8.0 Claims

As a Participating Provider billing for services with a fee-for-service contract with the Mid-Atlantic Permanente Medical Group (MAPMG), please follow the procedures listed below. Participating Providers billing for services rendered to Flexible Choice members, see Chapter 15 of this manual.

8.1 Methods of Claim Filing

Electronic Data Interchange (EDI)
Electronic Claim Submissions: Kaiser Permanente encourages electronic submission of claims.

EDI is an electronic exchange of information in a standardized format that adheres to all Health Insurance Portability and Accountability Act (HIPAA) requirements. EDI transactions replace the submission of paper claims. Required data elements (for example, claims data elements) are entered into the computer only ONCE - typically at the provider's office or at another location where services were rendered.

Benefits of EDI Submission

- Reduced overhead expenses: Administrative overhead expenses are reduced, because the need for handling paper claims is eliminated.
- Improved data accuracy: Because the claims data submitted by the Provider is sent electronically to Kaiser Permanente via the clearinghouse, data accuracy is improved, as there is no need for re-keying or re-entry of data.
- Low error rate: Additionally, "up-front" edits applied to the claims data while information is being entered at the provider's office, and additional payer-specific edits applied to the data by the clearinghouse before the data is transmitted to the appropriate payer for processing, increase the percentage of clean claim submissions.
- Bypass U.S. mail delivery: The usage of envelopes and stamps is eliminated. Providers save time by bypassing the U.S. mail delivery system.
- Standardized transaction formats: Industry-accepted standardized medical claim formats may reduce the number of "exceptions" currently required by multiple payers.

Electronic Claims Forms / Submission
Kaiser Permanente accepts all claims submitted by mail or electronically.
Professional and facility claims can be submitted electronically via the current version of:

- 837P must be used for all professional services and suppliers
- 837I must be used by all facilities (e.g., hospitals)

Standardized Transaction Formats
Industry- accepted standardized medical claim formats may reduce the number of "exceptions" currently required by multiple payers.

Supporting Documentation for EDI Claims

Kaiser Permanente offers an electronic solution, Online Affiliate, for submitting supporting documents. You can easily view pending Kaiser Permanente Requests for Information in a new Request for Information Activity tab. You can quickly determine which claims require additional documentation for processing by navigating to the Online Affiliate Request for Information Activity tab. You will be presented with the Kaiser Permanente claim number, date of request, and reason we are requesting additional information.

Otherwise, Kaiser Permanente will request supporting documentation by sending a request for information (RFI) letter via USPS, which can be responded to via Online Affiliate.

To submit electronically or enroll for access to Online Affiliate, navigate to kp.org/providers/mas and select **Online Provider Tools** from the Provider Resources menu.

Coordination of Benefits Claims Submissions
Specific 837 data elements work together to coordinate benefits between Kaiser and other carriers. Following the Provider-to-Payer-to-Provider model;

The provider sends the 837 to the primary payer. The primary payer adjudicates the claim and sends an 835 Payment Advice to the provider.

The 835 includes the claim adjustment reason code and/or remark code for the claim.
Upon receipt of the 835, the provider sends a second 837 with COB information populated in Loops2320, 2330A-G, and/or 2430 to the secondary payer. The secondary payer adjudicates the claim and sends an 835 Payment Advice to the provider.

Kaiser recognizes submission of an 837 transaction to a sequential payer populated with data from the previous payer's 835. Based on the information provided and the level of policy, the claim will be adjudicated without the paper copy of the Explanation of Benefits from Medicare or the primary carrier.

When more than one payer is involved on a claim, data elements for all prior payers must be present (i.e., if a tertiary payer is involved, then all the data elements from the primary and secondary payers must also be present).

Contact your clearinghouse for assistance sending COB claims electronically.

To Initiate Electronic Claims Submissions
Trading partners or trading parties interested in implementing EDI transactions with Kaiser Permanente should contact EDI Support for information by opening a support case at https://kpnationalclaims.my.site.com/EDI/s/.

Providers with existing electronic connectivity, please use the payor ID list below:
The Kaiser Permanente Mid-Atlantic States payor IDs are as follows:

- Office Ally: 52095
- Availity: 54294
- SSI: 52095
- Relay Health Alternate IDs: RH010 & NG008

Electronic Payment and Remittance Advice
Kaiser Permanente has partnered with Citi Payment Exchange to provide a portal for enrolling in Electronic Fund Transfer (EFT) and Electronic Remittance Advice (ERA). With this partnership, Kaiser Permanente requests that all vendors pursuing EFT/ERA enrollments utilize the Payment Exchange portal for enrollment and changes to existing EFT/ERA. The portal is open 24 hours a day and 7 days a week for new enrollments or changes.

Reduce turn-around-time for receipt of payments and remove overhead costs associated with handling paper correspondence by signing up for EFT/ERA today. Each Kaiser Permanente region requires a separate enrollment.

Create a new enrollment for EFT/ERA in the Mid-Atlantic region - Click here to enter a secure portal. Activation code R4GWM4 is required at login.

Paper Claim Forms
Professional charges must be submitted on a preprinted OCR red lined CMS-1500 v 0212 form (or successor form) with current ICD-10 diagnostic and CPT-4 procedure coding (or successor coding accepted commonly in the industry). Entries must be completed in accordance with National Uniform Claim Committee (NUCC) directions and contain all mandatory entries, and as required by applicable statutes and regulations. Reference material can be found at WWW.NUCC.ORG.

Institutional charges must be submitted using a preprinted OCR red lined UB-04 claim form (or successor form) with appropriate coding. Entries must be completed in accordance with National Uniform Billing Committee (NUBC) directions and contain all mandatory entries, and as required by applicable statutes and regulations. Reference material can be found at WWW.NUBC.ORG

Kaiser Permanente does not accept claims that are handwritten, faxed or photocopied.

All claims/bills should be mailed to:

Mid-Atlantic Claims Administration
Kaiser Permanente
P.O. Box 371860
Denver, CO 80237-9998

Payment is generally made within thirty (30) days of receiving the claim/bill. Providers may check the status of a claim/bill submitted for payment electronically using Online Affiliate. Any questions related to a previously submitted claim, billing, or utilization will need to be directed to Online Affiliate using the claim features. The claims features allows users to do the following:

- View detailed claim information
- Perform the following “Take Action” on a claim:
  - Submit a claim inquiry related to ‘denied’ or ‘in progress’ claims
  - Submit an inquiry related to a check payment, receive a copy of a check or report a change of address for a specific claim.
  - Submit appeals or disputes – request a reconsideration of a payment
  - Respond to Kaiser Permanente request for information (RFI)

You can find out more information or enroll with Online Affiliate by going to kp.org/providers/mas and selecting **Online Provider Tools** from the Provider Resources menu.

Timely Filing Requirements
Claims/bills for services provided to non-Medicare members must be received within one hundred eighty (180) calendar days of the date of service to be considered for processing and payment.

Claims/bills for services provided to Medicare Advantage members must be received within 12 months (365 days) unless their contract or letter of agreement (LOA) differs.

8.2 Clean Claim

Kaiser Permanente considers a claim "clean" when the following requirements are met:

- Correct Form: Kaiser Permanente requires all professional claims to be submitted using the 837P EDI Format or Original Red Industry Standard CMS Form 1500 ver 02/12, and all facility claims (or appropriate ancillary services) to be submitted using the 837I EDI Format or CMS Form 1450 (UB04) based on CMS guidelines.
- Standard Coding: All fields should be completed using industry standard coding.
- Applicable Attachments: Attachments should be included in your submission when circumstances require additional information.
- Completed Field Elements for 837P/CMS Form 1500 (02/12 based on CMS guidelines) Or 837I/CMS 1450 (UB-04 based on CMS guidelines): All applicable data elements of CMS forms should be completed.

A claim is not considered to be "clean" or payable if one or more of the following are missing or are in dispute:

- The format used in the completion or submission of the claim is missing required fields or codes are not active.
- The eligibility of a member cannot be verified.
- The service from and to dates are missing.
- The rendering physician is missing or incorrect (all claims submitted to Kaiser Permanente must include the name and NPI number of the physician, practitioner, or clinician who rendered the services reported on the claim form).
- The vendor is missing.
- The diagnosis is missing or invalid.
- The place of service is missing or invalid.
- The procedures/services are missing or invalid.
- The amount billed is missing or invalid.
- The number of units/quantity is missing or invalid.
- The type of bill, when applicable, is missing or invalid.
- The responsibility of another payor for all or part of the claim is not included or sent with the claim.
- Other coverage has not been verified.
- Additional information is required for processing such as COB information, operative report or medical notes (these will be requested upon denial or pending of claim).
- The claim was submitted fraudulently.
- The claim does not comply with coding standards (detailed in Sections 5.39-5.40 of this Provider Manual).
- The original claim number for any corrected or voided claim submission (see Sections 5.30 Fully Funded: Claim Adjustments/Corrections (Retrospective or Otherwise), 5.31 Self-Funded: Claim Adjustments/Corrections (Retrospective or Otherwise), and the section for Correcting a Previously Submitted Claim).

Clean claims for covered benefits will be processed according to jurisdictional regulations and paid, unless covered under a capitation agreement. Inaccurate coding may result in claim processing and payment delays. As many factors are considered in the processing of a

claim, we note that a pre-authorized referral does not guarantee payment, except under very limited conditions.

Coding Standards
Coding – All fields should be completed using industry standard coding as outlined below.

Code Set	Standard
CPT-4 (Current Procedure Terminology)	Maintained and distributed by the American Medical Association, including its codes and modifiers, and codes for anesthesia services
CDT-1 (The Code on Dental Procedures and Nomenclature)	Maintained and distributed by the American Dental Association
ICD-10 CM (International Classification of Diseases, Clinical Modification)	Maintained and distributed by the U.S. Department of Health and Human Services
HCPCS and **Modifiers** (Healthcare Common Procedure Coding System)	Maintained and distributed by the U.S. Department of Health and Human Services
NDC (National Drug Codes)	Prescribed drugs, maintained and distributed by the U.S. Department of Health and Human Services
ASA (American Society of Anesthesiologists)	Anesthesia services, the codes maintained and distributed by the American Society of Anesthesiologists
DSM-IV (American Psychiatric Services)	For psychiatric services, codes distributed by the American Psychiatric Association
Revenue Code	Approved by the Health Services Cost Review Commission for a hospital located in the State of Maryland, or of the national or state uniform billing data elements specifications for a hospital not located in that State

Supporting documentation is required only when requested upon the denial or pending of a claim. The need for this information will be indicated by the remark codes returned on the 835 electronic transaction or paper remittance advice. Your claim will not be reprocessed until the information is received. Any claim supporting documentation can be submitted via Online Affiliate (refer to page 6 for details).

When billing with an unlisted CPT code, to expedite claims processing and adjudication, providers should submit supporting written documentation.

Telehealth
Telehealth is the mode of delivering health care services via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care. All laws regarding the confidentiality of health care information and a patient's rights to the patient's medical information shall apply to telehealth interactions. Kaiser Permanente follows federal and state guidelines related to the specific services which may be eligible for telehealth.

Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions, and asynchronous store-and-forward transfers. Telehealth may be conducted using audio and video or audio only.

Reimbursements for telehealth continue to evolve, so it is important to reference resources on billing and reimbursement for Medicare, Medicaid, and private insurers. Kaiser Permanente will process claims for payment with the appropriate CPT-4 or HCPCS codes when coding for services delivered by telehealth, for both synchronous and asynchronous interactions.

Claims Editing Software Program
Services must be reported in accordance with the reporting guidelines and instructions contained in the American Medical Association (AMA) CPT Manual, "CPT® Assistant," HCPCS publications, CMS guidelines and other industry coding guidelines. Providers are responsible for accurately reporting the medical, surgical, diagnostic, and therapeutic services rendered to a member with the correct CPT and/or HCPCS codes, and for appending the applicable modifiers, when appropriate. Provider documentation must support services billed.

Claims are processed utilizing claims editing software product ClaimsXten Portfolio. ClaimsXten includes edit rules such as incidental, bundled and mutually as well as other edits that are recognized by industry guidelines. ClaimsXten is updated at a minimum quarterly. The software is reviewed on a regulatory basis to ensure that the clinical content used in ClaimsXten is clinically appropriate and withstands the scrutiny of both payers and providers.

The code edit software may change and edit your claim, perhaps substantially, as a result of industry coding guidelines. When a change is made to your submitted code(s), Kaiser Permanente will provide an explanation of the reason for the change.

Possible outcomes include:

- Accepting the code(s) as submitted.
- Adding a new code to a claim to comply with generally accepted coding practices that are consistent with Physicians CPT, the HCPCS Code Book.
- Denying services for outdated or invalid codes.
- Denying line items for coding guidelines such as medically unlikely or CMS' National Correct Coding Initiative (NCCI).
- Deny services for bundling or unbundling codes as appropriate.
- Denying code(s) as incidental or inherent part of the more global code billed.
- Seeking additional information from the physician's office due to inconsistent information in the claim.

Fraudulent coding will be investigated by Kaiser Permanente. In addition, individual physician evaluation and management coding statistics are routinely trended and compared with national statistics. Aberrant coding statistics may result in contract termination and investigation by federal regulators.

8.3 Multiple Procedure Reimbursement Policy*

Multiple procedures performed in the same operative session will be reimbursed at 100% of the rate indicated for the first procedure from the highest payment group. All other procedures will be paid at 50% of respective rates.

*This policy applies to the professional service component only

Claim Code Edits and Descriptions

Supplies on the same day as surgery – CMS has established that certain supplies should be denied when billed on the same day as surgical procedures for which the concept of the global surgical package applies.

Bundled service – Identifies procedures indicated by CMS as always bundled when billed with any other procedure.

According to CMS, certain codes are always bundled when billed with other services on the same date of service.

Deleted procedure codes – Identifies deleted service and procedure codes that were in past editions of the CPT and HCPCS books.

CMS does not permit reimbursement of AMA deleted codes when they are submitted after the deletion date and beyond the permitted submission period.

Inappropriate procedure for gender – Identifies procedures that are inconsistent with the member's gender

Duplicate line items – Identifies duplicate line items; those claim lines that match previously submitted claim lines.

Global surgical package – Procedure codes have a time frame associated with them which includes services and supplies associated with the procedure. The time frames are set by both CMS and broadly accepted industry sources.

Modifier validation – According to CMS or industry accepted standards, the professional component modifier should have been reported for services rendered in this place of service.

New patient code – The AMA has established that a provider practice can only bill a patient code as new once every three years.

According to AMA, add-on procedures are to be listed in addition to the primary (base code) procedure) . Primary (base code) procedures are typically billed with a quantity of one. When a provider is billing a primary (base code) procedure with quantity of (1) one, those additional services beyond the primary (base code) procedure should be billed as add-on codes.

Inappropriate CPT to modifier combination – Certain procedure codes and modifier combinations are not appropriate.

Medical Imaging: 3D rendering and interpretation of CT, MRI, US and rereads of imaging studies – Kaiser Permanente considers 3D rendering of imaging studies to be included in the reimbursement for most imaging studies performed and 3D rendering of CT, MRI or US imaging will not be separately reimbursed. When reimbursed, the 3D rendering must be ordered by the provider ordering the study and the 3D imaging is referred to in the resulting report and interpretation. This policy does not apply to breast tomosynthesis (3D Mammography). Additionally, reimbursement for the same service more than once represents duplicate reimbursement. This includes multiple interpretations of the same diagnostic study (e.g., imaging or laboratory service). Kaiser Permanente will not reimburse subsequent

interpretation or reviews of medical imaging exams performed in the same place of service or elsewhere.

8.4 Clinical Review

The National Clinical Review (NCR) team reviews facility and professional claims to ensure that providers comply with commonly accepted standards of coding and billing, that services rendered are appropriate and Medically Necessary, and that payment is made in accordance with any applicable provider contract and/or Provider Manual, as well as member benefit requirements. If we do not have enough information to adjudicate a claim, we will mail you a request for specific additional medical records. We may also request itemized bills.

Clinical Review Payment Determination Policy uses sources of commonly accepted standards of coding and billing such as CMS guidelines and practice, the National Uniform Billing Committee (NUBC), the National Correct Coding Initiative (NCCI), professional specialty organizations (e.g., American College of Surgeons, American Academy of Orthopaedic Surgeons), and state and federal mandates. Kaiser Permanente medical policies and other publicly available industry policies and standards, professional and academic journals and publications such as the American Medical Association Current Procedural Terminology (CPT).

If you would like more information about commonly accepted standards applied by Kaiser Permanente, please contact Kaiser Permanente Member Services at 1-800-777-7902.

Examples of these standards include, but are not limited to:

Edit	Description
Medical Necessity	A determination of medical necessity must adhere to the standard of care and always be made on a case-by-case basis that applies to the actual direct care and treatment of the patient.
Trauma Activation	Trauma activation is only payable when all criteria based on CMS guideline are met, including that the invoice contain a charge for critical care (CPT 99291/99292).
3-day Look Back	Medicare 3-day look back rule requires that certain hospital outpatient services and services rendered under Part B entities such as ambulatory care centers, wholly owned or operated hospitals, be bundled/included in the hospital's claim for inpatient stay.
Multiple Procedure Payment Reductions – Facility Cardiac and Ophthalmology	When services are performed at the same patient encounter, there is an overlap of the pre-procedure and post-procedure work. Kaiser Permanente will apply payment reductions as indicated by CMS.
Intra Operative Neuromonitoring (IONM)	IONM is utilized to minimize neurological morbidity from operative manipulations. Reimbursement for IONM will be based on Kaiser Permanente's Payment Determination Policy and IONM criteria.

Multiple Procedure Payment Reduction (MPPR) for Diagnostic Imaging Services	Adhering to CMS guidelines, Kaiser Permanente will apply reductions to the secondary and subsequent technical component for diagnostic imaging procedures when multiple services are furnished at the same facility to the same patient in the same session on the same day. The technical component is for the use of equipment, facilities, non-physician medical staff, and supplies. The imaging procedure with the highest technical component is paid at 100% of the contractual allowable and the technical components for additional less-technical services in the same code family will be reduced by 50% of the contractual allowable. For additional information on the MPPR for diagnostic imaging services, go to www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/r995otn.pdf.
Emergency Department Claim Evaluation and Management (E/M) Coding Review (Effective January 1, 2022, for DC and Virginia facilities; effective January 1, 2024, for MD facilities)	To ensure coding accuracy for outpatient emergency department claims, Kaiser Permanente uses the Optum EDC Analyzer tool for claims that are submitted with levels 3 through 5 E/M codes 99283 through 99285. For more information on this review, go to www.EDCAnalyzer.com.
30-Day Readmission	In accordance with CMS' Hospital Readmissions Reduction Program (HRRP), Kaiser Permanente will not allow separate reimbursement for claims that have been identified as a readmission, within 30 days of a previous discharge, to the same hospital for the same, similar or related condition unless provider, state, federal, or CMS contract and/or requirements indicate otherwise. Kaiser Permanente will perform retrospective utilization and case management review and issue coverage denial notices for non-covered services. Kaiser Permanente will use the following standards in the review: a. Readmission within 30 days from discharge b. Same diagnosis or diagnoses that fall into the same grouping For more information on the HRRP, go to www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.
Level of Care Review	Level of Care (LOC) Review applies to inpatient claims. Review of facility claims ensure that the level of care being billed matches the LOC that was authorized so that appropriate reimbursement is made. The review will entail reviewing the days billed for each level of care to match what is billed.

	If a provider bills for additional days on a higher level of care than what is billed, the claim will be denied, and the provider will submit a corrected claim for payment.

8.5 Reimbursement Policy for Comprehensive and Component Codes

When two (2) or more related procedures are performed on a patient during a single session or visit, there are instances when a claim is submitted with multiple codes instead of one comprehensive code that fully describes the entire service. Kaiser Permanente will allow the comprehensive procedure code.

The specific procedure code relationships in this Reimbursement Policy are modeled after The Correct Coding Initiative (CCI) administered through the CMS, AMA CPT and other general industry-accepted guidelines.

Same Service/Same Code Billed by Multiple Providers - In accordance with CMS Medicare guidelines for payment of claims, Kaiser Permanente will only pay for an "interpretation and report" of an x-ray or an echocardiogram (EKG) procedure and not a "review" of the same procedures. As defined in the Medicare claims manual, an interpretation and report should address the findings, relevant clinical issues, and comparative data (when available). A professional component billing based on a "review" of the findings of the procedure without a complete, written report similar to that which would be prepared by a specialist in the field, does not meet the conditions for a separate payment.

Exceptions to this policy will only be made under unusual circumstances for which documentation is provided justifying a second interpretation. The studies subject to this policy are:

- EKG
- Neurological testing such as electroencephalogram (EEG)
- X-rays, plain films, ultrasound, magnetic resonance imaging (MRI), computed tomography (CT), positron emission tomography (PET), and fluoroscopy studies

8.6 Evaluation and Management (E&M) on Same Day as Surgery

When a Kaiser Permanente Participating Provider performs an established E&M or inpatient/outpatient consult procedure on the same day a surgical procedure is performed, the E&M procedure is included in the fee for the surgical procedure. The fee for certain supplies associated with the procedure is also included in the reimbursement for the surgical procedure. In some cases, an appropriate modifier will override this adjustment.

8.7 Global Surgical Package (GSP)

A global period for surgical procedures is a long-established concept under which a "single fee" is billed and paid for all services rendered by a surgeon before, during, and after the procedure. According to CMS, the services included in the global surgical package may be furnished in any setting. (i.e., hospital, ambulatory surgery center, physician's office) Kaiser Permanente's GSP policy follows CMS guidelines with respect to the timeframes assigned to each global surgical procedure. All procedures with an entry of 10 or 90 days in the Medicare Fee Schedule Database (MFSDB) are subject to Kaiser Permanente's GSP Policy.

Under the GSP Policy, the fee for any evaluation and management procedure performed within the follow-up period is included in the reimbursement for the surgical procedure. The fee for the certain supplies associated with the procedure is also included in the reimbursement for the global surgical procedure if used within the follow-up period. If a Kaiser Permanente Participating Provider bills for such services and supplies separately, Kaiser Permanente will indicate on the claim that reimbursement for such services is included in the payment of the global surgical code.

8.8 Do Not Bill Event Policy

Kaiser Permanente adheres to guidelines and policies established by the CMS.

The Health Plan's "Do Not Bill Event" policy is based on payment rules that waive fees for all or part of health care services directly related to the occurrence of certain adverse events as defined by the CMS National Coverage Determinations (NCD) for surgical errors and the published listing of CMS Hospital Acquired Conditions (HACs). The "Do Not Bill Event" policy will apply to all claims for Health Plan Members enrolled in the Kaiser Permanente Medicare Advantage plan as well as those claims for Members enrolled in Commercial Health Plan products such as the Kaiser Permanente Signature℠ and Select plans.

Surgical "Do Not Bill Events" include an event in <u>any</u> care setting related to:

- Wrong surgical or invasive procedure(s) performed on a patient;
- Surgical or other invasive procedure(s) performed on the wrong part of the body;
- Surgical or other invasive procedure(s) performed on the wrong patient; and
- Unintended retention of a foreign object after surgery or procedure.

HACs include a condition or event that occurs in a general hospital or acute care setting. The 14 categories of HACs are listed below:

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Stage III and IV Pressure Ulcers
- Falls and Trauma:
  - Fractures
  - Dislocations
  - Intracranial Injuries
  - Crushing Injuries
  - Burns
  - Other Injuries
- Manifestations of Poor Glycemic Control:
  - Diabetic Ketoacidosis
  - Nonketotic Hyperosmolar Coma
  - Hypoglycemic Coma
  - Secondary Diabetes with Ketoacidosis
  - Secondary Diabetes with Hyperosmolarity
- Catheter-Associated Urinary Tract Infection (UTI)
- Vascular Catheter-Associated Infection
- Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)
- Surgical Site Infection Following Bariatric Surgery for Obesity:

    - Laparoscopic Gastric Bypass
    - Gastroenterostomy
    - Laparoscopic Gastric Restrictive Surgery
- Surgical Site Infection Following Certain Orthopedic Procedures:
    - Spine
    - Neck
    - Shoulder
    - Elbow
- Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)
- Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures:
    - Total Knee Replacement
    - Hip Replacement
- Latrogenic Pneumothorax with Venous Catheterization

Notification of Adverse Event to Kaiser Permanente
Participating Providers should notify the Health Plan when an adverse "Do Not Bill Event" or condition impacting a Member is discovered by contacting the Utilization Management Operations Center (UMOC) at ☎ **800-810-4766** or Provider Experience at ☎ **877-806-7470**.

Claims Submission and Adjustments Related to a "Do Not Bill Event"
Participating Hospital/Facility must include "Present on Admission" indicators on all Member claims. Participating Providers should ensure that their billing staff are aware when a "Do Not Bill Event" involving a Member's care has occurred prior to submitting the claim to Kaiser Permanente for processing.

When a "Do Not Bill Event" is recognized prior to claim submission, the UB-04 or CMS- 1500 form should include:

- The applicable ICD codes
- All applicable standard modifiers (including CMS NCD modifiers for surgical errors)

Additionally, the UB-04 or CMS 1500 form should reflect all services provided including those related to a "Do Not Bill Event" with an adjustment in fee to reflect the waiver of fees directly related to the event(s).

Any Member Cost Share related to a "Do Not Bill Event" should be waived or reimbursed to the Member. An impacted Member may not be balanced billed for any services related to a "Do Not Bill Event".

Do Not Bill Event Policy Exception for Maryland Hospitals
Participating Maryland hospitals are required to adopt the Health Services Cost Review Commission (HSCRC) payment policy for preventable hospital acquired conditions.

8.9 Three Month Grace Period for Members Electing APTC Subsidy

Members enrolled in a Kaiser Permanente Individuals and Families (KPIF) plan often elect to receive the federal premium subsidy to help them pay their monthly premium. When they make this election and they do not pay their monthly premium payment on time, they are entitled to a three-month grace period pursuant to federal law. During the first month of the grace period, the member's claims must be processed by Kaiser Permanente. If the member fails to make

payment during the second and/or third months (so that all the premiums owed for the three months are paid on or before the last day of the grace period), the member's claims are held and not processed, until the end of the grace period.

If premiums are not paid in full by the end of the grace period, the Member's coverage terminates on the last day of the first month of the grace period. Any claims incurred in the second and third months will be denied due to the retroactive termination of coverage based on the Member's failure to be enrolled on the date(s) of service due to their non-payment of premiums.

Kaiser Permanente notifies providers in writing of their patient's claim status when the patient enters the second month of the grace period. Providers may seek reimbursement directly from the member at the end of the three-month grace period, if the claim is denied for the member not being enrolled (and, therefore, ineligible), due to termination of coverage based on the non-payment of premiums.

Kaiser Permanente encourages providers to continue to see members as they may become current in their premiums. However, if they do not pay all premiums that are due on or before the last day of their grace period, then the member's coverage will be terminated as of the last day of the first month of the grace period. The former (terminated) member will be responsible for payment to the provider if they are terminated at the end of their grace period for services provided during the second and third months of their grace period.

8.9 Anesthesia Clinical Payment Policy for Obstetrics

The Kaiser Permanente Anesthesia Clinical Payment Policy for Obstetrics ensures that KPMAS Contracted and Non-Contracted Anesthesiologist meet the specific standards and guidelines from the American Medical Association (AMA), the American Society of Anesthesiologist (ASA), the CMS, and anesthesiabilling.org, as adopted by KPMAS.

Maternity-Related Anesthesia Reimbursements
Anesthesia procedure codes in the Obstetrics Section of AMA's CPT classifications are to be used by anesthesiologists and Certified Registered Nurse Anesthetists (CRNAs) to bill for maternity-related anesthesia services. Reimbursement for these services shall be paid in accordance with the practitioners' contractual agreement or in accordance with internal/regulatory non-contracted payment policies and procedures.

Billing for Labor and Delivery
Providers should bill CPT code 01967 (Neuraxial labor analgesia/anesthesia for planned vaginal deliveries (this includes the repeat subarachnoid needle placement and drug injection and/or any necessary replace of an epidural catheter during labor) for labor and delivery when epidural is used. For a vaginal delivery that turns cesarean (C-section) using an epidural, use code 01967 and add- on code 01968 with the time units for the C-section. For a scheduled/planned C-section delivery using an epidural, use code 01961 with the time units for the surgery. For a vaginal delivery with general anesthesia (no epidural), use code 01960 with time units for the delivery. For a C-section delivery with general anesthesia (no epidural), use 01961 with time units for the delivery. For a cesarean hysterectomy following neuraxial labor analgesia/anesthesia, use code 01967 in addition to 01969 for actual time units for the surgery.

Epidurals
Epidural analgesia involves the administration of a narcotic drug through an epidural catheter. When performed as the primary type of anesthesia, the time required is included in the total anesthesia minutes reported.

Labor Epidurals
Anesthesia for labor epidurals are time-based services and should be billed as total minutes.

- **01967**: Vaginal delivery with epidural for pain management code may be reported as a single anesthesia service. Reimbursement will be calculated in accordance with the current ASA guidelines including Base, Time and Modifying units as well as codes for Qualifying Circumstances (insertion through delivery) subject to a global cap of 7 hours or 420 minutes. Time units shall be based on whole fifteen (15) minute intervals. Time units greater than or equal to five (5) minutes will be reimbursed as one (1) unit; time units less than five (5) minutes will not be reimbursed.

    1. Report up to 60 minutes or 4 units of time for epidural catheter insertion and removal and delivery. [Note: These 60 minutes may be used at the discretion of the anesthesiologist.] If either the insertion/removal of the epidural catheter and/or the delivery, individually or combined, exceeds the 60 minutes threshold, additional time may be reported provided the medical record documentation supports the need for additional time.

    2. Report one (1) additional unit for each hour the patient is in labor. If billing in minutes, we will allow one (1) unit for each additional 60 minutes of time reported where the patient is in labor. A notation must be made in the medical record, signed by the anesthesiologist or CRNA, which confirms that they visited the laboring patient during each hour of labor (a short progress note is acceptable for this notation).
    3. Report actual time, in minutes, from time spent with the patient for the management of complications or adverse events, provided that actual care time is fully documented in the medical record.

Anesthesia Calculation:
There are a number of factors utilized in determining the payment for anesthesia services. These factors include, but are not limited to, modifiers, time units, base units, and the conversion factor. Payment for anesthesia services rendered during labor is calculated differently from that for other anesthesia services.

- **Base units** - the number of units (anesthesia value) assigned to each anesthesia CPT procedure code
- **Time units** - anesthesia time conversion that correspond to the difference between the start and stop times the service was provided
  Modifiers - Provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance, but not changed in its definition or code.

Anesthesia Conversion	15 minutes = 1 unit 60 minutes = 4 units Any anesthesia time over five (5) minutes = 1 unit **Example**: 81 minutes = 75 minutes (5 units) + 5 minutes (1 unit) = 6 units

	Important Note: General anesthesia codes 00100-01999 are intended for use by a provider other than the surgeon. The operating surgeon cannot also bill these codes when also providing anesthesia for the procedure(s). Local anesthesia administered by the surgeon is considered a part of the surgery and is not separately billable, and there are separate CPT codes for conscious sedation administered by the surgeon.
PM Military Time Conversion	Surgical procedures that begin or end after 12:00pm (noon), must be converted to military time. For times between the hours of 1:00am and 9:00am, a zero must be added in front of the number in the Claim Detail Anesthesia Time focus box. **Example**: Start time 1:29pm and End Time 9:03pm must be entered in the Claim Detail Anesthesia Time focus box as Start time 13:29 and End Time 21:03.

8.10 Billing Procedures for Medicare Members

Members who are Medicare beneficiaries and are enrolled with Kaiser Permanente will be covered by Medicare Advantage (a Medicare Risk product). To determine coverage, you can either check the member identification card or you can call ☎ 888-777-5536 for verification.

8.11 Provider Payment Dispute Process

Providers who disagree with a decision not to pay a claim in full or in part may file a payment dispute request. Payment disputes must be filed within one hundred eighty (180) days of the date of the denial and/or Explanation of Payment. The dispute process applies only to clean claims as outlined in Section 8.2 – Clean Claims.

Claims payment appeals received outside of the allowable time frame will be considered untimely and denied.

Online submission of payment disputes
Kaiser Permanente allows providers to submit payment disputes using Online Affiliate. When filing a dispute or appeal online, you will be prompted to complete a form with key information such as:

- Dispute amount
- Dispute reason (drop-down selection)
- Additional details regarding submission
- You may also submit PDF attachments to support your dispute

By submitting online, you will receive an online auto-acknowledgment letter and resolution letter.

To submit electronically or enroll for access to Online Affiliate, navigate to kp.org/providers/mas and select **Online Provider Tools** from the Provider Resources menu.

For help with Online Affiliate or to contact our support team, please access the Online Affiliate Support Site at https://kpnationalclaims.my.site.com/support/s/.

Provider disputes and appeals submitted in writing will need to be sent to:

Mid-Atlantic Claims Administration
Kaiser Permanente
PO Box 371860
Denver, CO 80237-9998

Your filed payment dispute request must include:

- A summary of the dispute
- Kaiser Permanente Claim number(s) at issue
- Necessary supporting documentation to review the request (i.e. pertinent medical records, proof of timely filing, other insurance carrier explanation of payment, and/or MSN).
- Specific payment and/or adjustment information

Timely Filing Requirements and Appeal of Timely Filing
All claims must be received within the timeframes included in Section 8.1.

Resubmitted claims along with proof of initial timely filing received within 180 days of the original date of denial or explanation of payment, will be allowed for reconsideration of claim processing and payment. Any claim resubmissions received for timely filing reconsideration beyond 180 days of the original date of denial or explanation of payment will be denied as untimely submitted.

Proof of Timely Filing
Claims submitted for consideration or reconsideration of timely filing must be reviewed with information that indicates the claim was initially submitted within the appropriate time frames outlined in Section 8.1. Acceptable proof of timely filing may include the following documentation and/or situations:

Proof or Documentation	**Examples**
System generated claim copies, account printouts, or reports that indicate the original date that claim was submitted, and to which insurance carrier. *Hand-written or typed documentation is not acceptable proof of timely filing.	• Account ledger posting that includes multiple patient submissions • Individual Patient ledger • CMS UB04 or 1500 with a system generated date or submission.
EDI Transmission report	• Reports from a Provider Clearinghouse (i.e. WebMD)
Lack of member insurance information. Proof of follow-up with member for lack of insurance or incorrect insurance information. *Members are responsible for providing current and appropriate insurance information each time services are rendered by a provider.	• Copies of dated letters requesting information or requesting correct information from the member. • Original hospital admission sheet or face sheet with incomplete, absent, or incorrect insurance information. • Any type of demographic sheet collected by the provider from the member with incomplete, absent, or incorrect insurance information.

8.12 Claim Adjustments/Corrections

Professional Claims

EDI:

- Corrected claims should be submitted using Frequency Type Code “7” Loop 2300 CLM05-3
- When submitting claims with claims frequency code 7, the original Kaiser Permanente claim number, also referred to as the Document Control Number (DCN) must be included.
- The Document Control Number (DCN) **must** be submitted in Loop 2300 REF02 – Payer Claim Control Number with qualifier F8 in REF01.
- The DCN can be obtained from the 835 Electronic Remittance Advice (ERA) or the providers EOP.
- Without the original Kaiser Permanente DCN, adjustment requests will generate a compliance error, and the claim will reject.

Paper:

- Identification of the corrected claim is based on codes entered in specific fields on the form. No additional notifications are required. For example, do not write “Corrected Claim” on the form or include a cover page indicating that a corrected claim is being submitted.
- The CMS 1500 0212 box (resubmission code) should contain a “7” and under the Original Ref. No., the Kaiser Permanente (Tapestry) claim number should be provided. Claims submitted without the valid original claim number will be rejected. The DCN/Original claim number can be obtained from the 835 Electronic Remittance Advice (ERA) or the provider’s EOP.
- If the Tapestry claim number is not provided, the claim will be rejected for missing the original claim number.

Mail the corrected claim(s) to Kaiser Permanente using the standard claims mailing address.

Institutional Claims

EDI:

- Corrected claims should be submitted using Frequency Type Code “7” Loop 2300 CLM05-3
- When submitting claims with claims frequency code 7, the original Kaiser Permanente claim number, also referred to as the Document Control Number (DCN) must be included.
- The Document Control Number (DCN) **must** be submitted in Loop 2300 REF02 – Payer Claim Control Number with qualifier F8 in REF01.
- The DCN can be obtained from the 835 Electronic Remittance Advice (ERA) or the providers EOP.
- Without the original Kaiser Permanente DCN, adjustment requests will generate a compliance error, and the claim will reject.

Paper:

- Identification of the corrected claim is based on codes entered in specific fields on the form. No additional notifications are required. For example, do not write “Corrected Claim” on the form or include a cover page indicating that a corrected claim is being submitted.

- On the UB04 claim, a correct claim is indicated by the last digit of the type of bill field (Block 4) being a “7” (ex. 117, 137, etc.). The original claim number is placed in Block 64 (Document Control Number), and it needs to be in the same row as the payor in Block 50. For example, if this is a corrected claim, and Kaiser Permanente has been identified in Row A in Block 50, the Tapestry claim number needs to be in Block 64 Row A when submitting a paper claim.
- If the Tapestry claim number is not provided, the claim will be rejected for missing the original claim number.

Mail the corrected claim(s) to Kaiser Permanente using the standard claims mailing address.

8.13 Claim Overpayment

In the case of an overpayment of a claim, Kaiser Permanente will provide the Participating Provider with a written notice of explanation. The Participating Provider should send the appropriate refund to Kaiser Permanente within thirty (30) days of receiving the overpayment notice, or when the Participating Provider confirms that he/she is not entitled to the payment, whichever is earlier.

Please include the following information when returning uncontested overpayments:

- Name of each Health Plan member who received care for which an overpayment was received
- Copy of each applicable remittance advice from other carriers
- Primary carrier information, if applied
- Each applicable member’s Kaiser Permanente medical record number (MRN)
- Claim number(s)
- Date(s) of service

Refunds should be mailed to the following address:

Kaiser Foundation Health Plan – Mid-Atlantic States
P.O. Box 740814
Los Angeles, CA 90074-0814

If for some reason the Participating Provider’s refund is not received within thirty (30) days of receiving the overpayment notice, Kaiser Permanente may deduct the refund amount from future payments.

8.14 Coordination of Benefits

There are many instances in which a member’s episode of care may be covered by more than one insurance carrier. Kaiser Permanente Participating Providers are responsible for determining the primary payor and for billing the appropriate party. In addition, providers are responsible for seeking authorization from another payor (if authorization is required) and/or responding to requests for information submitted by the other payor to make an authorization determination.

For assistance in determining the primary payor, review the guidelines listed below or call your Provider Experience Department for assistance at ☎ 877-806-7470.
To determine the Primary Payor:

1. The plan that covers the person other than as a dependent, for example as an employee, member, subscriber, policyholder, or retiree, is the primary plan, and the plan that covers the person as a dependent is the secondary plan. If the person is a Medicare beneficiary, then Centers for Medicare & Medicaid Services (CMS) Guidelines must apply.
2. For a dependent child whose parents are married or are living together and is covered by both parents, the “birthday rule” applies – the payor for the parent whose birthday falls earlier in the calendar year (month and day) is the primary payor.
3. When determining the primary payor for a child of separated or divorced parents, inquire about the court agreement or decree. In the absence of a divorce decree/court order stipulating parental healthcare responsibilities for a dependent child, insurance benefits for that child are applied according to the following order:

   Insurance carried by the:
   - natural parent with custody pays first;
   - step-parent with custody pays next;
   - natural parent without custody pays next;
   - step-parent without custody pays last.

   If the parents have joint custody of the dependent child, then benefits are applied according to the “birthday rule” referenced above.

4. The commercial benefits plan is primary for Medicare beneficiaries who are covered by a Large Employer Group Health Plan (EGHP) as a result of their own or a family member’s current employment status when the CMS Working Aged or Disabled Beneficiaries provisions apply.
5. Medicare is primary for Medicare beneficiaries who are covered by an Employer Group Health Plan (EGHP) whose subscriber is a retiree of the employer when the CMS Working Aged or Disabled Beneficiaries provisions apply.
6. Medicare is the primary payer for individuals eligible for or entitled to Medicare benefits based on ESRD after the duration of coordination period as stipulated under the Medicare Secondary Payer Provisions for End-Stage Renal Disease (ESRD) Beneficiaries.
7. In cases of work-related injuries, workers compensation is primary unless coverage for the injury has been denied.
8. In cases of services for injuries sustained in vehicle accidents or other types of accidents, primary payor status is determined on a jurisdictional basis. If the auto insurance is primary, KPMAS will require an EOB.

When Kaiser Permanente is secondary to another payor, Kaiser Permanente will coordinate benefits and determine the amount payable to the provider, where the standard payment determination methodology is to pay the difference between what the primary paid and their allowable, in an amount not to exceed the Kaiser Permanente benefit allowable.

Third Party Liability (TPL)

Kaiser Permanente may seek reimbursement from a member’s settlement or judgement due to injuries or illnesses caused by a third party. In order to prevent duplicate payments for healthcare costs that are also paid by another responsible party, providers are required to assist Kaiser Permanente in identifying all potential Third Party Liability situations and to provide Kaiser Permanente with information that supports Kaiser Permanente’s TPL inquiries

First and Third-Party Liability Definitions
First Party Liability refers to situations in which the member's own automobile or other policy covers healthcare costs related to injuries or illnesses due to an accident, regardless of fault. In the event that you receive a partial payment from an automobile or other carrier that falls under the category of First Party Liability (such as Med Pay, Personal Injury Protection, etc.), please submit your claim and indicate the automobile carrier name and amount paid along with the Explanation of Benefits (EOB).

Third Party Liability refers to situations in which a third party's automobile or other policy covers healthcare costs related to injuries or illness caused by or alleged to be caused by a third party.

Both definitions of alternate liability here shall be considered Third Pary Liability for the purposes of this section.

First and Third-Party Liability Guidelines:
Providers are required to assist and cooperate with Kaiser Permanente's efforts to identify these situations by entering the following information on the billing form, if applicable:

- Automobile carrier information in appropriate fields, along with payment information
- ICD-10 diagnosis data in appropriate fields
- Accident-related claim codes (e.g., occurrence codes, condition codes, etc.)

Kaiser Permanente retains the right to investigate TPL recoveries through retrospective review of ICD-10 and CPT-4 codes from the billing forms where a possible TPL is indicated.

Workers' Compensation
If a member indicates that his or her illness or injury occurred while the Member was "on the job", you should do the following:

- Document that the Member indicates the illness or injury occurred "on the job" on the claim
- Complete applicable fields on the billing form indicating a work-related injury
- Submit the claim to the patient's Workers' Compensation carrier/plan

If the Member's Workers' Compensation carrier/plan ultimately denies the Workers' Compensation claim, you may submit the claim for covered services to Kaiser Permanente in the same manner as you submit other claims for services. You must also include a copy of the denial letter or Explanation of Payment from the Workers Compensation carrier.

If you have received an authorization to provide such care to the Member, you should submit your claim to Kaiser Permanente in the same manner as you submit other claims for services. Your Agreement may specify a different payment rate for these services.

8.15 Primary Care Capitation Payment

Kaiser Permanente has established a process for the submission of bills for services covered by monthly capitation, and utilization information for all patient encounters.

Capitation payments will be made, on a monthly basis, on or about the 15th calendar day of each month. Monthly payments are retrospective and will cover the previous month.

The payment will be based on the age and sex of the members identified on the panel of each physician in a group practice. This amount will be adjusted for additional payments for open panel and extended hours provisions.

Each group practice will receive a Capitation Roster Report with their capitation payment. This report is a retrospective report listing members by name and identification number. This report will also show by member any payment adjustments made for retroactive membership (retroactive adjustments are limited to ninety (90) days).

If you have any issues or questions concerning the capitation payments, or the report accompanying the capitation payment, you may contact the Provider Experience Department by calling ☎ 877-806-7470.

8.16 Billing for Capitated Specialty Care Providers

Specialty Care Participating Providers with a capitated contract will not need to bill for services. However, Kaiser Permanente still requires the monthly submission of encounter data and utilization information. This is used to determine the volume and the types of services your office provides and will be used to determine future contract rates.

Follow the steps below to submit monthly utilization information:

1. Participating Providers will submit a CMS 1500 form, or another format indicated by contract agreement.
2. All utilization information submitted must include:
    - Patient Name
    - Patient Identification Number/Medical Record Number
    - Provider's Name
    - Tax Identification Number
    - Date of the Bill
    - Date(s) of Service
    - Current CPT-4 Codes
    - ICD-10 – CM Diagnosis Code
    - Billed Charges
    - Authorization Number
    - Narrative description of charges if billing an unlisted code.

Submit all utilization information to:

Kaiser Permanente
Attn: Data Management
4000 Garden City Drive
Hyattsville, Maryland, 20785

8.17 Capitation Reports

The following reports are forwarded to Participating PCPs with their capitation checks. If you have any questions regarding your capitation check or these reports, please feel free to contact the Provider Experience Department at ☎ 877-806-7470.

Eligibility List for Monthly Capitation Report
This report identifies capitation payments for each member enrolled or "eligible" during the specified time period. It also contains the member number, name, age, gender, and allocation

amounts. All allocations are distributed to primary care, laboratory, facility, or specialty service categories. These categories are used for reporting purposes and demonstrate the type of services covered under the capitation payment agreement.

Eligibility Adjustment List for Monthly Capitation Report
This report identifies retroactive capitation payments for each enrolled or “eligible” member. In addition to displaying the member number, name, age, gender, and allocation amounts, the report also indicates the reason for the change in membership with a code, the explanation of which appears at the end of the report. All allocations are distributed to primary care, laboratory, facility, or specialty service categories. These categories are used for reporting purposes and demonstrate the type of services covered under the capitation payment agreement.

Provider Member - Months by Actuarial Class Report
This report summarizes capitation payments by specific age/gender categories. These categories are established by the health plan and are used to generate each provider’s capitation payment. This report also contains the number of member-months and number of individual members accounted for in the report, as well as the allocation amounts. All allocations are distributed to primary care, laboratory, facility, or specialty service categories. These categories are used for reporting purposes and demonstrate the type of services covered under the capitation payment agreement.