POL-020 Clinical Review Payment Determination Policy – MOC

This policy applies to the following regions: Colorado, Georgia, Hawaii, Mid-Atlantic States, Northwest, and Washington 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 Ambulatory Payment Classification (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 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, footies/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.

2.1.2.12 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 family are reduced by 50%.

2.1.2.13 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% of the contracted/allowed rate.

2.1.2.14 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.

2.1.2.14.1 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.

2.1.2.14.2 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 Intraoperative Neurophysiologic Monitoring (IONM) (MOC)

2.2.1 Intraoperative neurophysiologic monitoring must be performed by either a licensed physician trained in clinical neurophysiology or trained technologist who is practicing within the scope of his/her license certification as defined by state law or appropriate authorities and is working under direct supervision of a physician trained in neurophysiology; AND

2.2.2 Intraoperative neurophysiologic monitoring must be interpreted by a licensed physician trained in clinical neurophysiology, other than the operating surgeon, who is either in attendance in the operating suite or present by means of a real-time remote mechanism for neurophysiologic monitoring situations and is immediately available; AND

2.2.3 Monitoring is conducted and interpreted real-time (either onsite or at a remote location) and continuously communicated to the surgical team; AND

2.2.4 The physician performing or supervising monitoring must be monitoring no more than three cases simultaneously; AND

2.2.5 Charges for services performed by a certified neurological intraoperative monitoring technologist will be reimbursed at allowable professional fee; AND

2.2.6 Charges related to intraoperative monitoring will only be reimbursed when billed on a HCFA 1500 claim form for professional charges; AND

2.2.7 Any charges related to intraoperative monitoring billed on a UB form are not reimbursable.

2.2.8 Specific information regarding intraoperative neuromonitoring may be requested through National Clinical Review.

2.3 Trauma Activation

2.3.1 Trauma activation reimbursement (National Claims Administration only) reimburses trauma activation when all criteria are met.

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

2.3.1.1.1 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.

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

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

2.3.1.1.4 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.

2.4 Diagnosis Related Group (DRG) Payment

2.4.1 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.

2.4.2 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.

2.4.3 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.

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

2.4.5 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.

2.5 Medical Necessity Review

2.5.1 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.

2.5.2 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:

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

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

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

2.6 Level of Care Review

2.6.1 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.

2.6.2 The review involves assessing whether the billed days for each level care are both authorized and medically necessary.

2.6.3 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.

2.7 Short Stay/2 Midnight Rule

2.7.1 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.

2.7.2 Exceptions to the 2 Midnight Rule:

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

2.7.2.2 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.

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

2.8 Post Stabilization

2.8.1 **(MOC)** The non-Plan treating provider or member will contact Kaiser Permanente to request prior authorization for post-stabilization care before the member receives the care. If a Kaiser Permanente provider determines the member requires the services as post-stabilization care and the services are covered, KP will authorize the services or arrange for Plan provider (or other designated provider) to provide services. If the services are not authorized, the request for reimbursement will be denied.

2.9 Neonatal Intensive Care Level of Care (NICU)

2.9.1 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.

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

2.10 Robotics (MOC)

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

2.11 Three-Day Lookback (MOC)

2.11.1 Medicare's 3-day rule requires that certain hospital outpatient services and services rendered by Part B entities (for example: ambulatory surgical centers) wholly owned or operated by hospitals, be included (bundled) in the hospital's claim for in-patient stay.

2.11.2 For hospitals reimbursed by DRG pricing, it is required that hospitals bundle the technical component of all outpatient diagnostic services (including diagnostic laboratory tests) and related non-diagnostic services (for example: therapeutic) with the claim for an inpatient stay when services are furnished to a member in the 3 days preceding an inpatient admission by the same facility.

2.11.3 All outpatient non-diagnostic services are deemed related to the patient admission unless the provider or hospital attests that the specific non-diagnostic services are unrelated to the hospital claim.

2.12 Thirty-Day Readmission (MOC)

2.12.1 Kaiser Permanente does not allow separate reimbursement for claims that have been identified as a readmission to the same hospital reimbursed by DRG pricing for the same, similar or related condition unless provider, state, federal or CMS contracts and/or requirements indicate otherwise. In the absence of provider, federal, state and/or contract mandates, Kaiser will use the following standards: (a) readmission within 30 days from discharge; (2) same diagnosis or diagnoses that fall into the same grouping.

2.12.2 Kaiser Permanente will use clinical criteria and licensed clinical professionals as part of the review process for readmissions from day 2 to day 30 in order to determine if the second admission is for: (a) the same or closely related condition or procedure as the prior discharge; (b) an infection or other complication of care; (c) a condition or procedure indicative of a failed surgical intervention; (d) an acute decompensation of a coexisting chronic disease; (e) a need that could have reasonably been prevented by the provision of appropriate care consistent with

accepted standards in the prior discharge or during the post discharge follow-up period; (f) an issue caused by a premature discharge from the same facility; (g) a reason that is medically unnecessary.

2.12.3 Exclusions: (a) Admissions for the medical treatment of cancer; (b) primary psychiatric disease and rehabilitation care; (c) Planned readmissions; (d) Patient transfers from one acute care hospital to another; (e) Patient discharged from the hospital against medical advice.

2.12.4 Kaiser does not apply the inpatient readmission criteria to Critical Access Hospitals (CAH) and considers the following as exclusions for the Washington State region: (a) Readmission due to patient nonadherence; (b) End-of-life and hospice care; (c) Obstetrical readmissions for birth after an antepartum admission; (d) Neonatal readmissions; (e) Transplant readmissions within 180 days of transplant.

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

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

2.13.2 This policy will apply to all facilities that submit ED claims with level 3, 4, or 5 E/M codes for members of the affected plans, regardless of whether they're under contract to participate in our in our network.

2.13.3 Certain claims are excluded from review:

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

2.13.3.2 Claims for children under 2.

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

2.13.3.4 Claims for patients who received critical care services.

2.13.4 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.

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

2.14 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.

2.14.1 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).

2.14.2 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.

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

2.15 Do Not Bill Events (DNBE)

2.15.1 Per CMS guidelines, providers will not be reimbursement for certain DNBE also known as "never events." DNBEs (never events), are errors in medical care that are of concern to both the public and health care. Examples include, but are 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

2.15.2 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.

3.0 Guidelines

N/A

4.0 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.

5.0 References

N/A

6.0 Frequently Asked Questions (FAQs)

N/A

(Updated: 10/02/23)

Revision History
Approvals