KAISER PERMANENTE®

RE: TRAUMA ACTIVATION INPATIENT ADMISSIONS AND PRE-PAYMENT BILLING REIMBURSEMENT CHANGES

Dear Provider,

Effective September 1, 2021, Kaiser Foundation Health Plan of Colorado is making the changes listed below regarding reimbursement of services for the following: 1 i) trauma activation charges, 2.) three-day payment window for services "incidental to" inpatient admissions and prepayment billing review criteria for inpatient and outpatient claims and 3) MPPR Cardio/Ophthalmology multiple procedure reductions. The change goes into effect based on the date of service, not by implementation date.

1. Trauma activation charges

Payment for trauma activation will be allowed only when all National Uniform Billing Guidelines (NUBG) criteria for trauma activation is met. Documentation may be required to validate billing, e.g. licensure as a certified trauma facility, appropriate certified trauma level, and that prenotification occurred.

- Charges for trauma activation, Revenue Code 681-684 and contains 99291 under rev code 450, will be considered for payment when a facility has received a pre-notification from EMS or someone who meets either local, state, or ASC field criteria and EMS or other party meeting the ACS criteria are given the appropriate team response,
- The admission type is trauma center indicated by admit type code "05",
- Includes Commercial and Medicare

When Revenue Code series 68X is billed in association with services other than critical care, payment for trauma activation is bundled into the other services provided on that day.

2. Three-day payment window for services "incident to" inpatient admissions

Currently commercial inpatient reimbursement is based on a Per Diem Rate, Diagnosis Related Group (DRG), or Case Rate, certain incidental services provided within 1 calendar day of the inpatient admission are included in the inpatient reimbursement and not paid separately.

Services that are considered incidental to an inpatient admission include:

- Surgical day care
- Observation stays
- Emergency room care
- Diagnostic and/or testing services

The payment window for commercial claims will be extended from "within 1 calendar day of the inpatient admission" to "within 3 calendar days of the inpatient admission". If the outpatient service does not meet criteria for separate payment, payment is considered bundled into the inpatient claim.

Includes Medicare / Commercial only when reimbursed at a DRG

3. MPPR Cardio / Ophthalmology – Multiple procedure reduction

The following MPPRs are applied specifically to the technical component of diagnostic imaging for cardiovascular and ophthalmology services if procedure is billed with another imaging procedure in the same family.

Cardiovascular services: Full payment is made for the TC service with the highest payment under the MPFS (Medicare Physician Fee Schedule), and 75% (seventy-five percent) for subsequent TC services furnished by the same physician, or by multiple in the same group practice, to the same patient on the same day.

Ophthalmology services: Full payment is made for the TC service with the highest payment under the MPFS and 80% (eighty percent) for subsequent TC services furnished by the same physician, or by multiple in the same group practice, to the same patient on the same day.

Includes Commercial and Medicare

If you have any questions about specific claims or this process, please contact your Provider Experience Consultant at 866-866-3951.

Thank you,

John Heintz
Executive Director, Hospital Contracting and Provider Relations