold Packs	Needles & insufflators	Temperature sensors
Drapes	Packs- Hot/Cold and Surgical	Tourniquets
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.

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