

APPENDIX 1

Please refer to this link for 'POL – 020 Clinical Review Payment Determination Policy' as referenced on page 46 of this HMO Provider Manual.

POL-020.3 Clinical Review Coding Payment Determination Policy

NTL

This policy applies to all NCA markets, all lines of business.

1.0 Business Policy

1.1 Payment Policy Statement

- 1.1.1** Kaiser Foundation Health Plan (KFHP) requires accurate and complete claims submissions that follow proper billing and submission guidelines according to industry standard Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. In addition, documentation (such as medical records, office notes etc.) must support services billed. KFHP may request additional supportive documentation to further validate billing, coding, and clinical accuracy of billed services prior to finalizing reimbursement on billed service(s). KFHP, in the interest of its members, reviews claims to ensure that KFHP pays the appropriate amounts on claims and does not overpay or pay for improper charges. While KFHP does not dictate to providers how to bill their claims, the industry recognizes that certain billing practices can lead to non-payable charges. If appropriate coding/billing guidelines or current reimbursement policies are not followed or documented in the records, KFHP may, depending on the circumstances: reduce or deny the claim, or claim line, consider a claim line paid by virtue of payment of another claim line or the claim as a whole, or recover/recoup the claim processed for payment in error. Unless otherwise noted within the policy, KFHP's reimbursement policies apply to contracted and non-contracted professional providers and facilities.

1.1.2 KFHP payment policies are not intended to cover every claim situation. KFHP policies may be superseded by state, federal and/or provider contractual requirements. KFHP will align with all applicable regulatory, state and federal guidelines. KFHP will employ clinical discretion and judgement, and coding expertise in its interpretation and application of the policy, and all payment policies are routinely updated.

1.1.3 KFHP recognizes commonly accepted standards to help determine what items and/or services are eligible for separate reimbursement. Commonly accepted standards include but are not limited to the following:

. American Academy of Professional Coders (AAPC) . American Medical Association (AMA)

- Associated Medical Societies (i.e.: American College of Obstetricians and Gynecologists (ACOG), American Academy of Family Physicians (AAFP), etc.)
- American Health Information Management Association (AHIMA)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- CMS Local Coverage and National Coverage Determinations (LCD NCD)
- CMS Manuals and Publications
- CPT Assistant
- CPT Manual, including code definitions and associated text
- Federal Register
- HCPCS Manual, including code definitions and associated text
- Integrated Outpatient Code Editor (I/OCE)
- International Classification of Diseases, 10th Revision (ICD-10-CM) official guidelines for coding and reporting
- Medically Unlikely Edits
- National Correct Coding Initiative Policy Manual for (NCCI)
- National Physician Fee Schedule Relative Value File
- National Uniform Billing Committee (NUBC)
- Professional and academic journals and publications

1.2 Scope

- 1.2.1** This policy provides an overview of coding and payment guidelines as they pertain to claims submitted to KFHP. The policy applies to both contracted and non-contracted providers across all lines of business, unless otherwise specified. Providers are required to use industry standard compliant codes on all claim submissions. Services must be billed with valid ICD-10 diagnosis codes, Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, place of service (POS) codes, and revenue codes as defined by the Centers for Medicare and Medicaid Services (CMS), and the American Medical Association's (AMA) CPT Manual. Billed codes must represent the services/procedures performed, and services must be clearly documented in the member's medical record.

2.0 Rules

- 2.1** **KFHP accepts standard diagnosis and procedure codes that comply with HIPAA Health Information Portability and Accountability Act (HIPAA) transaction code set standards KFHP routinely updates all standard code sets, including CPT, HCPCS, and ICD-10 CM to align with the most current publications released by organizations including but not limited to CMS, and AMA. KFHP complies with applicable state and federal laws regarding coverage of healthcare services, including mental health parity requirements. Types of standard coding include:**

- 2.1.1** CPT codes 5-digit numeric codes maintained by the American Medical Association (AMA). These codes have descriptors that correspond to a procedure or service. Codes range from 00100–99499 and are generally ordered into sub-categories based on procedure/service type and anatomy.
- 2.1.2** HCPCS Level II codes Alpha-numeric (1 letter followed by 4 numbers) codes, which are used to identify products, supplies and services not included in Level I CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office.
- 2.1.3** International Classification of Diseases, ICD-10-CM codes Used to indicate diagnosis or condition. ICD-10 codes are required on all claims. KFHP follows ICD-10-CM Official Guidelines for Coding and Reporting and may deny claims when billed inappropriately.
- 2.1.4** NDC (National Drug Code) codes A universal number that identified a drug. The NDC number consists of 11 digits in a 5-4-2 format (Do not bill with hyphens, only the 11-digit NDC).
- 2.1.5** Revenue codes 4-digit numeric codes used by institutional providers. HCPCS or CPT codes may be required in addition to specific revenue codes to describe the services rendered.

- 2.2.1** Supportive documentation may be requested to validate the accuracy of billed services before finalizing reimbursement. These practices apply to both contracted and non-contracted providers, hospitals, and suppliers eligible to bill for services.
- 2.2.2** Guidelines are based on nationally recognized standards, including but not limited to, CMS, AMA CPT coding guidelines, CMS's National Correct Coding Initiative (NCCI), provider manuals, associated medical societies, and billing and coding sources. As required by the Centers of Medicare and Medicaid Services (CMS) and Health Insurance Portability and Accountability Act (HIPAA), Providers must select CPT/ICD-10/HCPCS/Revenue codes that provide the highest degree of accuracy and completeness.

2.3 Medically Unlikely Edits (MUE)

- 2.3.1** KFHP applies CMS MUE edits to both facility and professional claims, including DME. In instances where a provider bills above the industry defined MUE for a particular procedure code, KFHP reserves the right to reimburse at the max allowable units to avoid unnecessary denials and delays in reimbursement.

2.4 Bundled Procedures

- 2.4.1** Facility Claims – OPPS Status Codes KFHP follows the Centers for Medicare and Medicaid services (CMS) Hospital Outpatient Prospective Payment System (OPPS). Reimbursable codes are determined based upon the assigned OPPS Status Indicator(s). CMS assigns Payment Status Indicators, and their definition can be found by accessing Addendum D1.
- 2.4.2** Professional Claims - Bundled/Unbundled when two or more procedure codes are submitted on a claim, the two codes are reviewed to determine if they are compatible or appropriate when performed together. The review identifies potential instances of unbundling or inappropriate billing, where separate procedures that should be billed together are instead billed separately.

2.5 Modifiers

- 2.5.1** Modifiers are two-character codes (letters or numbers) that are appended to CPT or HCPCS codes to provide more detail about a medical service. They indicate that a service or procedure has been altered but not changed in definition. Specific modifier reimbursement is found in the claims Modifier Reimbursement Policy.

2.6 Documentation Required:

2.6.1 When billing an E/M service along with a procedure, the documentation in the member's medical record must clearly demonstrate that:

2.6.1.1 Both the medically necessary E/M service and the procedure are appropriately and sufficiently documented by the physician in the patient's medical record.

2.6.1.2 The purpose of the evaluation and management service was to evaluate a specific complaint.

2.6.1.3 The key components of the appropriately selected E/M service were actually performed and address the presenting complaint.

2.6.1.4 The purpose of the visit was other than evaluating and/or obtaining information needed to perform the procedure/service.

2.7 Multiple Modifiers:

2.7.1 KFHP accepts the submission of multiple modifiers. Claims filed using multiple site of service modifiers must be filed on separate claim lines.

2.8 Site of Service Modifier:

2.8.1 Site of service modifiers are HCPCS Level II modifiers that include but are not limited to F1-9, E1-4, T1-9.

2.9 TC Technical Component:

2.9.1 TC modifier is used to indicate Technical Component. This refers to certain procedures that are a combination of a physician component and a technical component. KFHP follows CMS guidelines for correct usage of the TC component. The TC modifier should only be appended to health service codes that have a 1 in the PC/TC field on the National Relative Value Field file.

2.10 Modifier 24:

2.10.1 When using Modifier 24 the following shall apply:

2.10.1.1 The primary reason for the service needs to be unrelated to the prior condition. Incidental minor findings or lower levels of medical decision making do not warrant separate E/M reporting. The number and level of E/M in the post-operative period reflects a range of anticipated complexity and number of visits.

2.10.1.2 When eligible to be reported, the basis of code selection shall not include the key components related to the procedure post-operative E/M.

2.11 Modifier 25:

- 2.11.1** Modifier 25 is used to indicate that on the same date as a procedure or other service, a significant and separately identifiable evaluation and management (E/M) service was performed by the same provider.
- 2.11.2** Modifier 25 is appropriate only when the documentation clearly supports the distinct nature of the E/M service. KFHP reviews for proper use of Modifier 25 to ensure that the E/M was medically necessary, clearly documented, and not part of the routine care bundled into the procedure. Claims submitted with Modifier 25 that lack sufficient documentation or are appended inappropriately may be denied.

2.12 Modifier 26 Professional Component:

- 2.12.1** Modifier 26 is used to indicate the professional service associated with a procedure that consists of a combination of both technical and professional services. KFHP follows the CMS guidelines for correct usage of modifier 26.
- 2.12.2** This modifier should be appended to health service codes that have a 1 in the PC/TC field on the National Relative Value Field file. KFHP will automatically append modifier 26 to services performed in place of service 21, 22, or 23.

2.13 Pre, Post, and Intraoperative Care Modifiers (54, 55, 56):

- 2.13.1** These modifiers are used to indicate services provided during a global surgical period and are required to ensure accurate reimbursement across providers. For more information, please refer to the Modifier Reimbursement Policy:
 - 2.13.1.1 Modifier 54:** Used when the same provider completes both the surgery and the preoperative care.
 - 2.13.1.2 Modifier 55:** Appended when a different provider performs postoperative management.
 - 2.13.1.3 Modifier 56:** Leveraged when a different provider performs preoperative care.

2.14 Bilateral Surgery (LT/RT/50)

2.14.1 KFHP utilizes Medicare payment indicators on the CMS National Physicians Fee Schedule Relative Value Units (RVU) file to determine if co-surgeon services are reasonable and necessary for a specific HCPCS/CPT code. The following are the payment indicators utilized.

2.14.1.1 Indicator 1: This indicator identifies a bilateral service was performed. Providers must bill with the bilateral modifier or reported twice on the same day by any other means (e.g., with RT and LT modifiers, and with 1 in the unit field).

2.14.1.2 Indicator 2: The modifiers 50, -RT, and -LT do not apply.

2.14.1.3 Indicator 3: This indicator does not occur on any surgeries. KFHP requires providers to report using the correct anatomical modifier (-RT/-LT).

2.14.1.4 If a code is reported as a bilateral procedure and is reported with other procedure codes on the same day, the bilateral and multiple surgery guidelines will be applied.

2.15 Modifier 59, XE, XS, XP, XU:

2.15.1 Modifier 59 is utilized under certain circumstances to indicate a distinct procedure or service for non-evaluation and management (E/M) services provided on the same date of service.

2.15.2 Modifiers XE (Separate Encounter), XS (Separate Structure), XP (Separate Practitioner), and XU (Separate Unusual Non-Overlapping Service) gives greater detail in place of modifier 59, when specificity is needed. Modifier 59 should be used when no other more specific modifier is appropriate.

2.16 Co-Surgeons (Modifier 62):

2.16.1 KFHP utilizes Medicare payment indicators on the CMS National Physicians Fee Schedule Relative Value Units (RVU) file to determine if co-surgeon services are reasonable and necessary for a specific HCPCS/CPT code. The following are the payment indicators utilized:

2.16.1.1 Payment Indicator 0: Co-surgeon not permitted Payment Indicator 1: Co-surgeon may be allowed with supporting documentation to establish medical necessity. Claim requires review and operative notes may be requested by each provider at the time of the claim submission.

2.16.1.2 Payment Indicator 2: Co-surgeons are permitted without submission of documentation if the two specialty requirements are met. Claims submitted by two providers with different specialties will be adjudicated; however, it requires claim review prior to payment. Operative notes must be submitted by each provider at the time of claim submission.

2.16.1.3 Payment Indicator 9: Co-surgery concept does not apply

2.17 Team Surgery (Modifier 66)

2.17.1 KFHP utilizes Medicare payment indicators on the CMS National Physicians Fee Schedule Relative Value Units (RVU) file to determine if co-surgeon services are reasonable and necessary for a specific HCPCS/CPT code. The following are the payment indicators utilized:

2.17.1.1 Payment Indicator 0: Team surgeons not permitted for this procedure.

2.17.1.2 Payment Indicator 1: Team surgeons could be allowed. Supporting documentation is required to establish medical necessity of a team.

2.17.1.3 Payment Indicator 2: Team surgeons are permitted.

2.17.1.4 Payment Indicator 9: Team surgeon concept does not apply.

2.18 Assistant Surgeon (Modifiers 80, 81, 82, AS):

2.18.1 KFHP utilizes assistant surgeon indicators on the CMS National Physicians Fee Schedule Relative Value Units (RVU) file as a guideline to determine reimbursement. When there is an assistant surgeon, the surgeon of record must be listed as the primary surgeon.

2.18.2 The primary surgeon of record should be responsible for identifying the presence of the assistant surgeon and the work performed. The primary surgeon will report the procedures without a modifier and at their applicable fee and the assistant surgeon will append the appropriate assistant modifiers. The following modifiers should be used:

2.18.2.1 Payment Indicator 0: Assistant surgeon may be allowed with supporting documentation to establish medical necessity.

2.18.2.2 Payment Indicator 1: Assistant surgeon not permitted.

2.18.2.3 Payment Indicator 2: Assistant surgeon(s) are permitted.

2.18.2.4 Payment Indicator 9: Assistant surgeon concept does not apply. **2.19 Global**

Period

2.19.1 KFHP follows the CMS Global Surgery status indicators on the Medicare Physician Fee Schedule. These include:

2.19.2 000 Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; evaluation and management services on the day of the procedure generally not payable.

2.19.3 010 Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during this 10-day postoperative period are generally not payable.

2.19.4 090 Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule payment amount.

2.19.5 MMM Maternity codes; usual global period does not apply.

2.19.6 XXX Global concept does not apply.

2.19.7 YYY Carrier determines whether global concept applies and establishes postoperative period, if appropriate, at time of pricing.

2.19.8 ZZZ Code related to another service and is always included in the global period of the other service.

2.20 Multiple Procedure Payment Rules

2.20.1 The Multiple Procedure Payment Reduction (MPPR) is a policy implemented by CMS that reduces the reimbursement for the second and subsequent procedures performed on the same patient during the same encounter. MPPR guidelines are applied to surgery, diagnostic imaging, cardiology and ophthalmology services. MPPR impacts both professional and facility claims. Same providers are defined as physicians/providers in the same group practice who furnish multiple services to the same patient on the same day.

2.20.1.1 Surgery KFHP uses the CMS National Physicians Fee Schedule Relative Value Units (RVU) and CMS I/OCE files to determine which procedures are subject to multiple procedure reduction for professional and facility services.

2.20.1.2 Diagnostic Imaging KFHP uses the CMS National Physicians Fee Schedule Relative Value Units (RVU) and CMS I/OCE files to determine which procedures are subject to multiple procedure reduction for professional and facility services.

2.20.1.3 Ophthalmology KFHP uses the CMS National Physicians Fee Schedule Relative Value Units (RVU) file to determine which procedures are subject to multiple procedure reduction for facility services and services billed with modifier TC.

2.20.1.4 Cardiology KFHP uses the CMS National Physicians Fee Schedule Relative Value Units (RVU) file to determine which procedures are subject to multiple procedure reduction for facility services and services billed with modifier TC.

2.21 MPFS Status Indicator Codes:

2.21.1 KFHP recognizes the CMS assigned payment indicators as outlined within CMS National Physicians Fee Schedule Relative Value Units (RVU) file.

2.22 Anesthesia

2.22.1 KFHP will not cross walk surgical codes to anesthesia CPT codes. KFHP will not reimburse non-anesthesia services billed by anesthesia provider.

2.23 Emergency Department (ED) Facility Evaluation and Management (E&M) Coding

2.23.1 KFHP utilizes the EDC Analyzer™ tool to determine the appropriate level of facility reimbursement for outpatient emergency department (ED) services.

2.23.2 This policy will apply to all facilities that submit ED claims with level 3, 4, or 5 E/M, regardless of whether they are contracted or non-contracted. The review is based upon presenting problems as defined by the ICD 10 reason for visit, intensity of the diagnostic workup as measured by the diagnostic CPT codes, and based upon the complicating conditions as defined by the ICD 10 principal, secondary, and external cause of injury diagnosis codes.

2.23.3 To learn more about the EDC Analyzer TM tool, see [EDC Analyzer.com](https://www.edcanalyzer.com).

2.24 Diagnostic Exchange test identification codes (DEX Z-Codes)

2.24.1 KFHP leverages DEX Z-Codes to ensure claims are coding correctly for reimbursement. KFHP utilizes Palmetto GBA, the administrator of the Centers for Medicare & Medicaid Services (CMS) MoIDX® Program, which identifies and establishes coverage and reimbursement for molecular diagnostic tests.

2.25 Robotic Assisted Surgery

- 2.25.1** KFHP does not provide additional reimbursement based upon the type of instruments, technique or approach used in a procedure, such matters are left to the discretion of the surgeon. Additional professional or technical reimbursement will not be made when a surgical procedure is performed using robotic assistance.

2.26 Unlisted Codes

- 2.26.1** The CPT and HCPCS manuals provide unlisted procedure codes for healthcare providers to report services for which there is no specific code descriptor available. Providers should not use an "unlisted code", unless there is not an established code which adequately describes the procedure. Claims must be submitted with clinical documentation which includes detailed description of the procedure or service.

2.27 Outpatient Observation Services

- 2.27.1** Observation services are provided in place of inpatient admission. Observation services allow the necessary time to evaluate and provide needed services to a member whose diagnosis and treatment are not expected to be longer than forty-eight (48) hours without discharge or admission. Observation care can, for example, be delivered in a hospital emergency room, an area designated as "observation," a bed within a unit, or an entire unit designated as an observation area.
- 2.27.1.1** Admission to observation begins at the clock time documented in the medical record when the patient clearly transitions to observation level of care (i.e. Is placed in an observation bed), as confirmed by the initiation of services rendered and documented in accordance with the directions on the physician order.
- 2.27.1.2** Observation services should not be billed along with diagnostic or therapeutic services for which active monitoring is a part of the procedure. Documented observation time should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g., CT scans, MRI, colonoscopy, chemotherapy).
- 2.27.1.3** Observation time does not include the time patients remain in the hospital after treatment is finished, for reasons such as waiting for transportation home or while awaiting placement to another health care facility.
- 2.27.1.4** Routine preoperative preparation, monitoring and postoperative recovery is included in the allowance for the procedure. Prolonged services that require placing the patient in observation status are not eligible for payment unless a 6-hour threshold of post-operative monitoring is exceeded, regardless of the location of the postoperative monitoring.

2.28 Diagnosis Related Group (DRG) Payment

- 2.28.1** DRG validation is to ensure diagnostic and procedural information and discharge status of the beneficiary, as coded and reported by the facility on the submitted claim, matches both the attending physician's description and the information contained in the beneficiary's medical record. KFHP Clinical Review performs DRG reviews on claims with payment based on DRG reimbursement to determine the diagnosis and procedural information leading to the DRG assignment is supported by the medical record.
- 2.28.1.1** Validation must ensure diagnostic and procedural information and discharge status of the beneficiary, as coded and reported by the facility on its claim, matches both the attending physician's description and the information contained in the beneficiary's medical record.
- 2.28.1.2** Reviewers will validate principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG.
- 2.28.1.3** Comprehensive review of the patient's medical records will be conducted to validate:
- 2.28.1.3.1** Physician ordered inpatient status.
 - 2.28.1.3.2** Accuracy of diagnostic code assignment. **2.28.1.3.3** Accuracy of the procedural code assignments.
 - 2.28.1.3.4** Accuracy of the sequencing of the principal diagnosis and procedure codes.
 - 2.28.1.3.5** Accuracy of the present on admission (POA) indicator assignment.
 - 2.28.1.3.6** Accuracy of the DRG grouping assignment and associated payment.
 - 2.28.1.3.7** Accuracy of the Discharge Disposition Status Code assignment.
 - 2.28.1.3.8** Other factors that may impact DRG assignment and/or claim payment.
 - 2.28.1.3.9** Compliance with KP's payment policies including but not limited to those policies that address DRG inpatient facility, never events, hospital-acquired conditions, and readmissions or transfers to another acute care hospital.

3.0 Guidelines

N/A

4.0 Definitions

- 4.1 Centers for Medicare and Medicaid Services (CMS)** Part of the Department of Health and Human Services (HHS) that administers programs such as Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace.
- 4.2 Current Procedural Terminology (CPT)** A set of five-digit numeric or alphanumeric codes used to describe medical, surgical, and diagnostic services. These codes provide a uniform language that accurately describes medical services and procedures, facilitating efficient reporting, billing, and data analysis.
- 4.3 Healthcare Common Procedure Coding System (HCPCS) Level II** A standardized alphanumeric coding system used primarily to identify products, supplies, and services not included in the CPT® codes—such as ambulance services and durable medical equipment—for billing purposes. Each code consists of a single alphabetical letter followed by four numeric digits.
- 4.4 Integrated Outpatient Code Editor (I/OCE)** A tool developed by the Centers for Medicare & Medicaid Services (CMS) to validate and edit outpatient claims before they are submitted to Medicare.
- 4.5 International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)** A standardized coding system used in the United States to classify and code all diagnoses, symptoms, and procedures recorded in conjunction with hospital care. It is used by healthcare providers to document and report diseases and medical conditions (morbidity) for billing, statistical, and administrative purposes.
- 4.6 International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS)** A procedure classification system developed by the Centers for Medicare & Medicaid Services (CMS) for use in the United States. It is used to code procedures performed in hospital inpatient settings and is designed to support accurate and consistent reporting of inpatient procedures for billing and statistical purposes.
- 4.7 Local Coverage Determinations (LCDs)** Policies created by Medicare Administrative Contractors (MACs) to decide which services are considered reasonable and necessary for Medicare coverage within their specific jurisdictions.
- 4.8 Medicare Physician Fee Schedule (MPFS)** Medicare uses the MPFS when paying for professional services of physicians and other healthcare providers in private practice, services covered incident to physicians' services, diagnostic tests (other than clinical laboratory tests), and radiology services.
- 4.9 National Correct Coding Initiative (NCCI)/Correct Coding Initiative (CCI)** The Medicare National Correct Coding Initiative (NCCI), also known as CCI, was implemented to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. CMS developed the NCCI program to promote national correct coding of Medicare Part B claims.
- 4.10 National Coverage Determinations (NCD)** Policy decisions by the Centers for Medicare & Medicaid Services (CMS) that specify whether a particular item or service is considered reasonable and necessary for Medicare coverage on a nationwide basis.

- 4.11 National Uniform Billing Committee (NUBC)** An organization established to develop and maintain a standardized billing form and data set—specifically the UB-04—for use by institutional healthcare providers and payers across the United States. Its goal is to ensure uniformity in the data reported on healthcare claims, facilitating efficient processing and accurate reimbursement.
- 4.12 Outpatient Prospective Payment System (OPPS)** CMS generally makes payment for hospital outpatient department services through the Hospital Outpatient Prospective Payment System (OPPS).
- 4.13 Relative Value Units (RVUs)** Relative value units (RVUs) are the basic component of the Resource-Based Relative Value Scale (RBRVS), which is a methodology used by the Centers for Medicare & Medicaid Services (CMS) and private payers to determine physician payment.
- 4.14 Revenue Codes** Four-digit numeric codes used on institutional (facility) claims to indicate the specific department or type of service provided during a patient's visit. These codes help identify where the patient received care (e.g., emergency room, radiology) or what type of item or service was provided (e.g., medical supplies, room and board), and are essential for billing and reimbursement purposes.
- 4.15 The Health Insurance Portability and Accountability Act of 1996 (HIPAA)** Establishes federal standards for protecting patients' health information from disclosure without their consent.

5.0 References

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf> <https://www.cms.gov/medicare/coding-billing/ncci-medicare> <https://www.cms.gov/medicare/payment/fee-schedules/physician/pfs-relative-value-files>

https://www.aapc.com/resources/what-are-relative-value-units-rvus?srsId=AfmBOooizLh65MIIBqpJ0rYEhtEamQBpt7Lc6_sfJ2hTxMR0bCqsOj0x
<https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00097341>

<https://www.cms.gov/medicare/coverage/determination-process/local> Medicare Coverage Determination Process | CMS

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf#page=37> Section 30.6.1.1

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/downloads/CMS1392FC_Addendum_D1.pdf <https://www.cms.gov/status-indicators>

Medicare Claims Processing Manual: Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS), Section 290 Outpatient Observation Services. Accessed

03/16/2010 at <http://www.cms.hhs.gov/manuals/downloads/clm104c04.pdf> 2

Medicare Benefit Policy Manual: Chapter 6 - Hospital Services Covered Under Part B, Section 20.6 - Outpatient Observation Services (Rev. 107, Issued: 05-22-09, Effective: 07-01-09, Implementation: 07-06-09) A. Outpatient Observation Services Defined. Accessed 03/10/2011. <http://www.cms.hhs.gov/manuals/Downloads/bp102c06.pdf> 3

CMS Manual System. Pub. 100-02 Medicare Benefit Policy. December 16, 2005. January 2006 Update of the Hospital Outpatient Prospective Payment System (OPPS) Manual Instruction: Changes to Coding and Payment for Observation

6.0 Related Topics

POL-020.1 Clinical Review Itemized Bill Review Payment Determination Policy POL-020.2 Clinical Review Medical Record Review Payment Determination Policy POL-020.4 Clinical Review Implant Payment Determination Policy

POL-020.5 Clinical Review 30 Day Readmission Payment Determination Policy

POL-020.6 Clinical Review Intraoperative Neuromonitoring (IONM) Payment Determination Policy

(Updated: 09/08/2025)

[Revision History](#)

[Approvals](#)



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- National Uniform Billing Committee (NUBC)
- Professional and academic journals and publications

1.2 Scope

- 1.2.1** This policy provides an overview of Kaisers reimbursement guidelines for devices and implants. The policy applies to both contracted and non-contracted providers across all lines of business, unless otherwise specified.

2.0 Rules

- 2.1 Kaiser will not consider implants for reimbursement that do not meet the U.S. Food and Drug Administration (FDA) definition of implants. According to the FDA an implant is defined as:**

1.2 Scope

- 1.2.1** This policy provides an overview of Kaisers reimbursement guidelines for devices and implants. The policy applies to both contracted and non-contracted providers across all lines of business, unless otherwise specified.

2.0 Rules

- 2.1 Kaiser will not consider implants for reimbursement that do not meet the U.S. Food and Drug Administration (FDA) definition of implants. According to the FDA an implant is defined as:**

- 2.1.1** "A device that is placed into a surgically or naturally formed cavity of the human body and is intended to remain implanted continuously for 30 days or more, unless otherwise determined by the FDA to protect human health."

2.2 Reimbursement Guidelines

2.2.1 Humanitarian Use Device (HUD)

2.2.1.1 KFHP Clinical Review evaluates the use of Humanitarian Use Devices (HUDs) to determine appropriate reimbursement. HUDs will not be reimbursed for investigational or off-label use. The following will be reviewed to determine the appropriate reimbursement.

2.2.1.2 Is the device approved by the FDA under a Humanitarian Device Exemption (HDE).

2.2.1.3 Was the device used strictly in accordance with FDA-approved indications.

2.2.1.4 Was the device administered in a non-research clinical setting with Institutional Review Board (IRB) approval.

2.2.1.5 Was the device deemed medically necessary, with no suitable alternative treatment available.

2.2.1.6 Was there comprehensive supporting documentation provided, including FDA approval, IRB approval, medical necessity justification, and patient consent.

2.2.2 Non-Covered Examples

2.2.2.1 (This is not an exhaustive list, nor is it intended to cover every claim scenario)

2.2.2.2 Temporary items Objects that do not remain in the member's body upon discharge are not considered implants.

2.2.2.2.1 Examples include, without limitation, the following: screws, clips, pins, wires, nails, and temporary drains.

2.2.2.3 Disposable items Single-use products not intended to remain in the body or be reused.

2.2.2.3.1 Examples include, without limitation, the following: surgical drapes, irrigation tubing, wedge positioning pads, accessory packs, needles and syringes.

2.2.2.4 Supplies and instruments Tools or materials used during procedures but not implanted.

2.2.2.4.1 Examples include, without limitation, the following: surgical instruments (e.g., forceps, scalpels), sterile drapes, tubes, guidewires, operating room kits, and diagnostic tools (e.g., endoscopes).

2.2.2.5 Unused or discarded items Devices or implants that are opened or prepared but not implanted for any reason. This includes surgical changes, complications, or handling errors. All of which are considered waste and are not reimbursable.

2.2.2.5.1 Examples include, without limitation, the following: implantable screw(s) not used due to a change in approach by the treating provider, biologic mesh discarded after plan change, pacemaker lead not implanted due to complications.

2.2.2.6 Absorbable materials and biological products not classified as implants by the FDA Includes tissue-based or absorbable products intended for temporary use that do not meet the FDA's definition of an implant.

2.2.2.6.1 Examples include, without limitation the following: absorbable hemostats, and topical thrombin's (e.g., Surgicel®). Temporary wound matrices (e.g., Integra®), amniotic membrane grafts, collagen-based scaffolds, skin substitutes used as temporary coverings, bone putty or cement, and absorbable sutures.

2.2.2.7 Off-label or non-indicated use Biological products used outside their FDA-approved purpose—such as absorbable scaffolds or tissue grafts used for structural support—are not covered.

2.2.2.8 Procedural tools and temporary devices Devices used during procedures but not intended to remain in the body.

2.2.2.8.1 Examples include, without limitation, the following: Catheter, transluminal atherectomy, rotational, Adhesion barrier, Intracardiac introducer/sheath (non-peel-away), Guide wire, Retrieval device (e.g., for fractured implants), Pulmonary sealant (liquid), and Cryoablation probe/needle.

3.0 Guidelines

N/A

4.0 Definitions

4.1 Biological Products Products derived from living organisms (such as human or animal tissue) that are used in the prevention, treatment, or cure of diseases. When not classified as implants by the FDA—such as absorbable or temporary tissue-based products—they are not considered reimbursable implants.

- 4.2 Centers for Medicare & Medicaid Services (CMS)** A federal agency within the U.S. Department of Health and Human Services (HHS) that administers Medicare, Medicaid, and other health programs. CMS establishes national coverage policies and reimbursement methodologies, including those related to implantable devices.
- 4.3 Disposable Medical Supplies** Single-use items utilized during a procedure that are not retained in the body after discharge. These are not considered implants and are typically not reimbursed separately.
- 4.4 HCPCS Code** The Healthcare Common Procedure Coding System (HCPCS) is used to report medical procedures, services, and devices. A valid HCPCS code must be submitted for any implant billed on a claim.
- 4.5 Humanitarian Use Device (HUD)** A medical device intended to benefit patients by treating or diagnosing a disease or condition that affects fewer than 8,000 individuals in the U.S. per year. HUDs must have FDA approval for the specific indication to be eligible for reimbursement.
- 4.6 Implant** A device placed into a surgically or naturally formed cavity of the human body and intended to remain continuously for 30 days or more, as defined by the FDA.
- 4.7 Skin Substitutes** Products used to temporarily or permanently replace the skin's structure and function. Only those intended for permanent implantation may be considered for reimbursement; temporary wound coverings or dressings are not reimbursed as implants.

5.0 References

- 5.1** Centers for Medicare & Medicaid Services (CMS). Medicare Claims Processing Manual, Chapter 4 – Part B Hospital (Including Inpatient Hospital Part B and OPPS)
- 5.2** U.S. Food and Drug Administration (FDA). Implants and Prosthetics Guidance <https://www.fda.gov>
- 5.3** U.S. Food and Drug Administration (FDA). IDE Definitions and Acronyms [IDE Definitions and Acronyms | FDA](#)
- 5.4** CPT® Manual and CPT® Assistant, published by the American Medical Association (AMA)
- 5.5** HCPCS Level II Manual, published by CMS
- 5.6** ICD-10-CM Official Guidelines for Coding and Reporting

6.0 Related Topics

POL-020.1 Clinical Review Itemized Bill Review Payment Determination Policy

POL-020.2 Clinical Review Medical Record Review Payment Determination Policy

POL-020.3 Clinical Review Coding Payment Determination Policy

POL-020.5 Clinical Review 30 Day Readmission Payment Determination Policy

POL-020.6 Clinical Review Intraoperative Neuromonitoring (IONM) Payment Determination Policy

(Updated: 09/08/2025)

[Revision History](#)

[Approvals](#)

POL-020.2 Clinical Review Medical Record Review Payment Determination Policy



This policy applies to all NCA markets, all lines of business.

1.0 Business Policy

1.1 Payment Policy Statement

- 1.1.1** Kaiser Foundation Health Plan (KFHP) requires accurate and complete claims submissions that follow proper billing and submission guidelines according to industry standard Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. In addition, documentation (such as medical records, office notes etc.) must support services billed. KFHP may request additional supportive documentation to further validate billing, coding, and clinical accuracy of billed services prior to finalizing reimbursement on billed service(s). KFHP, in the interest of its members, reviews claims to ensure that KFHP pays the appropriate amounts on claims and does not overpay or pay for improper charges. While KFHP does not dictate to providers how to bill their claims, the industry recognizes that certain billing practices can lead to non-payable charges. If appropriate coding/billing guidelines or current reimbursement policies are not followed or documented in the records, KFHP may, depending on the circumstances: reduce or deny the claim or claim line, consider a claim line paid by virtue of payment of another claim line or the claim as a whole, or recover/recoup the claim processed for payment in error. Unless otherwise noted within the policy, KFHP's reimbursement policies apply to contracted and non-contracted professional providers and facilities.
- 1.1.2** KFHP payment policies are not intended to cover every claim situation. KFHP policies may be superseded by state, federal and/ or provider contractual requirements. KFHP will align with all applicable regulatory, state and federal guidelines. KFHP will employ clinical discretion and judgement, and coding expertise in its interpretation and application of the policy, and all payment policies are routinely updated.
- 1.1.3** KFHP recognizes commonly accepted standards to help determine what items and/or services are eligible for separate reimbursement. Commonly accepted standards include but are not limited to the following:
- . American Academy of Professional Coders (AAPC) . American Medical Association (AMA)

- Associated Medical Societies (i.e.: American College of Obstetricians and Gynecologists (ACOG), American Academy of Family Physicians (AAFP), etc.)
- American Health Information Management Association (AHIMA)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- CMS Local Coverage and National Coverage Determinations (LCD NCD)
- CMS Manuals and Publications
- CPT Assistant
- CPT Manual, including code definitions and associated text
- Federal Register
- HCPCS Manual, including code definitions and associated text
- Integrated Outpatient Code Editor (I/OCE)
- International Classification of Diseases, 10th Revision (ICD-10-CM) official guidelines for coding and reporting
- Medically Unlikely Edits
- National Correct Coding Initiative Policy Manual for (NCCI)
- National Physician Fee Schedule Relative Value File
- National Uniform Billing Committee (NUBC)
- Professional and academic journals and publications

1.2 Scope

- 1.2.1** This policy provides an overview of KFHP's Clinical Review medical record review. Clinical Review will review the medical records provided for medical appropriateness and/or medical necessity to facilitate accurate claims reimbursement. This policy applies to both contracted and non-contracted providers across all lines of business, unless otherwise specified.

2.0 Rules

- 2.1** **Clinicians within the Clinical Review department will review the medical records to determine whether the billed services are medically appropriate or necessary, and correctly coded for reimbursement. When medical records or clinical information is requested, all the specific**

information required to make the medical determination must be clearly documented in the records. In addition, services must be considered a covered benefit. Determinations of medical necessity adhere to the standard of care and focus on the direct care and treatment of the patient. KFHP Clinical Review follows CMS and other industry guidelines, clinical literature, and accepted medical necessity criteria.

2.2 Each medical record must be documented for the date of services and specific services billed including, but not be limited to physician orders, diagnoses, evaluations, consultations, medications, treatments, test reports and results, history and physical, emergency room records, care plans, discharge plans, and discharge summaries.

2.3 Reimbursement Guidelines

2.3.1 Clinical Review will review the medical records to assess:

2.3.1.1 Whether the provider exercised appropriate clinical judgment and decision-making in evaluating, diagnosing, and treating the member's condition.

2.3.1.2 Whether the treatment provided was appropriate and clearly documented in the medical record.

2.3.1.3 Whether the level of care billed accurately reflects the services rendered.

2.3.1.4 Whether the services are cosmetic, experimental, or investigational in nature.

2.3.1.5 Whether the coding and billing is accurate and appropriate. **2.3.1.6** Whether the authorization reflects what is billed.

2.3.2 Determining medical appropriateness or necessity should follow the standard of care and focus on the direct care and treatment of the patient. This includes, but is not limited to an assessment of the following:

2.3.2.1 Whether treatment of the members' condition, illness, disease, or injury is appropriate and clearly documented in the medical record.

2.3.2.2 Whether services provided are for the diagnosis and direct treatment of the member's medical condition.

2.3.2.3 Whether the services provided meet applicable standards of good medical practice.

2.3.2.4 Based on the review of the medical records, the payment for the service(s) billed may be denied, reduced, or otherwise adjusted, in part or in whole. Medical necessity reviews that result in a partial or full denial of a service require review and approval by a physician.

2.4 Trauma Activation

2.4.1 Trauma activation will be considered for reimbursement only (when all the following criteria are met.

2.4.1.1 To receive reimbursement for trauma activation, a facility must:

2.4.1.2 Have received prehospital notification based on triage information from EMS or prehospital caregivers, who meet either local, state, or ACS field criteria and are given the appropriate team response.

2.4.1.3 Bill for trauma activation costs only. Clinical Review will request records to review for documentation of the team members being called to support the trauma activation.

2.4.1.4 Code the claim with type of admission/visit code 05 (trauma center).

2.4.1.5 Bill evaluation and management codes for critical care under Revenue Code 450. When revenue code series 68x trauma response is billed in association with services other than critical care, payment for trauma activation is bundled into the other services provided on that day.

2.5 Level of Care (LOC) Review

2.5.1 LOC Review applies to inpatient facility claims to determine whether the level of care billed matches the LOC that was authorized so that appropriate reimbursement is made.

2.5.2 The review involves assessing whether the billed days for each LOC are both authorized and medically necessary.

2.5.3 If the provider bills additional days or a higher LOC than what is authorized, the claim will be denied, and the provider will need to submit a corrected claim for payment.

2.5.4 LOC will be reviewed based on the patient's specific clinical information, as documented within the medical record.

2.6 Neonatal Intensive Care Level of Care (NICU)

2.6.1 The medical criteria in this section provides guidance for reimbursement of NICU and neonatal care levels 2 through 4. Level 1 admission and discharge criteria such as coupling or mother/baby care was intentionally omitted as it now replaces routine nursery care.

2.6.2 Specific information regarding neonatal level of care may be requested through National Clinical Review.

2.6.3 Level of care will be reviewed/approved based on the patient's specific clinical information as documented within the medical record.

2.7 Post Stabilization

- 2.7.1** The treating provider or member must contact KFHP to request prior authorization for post-stabilization care before post-stabilization care is provided. Upon request for prior authorization, KFHP may arrange to take over the member's care via transfer or authorize post-stabilization care that is medically necessary to maintain the member's stabilized condition. Unauthorized post-stabilization care is not a covered benefit and claims for post-stabilization that are not authorized by KFHP will be denied.

2.8 Short Stay/2 Midnight Rule

- 2.8.1** KFHP follows Medicare reimbursement guidelines to determine whether inpatient services are reimbursable. If a doctor anticipates a patient will need medically necessary/appropriate hospital care for at least two nights (spanning two midnights), the stay can be billed as inpatient admission and will be reimbursed accordingly. Medical records must support inpatient admission and must be clearly documented. If the anticipated stay is less than two midnights, the care is typically considered outpatient and should be billed accordingly. There are some exceptions to the two-midnight rule, such as:
- 2.8.2** The patient is discharged against medical advice (AMA).
- 2.8.3** The patient dies during the stay.
- 2.8.4** In these cases, the patient may still be classified as an inpatient, even if their stay did not span two midnights if the initial expectation of a longer stay was reasonable and documented in the medical records.

2.9 Present on Admission (POA):

- 2.9.1** Consistent with Medicare requirements, KFHP requires POA indicator reporting for all claims involving inpatient admissions to general acute care hospitals or other facilities. General requirements to follow are:
- 2.9.2** Refer to UB-04, also known as the CMS-1450 Data Specifications Manual and the ICD-10-CM guidelines for Coding and Reporting to facilitate the assignment of the
- 2.9.3** POA indicator for each "principal" diagnosis and "other" diagnoses codes reported on claims forms UB-04.
- 2.9.4** Providers shall ensure any resequencing of diagnosis codes prior to claims submission include a resequencing of POA indicators.
- 2.9.5** Issues related to inconsistent, missing, conflicting, or unclear documentation must be resolved by the provider.

2.10 Provider Preventable Conditions (PPC)

- 2.10.1** Clinical Review determines if the service provided meets the clinical guidelines set forth by CMS to ensure PPC services are not reimbursed. PPCs are defined into 2 types – Hospital Acquired Conditions (HACs) and Never Events/Serious Reportable Events (SREs).
- 2.10.2** Hospital Acquired Conditions (HACs) – These are conditions that could reasonably have been prevented through the application of evidence based clinical guidelines.
- 2.10.3** Inpatient Acute Care Hospitals are required to document these in the medical records and are reportable as Medicare requirements.
- 2.10.4** Never Events/SREs – These events are defined by CMS to include: **2.10.4.1** Wrong surgery/invasive procedure.
- 2.10.4.2** Surgery/invasive procedure performed on the wrong patient. **2.10.4.3** Surgery/invasive procedure performed on the wrong body part.
- 2.10.5** Providers will not be reimbursed for these services, as these are errors in medical care that are of concern to both the public and health care. Providers must report these when these occur in any health care setting.

2.11 Thirty Day Readmissions

- 2.11.1** KFHP does not allow separate reimbursement for claims that have been identified as readmission to the same hospital or Hospital System reimbursed by DRG pricing for the same, similar or related condition unless provider, state, federal or CMS contracts and/or requirements indicate otherwise. In the absence of provider, federal, state and/or contract mandates, KFHP will use the following standards: (a) readmission within 30 days from discharge; (b) same diagnosis or diagnoses that fall into the same grouping.

2.12 Chimeric antigen receptor T-cel (CAR-T)

- 2.12.1** KFHP follows CMS guidelines for CAR-T reimbursement.

3.0 Guidelines

N/A

4.0 Definitions

- 4.1 Centers for Medicare & Medicare Services (CMS)** Part of the Department of Health and Human Services (HHS) who administers programs such as Medicare, Medicaid, and Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace.
- 4.2 Post Stabilization Care** Following stabilization of the member's emergency

medical condition, post-stabilization care are those medically necessary services needed to maintain a member's stabilized condition, or as otherwise defined by applicable law.

4.3 Clinical Literature Literature, published in a peer-reviewed journal, describes research specifically designed to answer a relevant clinical question.

4.4 Generally Accepted Standards of Medical Practice Standards based on credible scientific evidence published in peer-reviewed medical literature and widely recognized by the relevant medical community. They include recommendations from physician specialty societies, the consensus of medical professionals practicing in relevant clinical fields, and pertinent factors.

5.0 References

<https://www.cms.gov/newsroom/fact-sheets/fact-sheet-two-midnight-rule-0>

[Eliminating Serious, Preventable, and Costly Medical Errors - Never Events | CMS](#)

[Hospital Acquired Conditions | CMS Hosp. Readmission Reduction | CMS](#)

[Medicare.gov: https://www.medicare.org/articles/what-does-medically-necessary-mean/](#)

[Frequently Asked Questions CR 7502](#)

[National Uniform Billing Committee | NUBC](#)

6.0 Related Topics

[POL-020.1 Clinical Review Itemized Bill Review Payment Determination Policy](#)

[POL-020.3 Clinical Review Coding Payment Determination Policy](#)

[POL-020.4 Clinical Review Implant Payment Determination Policy](#)

[POL-020.5 Clinical Review 30 Day Readmission Payment Determination Policy](#)

[POL-020.6 Clinical Review Intraoperative Neuromonitoring \(IONM\) Payment Determination Policy](#)

(Updated: 09/08/2025)

[Revision History](#)

[Approvals](#)

POL-020.1 Clinical Review Itemized Bill Review Payment Determination Policy



This policy applies to all NCA markets, all lines of business.

1.0 Business Policy

1.1 Payment Policy Statement

- 1.1.1** Kaiser Foundation Health Plan (KFHP) requires accurate and complete claims submissions that follow proper billing and submission guidelines according to industry standard Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. In addition, documentation (such as medical records, office notes etc.) must support services billed. KFHP may request additional supportive documentation to further validate billing, coding, and clinical accuracy of billed services prior to finalizing reimbursement on billed service(s). KFHP, in the interest of its members, reviews claims to ensure that KFHP pays the appropriate amounts on claims and does not overpay or pay for improper charges. While KFHP does not dictate to providers how to bill their claims, the industry recognizes that certain billing practices can lead to non-payable charges. If appropriate coding/billing guidelines or current reimbursement policies are not followed or documented in the records, KFHP may, depending on the circumstances: reduce or deny the claim or claim line, consider a claim line paid by virtue of payment of another claim line or the claim as a whole, or recover/recoup the claim processed for payment in error. Unless otherwise noted within the policy, KFHP's reimbursement policies apply to contracted and non-contracted professional providers and facilities.
- 1.1.2** KFHP payment policies are not intended to cover every claim situation. KFHP policies may be superseded by state, federal and/ or provider contractual requirements. KFHP will align with all applicable regulatory, state and federal guidelines. KFHP will employ clinical discretion and judgement, and coding expertise in its interpretation and application of the policy, and all KFHP payment policies are routinely updated.
- 1.1.3** KFHP recognizes commonly accepted standards to help determine what items and/or services are eligible for separate reimbursement. Commonly accepted standards include but are not limited to the following:

. American Academy of Professional Coders (AAPC) . American Medical

Association (AMA)

- Associated Medical Societies (i.e.: American College of Obstetricians and Gynecologists (ACOG), American Academy of Family Physicians (AAFP), etc.)
- American Health Information Management Association (AHIMA)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- CMS Local Coverage and National Coverage Determinations (LCD NCD)
- CMS Manuals and Publications
- CPT Assistant
- CPT Manual, including code definitions and associated text
- Federal Register
- HCPCS Manual, including code definitions and associated text
- Integrated Outpatient Code Editor (I/OCE)
- International Classification of Diseases, 10th Revision (ICD-10-CM) official guidelines for coding and reporting
- Medically Unlikely Edits
- National Correct Coding Initiative Policy Manual for (NCCI)
- National Physician Fee Schedule Relative Value File
- National Uniform Billing Committee (NUBC)
- Professional and academic journals and publications

1.2 Scope

- 1.2.1** This policy provides an overview of KFHP's Clinical Review Itemize Bill Review (IBR) procedures and reimbursement guidelines. This policy applies to contracted and non-contracted providers across all lines of business, unless otherwise specified. Clinical Review is responsible for reviewing facility and professional claims to ensure providers comply with billing and coding standards, that services rendered are appropriate and medically necessary, and that reimbursement is made in accordance with applicable legal and contractual/provider manual requirements.

2.0 Rules

2.1 The Clinical Review department will review the itemized bill, and if applicable, in the reviewer's discretion, the medical records to determine whether the billed services are medically appropriate, correctly coded for reimbursement, and are not inclusive of, or an integral part of another procedure or service.

- 2.1.1** The review is conducted on a pre-adjudication basis.
- 2.1.2** Reimbursement is made in accordance with industry standard billing guidelines, regulatory guidance, and applicable provider contract and/or provider manual requirements.
- 2.1.3** Clinical Review staff will submit a request for information (RFI) to the provider, requesting an itemized bill and/or medical records.
- 2.1.4** The IBR review will be completed upon receipt of the itemized bill and, or medical records. If the itemized bill and/ or medical records are not received timely a denial will be rendered.
- 2.1.5** For Inpatient facility services that are reimbursed under a prospective payment system, the payment amount for a particular service is based on the classification system of that service. In addition to the basic prospective payment, an outlier payment is made for certain claims that incur costs above the facility-specific threshold. DRG cost outlier claims are repriced based upon the IBR results.
- 2.1.6** KFHP will apply commonly accepted standards to determine which of the billed items or services are eligible for appropriate reimbursement. Commonly accepted standards include, without limitations, CMS guidelines, National Uniform Billing Committee (NUBC) standards, National Correct Coding Initiative (NCCI) standards, and various professional and academic journals and publications as outlined above. KFHP clinicians will interpret these standards and apply them to claims using clinical discretion and judgment.

2.2 Reimbursement Guidelines

- 2.2.1** Clinical Review will not reimburse providers for items or services that are considered inclusive of, or an integral part of another procedure or service. Such services will be paid as part of the larger related service and are not eligible for separate reimbursement. Services to be considered for separate reimbursement should be clearly documented on the itemized bill and medical record. The Clinical reviewer will review the itemized bill and/or medical records for these charges.
 - 2.2.1.1** The following types of charges are examples of charges that a KFHP clinician may determine to be inclusive of, or an integral part of another procedure or service and therefore not separately payable. KFHP will use clinical discretion and judgment and will consider commonly accepted standards as applicable to the facts and circumstances of each case.

2.2.2 Charges for the use of capital equipment, whether rented or purchased, can be denied as not separately reimbursable. The use of such equipment is part of the administration of a service. Examples include, without limitation, the following:

- Anesthesia Machines
- Balloon Pumps
- Instruments/Instrument Trays
- IV/feeding pumps
- Furniture (including bed, mattress, sheets, pillows etc.)
- Monitors (Blood Pressure, Cardiac, Fetal, EMG, Temperature, Apnea, Neuro, Oximetry, Cautery Machines, Hemodynamic Monitoring Catheters)
- Scopes/Microscopes
- Specialty Beds
- Thermometers, Temperature probes etc.
- Ventilators
- Video or digital equipment used in the operating room (including batteries, anti-fogger solution, tapes, cell savers, lasers etc.)

2.2.3 Charges for IV flushes (for example, heparin and/or saline) and solutions to dilute or administer substances, drugs, or medications, can be denied as not separately reimbursable. The use of these is part of the administration of a service. Examples include, without limitation, the following:

- Access of indwelling catheter, subcutaneous catheter or port
- IV start/flushes at the beginning and end of an infusion
- Preparation of IV prescribed drugs
- Standard tubing/syringes/supplies

2.2.4 Charges for hydration are not separately payable unless the hydration services are therapeutic, in which case consideration for reimbursement can be made, based on the medical record documentation.

2.2.5 Charges for services that are necessary or otherwise integral to the provision of a specific service and/or delivery of services in a specific location are considered routine services and are not separately reimbursable. This applies to both the inpatient and outpatient settings.

These services are part of the room and board charges. Examples include, without limitation, the following:

- Administration of medications (IV, PO, PMIM, chemotherapy)
- Incremental nursing care
- Infusion of IV fluids
- Insertion of tubes (IV lines, PICC lines, tube feeding)
- Measuring blood oxygen levels
- Misc. charges (dressing changes, specimen collection, balloon pumps)
- Nasogastric tube (NGT) insertion
- Point of care testing
- Respiratory treatment (sputum treatment, airway clearance (For example, suctioning), incentive spirometer, nebulizer treatment)
- Saline flushes
- Urinary catheterization
- Venipuncture

2.2.6 Charges that are considered bundled or packaged into another service or procedure can be denied as not separately reimbursable, as they are considered integral to the primary service or procedure. Examples include, without limitation, the following:

- Guidewires
- Lidocaine used for procedures
- Ultrasound guidance for placement of line
- Xray confirming placement of PICC line, central lines, and NG tubes

2.2.7 Under the Outpatient Prospective Payment System (OPPS), any charges for line items or Healthcare Common Procedure Coding System (HCPCS) codes that are bundled together under a single payment for surgical procedures should not be reimbursed separately. Costs for these items and services are inclusive of overall payment in the Ambulatory Payment Classification (APC).

2.2.8 KFHP follows the Centers for Medicare and Medicaid Services (CMS) Hospital Outpatient Prospective Payment System (OPPS) Fee Scheduled for

all codes that are covered but not separately reimbursed. Examples include but are not limited to:

2.2.8.1

Status Indicator	Item/Code/Service	OPPS Payment Status
D	Discontinued codes	Not paid under OPPS or any other Medicare payment system.
N	Items or services packaged into APC rates	Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment

2.2.9 Charges for personal care items do not contribute to the meaningful treatment of the patient's condition. Examples include, without limitation, the following:

- Admission kits
- Band aids
- Footies/slippers
- Oral swabs/mouthwash
- Other patient convenience items (such as diapers, deodorant, hair care items, mouthwash, toothbrush and toothpaste)

2.2.10 Charges for respiratory therapy services provided at a Specialty Care Unit (such as ICU, Pediatric ICU, CCU, ED, or intermediate intensive care units) are generally not separately reimbursable. The use of these services is part of the administration of care at a Specialty Care Unit. Examples include, without limitation, the following:

- Arterial punctures
- CO2 monitoring/trending
- Endotracheal suctioning
- Extubation
- Heated aerosol/heated aerosol treatments while patient on ventilator
- Oxygen
- Ventilator supplies

- 2.2.11** Allow one daily ventilator management charge or BiPAP while the patient is in the specialty care unit.
- 2.2.12** Allow Continuous Positive Airway Pressure (CPAP) while the patient/neonate is in the neonatal intensive care unit (NICU).
- 2.2.13** CPAP for routine use, including use for obstructive sleep apnea is not separately payable.
- 2.2.14** Charges for respiratory services provided in the inpatient setting other than at a specialty care unit are limited to one unit/charge per date of service regardless of the number of respiratory treatments and/or procedures provided. Examples include, without limitation, the following:
- Chest percussions if done by a respiratory therapist
 - Demonstration of Metered Dose Inhaler (MDI) use or respiratory equipment by a respiratory therapist
 - Heated aerosol and oxygen
 - Nebulizers
- 2.2.15** Charges for Routine Floor Stock items and supplies necessary or otherwise integral to the provision of a specific service or delivery of service in a specific location are considered routine and are not separately reimbursable. The use of these services is part of the administration of care at a hospital or skilled nursing facility and are used during the normal course of treatment, which may be related to and/or part of a separately reimbursable treatment.
- 2.2.16** Charges for Point of Care (POC) tests are generally not separately reimbursed. These tests are performed by facility nursing staff, at the site where patient care is provided as part of the room and board services.
- 2.2.17** KFHP follows commonly accepted standards to not reimburse for duplicative charges and claims. Such duplicative charges and claims are not reimbursable. According to Medicare guidelines, the hospital must install adequate billing procedures to avoid submission of duplicate charges or claims.
- 2.2.18** Over the counter drugs (OTC) or, drugs which can be self-administered by the patient, are often not separately reimbursed in an inpatient setting. OTC drugs are typically included in the overall inpatient reimbursement.
- 2.2.19** Routine administrative services are included in the room and board or outpatient facility reimbursement. Routine services in a hospital are those services included by the provider in a daily service charge, commonly referred to as "room and board" charge. Examples include, without limitation, the following:

- Room and board supplies
- Nursing administered services, such as medication administration, blood glucose monitoring, occult blood testing, wound care (including cleaning, dressing changes, and monitoring for infection), pulse oximetry, urine/blood specimen collection etc.
- Routine medical and surgical supplies, such as alcohol wipes, bed pans, blood pressure monitors/cuffs, cardiac monitors, cotton balls, gloves/gowns used by staff, ice bags/packs, heating pads, IV pumps, masks used by staff, saline solutions, syringes, thermometers, and patient gowns.

2.3 Implants - For more information please refer to POL 020.4 Clinical Review Implant Payment Determination Policy.

2.3.1 According to the Food and Drug Administration (FDA), implants are devices or materials placed surgically inside the body or surface of the body. Many implants are intended to replace body parts, monitor body functions or provide support to organs or tissues. KFHP does not allow reimbursement for implants that are not implanted in the member, deemed contaminated or considered waste.

2.3.2 Instruments that are designed to be removed or discarded during the same operative session during which they are placed in the body are not implants. In addition, implants must also remain in the member's body upon discharge from the inpatient stay or outpatient procedure. Staples, guide wires, sutures, clips, as well as temporary drains, tubes, and similar temporary medical devices are not considered implants. Therefore, no separate reimbursement shall be made.

3.0 Guidelines

N/A

4.0 Definitions

4.1 Centers for Medicare and Medicaid Services (CMS) Part of the Department of Health and Human Services (HHS) responsible for administering programs such as Medicare, Medicaid, and Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace.

4.2 Capital equipment ~~Items that are used by multiple patients during the lifetime of that piece of equipment.~~

4.3 Routine services Inpatient routine services in a hospital or skilled nursing facility are those services included in the providers daily service charge sometimes referred to as the "room and board" charge. Routine services are composed of two room and board components: (1) general routine services, and (2) special care units (SCU's), including coronary care units (CCU's) and intensive care units (ICU's).

- 4.4 Diagnosis Related Group (DRG)** A system of classifying or categorizing inpatient stay into relatively homogenous groups for the purpose of payment by CMS.
- 4.5 Personal care items** Items used by the patient for non-medical use such as hygiene and comfort.
- 4.6 Point of Care (POC) tests** Tests that are performed at site where patient care is provided. Point of care (POC) tests do not require the equipment or supplies of a CLIA lab nor the skills of licensed or certified technicians or technologists. Under the Clinical Laboratory Amendments of 1988 (CLIA), a POC must have a Certificate of Waiver license in order for the site to allow CLIA- waived POC testing.
- 4.7 Routine floor stock** Supplies that are available to all patients in the floor or area of a hospital or skilled nursing facility. These are supplies provided to a patient during the normal course of treatment. Personal care items are non-chargeable because they do not contribute to the meaningful treatment of the patient's condition.
- 4.8 Specialty care unit** A specialized unit located within a hospital that must be physically identified as separate from general care areas; the unit's nursing personnel must not be integrated with general care nursing personnel. The unit must be one in which the nursing care required is extraordinary and on a concentrated and continuous basis. Extraordinary care incorporates extensive lifesaving nursing services of the type associated with nursing services provided in burn, coronary care, pulmonary care, trauma, and intensive care units. Special life-saving equipment should be routinely available in the unit.
- 4.9 Room charge** A room and board or room care charge for a semi-private, private, or 3+ bedroom shall include the room, dietary services, all nursing care, personnel, and routine disposable or reusable equipment, supplies and items appropriate for that setting.
- 4.10 Inpatient** Patient whose condition requires treatment in a hospital or other health care facility, and when the patient is formally admitted to the facility by a doctor. It involves an overnight stay or prolongs the stay of a patient in a licensed healthcare facility.
- 4.11 Outpatient** Patient who receives medically necessary services at a hospital, clinic, or associated facility for diagnosis or treatment but has not formally been admitted on an inpatient basis.

5.0 References

Centers for Medicare & Medicaid Services website. Medicare Benefit Policy Manual. Chapter 1 – Inpatient Hospital Services Covered Under Part A. Section 40 – Supplies, Appliances, and Equipment

Centers for Medicare & Medicaid Services website. Medicare Claims Processing Manual. Chapter 4 – Part B Hospital (Including Inpatient Hospital Part B and OPPOS). Section 240 – Inpatient Part B Hospital Services

Centers for Medicare & Medicaid Services website. The Provider Reimbursement Manual – Part 1. Chapter 22 – Determination of Cost of Services. Sections 2202.4, 2202.6, 2202.8 and 2203

Centers for Medicare & Medicaid Services website. Medicare Claims Processing Manual. Chapter 20 – Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS). Section 210 – CWF Crossover Editing for DMEPOS Claims During an Inpatient Stay

National Uniform Billing Committee | NUBC

Test Complexities | Clinical Laboratory Improvement Amendments (CLIA) | CDC (CLIA section 2.1.1.10)

Implants and Prosthetics | FDA (implants section)

2.1.1.12 over the counter drugs: Medicare Benefit Policy Manual, Chapter 15, Section 50.5.3 and 50.5.4

2.1.1.11 Medicare claims processing manual chapter 1 section 120 for duplicate claims

2.1.1.8 American Association for Respiratory Care aarc-coding-guidelines.pdf

https://www.ssa.gov/OP_Home/ssact/title18/1886.htm

<https://www.cms.gov/regulations-and-guidance/guidance/transmittals/2017downloads/r475pr1.pdf>

<https://www.cms.gov/medicare/payment/prospective-payment-systems>

6.0 Related Topics

POL-020.2 Clinical Review Medical Record Review Payment Determination Policy

POL-020.3 Clinical Review Coding Payment Determination Policy

POL-020.4 Clinical Review Implant Payment Determination Policy

POL-020.5 Clinical Review 30 Day Readmission Payment Determination Policy

POL-020.6 Clinical Review Intraoperative Neuromonitoring (IONM) Payment Determination Policy

(Updated: 09/08/25)

[Revision History](#)

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POL-020.6 Clinical Review Intraoperative Neuromonitoring (IONM) Payment Determination Policy



This policy applies to all NCA markets, all lines of business.

1.0 Business Policy

1.1 Payment Policy Statement

- 1.1.1** Kaiser Foundation Health Plan (KFHP) requires accurate and complete claims submissions that follow proper billing and submission guidelines according to industry standard Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. In addition, documentation (such as medical records, office notes etc.) must support services billed. KFHP may request additional supportive documentation to further validate billing, coding, and clinical accuracy of billed services prior to finalizing reimbursement on billed service(s). KFHP, in the interest of its members, reviews claims to ensure that KFHP pays the appropriate amounts on claims and does not overpay or pay for improper charges. While KFHP does not dictate to providers how to bill their claims, the industry recognizes that certain billing practices can lead to non-payable charges. If appropriate coding/billing guidelines or current reimbursement policies are not followed or documented in the records, KFHP may, depending on the circumstances: reduce or deny the claim, or claim line, consider a claim line paid by virtue of payment of another claim line or the claim as a whole, or recover/recoup payment for claim processed in error. Unless otherwise noted within the policy, KFHP's reimbursement policies apply to contracted and non-contracted professional providers and facilities.
- 1.1.2** KFHP payment policies are not intended to cover every claim situation. KFHP policies may be superseded by state, federal and/ or provider contractual requirements. KFHP will align with all applicable regulatory, state and federal guidelines. KFHP will employ clinical discretion and judgement, and coding expertise in its interpretation and application of the policy, and all KFHP payment policies are routinely updated.
- 1.1.3** Kaiser recognizes commonly accepted standards to determine what items and/or services are eligible for separate reimbursement. Commonly accepted standards include but are not limited to the following:
- . American Academy of Professional Coders (AAPC) . American Medical Association (AMA)

- Associated Medical Societies (i.e.: American College of Obstetricians and Gynecologists (ACOG), American Academy of Family Physicians (AAFP), etc.)
- American Health Information Management Association (AHIMA)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- CMS Local Coverage and National Coverage Determinations (LCD NCD)
- CMS Manuals and Publications
- CPT Assistant
- CPT Manual, including code definitions and associated text
- Federal Register
- HCPCS Manual, including code definitions and associated text
- Integrated Outpatient Code Editor (I/OCE)
- International Classification of Diseases, 10th Revision (ICD-10-CM) official guidelines for coding and reporting
- Medically Unlikely Edits
- National Correct Coding Initiative Policy Manual for (NCCI)
- National Physician Fee Schedule Relative Value File
- National Uniform Billing Committee (NUBC)
- Professional and academic journals and publications

1.2 Scope

- 1.2.1** This policy outlines Kaiser's requirements for the review and reimbursement of Intraoperative Neuromonitoring (IONM) services. This policy applies to contracted and non-contracted providers across all lines of business, unless otherwise specified.
- 1.2.2** Clinical Review will evaluate submitted documentation to determine the medical appropriateness and/or medical necessity of IONM services in accordance with Kaiser medical policy for Intraoperative Neuromonitoring. The review process ensures that claims are submitted in compliance with federal and state regulations, industry-standard coding practices, and evidence-based literature.

- 1.2.3** Clinical Review will apply Kaiser's IONM Medical Policy criteria, and applicable regulatory, state, and federal guidelines to determine whether IONM services are reimbursable or non-reimbursable, based on the member's benefit plan.

2.0 Rules

2.1 Criteria

~~**2.1.1** This payment policy aligns with Kaiser's internal~~ IONM Medical Policy. The criteria was established using evidence-based guidelines and nationally recognized standards to determine the medical necessity of services. Medical necessity and appropriateness requirements apply.

2.1.2 IONM is considered medically necessary only when performed for high-risk surgical procedures with a demonstrated benefit in reducing neurological complications. Standards are reviewed and updated regularly to reflect current clinical evidence and regulatory requirements.

- Charges related to intraoperative monitoring are billed on a HCFA 1500 claim form for professional charges. Any charges related to IONM billed on a UB form are not reimbursable.
- Codes for automated monitoring devices that do not require continuous attendance by someone who is qualified to interpret the information should not be reported separately.
- Kaiser will consider IONM for reimbursement when performed in place of service (POS) 19, 21, 22, or 24.
- Recording and testing are performed either personally by the surgeon or anesthesiologist, or by a technologist who is physically present with the patient during the service.
- Remote monitoring can be performed by a qualified professional using a real-time audio and visual connection.

2.1.3 Kaiser will not consider additional reimbursement when IONM is performed by the surgeon or anesthesiologist. In this case, the professional services are included in the primary service code(s) for the procedure and should not be reported separately.

2.1.4 Accurate coding is essential for appropriate reimbursement of IONM services. Standard coding guidelines should be followed, with all claim information supported by the medical record:

- IONM codes should be reported based upon the time spent monitoring only, and not the number of baseline tests performed, or parameters monitored.

- The monitoring professional should be solely dedicated to the intraoperative neurophysiologic monitoring service, and available to intervene immediately, if necessary, throughout the duration of the procedure.
- Time reported should not include items such as time to set up, record, and interpret baseline studies, time to remove electrodes at the end of the procedure, or standby time.

3.0 Guidelines

N/A

4.0 Definitions

- 4.1 Intraoperative Neuromonitoring (IONM)** The use of electrophysiological techniques to monitor the functional integrity of neural structures (e.g., spinal cord, brain, ~~cranial nerves~~) during surgical procedures that pose a risk of neurological injury.
- 4.2 Real-Time Supervision** Continuous monitoring and interpretation of IONM data by a qualified physician who is immediately available via telecommunication and in direct communication with the surgical team throughout the procedure.
- 4.3 Technologist** A trained and credentialed individual who performs IONM in the operating room under the supervision of a qualified physician. The technologist must be present for the entire procedure and may not perform other clinical duties.
- 4.4 Supervising Physician** A licensed physician with expertise in neurophysiology who provides real-time interpretation of IONM data. The supervising physician must not be the operating surgeon or anesthesiologist.
- 4.5 CPT/HCPCS Codes** Standardized codes used to report medical procedures and services. For IONM, these include CPT codes 95940, 95941, and HCPCS code G0453.

5.0 References

American Medical Association (AMA). CPT® Manual and CPT® Assistant

CMS Article A56722. Billing and Coding: Intraoperative Neurophysiological Testing

Healthcare Common Procedure Coding System (HCPCS) Manual

International Classification of Diseases, 10th Revision (ICD-10-CM) – Official Guidelines for Coding and Reporting

National Correct Coding Initiative (NCCI) Policy Manual

National Uniform Billing Committee (NUBC) – UB-04 Data Specifications Manual

6.0 Related Topics

POL-020.1 Clinical Review Itemized Bill Review Payment Determination Policy

POL-020.2 Clinical Review Medical Record Review Payment Determination Policy

POL-020.3 Clinical Review Coding Payment Determination Policy

POL-020.4 Clinical Review Payment Implant Determination Policy

POL-020.5 Clinical Review 30 Day Readmission Payment Determination Policy

(Updated: 09/08/2025)

[Revision History](#)

[Approvals](#)

POL-020.5 Clinical Review 30 Day Readmission Payment Determination Policy



This policy applies to all NCA markets, all lines of business.

1.0 Business Policy

1.1 Payment Policy Statement

- 1.1.1** Kaiser Foundation Health Plan (KFHP) requires accurate and complete claims submissions that follow proper billing and submission guidelines according to industry standard Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. In addition, documentation (such as medical records, office notes etc.) must support services billed. KFHP may request additional supportive documentation to further validate billing, coding, and clinical accuracy of billed services prior to finalizing reimbursement on billed service(s). KFHP, in the interest of its members, reviews claims to ensure that KFHP pays the appropriate amounts on claims and does not overpay or pay for improper charges. While KFHP does not dictate to providers how to bill their claims, the industry recognizes that certain billing practices can lead to non-payable charges. If appropriate coding/billing guidelines or current reimbursement policies are not followed or documented in the records, KFHP may, depending on the circumstances: reduce or deny the claim or claim line, consider a claim line paid by virtue of payment of another claim line or the claim as a whole, or recover/recoup the claim processed for payment in error. Unless otherwise noted within the policy, KFHP's reimbursement policies apply to contracted and non-contracted professional providers and facilities.
- 1.1.2** KFHP payment policies are not intended to cover every claim situation. KFHP policies may be superseded by state, federal and/ or provider contractual requirements. KFHP will align with all applicable regulatory, state and federal guidelines. KFHP will employ clinical discretion and judgement, and coding expertise in its interpretation and application of the policy, and all KFHP payment policies are routinely updated.
- 1.1.3** KFHP recognizes commonly accepted standards to help determine what items and/or services are eligible for separate reimbursement. Commonly accepted standards include but are not limited to the following:
- . American Academy of Professional Coders (AAPC) . American Medical Association (AMA)

- Associated Medical Societies (i.e.: American College of Obstetricians and Gynecologists (ACOG), American Academy of Family Physicians (AAFP), etc.)
- American Health Information Management Association (AHIMA)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- CMS Local Coverage and National Coverage Determinations (LCD NCD)
- CMS Manuals and Publications
- CPT Assistant
- CPT Manual, including code definitions and associated text
- Federal Register
- HCPCS Manual, including code definitions and associated text
- Integrated Outpatient Code Editor (I/OCE)
- International Classification of Diseases, 10th Revision (ICD-10-CM) official guidelines for coding and reporting
- Medically Unlikely Edits
- National Correct Coding Initiative Policy Manual for (NCCI)
- National Physician Fee Schedule Relative Value File
- National Uniform Billing Committee (NUBC)
- Professional and academic journals and publications

1.2 Scope

- 1.2.1** This policy provides an overview of KFHP's review of institutional/facility claims that are readmissions for the same member to the same hospital or hospital system, that fall within 30 days of discharge. This policy applies to contracted and non-contracted providers across all lines of business, unless otherwise specified. Clinical Review will review the medical records to determine if the claim is a continuation of care or readmission, unrelated to the first claim for the same hospital or hospital system within 30 days for the same member with the same, similar or related diagnoses.

2.0 Rules

2.1 The Clinical Review department will request/ review medical records to determine if the readmission within 30 days was continuation of care or a readmission to the same hospital or health system. When medical records or clinical information is requested, all the specific information required to make the medical determination must be clearly documented in the records.

2.2 KFHP follows Centers for Medicare and Medicaid Services (CMS) guidelines for Readmissions within 30 calendar days of discharge from the initial admission. Payment for a readmission to the same hospital or hospital system within 30 calendar days may be denied if the admission was deemed preventable, medically unnecessary or was due to a premature discharge of the prior admission.

2.3 Reimbursement Guidelines

2.3.1 KFHP does not allow separate reimbursement for claims that have been identified as readmission to the same hospital or hospital system reimbursed by DRG pricing for the same, similar or related condition unless provider contracts, state, federal or CMS requirements indicate otherwise. In the absence of provider, federal, state and/or contract mandates, KFHP will use the following standards: (a) readmission within 30 days of discharge; (b) for the same member with the same, similar or related diagnoses.

2.3.2 KFHP will use clinical criteria and licensed clinical professionals as part of the review process for readmissions from day 2 to day 30 in order to determine if the second admission is for:

- A need that could have reasonably been prevented by the provision of appropriate care consistent with accepted standards in the prior discharge.
- An acute decompensation of a coexisting chronic disease.
- An infection or other complication of care.
- An issue caused by a premature discharge from the same hospital or hospital system.
- Condition or procedure is indicative of a failed surgical intervention.
- The same, similar or related diagnoses or procedure as the prior discharge.

2.4 Preventable/Inappropriate Readmissions

2.4.1 Readmissions which are deemed preventable or considered inappropriate pursuant to the following criteria may be denied:

- A medical complication related to care during the previous admission.

- A medical readmission for a continuation or recurrence for the previous admission or closely related condition
- The readmission resulted from a failure of proper coordination between the inpatient and outpatient health care teams
- An unplanned readmission for surgical procedure to address:
 - Complication or recurrence of a problem causing this admission.
 - Complications related to Serious Reportable Events (SREs)
 - Suspected complication that was not treated prior to discharge.
 - Surgical procedure to address a complication resulting from care from the previous admission.
- The readmission resulted from a failure of proper and adequate discharge planning.
- The readmission resulted from a premature discharge or is related to the previous admission, or that the readmission was for services that should have been rendered during the previous admission.
- If a readmission falls under one of the criteria listed above and KFHP denies the claim, the hospital may not bill the member for the readmission

3.0 Guidelines

3.1 Exclusions

~~3.1.1~~ Exclusions from the criteria listed above may apply. Examples include but are not limited to:

- Admissions associated with malignancies (limited to those who are in an active chemotherapy regimen-both infusion and oral), burns, or cystic fibrosis.
- Admissions with a documented discharge status of "left against medical advice."
- Behavioral health readmissions.
- In-network facilities that are not reimbursed based on contracted DRG or case rate methodology (e.g., per diem).
- Obstetrical readmissions for birth after an antepartum admission.

- Readmissions that are planned for repetitive treatments such as cancer chemotherapy, transfusions for chronic anemia, for similar repetitive treatments, or for elective surgery. These include:
 - Transfers from one acute care hospital to another.
 - Critical Access Hospitals (CAHs).
 - Exclusions for the Washington State region ONLY: (a) Readmission due to patient nonadherence; (b) End-of-life and hospice care; (c) Obstetrical readmissions for birth after an antepartum admission; (d) Neonatal readmissions; (e) Transplant readmissions within 180 days of transplant.
- Substance use readmissions.
- Transplant services (within 180 days of transplant), including organ, tissue, or bone marrow transplantation from a live or cadaveric donor.

4.0 Definitions

- 1.1 Centers for Medicare & Medicaid Services (CMS)** Part of the Department of Health and Human Services (HHS) who administers programs such as Medicare, Medicaid, and ~~Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace.~~
- 1.2 Readmission** A subsequent inpatient admission to any acute care hospital which occurs within 30 days of the discharge date; excluding any exceptions or planned readmissions.
- 1.3 Planned Readmissions** A non-acute admission for a scheduled procedure for limited types of care that may include, obstetrical delivery, transplant surgery, maintenance of chemotherapy/radiotherapy/immunotherapy.
- 1.4 Preventable Readmissions** A readmission within a specific time frame that is clinically related and may have been prevented had appropriate care been provided during the initial hospital stay and discharge process.

5.0 References

- 1.5** Centers for Medicare & Medicaid Services (CMS). Medicare Claims Processing Manual. Chapter 3: Inpatient Hospital Billing. §40.2.4: IPPS Transfers Between Hospitals. Part A: Transfers Between IPPS Prospective Payment Acute Care Hospitals; p.116. [CMS Web site]. 12/10/10. Available at: <http://www.cms.gov/manuals/downloads/clm104c03.pdf>. Accessed ~~September 29, 2011.~~
- 1.6** Centers for Medicare & Medicaid Services (CMS). Medicare Learning Network. Acute Care Hospital Inpatient Prospective Payment. [CMS Web site]. 12/17/10. Available

at: <http://www.cms.gov/MLNProducts/downloads/AcutePaymtSysfctsht.pdf>. Accessed September 29, 2011

1.7 [Hospital-Acquired Condition Reduction Program | CMS](#)

1.8 [Medicare Claims Processing Manual \(CMS-Medicare Claims Processing Manual, Chapter 3: Inpatient Hospital Billing\)](#)

6.0 Related Topics

POL-020.1 Clinical Review Itemized Bill Review Payment Determination Policy POL-020.2

Clinical Review Medical Record Review Payment Determination Policy POL-020.3 Clinical

Review Coding Payment Determination Policy POL-020.4 Clinical Review Implant Payment

Determination Policy

POL-020.6 Clinical Review Intraoperative Neuromonitoring (IONM) Payment
Determination Policy

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