POL-020.2 Clinical Review Medical Record Review Payment Determination Policy

NTL

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 KFHP policies may be superseded by state, federal and/ or provider contractual requirements.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 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 medical record review. Clinical Review will review the medical records provided for medical appropriateness and/or medical necessity to facilitate accurate claims reimbursement. This policy applies to both contracted and non-contracted providers across all lines of business, unless otherwise specified.

2.0 Rules

2.1 Clinicians within the Clinical Review department will review the medical records to determine whether the billed services are medically appropriate or necessary, and correctly coded for reimbursement. When medical records or clinical information is requested, all the specific

information required to make the medical determination must be clearly documented in the records. In addition, services must be considered a covered benefit. Determinations of medical necessity adhere to the standard of care and focus on the direct care and treatment of the patient. KFHP Clinical Review follows CMS and other industry guidelines, clinical literature, and accepted medical necessity criteria.

2.2 Each medical record must be documented for the date of services and specific services billed including, but not be limited to physician orders, diagnoses, evaluations, consultations, medications, treatments, test reports and results, history and physical, emergency room records, care plans, discharge plans, and discharge summaries.

2.3 Reimbursement Guidelines

2.3.1 Clinical Review will review the medical records to assess:

2.3.1.1 Whether the provider exercised appropriate clinical judgment and decision-making in evaluating, diagnosing, and treating the member's condition.

2.3.1.2 Whether the treatment provided was appropriate and clearly documented in the medical record.

2.3.1.3 Whether the level of care billed accurately reflects the services rendered.

2.3.1.4 Whether the services are cosmetic, experimental, or investigational in nature.

2.3.1.5 Whether the coding and billing is accurate and appropriate.

2.3.1.6 Whether the authorization reflects what is billed.

2.3.2 Determining medical appropriateness or necessity should follow the standard of care and focus on the direct care and treatment of the patient. This includes, but is not limited to an assessment of the following:

2.3.2.1 Whether treatment of the members' condition, illness, disease, or injury is appropriate and clearly documented in the medical record.

2.3.2.2 Whether services provided are for the diagnosis and direct treatment of the member's medical condition.

2.3.2.3 Whether the services provided meet applicable standards of good medical practice.

2.3.2.4 Based on the review of the medical records, the payment for the service(s) billed may be denied, reduced, or otherwise adjusted, in part or in whole. Medical necessity reviews that result in a partial or full denial of a service require review and approval by a physician.

2.4 Trauma Activation

2.4.1 Trauma activation will be considered for reimbursement only (when all the following criteria are met.

2.4.1.1 To receive reimbursement for trauma activation, a facility must:

2.4.1.2 Have received prehospital notification based on triage information from EMS or prehospital caregivers, who meet either local, state, or ACS field criteria and are given the appropriate team response.

2.4.1.3 Bill for trauma activation costs only. Clinical Review will request records to review for documentation of the team members being called to support the trauma activation.

2.4.1.4 Code the claim with type of admission/visit code 05 (trauma center).

2.4.1.5 Bill evaluation and management codes for critical care under Revenue Code 450. 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 Level of Care (LOC) Review

2.5.1 LOC Review applies to inpatient facility claims to determine whether the level of care billed matches the LOC that was authorized so that appropriate reimbursement is made.

2.5.2 The review involves assessing whether the billed days for each LOC are both authorized and medically necessary.

2.5.3 If the provider bills additional days or a higher LOC than what is authorized, the claim will be denied, and the provider will need to submit a corrected claim for payment.

2.5.4 LOC will be reviewed based on the patient's specific clinical information, as documented within the medical record.

2.6 Neonatal Intensive Care Level of Care (NICU)

2.6.1 The medical criteria in this section provides guidance for reimbursement of NICU and neonatal care levels 2 through 4. Level 1 admission and discharge criteria such as coupling or mother/baby care was intentionally omitted as it now replaces routine nursery care.

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

2.6.3 Level of care will be reviewed/approved based on the patient's specific clinical information as documented within the medical record.

2.7 Post Stabilization

2.7.1 The treating provider or member must contact KFHP to request prior authorization for post-stabilization care before post-stabilization care is provided. Upon request for prior authorization, KFHP may arrange to take over the members care via transfer or authorize post-stabilization care that is medically necessary to maintain the member's stabilized condition. Unauthorized post-stabilization care is not a covered benefit and claims for post-stabilization that are not authorized by KFHP will be denied.

2.8 Short Stay/2 Midnight Rule

2.8.1 KFHP follows Medicare reimbursement guidelines to determine whether inpatient services are reimbursable. If a doctor anticipates a patient will need medically necessary/appropriate hospital care for at least two nights (spanning two midnights), the stay can be billed as inpatient admission and will be reimbursed accordingly. Medical records must support inpatient admission and must be clearly documented. If the anticipated stay is less than two midnight, the care is typically considered outpatient and should be billed accordingly. There are some exceptions to the two-midnight rule, such as:

2.8.2 The patient is discharged against medical advice (AMA).

2.8.3 The patient dies during the stay.

2.8.4 In these cases, the patient may still be classified as an inpatient, even if their stay did not span two midnights if the initial expectation of a longer stay was reasonable and documented in the medical records.

2.9 Present on Admission (POA):

2.9.1 Consistent with Medicare requirements, KFHP requires POA indicator reporting for all claims involving inpatient admissions to general acute care hospitals or other facilities. General requirements to follow are:

2.9.2 Refer to UB-04, also known as the CMS-1450 Data Specifications Manual and the ICD-10-CM guidelines for Coding and Reporting to facilitate the assignment of the

2.9.3 POA indicator for each "principal" diagnosis and "other" diagnoses codes reported on claims forms UB-04.

2.9.4 Providers shall ensure any resequencing of diagnosis codes prior to claims submission include a resequencing of POA indicators.

2.9.5 Issues related to inconsistent, missing, conflicting, or unclear documentation must be resolved by the provider.

2.10 Provider Preventable Conditions (PPC)

2.10.1 Clinical Review determines if the service provided meets the clinical guidelines set forth by CMS to ensure PPC services are not reimbursed. PPCs are defined into 2 types – Hospital Acquired Conditions (HACs) and Never Events/Serious Reportable Events (SREs).

2.10.2 Hospital Acquired Conditions (HACs) – These are conditions that could reasonably have been prevented through the application of evidence based clinical guidelines.

2.10.3 Inpatient Acute Care Hospitals are required to document these in the medical records and are reportable as Medicare requirements.

2.10.4 Never Events/SREs – These events are defined by CMS to include:

2.10.4.1 Wrong surgery/invasive procedure.

2.10.4.2 Surgery/invasive procedure performed on the wrong patient.

2.10.4.3 Surgery/invasive procedure performed on the wrong body part.

2.10.5 Providers will not be reimbursed for these services, as these are errors in medical care that are of concern to both the public and health care. Providers must report these when these occur in any health care setting.

2.11 Thirty Day Readmissions

2.11.1 KFHP does not allow separate reimbursement for claims that have been identified as readmission to the same hospital or Hospital System 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, KFHP will use the following standards: (a) readmission within 30 days from discharge; (b) same diagnosis or diagnoses that fall into the same grouping.

2.12 Chimeric antigen receptor T-cel (CAR-T)

2.12.1 KFHP follows CMS guidelines for CAR-T reimbursement.

3.0 Guidelines

N/A

4.0 Definitions

4.1 **Centers for Medicare & 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.

4.2 **Post Stabilization Care** Following stabilization of the member’s emergency

medical condition, post-stabilization care are those medically necessary services needed to maintain a member's stabilized condition, or as otherwise defined by applicable law.

4.3 **Clinical Literature** Literature, published in a peer-reviewed journal, describes research specifically designed to answer a relevant clinical question.

4.4 **Generally Accepted Standards of Medical Practice** Standards based on credible scientific evidence published in peer-reviewed medical literature and widely recognized by the relevant medical community. They include recommendations from physician specialty societies, the consensus of medical professionals practicing in relevant clinical fields, and pertinent factors.

5.0 References

https://www.cms.gov/newsroom/fact-sheets/fact-sheet-two-midnight-rule-0

Eliminating Serious, Preventable, and Costly Medical Errors - Never Events | CMS

Hospital Acquired Conditions | CMS

Hosp. Readmission Reduction | CMS

Medicare.gov: https://www.medicare.org/articles/what-does-medically-necessary-mean/
Frequently Asked Questions CR 7502

National Uniform Billing Committee | NUBC

6.0 Related Topics

POL-020.1 Clinical Review Itemized Bill 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: 09/08/2025)

Revision History

Approvals