



Highmark Blue Cross Blue Shield (Highmark BCBS) partners with Wellpoint companies to administer certain services to Medicaid Managed Care (MMC), Health and Recovery Plan (HARP), Child Health Plus (CHPlus), and Essential Plan members. Please note, this information is specific to the MMC, HARP, CHPlus, and Essential Plan programs only.

Reimbursement Policy	
Subject: Medical Recalls	
Policy Number: G-06111	Policy Section: Administration
Last Approval Date: 2/10/2022	Effective Date: 11/01/2018

**** Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to providerpublic.mybcbswny.com. ****

Disclaimer

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

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

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

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

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. Highmark BCBS strives to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date in accordance with the

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policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

Highmark BCBS does not allow reimbursement for repair or replacement of items due to a medical recall unless provider, state, federal, or CMS contracts, and/or requirements indicate otherwise. The applicable items are:

- Durable medical equipment
- Supplies
- Prosthetics
- Orthotics
- Drugs/ vaccines

Highmark BCBS allows reimbursement of medically necessary procedures to remove and replace recalled or replaced devices.

Highmark BCBS will not be responsible for the full cost of a replaced device if an inpatient or outpatient facility is receiving a partial or full credit for a device due to recall. Payment will be reduced by the amount of the device credit.

Highmark BCBS will:

- Participate and provide any applicable documentation required in any applicable class-action lawsuits due to a medical recall.
- Supply providers with medical recall information for dissemination to applicable members.

In circumstances where Highmark BCBS has reimbursed the provider for repair or replacement of items, or procedures related to items due to a medical recall, Highmark BCBS is entitled to recoup or recover fees from the manufacturer and/or distributor, as applicable.

In circumstances where Highmark BCBS has reimbursed the provider the full or partial cost of a replaced device and the provider received a full or partial credit for the device, Highmark BCBS is entitled to recoup or recover fees from the provider.

In applicable circumstances, providers should bill the appropriate condition code, value code, modifier, and/or diagnosis code to identify a medically recalled item.

Related Coding	
Standard correct coding applies	

Policy History	
02/10/2022	Biennial review approved: Reference and Research Material, and Related coding sections updated
09/30/2019	Biennial review approved: Policy template updated

12/15/2017	Review approved 12/15/2017 and effective 11/01/2018: Policy language regarding providers receiving full or partial credit for a device and recoupment added
09/28/2017	Biennial review approved 09/28/2017 and effective 11/01/2018: Policy language regarding procedures related to items due to a recall and manufacturer recoupment added
03/14/2016	Initial policy approved 03/14/2016 and effective 01/01/2017

References and Research Materials	
This policy has been developed through consideration of the following:	
<ul style="list-style-type: none"> • CMS • State Medicaid • State contract • Code of Federal Regulations (CFR) Subpart A-Payments §416.179 • U.S. Food and Drug Administration: Medical Device Recalls 	

Definitions	
General Reimbursement Policy Definitions	

Related Policies and Materials	
Documentation Standards for Episodes of Care	
Modifier Usage	
Reimbursement for Items Under Warranty	