POL-020.1 Clinical Review Itemized Bill Review Payment Determination Policy

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

1.0 Business Policy

1.1 Payment Policy Statement

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

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 KFHP policies may be superseded by state, federal and/ or provider contractual requirements.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

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

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

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

1.2 Scope

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

2.0 Rules

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

2.1.1 The review is conducted on a pre-adjudication basis.

2.1.2 Reimbursement is made in accordance with industry standard billing guidelines, regulatory guidance, and applicable provider contract and/or provider manual requirements.

2.1.3 Clinical Review staff will submit a request for information (RFI) to the provider, requesting an itemized bill and/or medical records.

2.1.4 The IBR review will be completed upon receipt of the itemized bill and, or medical records. If the itemized bill and/ or medical records are not received timely a denial will be rendered.

2.1.5 For Inpatient facility services that are reimbursed under a prospective payment system, the payment amount for a particular service is based on the classification system of that service. In addition to the basic prospective payment, an outlier payment is made for certain claims that incur costs above the facility-specific threshold. DRG cost outlier claims are repriced based upon the IBR results.

2.1.6 KFHP will apply commonly accepted standards to determine which of the billed items or services are eligible for appropriate reimbursement. Commonly accepted standards include, without limitations, CMS guidelines, National Uniform Billing Committee (NUBC) standards, National Correct Coding Initiative (NCCI) standards, and various professional and academic journals and publications as outlined above. KFHP clinicians will interpret these standards and apply them to claims using clinical discretion and judgment.

2.2 Reimbursement Guidelines

2.2.1 Clinical Review will not reimburse providers for items or services that are considered inclusive of, or an integral part of another procedure or service. Such services will be paid as part of the larger related service and are not eligible for separate reimbursement. Services to be considered for separate reimbursement should be clearly documented on the itemized bill and medical record. The Clinical reviewer will review the itemized bill and/or medical records for these charges.

2.2.1.1 The following types of charges are examples of charges that a KFHP clinician may determine to be inclusive of, or an integral part of another procedure or service and therefore not separately payable. KFHP will use clinical discretion and judgment and will consider commonly accepted standards as applicable to the facts and circumstances of each case.

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

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

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

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

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

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

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

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

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

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

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

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

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

2.2.8.1

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

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

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

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

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

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

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

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

2.2.14 Charges for respiratory services provided in the inpatient setting other than at a specialty care unit are limited to one unit/charge per date of service regardless of the number of respiratory treatments and/or procedures provided. Examples include, without limitation, the following:

- Chest percussions if done by a respiratory therapist
- Demonstration of Metered Dose Inhaler (MDI) use or respiratory equipment by a respiratory therapist
- Heated aerosol and oxygen
- Nebulizers

2.2.15 Charges for Routine Floor Stock items and supplies necessary or otherwise integral to the provision of a specific service or delivery of service in a specific location are considered routine and are not separately reimbursable. The use of these services is part of the administration of care at a hospital or skilled nursing facility and are used during the normal course of treatment, which may be related to and/or part of a separately reimbursable treatment.

2.2.16 Charges for Point of Care (POC) tests are generally not separately reimbursed. These tests are performed by facility nursing staff, at the site where patient care is provided as part of the room and board services.

2.2.17 KFHP follows commonly accepted standards to not reimburse for duplicative charges and claims. Such duplicative charges and claims are not reimbursable. According to Medicare guidelines, the hospital must install adequate billing procedures to avoid submission of duplicate charges or claims.

2.2.18 Over the counter drugs (OTC) or, drugs which can be self-administered by the patient, are often not separately reimbursed in an inpatient setting. OTC drugs are typically included in the overall inpatient reimbursement.

2.2.19 Routine administrative services are included in the room and board or outpatient facility reimbursement. Routine services in a hospital are those services included by the provider in a daily service charge, commonly referred to as "room and board" charge. Examples include, without limitation, the following:

- Room and board supplies

- Nursing administered services, such as medication administration, blood glucose monitoring, occult blood testing, wound care (including cleaning, dressing changes, and monitoring for infection), pulse oximetry, urine/blood specimen collection etc.

- Routine medical and surgical supplies, such as alcohol wipes, bed pans, blood pressure monitors/cuffs, cardiac monitors, cotton balls, gloves/gowns used by staff, ice bags/packs, heating pads, IV pumps, masks used by staff, saline solutions, syringes, thermometers, and patient gowns.

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

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

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

3.0 Guidelines

N/A

4.0 Definitions

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

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

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

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

4.5 **Personal care items** Items used by the patient for non-medical use such as hygiene and comfort.

4.6 **Point of Care (POC) tests** Tests that are performed at site where patient care is provided. Point of care (POC) tests do not require the equipment or supplies of a CLIA lab nor the skills of licensed or certified technicians or technologists. Under the Clinical Laboratory Amendments of 1988 (CLIA), a POC must have a Certificate of Waiver license in order for the site to allow CLIA- waived POC testing.

4.7 **Routine floor stock** Supplies that are available to all patients in the floor or area of a hospital or skilled nursing facility. These are supplies provided to a patient during the normal course of treatment. Personal care items are non-chargeable because they do not contribute to the meaningful treatment of the patient's condition.

4.8 **Specialty care unit** A specialized unit located within a hospital that must be physically identified as separate from general care areas; the unit's nursing personnel must not be integrated with general care nursing personnel. The unit must be one in which the nursing care required is extraordinary and on a concentrated and continuous basis. Extraordinary care incorporates extensive lifesaving nursing services of the type associated with nursing services provided in burn, coronary care, pulmonary care, trauma, and intensive care units. Special life-saving equipment should be routinely available in the unit.

4.9 **Room charge** A room and board or room care charge for a semi-private, private, or 3+ bedroom shall include the room, dietary services, all nursing care, personnel, and routine disposable or reusable equipment, supplies and items appropriate for that setting.

4.10 **Inpatient** Patient whose condition requires treatment in a hospital or other health care facility, and when the patient is formally admitted to the facility by a doctor. It involves an overnight stay or prolongs the stay of a patient in a licensed healthcare facility.

4.11 **Outpatient** Patient who receives medically necessary services at a hospital, clinic, or associated facility for diagnosis or treatment but has not formally been admitted on an inpatient basis.

5.0 References

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

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

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

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

National Uniform Billing Committee | NUBC

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

Implants and Prosthetics | FDA (implants section)

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

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

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

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

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

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

6.0 Related Topics

POL-020.2 Clinical Review Medical Record Review Payment Determination Policy

POL-020.3 Clinical Review Coding Payment Determination Policy

POL-020.4 Clinical Review Implant Payment Determination Policy

POL-020.5 Clinical Review 30 Day Readmission Payment Determination Policy

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

(Updated: 09/08/25)

Revision History

Approvals