Kaiser Foundation Health Plan, Inc.
CLAIMS SETTLEMENT PRACTICES
PROVIDER DISPUTE RESOLUTION MECHANISMS
Northern California Region

Kaiser Permanente ("KP") values its relationship with the contracted community providers who also serve the health care needs of our Kaiser Foundation Health Plan ("KFHP") Northern California members. Our general practice is to annually provide you with this summary of our claims submission requirements and settlement practices, as well as a description of our provider dispute resolution mechanisms. We are updating this summary to include our reimbursement policy entitled "POL-020 Clinical Review Payment Determination Policy," as set forth below.

I. CLAIMS SUBMISSION

KP encourages providers to submit electronic claims (837I/P transaction). Electronic claim transactions eliminate the need for paper claims. Electronic Data Interchange (EDI) is an electronic exchange of information in a standardized format that adheres to all Health Insurance Portability and Accountability Act (HIPAA) requirements. KP requires all EDI claims be HIPAA compliant. For information or questions regarding EDI with KP, send an email to:

EDISupport@kp.org

Detailed instructions regarding filing requirements and your EDI options are also available in the Northern California Provider Manuals posted for your convenience on the Community Provider Portal at:

http://kp.org/providers/ncal/

A. Emergency Claims

1. Sending Emergency Claims to KP

Paper claims for emergency services provided to KFHP members must be sent to the following:

By U.S. Mail:	**Kaiser Foundation Health Plan, Inc.** **National Claims Administration** **P.O. Box 12923** **Oakland, CA 94604-2923**

Paper claims for emergency services provided to KFHP members may be physically delivered (e.g., by courier) to the following:

By Physical Delivery Other than by U.S. Mail:	**Kaiser Foundation Health Plan, Inc.** **National Claims Administration** **1800 Harrison Street, 12th Floor** **Oakland, CA 94612**

2. Calling KP Regarding Emergency Claims

Inquiries regarding emergency claims may be directed to KP at: **1-800-390-3510**.

B. Referred Service Claims

1. Sending Referred Service Claims to KP

Unless otherwise indicated on the written Authorization for Medical Care, paper claims for referred services should be sent to:

Kaiser Referral Invoice Service Center (RISC)
2829 Watt Avenue, Suite #130
Sacramento, CA 95821-6242

Phone: (800) 390-3510

Claims for **DME, SNF, CBAS, ICF/DD, ICF/DD-H, ICF/DD-N, Home Health, and Hospice** Services should be sent to:

Kaiser Foundation Health Plan, Inc.
National Claims Administration
P.O. Box 12923
Oakland, CA 94604-2923

Phone: (800) 390-3510

Claims as part of a **transplant** case should be sent to:

Kaiser Permanente
Transplant Claims Processing Unit
1950 Franklin St., 7th Floor
Oakland, CA 94612

2. Calling KP Regarding Referred Service Claims

Inquiries regarding claims for referred services may be directed to KP at: (**800) 390-3510.**

C. Claims Submission Requirements

The following is a listing of claim submission requirements (including timeliness standards and required supporting documentation), as well as supplemental information we believe is important for you to know in submitting claims to KP. You are required to submit "complete claims" as defined in Title 28, California Code of Regulations, Section 1300.71(a)(2) for the services provided. A "complete claim" must include the following information, as applicable:

- Correct Form: All professional claims should be submitted using preprinted red OCR CMS-1500 or the EDI 837P file, and all facility claims (or appropriate ancillary services) should be submitted using preprinted red OCR UB-04 or EDI 837I file based on CMS guidelines;
- Standard Coding: All fields should be completed using industry-standard coding, including the use of ICD-10 code sets;
- Applicable Attachments: Attachments should be included in the submission when circumstances require additional information, or this additional information can be submitted via KP's **Online Affiliate** tool. Providers are invited and encouraged to request access to KP's Online Affiliate tool. These and other functions are available on a self-serve basis, 24/7. Please see the Northern California Community Provider Portal (CPP) for more information;
- Completed Field Elements for CMS Form 1500 or CMS Form UB04: All applicable data elements of CMS forms should be completed, including correct loops and segments on electronic submissions.

In general, additional information is not required; the standard claims forms and EDI are sufficient in most instances. When additional information is required it will be requested. Note this additional information can be submitted via KP's **Online Affiliate** tool. Additional information may include the following, to the extent applicable to the services provided:

- ✓ Admitting face sheet
- ✓ Discharge summary
- ✓ Operative report(s)
- ✓ Emergency room records with respect to all emergency services
- ✓ Treatment and visit notes as reasonably relevant and necessary to determine payment
- ✓ A physician report relating to any claim under which a physician is billing a CPT-4 code with a modifier, demonstrating the need for the modifier
- ✓ A physician report relating to any claim under which a physician is billing an "Unlisted Procedure", a procedure or service that is not listed in the current edition of the CPT codebook
- ✓ Physical status codes and anesthesia start and stop times whenever necessary for anesthesia services
- ✓ Therapy logs showing frequency and duration of therapies provided for skilled nursing facility services

Under certain circumstances, KP is required by law to report and verify appropriate supporting documentation for member diagnoses in accordance with industry-standard coding rules and practices. As a result, KP may from time to time, in accordance with your agreement, request that you provide, or cause to be provided by any subcontractors or other parties, copies of or access to (including on-site or remote access by KP personnel) medical records, books, materials, notes, paper or electronic files, and any other items or data to verify appropriate documentation of the diagnoses and other information reflected on claims or invoices submitted to KP. KP expects that the medical records properly indicate the diagnoses in terms that comply with industry-standard coding rules and practices. Further, it is essential that access to, or copies of, this documentation

be promptly provided, and in no event should you do so later than five (5) business days after a request has been made so KP may make any necessary corrections and report to appropriate governmental programs in a timely fashion.

If additional documentation is considered to be reasonably relevant information and/or information necessary to determine payment to, we will notify you in writing.

For inpatient services only, we will accept separate claims on a weekly basis for services provided in an inpatient facility to the extent required by 28 CCR 1300.71(a)(7)(B). Interim facility claims should be submitted using the facility's same patient control number/account number as used on the facility's initial claim. KP will accept the initial interim claim billed with Bill Type 112. All subsequent interim claims must be billed as an adjusted claim with Bill Type 117, including the cumulative charges accrued to each subsequent "through" date. Interim inpatient facility claims must follow then-effective CMS billing requirements as provided in the CMS Claims Processing Manual. Interim claims not billed in accordance with these guidelines will be denied.

KP requests that providers submit claims for services provided to members within 90 calendar days of such service. However, all EDI or paper claims and encounter data must be sent to the appropriate address no later than 180 calendar days (or any longer period specified in your agreement or required by law) after the date of service or date of discharge, as applicable.

A referred service claim should be sent to the payment location indicated on the written authorization or referral for prompt payment consideration.

Claims received beyond the applicable filing period will be denied for untimely submission. In these instances, you, as a contracted provider of service, **may not** bill our KFHP member, but may resubmit the claim as a provider dispute. The resubmited claim must include the reason for your initial late submission of the claim, along with the other required information described in Section IV, "Dispute Resolution Process for Contracted Providers."

D. Claims Receipt Verification

Claim status inquiries are supported exclusively by our KP **Online Affiliate** tool. Whether you submit your claims via paper or EDI, the portal should be used to answer simple claim status questions such as:

- Did KP receive my claim?
- What is the status of my claim; is my claim in process or has adjudication been finalized?
- What is the status of my claim; has my claim been paid or denied?
- What is the amount paid on my claim?
- When was the check/payment sent? What is the check number?

Providers are invited and encouraged to request access to KP's **Online Affiliate** tool. Many functions, including but not limited to obtaining information on

benefits and eligibility, member cost share and claim status are available on a self-serve basis 24 hours per day, 7 days per week. For more information and to initiate the provisioning process, please visit KP's Northern California Community Provider Portal at:

http://kp.org/providers/ncal/

Your clearinghouse is an alternative method to verify KP has received your claim. When KP receives an EDI claim we transmit an electronic acknowledgement (277CA transaction) back to the clearinghouse.

II. CLAIMS REVIEW, EDITING AND COMMPENSATION METHODOLOGIES

The terms of your agreement and the terms of the applicable KP provider manual govern the amount of payment for services provided under your agreement.

KP's claims payment practices for provider services generally follow industry standards, including those specified below, as well as those described in our policy entitled "POL-020 Clinical Review Payment Determination Policy," a copy of which is attached hereto.

Our claims adjudication systems accept and identify all active CPT and HCPC codes as well as all coding modifiers. We use Medicare's parameters to define global surgery periods. When necessary to clarify billed charges, supporting documentation is required and, in addition, we require procedure reports for bills with "unlisted" procedure codes and the application of Modifier 26, 59, XE, XP, XS, XU and/or other modifiers if needed.

KP does not allow code unbundling for procedures for which all-inclusive codes should be used and we will re-bundle the procedures and pay according to the appropriate all-inclusive codes.

Claims for services such as multiple procedures, bilateral procedures, assistant surgeons, and co-surgeons and application of modifiers are adjudicated and paid in accordance with the terms of your agreement, Medicare guidelines and other commonly accepted standards. Billing as a co-surgeon with Modifier 62 or for increased services with Modifier 22 requires submission of a separate operative report.

KP will not reimburse for any professional component of clinical diagnostic laboratory services (such as automated laboratory tests) billed with a Modifier 26, whether performed inside or outside the hospital setting, provided that, consistent with CMS payment practices, reimbursement for such services, if any, is included in the payment to the applicable facility responsible for providing the laboratory services.

Notwithstanding the above, unless your agreement provides otherwise, for Medi-Cal member claims we will apply Medi-Cal coding policies as published from time to time by the Department of Health Care Services, as required by and in accordance with Medi-Cal program requirements.

Claims may be reviewed by a physician or other appropriate clinician, based on commonly accepted standards adopted by KP. Please see attached Policy 020 for further detail.

The terms of your agreement and the KP Provider Manual govern the amount of payment for services provided under your agreement. Depending on your specific agreement provisions, KP utilizes various compensation methodologies including, but not limited to, case rates, fee schedules, the Average Wholesale Price from the most recently published IBM Micromedex® Red Book® and/or Medicare guidelines. KP calculates anesthesia units in fifteen (15) minute increments. KP also uses PPS rates. Notwithstanding the effective date of any rate or rate exhibit to the agreement, and unless provided otherwise in the agreement, inpatient services for which the episode of care spans multiple days are generally paid in accordance with the rate(s) in effect on the date the episode began (i.e. the admit date or first date of service). This may include application of compensation methodologies such as per diems, percentage of charges, case rates, etc. When payment for inpatient hospital services is based on the Medicare allowable payment, the payment rate is based on the MS-DRG determined upon discharge. Outpatient services are generally paid in accordance with the applicable rate in effect on the date of service. Please refer to your agreement for more detailed information on the reimbursement method that applies to you.

III. RESPONSIBILITY FOR RECEIVING AND RESOLVING PROVIDER PAYMENT DISPUTES

A. **Emergency Claims.** The office responsible for receiving your provider payment disputes regarding emergency claims is: Kaiser Foundation Health Plan, Inc., National Claims Administration. Disputes regarding emergency claims are settled by the organization's Provider Dispute Resolution Committee.

B. **Referred Service Claims.** The office responsible for receiving your provider payment disputes regarding referred service claims is: Kaiser Foundation Health Plan, Inc., Referral Invoice Service Center (RISC). Disputes regarding referred service claims are settled by the organization's Provider Dispute Resolution Committee.

C. **Other Disputes.** For disputes not based on individualized payment or billing determinations, you should notify KP at the notice address(es) or telephone numbers set forth in your agreement.

IV. DISPUTE RESOLUTION PROCESS FOR CONTRACTED PROVIDERS

A. **Types of Disputes.** If you have a dispute relating to the adjudication of a claim or a billing determination (collectively referred to herein as "payment dispute") you may submit such payment disputes online via **Online Affiliate** or as a written notice to KP by U.S. Mail or other physical delivery. Either notice of a payment dispute is referred to in this document as a "Provider Dispute Notice."

Disputes relating to contractual issues other than individualized payment disputes are governed by a process consistent with the requirements of state

law, as set forth in your agreement. Section IV.C below describes the process applicable to such contract disputes.

The following describes the most common types of payment disputes:

1. **Claims Payment Disputes**: challenging, appealing or requesting reconsideration of a claim (or bundled group of claims) that has been denied, adjusted or contested by KP;

2. **Responding to Requests for Overpayment Reimbursements**: disputing a request initiated by KP for reimbursement by you of overpayment of a claim.

B. Provider Payment Dispute Requirements

1. Submitting Provider Payment Disputes Regarding Emergency Claims

If the payment dispute is related to a claim for emergency services provided to a member, the dispute may be submitted online via **Online Affiliate** or by U.S. Mail or by other physical delivery.

Online submission: For more information or to register for Online Affiliate, please visit KP's Northern California Community Provider Portal at:

http://kp.org/providers/ncal/

By U.S. Mail:

Kaiser Foundation Health Plan, Inc.
National Claims Administration
Attention: Provider Dispute Services Unit
P.O. Box 23100
Oakland, CA 94623

By Physical Delivery other than by U.S. Mail:

Kaiser Foundation Health Plan, Inc.
National Claims Administration
1800 Harrison Street, 8th Floor
Oakland, CA 94612

2. Calling KP Regarding Provider Payment Disputes of Emergency Claims
To inquire about filing a payment dispute and/or the status of previously submitted disputes, you may contact KP through Online Affiliate or by calling **(800) 390-3510**.

3. Sending Provider Payment Disputes Regarding Referred Service Claims
If the provider dispute is related to a claim for a service covered by your agreement and that was referred to you by a TPMG physician or designee, the dispute may be submitted online via **Online Affiliate** or by U.S. Mail or by other physical delivery.

Online submission: For more information or to register for Online Affiliate, please visit KP's Northern California Community Provider Portal at:

http://kp.org/providers/nca/

By U.S. Mail or other Physical Delivery:	**Kaiser Permanente** **Referral Invoice Service Center (RISC)** **Attention: Provider Disputes** **2829 Watt Avenue, Ste 130** **Sacramento, CA 95821-6242**

4. **Calling KP Regarding Provider Payment Disputes of Referred Service Claims**
   To inquire about filing a payment dispute and/or the status of previously submitted disputes, you may contact KP through Online Affiliate or by calling **(800) 390-3510**.

5. **Required Information for Provider Payment Disputes**
   Your Provider Dispute Notice must contain at least the information listed below, and as applicable to your payment dispute. If your Provider Dispute Notice does not contain all the applicable information listed below, we will reject the Provider Dispute Notice and will identify in writing the missing information necessary for us to consider the payment dispute. If you choose to continue the payment dispute, you must submit an amended Provider Dispute Notice to KP within thirty (30) business days from the date of such notification letter (but in no case later than 365 calendar days from KP's last action on the claim), making sure to include all elements noted therein as missing from your payment dispute. If KP does not receive your amended payment dispute within this time, our previous decision will be considered final, and you will have exhausted our provider payment dispute process.

   Required Information:

   - Your name, the Tax Identification Number under which services were billed and your contact information;
   - If the payment dispute concerns a claim or a request for reimbursement of an overpayment of a claim, a clear identification of the disputed item using KP's original claim number, the date of service, and a clear explanation of the basis upon which you believe that the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect;
   - If the payment dispute involves a member or a group of members, the name(s) and KP medical record number(s) of the member(s) must be included in addition to the information above.

C. Provider Contract Dispute Requirements

You should notify us of any contractual dispute (i.e., a dispute that is not an individualized payment dispute) in accordance with the requirements of your agreement, and it will be subject to resolution in accordance with the provisions of your agreement.

V. TIME PERIOD FOR SUBMISSION OF PROVIDER PAYMENT DISPUTES

Subject to any longer period specifically permitted under your agreement or required under applicable law, the Provider Dispute Notice must be received by KP within 365 calendar days from our action (or the most recent action if there are multiple actions) that led to the dispute, or in the case of inaction, the Provider Dispute Notice must be received by KP within 365 calendar days after our time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.

VI. TIMEFRAMES FOR ACKNOWLEDGMENT OF RECEIPT & DETERMINATION OF PROVIDER PAYMENT DISPUTES

We will acknowledge receipt of your Provider Dispute Notice submitted in accordance with the above requirements within fifteen (15) business days after KP's receipt of hardcopy submission, or within two (2) business days after KP's receipt of online submission. We will reject any payment dispute you submit that does not include all required information as described above as an incomplete payment dispute and will take no further action on that incomplete submission unless it is resubmitted completely as required above and within the applicable time frame. KP will issue a resolution letter explaining the reasons for our determination, to the extent required by applicable law, within forty-five (45) business days after the date of receipt of the complete Provider Dispute Notice.

VII. INSTRUCTIONS FOR FILING SUBSTANTIALLY SIMILAR PROVIDER PAYMENT DISPUTES

If you are considering submitting more than twenty (20) substantially similar payment disputes, you are encouraged to first reach out to one of the following KP resources as we may be able to identify a root cause and streamline the resolution process:

Referral and Continuum of Care claims payment disputes: **(510) 987-4102**

Emergency services claims payment disputes: **(800) 390-3510**

Online Affiliate cannot be utilized to submit batches of substantially similar payment disputes. If you proceed with filing substantially similar multiple payment disputes, they may be filed in writing in batches, submitted via U.S. Mail or other physical delivery, and include the following information:

Each claim being disputed must be individually numbered and contain the provider's name, the provider's tax identification number, the provider's contact information, the

original KP claim number (if the dispute is claim related), the member's KFHP medical record number (if the dispute concerns care provided to a specific KFHP member or members), date(s) of service, clear identification of the item(s) being disputed for each claim and an explanation of the basis for each dispute.

The submission must include all these data elements as well as any documentation you wish to submit to support your dispute. Any submission of substantially similar payment disputes that does not include all required elements will be rejected as incomplete and will need to be re-submitted with all necessary information.

VIII. CLAIM OVERPAYMENTS

A. Notice of Overpayment of a Claim

If KP determines that we have overpaid a claim, we will notify you in writing through a separate notice clearly identifying the claim, the name of the patient, the date(s) of service and a clear explanation of the basis upon which we believe the amount paid on the claim was in excess of the amount due. The refund request will include interest and penalties on the claim where applicable.

B. Contested Notice

If you contest our notice of overpayment of a claim, we ask that you send us a letter within thirty (30) business days of your receipt of the notice of overpayment to the address indicated by KP in the overpayment notice. Such letter should include the basis upon which you believe the claim was not overpaid. If your contest notice to KP does not include the basis upon which you believe the claim was not overpaid, then that basis must be provided in writing no more than 365 calendar days following your initial receipt of the KP notice of overpayment. We will process the completed letter of contest in accordance with the KP payment dispute resolution process described in Section IV above.

C. No Contest

If you do not contest our notice of overpayment of a claim, you must reimburse us within thirty (30) business days of your receipt of our notice of overpayment of a claim. Interest will begin to accrue at the rate of 10 (ten) percent per annum on the amount due beginning with the first business day following the initial 30 business day period.

D. Offsets to Payments

We will only offset an uncontested notice of overpayment of a claim against a provider's current claim submission when: (i) the provider fails to reimburse KP within the timeframe set forth in Section VIII.C, above, and (ii) KP's contract with the provider specifically authorizes KP to offset an uncontested overpayment of a claim from the provider's current claims submissions or KP has obtained other written offset authorization from the provider. In the event an overpayment of a claim or claims is offset, the Evidence of Payment (EOP) includes a Recoupment

Detail Report. This report provides additional details about your vendor balance and offset, including which claims the offset was applied to.

IX. INTERPRETATION UNDER CONTRACT

To the extent your agreement expressly sets forth any longer time frame or additional process than as set forth above, the contractual provisions shall apply to the extent not prohibited under applicable law.

POL-020-CA Clinical Review Payment Determination Policy - California

This policy applies to California for all lines of business.

1.0 Business Policy

This policy provides information on rules that govern National Payment Integrity (NPI) Clinical Review processes related to determining payment for claims under review. NPI Clinical Review is responsible for reviewing facility and professional claims to ensure that providers comply with billing and coding standards, that services rendered are appropriate and medically necessary, and that payment is made in accordance with applicable contract and/or provider manual requirements.

2.0 Rules

2.1 Itemized Bill Review (IBR)

2.1.1 National Claims Administration will not reimburse providers for items or services that are considered inclusive of, or an integral part of, another procedure or service, rather, non-separately payable services will be paid as part of the larger related service and are not eligible for separate reimbursement.

2.1.1.1 NPI Clinical Review will apply commonly accepted standards to determine what items or services are eligible for separate reimbursement. Commonly accepted standards include CMS guidelines, National Uniform Billing Committee (NUBC) standards, National Correct Coding Initiative (CCI) standards, and professional and academic journals and publications.

2.1.1.2 NCA staff will submit a request for information (RFI) to the provider to request an itemized bill and/or medical records if financial liability cannot be determined based on the submitted claim.

2.1.1.3 NCA intake staff will scan and attach itemized bills to related claims in order to complete claims processing.

2.1.2 National Claims Administration will not separately reimburse items and services as defined below.

2.1.2.1 Charges for use of capital equipment, whether rented or purchased, are not to be separately payable. The use of such equipment is part of the administration of a service. NPI Clinical Review will review claims for these charges and provide instructions to Claims staff to deny these services as not payable. Examples include automatic blood pressure machines/monitors,

anesthesia machines, cameras, cardiac monitors, fetal monitors, EMG, temperature monitor, apnea monitors, cautery machines, cell savers, instruments, IV/feeding pumps, lasers, microscopes, neuro monitors, oximetry monitors, scopes, specialty beds, thermometers, ventilators, balloon pumps, EKG machines, and hemodynamic monitoring catheters.

2.1.2.2 Charges for IV flushes (for example, heparin and/or saline) and solutions to dilute or administer substances, drugs, or medications, are not separately payable. The use of these is part of the administration of a service. NPI Clinical Review will review claims for these charges and provide instructions to Claims staff to deny these services as not payable. Examples include, IV start, access of indwelling catheter, subcutaneous catheter or port, flush at the end of an infusion, standard tubing/syringes/supplies, and preparation of chemotherapy agents.

2.1.2.3 Charges for hydration are not separately payable unless the hydration services are therapeutic, based on patient medical records. NPI Clinical Review will review claims for these charges, along with supporting medical records, to determine whether the services are therapeutic and therefore payable.

2.1.2.4 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 payable. This applies to both the inpatient and outpatient settings. These services are part of the room and board charges. NPI Clinical Review must review claims for these charges and provide instructions to Claims staff to deny these services as not payable. Examples include: IV insertion, saline flushes, infusion of IV fluids, administration of medications (IV, PO, IM), urinary catheterization, dressing changes, tube feeding, respiratory treatment or care such as (but not limited to): sputum induction, airway clearance (ex: suctioning), incentive spirometer, nebulizer treatment, if a potent drug was administered, point of care testing, nasogastric tube (NGT) insertion, incremental nursing care, measuring blood oxygen levels, and specimen collection.

2.1.2.5 Under the OPPS (Outpatient Prospective Payment System), any charges for line items or Healthcare Common Procedure Coding System (HCPCS) codes that are bundled together under a single payment for surgical procedure should not be paid separately. This is because the cost of these items and services is already included in the overall payment for the associated service. These bundled and or packaged items are considered an essential component of the procedure and included in the APC payment for the service of which they are an integral part. For instances when the claim contains services payable under cost reimbursement or services payable under a fee schedule, in addition to services that would be packaged if an Ambulatory Payment Classification (APC) were applicable, the packaged services are not separately payable.

Packaged services are identified in the OPPS Addendum B with Status indicator of "N".

2.1.2.6 Personal Care Items. These items do not contribute to the meaningful treatment of the patient's condition. NPI Clinical Review will review claims for these charges and provide instructions to Claims staff to deny these services as not payable. Examples include but are not limited to admission kits, oral swabs/mouthwash, footsies/slippers.

2.1.2.7 Charges for respiratory therapy services provided at a Specialty Care Unit

(such as ICU, Pediatric ICU, CCU, ED, or intermediate intensive care units) are not separately payable. The use of these services is part of the administration of care at a Specialty Care Unit. NPI Clinical Review will review claims for these charges and provide instructions to Claims staff to deny these services as not payable. Examples include but not limited to ventilator supplies, heated aerosol/heated aerosol treatments while patient on ventilator, oxygen, oximetry reading or trending, CO2 monitoring/trending, arterial punctures, endotracheal suctioning, and extubation.

2.1.2.7.1 Allow one daily ventilator management charge or BiPAP while the patient is in the specialty care unit.

2.1.2.7.2 Allow Continuous Positive Airway Pressure (CPAP) while the patient/neonate is in the neonatal intensive care unit (NICU).

2.1.2.7.3 CPAP for routine use, including use for obstructive sleep apnea is not separately payable.

2.1.2.7.4 Charges for respiratory services provided in the inpatient setting other than at a specialty care unit are limited to 1 unit/charge per date of service regardless of the number of respiratory treatments and/or procedures provided. Examples include but are not limited to CPT if done by a respiratory therapist, nebulizers, heated aerosol and oxygen, chest percussions if done by a respiratory therapist, and demonstration of MDI use or respiratory equipment by a respiratory therapist. Examples of non-specialty care units:

- Telemetry units
- Medical surgical units

2.1.2.8 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 payable. 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 payable treatment. NPI Clinical Review will review claims for these charges and provide instructions to Claims staff to deny these services as not payable.

2.1.2.9 Charges for Point of Care (POC) tests are not separately payable. These tests are performed at the site where the patient care is provided by the nursing staff at the facility as part of the room and board services. Under the Clinical Laboratory Amendments of 1988 (CLIA), a POC must have a Certificate of Waiver license in order for the site to allow POC testing. NPI Clinical Review will review claims for these charges and provide instructions to Claims staff to deny these services as not payable.

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

2.1.2.10.1 Cardiovascular services: Full payment is made for the TC service with the highest payment under the MPFS (Medicare Physician Fee Schedule), and 75% (seventy-five percent) for subsequent TC services furnished by the

same physician, or by multiple in the same group practice, to the same patient on the same day.

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

2.1.2.11 Multiple Procedure Payment Reduction (MPPR). Kaiser Permanente will reimburse the highest-valued procedure at the full fee schedule or contracted /negotiated rate and will reduce payment for the second and subsequent procedures. The National Correct Coding Initiative (NCCI) policy states: "Most medical and surgical procedures include pre-procedure, intra-procedure, and post-procedure work. When multiple procedures and or surgeries are performed at the same patient encounter, there is often overlap of the pre-procedure and post-procedure work. The payment methodologies for surgical procedures account for the overlap of the pre- procedure and post-procedure work."

The primary or highest valued procedure will be reimbursed at 100% of the fee schedule value or contracted/negotiated rate. Second and/or subsequent procedures will be reimbursed at 50% of the fee schedule value or contracted/negotiated rate.

2.1.2.11.1 Kaiser Permanente will apply reductions to the secondary and subsequent technical component of imaging procedures when multiple services are ordered by the same physician for 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% and the technical components for additional less-technical services in the same code.

2.1.2.11.2 When more than one surgical procedure is performed during the same operative session by the same provider, all procedures should be billed on the same claim. Payment for multiple surgeries is based on whether the surgical procedure itself may be subject to a multiple surgery reduction. If the multiple surgery reduction applies, the procedure with the highest allowed amount will be allowed at 100% of the contracted/allowed rate. The multiple surgery reduction will be applied to the procedure(s) with a lesser allowed amount at 50 percent of the contracted/allowed rate.

2.1.2.12 Implants. According to the Food and Drug Administration (FDA), implants are devices or materials placed surgically inside or surface of the body. Implants can be permanent or removed when no longer needed. Many implants are intended to replace body parts, deliver medication, monitor body functions, or provide support to organs or tissues.

2.1.2.12.1 A medical device must meet the following requirements to be eligible for reimbursement:

If required by the FDA, the device must have received FDA approval or clearance (except for a device that has received an FDA investigational device exemption (IDE) and has been classified as a Category B device by the FDA in accordance with §§405.203 through 405.207 and 405.211 through 405.215 of the regulations) or another appropriate FDA exemption.

The device is reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body part (as required by section 1862(a)(1)(A) of the Social Security Act).

The device is an integral and subordinate part of the service furnished, is used for one patient only, comes in contact with human tissue, is surgically implanted or inserted through a natural or surgically created orifice or surgical incision in the body, and remains in the patient when the patient is discharged from the hospital.

2.1.2.12.2 The device is not any of the following:

Equipment, an instrument, apparatus implement, or item of this type for which depreciation and financing expenses are recovered as depreciable assets as defined in Chapter 1 of the Medicare Provider Reimbursement Manual (CMS Pub. 15-1).

A material or supply furnished to a service such as sutures, surgical clip, other than a radiological site marker.

A medical device that is used during a procedure or service and does not remain in the patient when the patient is released from the hospital.

Material that may be used to replace human skin (for example, a biological or synthetic material).

2.2 Trauma Activation

2.2.1 In order to receive reimbursement for trauma activation, a facility must:

2.2.2 Have received a pre-notification from EMS or someone who meets either local, state, or ACS field criteria and are given the appropriate team response.

2.2.3 Bill for trauma activation cost only. Clinical Review will look for documentation of the team members being called to support the trauma activation.

2.2.4 Reported in conjunction with type of admission/visit code 05 (trauma center).

2.2.5 Evaluation and Management codes for critical care must be billed under Revenue Code 450 in order to receive trauma activation reimbursement. 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.

2.3 Diagnosis Related Group (DRG) Payment

2.3.1 The purpose of DRG validation is to ensure diagnostic and procedural information and discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician's description and the information contained in the beneficiary's medical records.

2.3.2 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.

2.3.3 Validation must ensure diagnostic and procedural information and discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician's description and the information contained in the beneficiary's medical record.

2.3.4 Reviewers will validate principal diagnosis, secondary diagnoses, and procedures affecting or potentially affecting the DRG.

2.3.5 The comprehensive review of the patient's medical records will be conducted to validate:

- Physician-ordered inpatient status.
- Accuracy of diagnostic code assignment.
- Accuracy of the procedural code assignments.
- Accuracy of the sequencing of the principal diagnosis and procedure codes.
- Accuracy of present-on-admission (POA) indicator assignment.
- Accuracy of DRG grouping assignment and associated payment.
- Accuracy of Discharge Disposition Status Code assignment.
- Other factors that may impact DRG assignment and/or claim payment.
- 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.

2.4 Medical Necessity Review

2.4.1 A decision by Clinical Review may be made that a request for benefit coverage under the patient's plan does not meet the requirements for Medical Necessity. Such requests are reviewed for: appropriateness of treatment, levels of care billed, or the request may be determined to be cosmetic in nature, experimental, or investigational. The requested benefit may therefore be denied, reduced, or payment not provided or made, in part or in whole.

2.4.2 Determinations of medical necessity should 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. Considerations include:

2.4.3 Appropriate for the symptoms and diagnosis or treatment of the member's condition, illness, disease, or injury.

2.4.4 Provide for the diagnosis, direct care, and treatment of the medical condition.

2.4.5 Meet the standard of good medical practice and is not mainly for the convenience of the provider or patient.

2.5 Level of Care Review

2.5.1 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.

2.5.2 The review will involve assessing whether the billed days for each level care are both authorized and medically necessary.

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

2.6 Short Stay/2 Midnight Rule Kaiser Permanente will reimburse a provider for an inpatient admission if the medical records support inpatient admission and if at time of or before admission, the admitting physician reasonably expects the patient's hospital care would cross two midnights**.**

2.6.1 Exceptions to the 2 Midnight Rule:

2.6.1.1 Unforeseen circumstances such as the patient's death or transfer that will result in a shorter patient stay than what the admitting physician expected.

2.6.1.2 For admissions not meeting 2 Midnight Rule, inpatient admission less than 2 days will be considered on a case-by-case basis where the medical records support the physician's determination that the patient requires inpatient care despite the lack of a two-midnight expectation.

2.6.1.3 An inpatient admission for a surgical procedure specified by Medicare as inpatient only

2.7 Post Stabilization

2.7.1 (California) Non-Plan treating providers or the member are required to contact Kaiser Permanente to request prior authorization for post-stabilization care. After receiving a request for authorization, Kaiser Permanente must either authorize care or arrange for transfer to a Plan provider. Kaiser Permanente does not reimburse for unauthorized post-stabilization services.

2.8 Neonatal Intensive Care Level of Care (NICU)

2.8.1 This medical criteria provides guidance for NICU and neonatal care levels 2 through 4. Level 1 admission and discharge criteria as coupling or mother/baby care was intentionally omitted as it now replaces routine nursery care.

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

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

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

2.9.2 Certain claims are excluded from review:

2.9.2.1 Claims with certain diagnosis codes (e.g., sexual assault, homicidal ideations, bipolar disorder, schizophrenia).

2.9.2.2 Claims for children under 2.

2.9.2.3 Claims for patients who died in the emergency department or were discharged/transferred to another care setting.

2.9.2.4 Claims for patients who received critical care services.

2.9.3 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.

2.9.4 To learn more about the EDC Analyzer ™ tool, see: EDC Analyzer.com.

2.10 Provider Preventable Conditions (PPC) review applies to the Medicaid line of business. Per CMS guidelines, reimbursement is prohibited to providers for services which meet certain conditions, for example, surgery performed on the wrong body parts.

2.10.1 The Clinical Review department reviews claims that have been pended for review to determine whether the claim contains any PPC services based upon a defined list of Health Care Acquired Conditions (HAC) and Other Provider Preventable Conditions (OPPCs).

2.10.2 The Clinical Review department will determine if the service provided meets the clinical guidelines set forth by CMS to ensure PPC services are not reimbursed.

2.10.3 The Clinical Review department will instruct the claims examiner not to reimburse any non-payable service lines or portion of those service lines.

2.11 DO NOT BILL EVENTS (DNBE)

Per CMS guidelines, providers will not be reimbursement for certain DNBE also known as "never events." DNBE (Never Events), are errors in medical care that are of concern to both the public and health care. Examples are included, but not limited to the below. KP may reduce payment for services directly related to a Do Not Bill Event.

- Wrong surgery or invasive procedure on patient
- Surgery or invasive procedure on wrong patient
- Surgery or invasive procedure on wrong body part

2.11.1 Hospital Acquired Condition is a condition that could reasonably have been prevented through the application of evidence-based guidelines.

The charges for these events will be disallowed. Medical records are used to confirm the DNBE/HAC/Sentinel Event and an Itemized Statement is used to identify related charges.

3 Guidelines

N/A

4 Definitions

4.1 Capital equipment - Items that are used by multiple patients during the lifetime of that piece of equipment.

4.2 Center for Medicare and 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.

4.3 Diagnosis Related Group (DRG) - A system of classifying or categorizing inpatient stay into relatively homogenous groups for the purpose of payment by CMS.

4.4 Medical Necessity - Medical Necessity is the standard terminology that all health care professionals and entities use for the review process to determine whether medical care is appropriate and essential and is an appropriate health care service and supply provided by health care entities, appropriate to the evaluation and treatment of a disease, condition, illness or injury, and is consistent with the applicable standard of care. Criteria used to determine whether services are medically necessary are evidence based.

4.5 Personal Care Items - Items used by the patient for non-medical use such as hygiene and comfort. Examples include: admission kits, pillows/blankets/linens/towels, cosmetics/cleansers/soap/deodorizers, diapers/wipes, lotions/creams, oral swabs/mouthwash/shaving supplies/toothpaste/toothbrush, nutritional supplies, bath comfort kits (shampoo, conditioner, hairspray), slippers/footies, hairbrush/comb, and facial tissues.

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 nor the skills of licensed or certified technicians or technologists.

4.7 Post Stabilization Care - Medically necessary services related to the member's emergency condition that the member receives after the treating physical determines the member's condition is stabilized.

4.8 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. Examples of routine supplies or floor stock include: thermometers, respiratory supplies such as oxygen masks/ambu bags, suction tips, tubing, oxygen, preparation kits, irrigation solutions (sterile water, normal saline), gauze/sponge sterile or non-sterile, oximeters/oximeter probes, syringes, gloves/masks, supplies used ordinarily for surgery such as surgery drapes/sutures, sequential compression socks, bedpans/urinals, hypo/hyperthermia blankets, EKG electrodes, lab supplies, hypodermic needles, and personal care items.

4.9 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 generally 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.

5 References

N/A

6 Frequently Asked Questions (FAQs)

N/A

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