KAISER PERMANENTE®

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

Kaiser Permanente values its relationship with the community partners who serve the health care needs of our Kaiser Foundation Health Plan 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

A. Sending Claims to Kaiser Permanente

Claims for services provided to Kaiser Foundation Health Plan members must be sent to the following:

By U.S. Mail:
Kaiser Foundation Health Plan, Inc.
Claims Administration Department
P.O. Box 7004
Downey, California 90242-7004

By Physical Delivery Other Than by U.S. Mail:
Kaiser Foundation Health Plan, Inc.
Claims Administration Department
12254 Bellflower Boulevard
Downey, California 90242

By Electronic Delivery:
Contact your local HIPAA compliant clearinghouse for instructions on submitting electronic claims

B. Calling Kaiser Permanente Regarding Claims

For claim filing requirements or status inquiries, you may contact Kaiser Permanente by calling: **1-800-390-3510.**

C. Claims Submission Requirements

You are required to submit "complete claims" as defined in the Claims and Dispute Resolution Regulations for the services provided, which must include the following information, as applicable:

- A UB-04 form or a CMS 1500 form with all National Uniform Billing Committee (NUBC) or National Uniform Claim Committee (NUCC) mandatory entries completed.
- All services and diagnoses must be billed using standard billing codes:
  Revenue codes – Codes used to identify specific accommodation, ancillary service or billing calculation

  CPT-4 – Physicians Current Procedural Terminology
  HCPCS – HCFA Common Procedure Coding System
  ICD-9-CM – Medical Index for medical diagnostic coding (through 09/30/14)
  ICD-10– Medical Index for medical diagnostic coding (starts 10/01/14)
  DSM-IV-R – Mental Health diagnostic coding
- The Kaiser Foundation Health Plan member's identification number, commonly referred to as the Medical Record Number.

- The Kaiser Permanente Authorization/Referral Control Number, for non-emergency services.
- All supporting documentation (*e.g.*, admitting face sheet, discharge summary, operative reports, emergency room reports, medical records, etc.) that is reasonably relevant to the specific claim, and is therefore necessary in determining payment on such claims, should accompany the initial claim(s) submission. If documentation is required beyond what you have provided, we will promptly notify you in writing.
- Treatment notes reasonably relevant and necessary to determine payer liability, including information that demonstrates the need for any CPT code modifier used.

In addition, depending on the claim, additional information may be necessary if it is "reasonably relevant information" and "information necessary to determine payer liability" (as each such term is defined in Section 1300.71(a)(10) and (a)(11) of the Claim and Dispute Regulations).

You are required to submit claims within ninety (90) days after the date of service as a condition for payment, unless your agreement with us provides for a longer timeframe and except as otherwise required or permitted by any state or federal law or regulation. 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 Health Plan member, but you may resubmit the claim as a provider dispute. If you choose to resubmit the claim, you must include the reason for your initial late submission of the claim, along with the other required information described in Section IV. "Provider Dispute Resolution Process".

For inpatient services only, we will accept separately billable claims for services in an inpatient facility on a bi-weekly basis, to the extent required by the Claim and Dispute Regulations.

D. Claims Receipt Verification

Depending on whether you submitted your claim electronically or in paper format, we offer two options to verify the receipt of your claims:

1) For claims filed electronically (through the process known as electronic data interchange or EDI), we will acknowledge to the data clearinghouse, through which you submitted the claim to Kaiser Permanente, our receipt of the claim within two (2) working days of our receiving it from the data clearinghouse.

2) For claims submitted to us in a paper format, you may obtain acknowledgment of receipt by calling our Member Services Call Center at 1-800-390-3510; please allow at least fifteen (15) working days after you submit your paper claim before telephoning to verify our receipt. During that call, the representative will be able to tell you the date the claim was received and the Kaiser Permanente identification number assigned to your claim should you need to contact us again regarding some aspect of the claim's status or disposition.

II. CLAIMS PAYMENT POLICY

For services entitled to payment under the terms of a provider contract, the terms of that contract control the amount of payment. Please refer to your contract for more detailed information on the reimbursement method and rates that apply to you. The following general rules apply to our payment policies.

Kaiser Permanente's claims payment policies for provider services 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.

Routinely updated code editing software from a leading national vendor is used for processing all relevant bills in a manner consistent with the Medicare Correct Coding Initiative, American Society of Anesthesiologists (ASA) and the AMA's Current Procedural Terminology (CPT) guidelines. Our claims adjudication systems accept and identify all active CPT and HCPCS codes as well as all coding modifiers. Payment for services such as multiple procedures, bilateral procedures, assistant surgeons, co-surgeons and application of modifiers are reimbursed in accordance with Medicare guidelines. When applicable, we request supporting documentation for "unlisted" procedure codes and the application of Modifier 26.

We do not allow code unbundling for procedures for which Medicare requires all-inclusive codes and we will re-bundle the procedures and pay according to Medicare's all-inclusive codes.

Depending on your specific contract provisions, Kaiser Permanente utilizes case rates, fee schedules, the Average Wholesale Price from the periodically updated Red Book, published by Thomson Healthcare, and/or Medicare guidelines for the reimbursement of immunizations and injectable medications.

Kaiser Permanente calculates anesthesia units in fifteen (15) minute increments.

If your contract so provides, Kaiser Permanente uses reasonable and customary rates to reimburse those services that are not subject to contracted rates. Reasonable and customary rates are determined using a statistically credible database updated at least annually. Kaiser Permanente also uses Medicare Prospective Payment System (PPS) rates, when applicable.

II. OFFICE RESPONSIBLE FOR PROVIDER DISPUTES

The office responsible for provider disputes is the Department of Research and Resolution, Kaiser Foundation Health Plan, Inc., Claims Administration Department, P.O. Box 7006, Downey, California 90242-7006.

III. PROVIDER DISPUTE RESOLUTION PROCESS

A. Types of Disputes

You must submit a written notice to us if you have a dispute. Your written notice of a dispute is referred to in this document as a "Provider Dispute Notice".

The following describes the most common types of disputes:

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

2. **Billing Determinations Disputes**: seeking resolution of a billing determination (or bundled group of billing determinations) by us.

3. **Responding to Requests for Overpayment Reimbursements**: disputing a request by us of reimbursement by you of overpayment of a claim; and

4. **Other Contract Disputes**: seeking resolution of a contract dispute (or bundled group of contract disputes) between you and us.

B. Provider Dispute Requirements

1. **Directions for Delivery and Mailing of Provider Disputes**

By U.S. Mail: **Kaiser Foundation Health Plan, Inc.**
Department of Research and Resolution c/o

Claims Administration Department P.O. Box 7006
Downey, California 90242-7006

By Physical Delivery Other Than By U.S. Mail:

Kaiser Foundation Health Plan, Inc.
Claims Administration Department
12254 Bellflower Boulevard
Downey, California 90242

2. Calling Kaiser Permanente Regarding Provider Disputes

For provider dispute inquiries and filing information, you may contact Kaiser Permanente by calling: **1-800-390-3510**.

3. Required Information for Provider Disputes

Your Provider Dispute Notice must contain at least the information listed below, as applicable to your dispute. If your Provider Dispute Notice does not contain all of the applicable information listed below, we may return the Provider Dispute Notice to you and we will identify in writing the missing information necessary for us to consider the dispute. If you want to continue the dispute, you must submit an amended Provider Dispute Notice within thirty (30) working days after the date that you received your Provider Dispute Notice back from us.

Required Information:

- Your name, your provider identification number, and your contact information.
- If the dispute concerns a claim or a request for reimbursement of an overpayment of a claim, a clear identification of the disputed item using the same number assigned to the original claim, 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 dispute is not about a claim, a clear explanation of the issue and your position on the issue.
- If the dispute involves a member or a group of members, the name and Medical Record Number(s) of the member(s), a clear explanation of the disputed item(s), including the date(s) of service and your position about the item.

You may submit your Provider Dispute Notice on our Provider Dispute Resolution Request form (PDRR) (Attached). You may contact us at 1-800-390-3510 to obtain the form. You may also submit a dispute in writing in any format you prefer, so long as it includes all the information described above.

Your Provider Dispute Notice may be submitted by you or by your authorized representative (for example, a billing service, a collection agency, or an attorney) authorized by you to perform this function. If your authorized representative submits your Provider Dispute Notice, that representative will be required to provide confirmation that an executed business associate agreement that complies with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is in place between you and such representative.

V. TIME PERIOD FOR SUBMISSION OF PROVIDER DISPUTES

Subject to any longer period specifically stipulated under your agreement or required under applicable law, contracted provider disputes must be received by Kaiser Permanente within 365 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, contracted provider disputes must be received by Kaiser Permanente within 365 days after our time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired. To the extent that your contract contains a specified process for resolving provider disputes that is different from that described in this Notice, that process will be available to you as specified in your contract after you have submitted your dispute and received our written determination as described above.

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

We will acknowledge receipt of your provider dispute within fifteen (15) working days after the date of receipt by the office designated above. Our return to you of a dispute that does not include all required information constitutes our acknowledgment of receipt of your initially submitted dispute. Kaiser Permanente will issue a written determination stating the pertinent facts and explaining the reasons for its determination of a dispute, to the extent required by applicable law, within forty-five (45) working days after the date of receipt of the contracted provider dispute or an amended contracted provider dispute.

VII. INSTRUCTIONS FOR FILING SUBSTANTIALLY SIMILAR CONTRACTED PROVIDER DISPUTES

Substantially similar multiple payment disputes may be filed in batches as a single dispute, provided that such disputes are submitted in the following format:

Each claim must be individually numbered and contain the provider's name, the provider's identification number, the provider's contact information, the original Kaiser Permanente claim number (if the dispute is claim related), and the Health Plan member's identification number, also known as the member's Medical Record Number (if the dispute concerns care provided to a specific Health Plan member or members).

VIII. CLAIM OVERPAYMENTS

A. Notice of Overpayment of a Claim

If Kaiser Permanente determines that it has overpaid a claim, Kaiser Permanente will notify the provider in writing through a separate notice clearly identifying the claim, the name of the patient/member, the date(s) of service and a clear explanation of the basis upon which Kaiser Permanente believes the amount paid on the claim was in excess of the amount due. The refund request will include interest and penalties on the claim.

B. Contested Notice

If the provider contests the Kaiser Permanente notice of overpayment of a claim, the provider, within thirty (30) working days of the receipt of the notice of overpayment of a claim, must send written notice to Kaiser Permanente stating that it contests the overpayment notice. If the contest notice to Kaiser Permanente does not include the basis upon which the provider believes that the claim was not overpaid, then that basis must be provided in writing no more than 365 days following the provider's initial receipt of the Kaiser Permanente notice of overpayment. Kaiser Permanente will process the completed contested notice in accordance with the Kaiser Permanente contracted provider dispute resolution process described in Section IV above.

C. No Contest

If the provider does not contest the Kaiser Permanente notice of overpayment of a claim, the provider must reimburse Kaiser Permanente within thirty (30) working days of the provider's receipt of the notice of overpayment of a claim. Failure to do so will result in interest accruing on the unpaid amount beginning with the first calendar day following the thirty working day provider response period.

D. Offsets to Payments

Kaiser Permanente 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 Kaiser Permanente within the timeframe set forth in Section VII.C, above, and (ii) Kaiser Permanente's contract with the provider, or some other written agreement, specifically allows Kaiser Permanente to offset an uncontested notice of overpayment of a claim from the provider's current claims submission. In the event that an overpayment of a claim or claims is offset pursuant to this section, Kaiser Permanente will supply the provider with a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim or claims.

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.

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KAISER PERMANENTE®

TRACKING NUMBER

PROVIDER PAYMENT

DISPUTE RESOLUTION REQUEST

NOTE: SUBMISSION OF THIS FORM CONSTITUTES AN AGREEMENT NOT TO BILL THE PATIENT DURING THE PAYMENT DISPUTE RESOLUTION PROCESS.

PROVIDER NAME:

PROVIDER TAX ID:

☐ **PROVIDER TYPE:** MD Hospital Inpatient Psych Facility Outpatient Services SNF DME Inpatient Rehab Facility Home Health Ambulance Other Professional (please specify)

CLAIM INFORMATION

Patient Name:		
Kaiser Permanente Medical Record Number:	Kaiser Permanente Claim ID Number:	Provider Patient Account Number:
Service "From" Date:	Original Claim Amount Billed:	Original Claim Amount Paid:

SUMMARY OF SERVICES PROVIDED

DETAILED DESCRIPTION OF REASON FOR DISPUTE

NOTE: Please attach any support for your dispute, which may include additional supporting documentation, medical documentation (if appropriate), any related laws/regulations you believe are relevant, or any other information you believe would be helpful.

Contact Name (Please Print) Title

Signature Phone Number Date

Please return form to: Kaiser Foundation Health Plan Inc. Claims Administration Department Post Office Box 7006 Downey, CA 90242-7006

Copy of POL-020 Clinical Review Payment Determination Policy

NTL

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 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: use of local anesthesia, 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 will 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), charges for line items or Healthcare Common Procedure Coding System (HCPCS) codes that are packaged into a payment for surgical procedure should not be paid separately because the cost of these items and services is included in the APC payment for the service in which it is an integral part.

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

2.1.2.7 Charges for respiratory therapy services provided at a Specialty Care Unit (such as ICU, Pediatric ICU, CCU, or ED, 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: 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 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: nebulizers, heated aerosol and oxygen, Chest percussions if done by a respiratory therapist, demonstration of MDI use or use of respiratory equipment by a respiratory therapist.

2.1.2.7.4.1 Telemetry units

2.1.2.7.4.2 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 In accordance with CMS, Kaiser Permanente will apply reductions to the secondary and subsequent technical component of imaging procedures when multiple services are furnished by the same physician 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% and the technical components for additional less-technical services in the same code family are reduced by 50%.

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

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

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

2.1.2.11 Multiple Procedure Payment Reduction (MPPR). Kaiser Permanente will reimburse the highest-valued procedure at the full fee schedule 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 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. Second and/or subsequent procedures will be reimbursed at 50% of the fee schedule value.

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.

2.1.12.2 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 Medical Necessity Review

2.2.1 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.

2.2.2 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:

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

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

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

2.3 Post Stabilization

2.3.1 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.

Policies effective May 2021

2.4 Trauma Activation

2.4.1 Trauma activation will be reimbursed when all criteria are met.

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

2.4.1.1.1 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.

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

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

2.4.1.1.4 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.

2.5 Diagnosis Related Group (DRG) Payment

2.5.1 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.

2.5.2 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.

2.5.3 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.

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

2.5.5 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

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

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

2.6.2 Certain claims are excluded from review

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

2.6.2.1.2 Claims for children under 2

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

2.6.2.1.4 Claims for patients who received critical care services.

2.6.3 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.

2.6.4 To learn more about the EDC Analyzer ™ tool, please visit:
http://edcanalyzer.com

3.0 Guidelines

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

7.0 Related DLPs

N/A

(Updated 3/17/2021)

Revision History

Updated IBR section to include 2.1.2.12 Implants. 2.1.2.7. Added sentence CO2 monitoring arterial punctures and extubation. Subsection: 2.1.2.7.4.1 telemetry units and 2.1.2.7.4.2 medical surgical units. Updated subsection section 2.2.1.1.4 changed code 99291 to Evaluation and Management codes for critical care and Emergency Department visits. Removed sections on Robotics, Three-day lookback, Intraoperative Neuromonitoring and Neonatal Intensive Care Level of Care and policy numbering changed.

New Policies effective May 2021:

Section 2.4 Trauma Activation.

Section 2.5 DRG

Section 2.6 Emergency Department (ED) Facility Evaluation and Management (E&M) Coding

11/11/19: Added following sections: Intraoperative Neuromonitoring and Neonatal Intensive Care Level of Care; in IBR section for Specialty Care Unit added Clinical Review will allow a CPAP while patient is in the neonatal intensive care unit; and added section for multiple procedure payment reduction (MPPR).

07/15/19: Added following sections: Trauma Activation, Diagnosis Related Group Payment, Medical Necessity Review, Post Stabilization, Robotics, and Three-Day Lookback. Updated IBR section to include: 2.1.2.4: added sentence that services integral to provision of specific service in a specific location must not be separately payable; and applies to both inpatient and outpatient settings; added sub-section 2.1.2.5 for Outpatient Prospective Payment System (OPPS); section 2.1.2.6 Personal Care Items, added item examples; section 2.1.2.7 Specialty Care Unit, added NICU and Pediatric ICU; section 2.1.2.8 Routine items/supplies, added sentence that services integral to provision of specific service in a specific location must not be separately payable; section 2.1.2.9 Point of Care, added POC tests are performed at the site where the patient care is provided by the nursing site; added section 2.1.2.10 for adhering to CMS guidelines for applying reductions to secondary and subsequent technical components of imaging procedures when multiples services re furnished by the same physician to the same patient in the same session on the same day.

12/10/18: Removed American Academy of Professional Coders from 2.1.1.1.

06/25/18: Added definitions and restructured Line Item Deductions IBR section.

12/18/17: First published. Effective as of 05/01/17.