Kaiser Permanente Northwest Provider Manual 2018

Billing and Payment

We created this section of the manual to help guide you and your staff in working with Kaiser Permanente's billing and payment policies and procedures. It provides a quick and easy resource with contact phone numbers, detailed processes, and site lists for services.

If you have questions or concerns about this manual, contact our Provider Inquiry Department at 503-735-2727 or 1-866-441-1221.

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Introduction

At the heart of Kaiser Permanente's claim processing operation is the set of policies and procedures that are followed to determine the appropriate handling and reimbursement of claims received.

Kaiser Permanente uses code editing software from third party vendors to help determine the correct handling and reimbursement of claims. Currently, we use ClaimsXten™ (CXT). On occasion, we might change this coding editor or the specific rules it uses in analyzing claims submissions. Our goal is to help ensure the accuracy of claims payments.

- ClaimsXten™ (CXT) is McKesson's solution for applying clinically based claims auditing. It offers flexible rules creation and application and enables payors to process each claim under the specific terms and conditions of individual benefit plans.
- We've contracted ClaimsXten nationally as our enterprise code editing solution to be integrated with Tapestry Accounts Payable on the Kaiser Permanente Claims Connect platform.
- ClaimsXten combines the strength and flexibility of the McKesson Total Payment™ platform with a comprehensive library of McKesson clinical rule content, and a services team of medical claims experts to provide increased medical and administrative savings opportunities.
  - Evaluates codes billed on a claim, and makes coding recommendations in conjunction with industry guidelines (e.g., AMA, CMS, etc.)
  - Use of claims history in editing and reporting
  - Ability to comply with regulatory requirements

To help illustrate how this process works, we've provided examples where appropriate.

Section 5: Billing and Payment

You're responsible for submitting itemized claims for services provided to members in a complete and timely manner in accordance with your Agreement, this manual, and applicable law. The member's payer is responsible for paying claims in accordance with your Agreement.

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5.1 Whom to Contact with Claims Questions

Department	Topics	Contact Information
Provider Inquiry	• Benefits/Co-Pay Information • Claim Payment Inquiries • Claim Status • Claim Submission • Explanation of Payment (EOP) • Medical Policy Questions • Member Eligibility • Referral Questions • Provider Appeals and Disputes **Note:** You might be asked to **mail or fax** a list of the claims in question if you're asking about a large number of claims.	503-735-2727 or 1-866-441-1221 **Fax:** 1-866-518-3437 Kaiser Permanente National Claims Administration P.O. Box 370050 Denver, CO 80237-9998
Provider Contracting & Relations	• Contracts • Credentialing • Fee Schedule • Participation Request • Participation Status • Practice Demographic Updates • Referral Policy • Orientation	**Fax:** 503-813-2017 **Address:** Kaiser Permanente Provider Contracting & Relations 500 NE Multnomah Street Ste. 100 Portland, OR 97232-2099

5.2 Billing, Coding and Payment Instructions

Kaiser Permanente of the Northwest accepts all claims submitted electronically or by mail. We prefer electronic submissions.

5.2.1 Electronic Claims (EDI)

Use 837 P for all professional claims and supplies.

Use 837I for facilities. Any professional services (for example, radiology, ER physicians) should be billed using 837 P, unless you're contracted under a global rate, in which case you shouldn't bill professional services separately.

5.2.2 Paper Claim Forms

Use CMS-1500 (2/12) for all professional services and suppliers.

Use UB-04 (CMS-1450) for all facilities (e.g., hospitals).

Use CMS-1500 claim forms for any professional services (e.g., radiology, ER physicians), unless you're contracted under a global rate, in which case you shouldn't bill professional services separately.

Please use standard claim forms formatted with red ink to ensure maximum compatibility with Kaiser Permanente's optical scanning equipment. We cannot accept claim forms formatted with black or blue lines.

5.3 Record Authorization Number

Services that require prior authorization must have an authorization number reflected on the claim form.

EDI:

Loop 2300, REF 01 both 837P and 837I. 837 P requires that the referring provider use loop 2310A

Paper:

CMS 1500(2/12) Form

Enter the authorization number in Field 23 and the name of the referring provider in Field 17 to ensure efficient claims processing and handling.

UB-04 (CMS 1450)

Enter the authorization number in Field 63.

5.4 One Member/Provider per Claim Form

One member per claim, one provider per claim

- Do not bill for different members on the same claim.
- Do not bill for different providers on the same claim.

Complete separate claims for each member and provider.

5.5 No Fault/Workers' Compensation/Other Accident

Be sure to indicate "Is Patient's Condition Related To" other subscriber information.

EDI:

837P: Loop 2320, SBR09

837I: Loop 2000B, SBR03

Paper:

CMS 1500(2/12): Boxes 10A-10C

UB-04 (CMS 14500: Boxes 58 A-C and 60 A-B

5.6 Entering Dates

Report all dates (dates of birth, dates of service, etc.) in this format: month, day, and **four digits** for the year (MM/DD/YYYY).

Example: 01/05/2015

Consecutive Dates Of Service

You can bill consecutive dates of service on one claim line as long as the units entered in Field 24g equal the total number of days billed.

Example:

Correct Way to Bill

CPT/HCPCS	DATE OF SERVICE	UNITS
97110	01/05/2015-01/07/2015	**3**
97110	01/09/2015-01/13/2015	**5**

Incorrect Way to Bill

CPT/HCPCS	DATE OF SERVICE	UNITS
97110	01/05/2015-01/13/2015	**5**

5.7 Multiple Dates of Services and Place of Services

Different Places of Service

When services are rendered in ***different places of services*** *(locations)*, you must submit a ***separate claim*** for ***each*** place of service.

Same Places of Service

When services are provided in the ***same*** **place of service**, on **different dates**, these services may be **reported and listed as separate lines** on ONE claim along with the corresponding date, diagnosis code(s), procedure code(s), and charges.

5.8 Surgical and/or Obstetrical procedures

If any surgical and/or obstetrical procedures were performed, submit the ICD-10-CM principal procedure and date in loop 2300, segment HI01, qualifier BBR. For additional procedure codes and corresponding dates, enter Loop 2300, HI01/HI02, qualifier BBQ.

For paper claims, use Field 80 (Principal Procedure Code and Date) and enter any additional ICD-10-CM procedure codes and corresponding dates in Field 81A-E (Other Procedure Codes and Dates). When submitting the UB-04, use Field 74A-E (Principal Procedure Code and Date).

5.9 Billing Inpatient Claims That Span Different Years

When an inpatient claim spans different years (for example, the patient was admitted in December and discharged in January), it is **not** necessary to submit two claims for these services. Bill all services for this inpatient stay on one claim if possible), reflecting the correct

dates of admission and discharge. Kaiser Permanente will apply the appropriate/applicable payment methodologies when processing these claims.

5.10 Supporting Documentation

Supporting documentation is only required when requested upon the denial or pending of a claim. The need for this information will be indicated by the remark codes returned on the 835 Electronic Remittance Advice (ERA) transaction or paper Explanation of Payment. Your claim won't be reprocessed until we receive this information.

When billing with an unlisted CPT code, to expedite claims processing and adjudication, you should submit:

- **EDI**: Notes on the NTE segment on the line level (loop 2400)
- **Paper**: Supporting written documentation

5.11 Where to Mail Paper Claims

Kaiser Permanente

National Claims Administration

P.O. Box 370050

Denver, CO 80237-9998

A critical requirement for correct claims payment is making sure the TIN in Box 25 belongs to the vendor named in Boxes 33 and 33a, and are all data values that represent the same entity. While an organization may take on responsibility for billing for another provider or vendor, Kaiser Permanente will match to the TIN and NPI and issue the check /payment to the entity that owns the TIN and NPI.

5.12 Electronic Data Interchange (EDI)

Kaiser Permanente prefers electronic claims submission.

Electronic data interchange, (EDI) is an electronic exchange of information in a standardized format that follows all Health Insurance Portability and Accountability Act (HIPAA) and Affordable Care Act (ACA) requirements. Benefits include:

- Reduced administrative overhead expenses, because the need for handling paper claims is eliminated.
- Improved data accuracy, because the provider submits claims data electronically to Kaiser Permanente via a clearinghouse or trading partner, so there's no need to re-key or reenter the data.
- Save time and budget by bypassing postal mail, because you don't need to use envelopes and stamps or wait for delivery.
- Uniformity for all transactions, because of standardized transaction formats for all payors through ACA and Administrative Simplification.

Notice to providers: Even though you may be reimbursed under a capitated arrangement, periodic interim payments (PIP), or other reimbursement methodology, you are still required to

submit member encounter data to Kaiser Permanente electronically using 837 I or 837 P (preferred) or via standard claim forms (CMS-1500/02/12 or UB-04), and to follow all claims completion instructions set forth in this manual and HIPAA guidelines.

5.13 Electronic Claims

Currently, Kaiser Permanente receives and sends the following electronically via the current 5010 version through our contracted clearinghouses/trading partners.

- 837P must be used for all professional services and suppliers.
- 837I must be used by all facilities (e.g., hospitals).

A critical requirement to correct claims payment is ensuring that the TIN in Loop 2010AA (Box 25) belongs to the vendor named in Loop 2010AA (Boxes 33 and 33a) are all data values that must represent the same entity. While an organization may take on responsibility for billing for another provider or vendor, Kaiser Permanente will match to the TIN and NPI and issue the payment to the entity that owns the TIN and NPI.

5.14 To Initiate Electronic Claims Submissions

We may contact you to encourage you to submit claims electronically. You don't need to notify us when beginning EDI submissions.

If you are currently submitting paper claims to our Colorado office, you'll no longer have to do this; you can submit them electronically through the NW region's contracted trading partners. Each Kaiser region is separated for electronic claim submission, so each has its own payor ID.

Several transactions types are available:

- Claim submission for processing: 837I (UB-04) and 837P (CMS 1500)
- Electronic Remittance Advice: 835 ERA (please see list of trading partners for this transaction)

Acknowledgment/claim rejections: 277CA

NW region contracts with these trading partners:

Trading Partner	Payor ID	Transaction Type
RelayHealth	RH002	837I, 837P, 835
Office Ally	NW002	837I, 837P, 835
SSI	SS002	837I, 837P, 836
Change Health/Emdeon (aka Capario)	93079	837I, 837P
Optimum360	NG009	837I, 837P, 835

You can use an intermediary but they must submit your claims to us via the trading partners listed above.

5.15 Electronic Submission Process

Practitioners'/Providers' EDI Responsibilities:

It's the provider's responsibility to contract with a clearinghouse or trading partner to submit electronic claims. The clearinghouse or trading partner might not directly contract with KPNW but they will contract with someone that does. This contract is between the provider and the clearinghouse/trading partner. All technical inquiries should follow your contract with clearinghouse/trading partner, and content inquiries should follow the contact information at the beginning of this section of the manual.

Clearinghouse/Trading Partner EDI Responsibilities:

Each Kaiser Permanente contracted trading partner has an EDI Companion Guide that lists general information by each KP region. Please refer to the NW region when submitting claims. A provider may ask their clearinghouse/trading partner which entity they use to submit claims for KPNW. This is good information to have for future troubleshooting.

Kaiser Permanente's EDI Responsibilities:

Kaiser Permanente receives EDI files from contracted trading partners each weekday. Upon receipt, we run HIPAA validations on each file. Files may be rejected for fatal errors and claims will be rejected individually if they have invalid or missing information.

When a file is received by our Kaiser Permanente EDI Gateway (KPEG), a 277CA is generated back to the provider. This is not only the file receipt acknowledgement, but also contains any claims rejected individually along with the error message, so the provider to correct and resubmit it.

Note: See the Claims Status Category and Reason Codes at http://www.wpc-edi.com/reference/ for a list of common error codes that prevent a claim from being accepted by Kaiser Permanente.

5.16 Electronic Funds Transfer (EFT) Payment

Kaiser Permanente supports EFT with all providers. We use CAQH EnrollHub for 835 ERA and EFT requests.

Visit https://solutions.caqh.org for information and to create your secure account. Or, call CAQH EnrollHub at 1-844-815-9763 from 7a.m–9p.m. ET Monday–Thursday or 7a.m.–7p.m. ET Friday.

5.17 HIPAA Requirements

Electronic claim submissions must follow all HIPAA and state requirements. These websites include more information on HIPAA and electronic loops and segments:

- www.hhs.gov
- www.oregon.gov (State of Oregon)
- www.wedi.org
- www.wpc-edi.com

Providers with no Internet access can order HIPAA Implementation Guides by calling Washington Publishing Company (WPC) at 301-949-9740.

5.18 Clean Claims

Kaiser Permanente considers a claim clean when these requirements are met.

Correct Forms

EDI:

837I for institutional claims

837P for professional claims

Paper:

Form UB-04 (CMS 1450) for institutional claims

Form CMS 1500(2/12) for professional claims

Complete all fields using industry-standard coding.

Applicable Attachments

EDI: Only upon request by the payor; this will be on the 835 ERA or paper EOP.

Paper: Include attachments when circumstances require additional information.

Include all applicable data elements to complete the claim or file. Here are some common mistakes:

- The format is missing required fields or the codes are not active.
- The eligibility of a member can't be verified.
- The service from and to dates are missing.
- The rendering physician is missing.
- The vendor is missing.
- The diagnosis is missing or invalid.
- The place of service is missing or invalid.
- The procedures/services are missing or invalid.
- The amount billed is missing or invalid.
- The number of units/quantity is missing or invalid.
- The type of bill, when applicable, is missing or invalid.
- Other coverage has not been verified.
- Additional information is required for processing such as COB information, operative report, or medical notes (these will be requested upon denial or pending of claim).
- The claim was submitted fraudulently.

Note: Failure to include all information will result in a delay in claim processing and payment and will be returned for any missing information. A claim missing any required information will not be considered clean.

Please visit the National Uniform Claim Committee website at www.nucc.org for more on the elements required for claim submission.

5.19 Claims submission Timeframes

- New claims: 365 Days from date of service (DOS)
- COB claims: 365 Days from date of Primary EOP
- Self-funded claims: 120 Days from DOS

5.20 Claims Processing Turn-Around Time

Please allow **30 days** for Kaiser Permanente to process and adjudicate your claim(s). Claims requiring additional supporting documentation and/or coordination of benefits may take longer to process.

> **Note:** While Kaiser Permanente may require the submission of specific supporting documentation for benefit determination (including medical and/or coordination of benefits information), we may have to make a decision on the claim before such information is received.

A “clean" claim is defined as one with no defect or impropriety (see Section 5.19).

Please visit the National Uniform Claim Committee website at www.nucc.org for additional information regarding the elements required for claim submission.

5.21 Appeal of Timely Claims Submission

Resubmitted claims—along with proof of initial timely filing received within 365 days of the original date of denial, or explanation of payment—will be allowed for reconsideration of claim processing and payment. Any claim resubmissions received for timely filing reconsideration beyond 365 days of the original date of denial or explanation of payment will be denied as untimely submitted.

5.22 Proof of Timely Claims Submission

Claims submitted for consideration or reconsideration of timely filing must be reviewed with information that shows the claim was initially submitted within the right timeframes. Acceptable

proof of timely filing includes the following documentation and/or situations:

Proof or documentation examples

- System-generated claim copies, account print-outs, or reports that indicate the original date that claim was submitted, and to which insurance payor (handwritten or typed documentation is not acceptable proof of timely filing)
- Account ledger posting that includes multiple patient submissions
- Individual patient ledger
- CMS UB-04 or 1500(2/12) with a system-generated date or submission
- EDI transmission report
- Reports from a provider clearinghouse/trading partner
- (If there's a lack of member insurance information). Proof of follow-up with member for lack of insurance or incorrect insurance information.

*Members are responsible for providing current and appropriate insurance information each time services are rendered by a provider.

5.23 Claim Adjustments/Corrections

Professional Claims

EDI: Submit a Frequency Type Code as a "7" which is a corrected claim. Loop 2300 CLM05-3. Please include the original claim number in the transaction.

Paper: A corrected CMS-1500 (02/12) paper claim to Kaiser Permanente for processing:

- Write "Corrected Claim" in the top (blank) portion of the standard claim form.
- Attach a copy of the corresponding page of Kaiser Permanente's *Explanation of Payment (EOP)* to each corrected claim, to prevent these claims from being rejected by Kaiser Permanente as duplicate claims.

Mail the corrected claim(s) to Kaiser Permanente using the standard claims mailing address.

Institutional Claims

EDI: Submit a Frequency Type Code "7" which designates this as a corrected claim. Loop 2300 CLM05-3. Please include the original claim number in the transaction.

Paper: When submitting a **corrected** UB-04 (CMS 1450) paper claim to Kaiser Permanente for processing:

- Include the appropriate **Type of Bill** code in Field 4.
- Attach a copy of the corresponding page of Kaiser Permanente's *Explanation of Payment (EOP)* to each corrected claim, to prevent these claims from being rejected by Kaiser Permanente as duplicate claims.

Mail the corrected claim(s) to Kaiser Permanente using the standard claims mailing address.

5.24 Incorrect Claims Payments

If you receive an incorrect payment (an **overpayment** or **underpayment**), please do one of the following:

Option 1: Do not cash or deposit the incorrect payment check.

Mail the incorrect payment check back to Kaiser Permanente, along with a copy of the *Explanation of Payment (EOP)* **and** a brief note explaining the payment error to:

Kaiser Permanente
National Claims Administration
P.O. Box 370050
Denver, CO 80237-9998

Option 2:
Call the Provider Inquiry Line at 503-735-2727 or 1-866-441-1221.

5.25 Rejected Claims Due to EDI Claims Error

Electronic Claim Acknowledgement Transaction 277CA: Kaiser Permanente sends an electronic claim acknowledgement to you from one of our contracted clearinghouses or trading partners. We'll forward this claims acknowledgement to you as confirmation of all claims we received.

Note: If you're using an intermediary that isn't one of Kaiser's, please ask them to send you the 277CA or give you access to it. If you're using one of Kaiser's contracted entities, ask them to send the file to you.

5.26 Federal Tax ID Number

The Federal Tax ID Number on all claims must match the information filed with the Internal Revenue Service (IRS).

When completing IRS Form W-9, please note the following:

- Name: This should be the equivalent of your "entity name" you use to file your tax forms with the IRS.
- Sole Provider/Proprietor: List your name, as registered with the IRS.
- Group Practice/Facility: List your "group" or "facility" name, as registered with the IRS.
- Business Name: Leave this field blank, unless you've registered with the IRS as a "Doing Business As" (DBA) entity. If you're doing business under a different name, enter that name on the IRS Form W-9.
- Address/City, State, Zip Code: Enter the address where Kaiser Permanente should mail your IRS Form 1099.

- Taxpayer Identification Number (TIN): The number reported in this field (either the Social Security number or the Employer Identification Number) **must** be used on all claims submitted to Kaiser Permanente.
  - Sole Provider/Proprietor: Enter your Taxpayer Identification Number, which will usually be your Social Security number (SSN), unless you have been assigned a unique Employer Identification Number (because you're "doing business as" an entity under a different name).
  - Group Practice/Facility: Enter your Taxpayer Identification Number, which will usually be your unique Employer Identification Number (EIN).
- If you have questions on IRS Form W-9, or correctly reporting your Federal Taxpayer ID Number on your claim forms, please contact the IRS helpline in your area, or refer to this website: http://www.irs.gov/formspubs/

Mail completed IRS Form W-9s to:

Kaiser Permanente
Provider Contracting and Relations
500 NE Multnomah
Ste. 100
Portland, OR 97232

5.27 Changes in Federal Tax ID Number

If your Federal Tax ID Number changes, please notify us immediately, so we can correct it in our files.

5.28 National Provider Identification (NPI)

HIPAA requires all providers use a standard unique identifier on all electronic transactions. NPI numbers are now required on all claims.

If you have your NPI numbers (both Individual Type 1 and/or Organization/Group Type 2), please notify Kaiser Permanente Provider Contracting & Network Management department.

You can find Individual (Type 1) and Organization/Group (Type 2) NPI applications and instructions at: https://nppes.cms.hhs.gov

5.29 Member Cost Share

Depending on the benefit plan, Kaiser Permanente members may be responsible to share some cost of the services provided. Copayment, co-insurance, and deductible (collectively, "Member Cost Share") are the fees a member is responsible to pay a provider for certain covered services. This information varies by plan, and all providers are responsible for collecting Member Cost Share in accordance with Kaiser Permanente member benefits unless explicitly stated otherwise in your Agreement.

Please verify applicable Member Cost Share at the time of service. You can get Member Cost Share information at http://www.providers.kaiserpermanente.org/nw or by contacting Member Services at 503-813-2000 or 1-800-813-2000.

5.30 Member Claims Inquiries

Please direct member to call Member Services at 503-813-2000 or 1-800-813-2000.

5.31 Visiting Members

Submit all non-Medicare claims and claims from Medicare Choice members directly to Kaiser Permanente for processing, per the claims submission instructions set forth in this manual.

For Medicare claims from Medicare FFS patients and Medicare Cost members, please refer to the section of this manual that discusses Coordination of Benefits (COB).

Reimbursement Rates:

Providers will be reimbursed for visiting members at the same rates negotiated for all other Kaiser Permanente members.

5.32 Coding for Claims

The contracted provider is responsible for making sure the billing codes on claims forms are current and accurate, that the codes reflect the services provided, that coding is consistent with the encounter documentation, and that the coding complies with Kaiser Permanente's coding standards.

Individual physician evaluation and management (E&M) coding statistics are routinely trended and compared with national statistics. A pattern of aberrant coding statistics may result in contract termination and investigation by federal regulators.

5.33 Coding Standards

Complete all fields using industry-standard coding as outlined below.

ICD-10

To code diagnoses and hospital procedures on inpatient claims, use the International Classification of Diseases- 9th Revision-Clinical Modification (ICD-10-CM) developed by the Commission on Professional and Hospital Activities. ICD-10-CM Volumes 1 & 2 codes appear as three-, four-, or five-digit codes, depending on the specific disease or injury being described. Volume 3 hospital inpatient procedure codes appear as two-digit codes and require a third and/or fourth digit for coding specificity.

CPT-4

The Physicians' Current Procedural Terminology, Fourth Edition (CPT) code set is a systematic listing and coding of procedures and services performed by participating providers. CPT codes are developed by the American Medical Association (AMA). Each procedure code or service is identified with a five-digit code.

If you'd like to request a new CPT code or suggest deleting or revising an existing CPT code, use the form from the AMA's website at

www.ama-assn.org/ama/pub/category/3112.html or submit your request and supporting documentation to:

CPT Editorial Research and Development
American Medical Association
AMA Plaza
330 North Wabash Avenue
Suite 39300
Chicago, IL 60611-5885

HCPCS

The Healthcare Common Procedure Coding System (HCPCS) Level 2 identifies services and supplies. HCPCS Level 2 codes begin with letters A–V and are used to bill services such as home medical equipment, ambulance, orthotics and prosthetics, drug codes, and injections.

HIPPS

Health Insurance Prospective Payment System (HIPPS) rate codes represent specific sets of patient characteristics (or case-mix groups) on which payment determinations are made under several prospective payment systems. Case-mix groups are developed based on research into utilization patterns among various provider types. For payment systems that use HIPPS codes, clinical assessment data is the basic input used to determine which case-mix group applies to a particular patient. A standard patient assessment instrument is interpreted by case-mix grouping software algorithms, which assign the case mix group. For payment purposes, at least one HIPPS code is defined to represent each case-mix group. These HIPPS codes are reported on claims to insurers. Institutional providers use HIPPS codes on claims in association with special revenue codes. One revenue code is defined for each prospective payment system that requires HIPPS codes. HIPPS codes are placed in data element SV202 on the electronic 837 institutional claims transaction or in Form Locator (FL) 44 ("HCPCS/rate") on a paper UB-04 claims form. The associated revenue code is placed in data element SV201 or in FL 42. In certain circumstances, multiple HIPPS codes may appear on separate lines of a single claim (for more details, visit cms.gov)

Revenue Code

This standard was approved by the Health Services Cost Review Commission for a hospital located in the State of Maryland, or the national or state uniform billing data elements specifications for a hospital not located in that state.

NDC (National Drug Codes)

This standard applies to prescribed drugs, maintained and distributed by the U.S. Department of Health and Human Services.

ASA (American Society of Anesthesiologists)

This standard is for anesthesia services, using codes maintained and distributed by the American Society of Anesthesiologists.

DSM-IV (American Psychiatric Services)

These codes distributed by the American Psychiatric Association and are used for psychiatric services.

5.34 Modifiers in CPT and HCPCS

Modifiers submitted with an appropriate procedure code further define and/or explain a service provided. You can find valid modifiers and their descriptions in the most current CPT, HCPCS/HIPPS coding book.

Note for CMS-1500 submitters: Kaiser Permanente processes up to four modifiers per claim line.

When submitting claims, use modifiers to:

- Identify distinct or independent services performed on the same day
- Reflect services provided and documented in a patient's medical record
- Most commonly used modifiers for Professional and Technical Services

Modifier 25

Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service: It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported. The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. You can report this circumstance by adding modifier 25 to the appropriate level of E/M service. Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

Modifier 26

Professional Component: Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding the modifier “-26” to the usual procedure number.

Modifier TC

Technical Component: The modifier TC is submitted with a CPT procedure code to bill for equipment and facility charges, to indicate the technical component.

Use with diagnostic tests, such as radiation therapy, radiology, and pulmonary function tests.

Indicates the provider performed only the technical component portion of the service.

Modifier 50

Bilateral Procedure: Add Modifier 50 to the service line of a unilateral 5-digit CPT procedure code to indicate that a bilateral procedure was performed. Modifier 50 can be used to bill surgical procedures at the same operative session, or to bill diagnostic and therapeutic procedures that were performed bilaterally on the same day.

Modifier 51

Multiple Procedures: When multiple procedures other than E/M services, physical medicine and rehabilitation services, or provision of supplies (e.g., vaccines), are performed at the same session by the same provider, you can report the primary procedure or service as listed. Identify the additional procedure(s) or service(s) adding modifier 51 to the additional procedure or service code(s). Note: Do not add this modifier to designated "add-on" codes.

Modifier 52

Reduced Services: Sometimes, the physician might partially reduce or eliminate a service or procedure. Under these circumstances, you can identify the service provided by its usual

procedure number, adding the modifier '-52' to signify that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient before or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

Modifier 57

Decision for Surgery: An evaluation and management service that resulted in the initial decision to perform the surgery can be identified by adding the modifier '-57' to the appropriate level of E/M service.

Modifier 59

Distinct Procedural Service: Under certain circumstances, it might be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Use modifier 59 to identify procedures or services, other than E/M services, that aren't normally reported together but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision or excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, use that instead of modifier 59. In fact, use modifier 59 only if no other descriptive modifier is available and modifier 59 best explains the circumstances. Note: Don't append modifier 59 to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

Modifier 62

Two Surgeons: When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each should report his/her distinct operative work by adding the modifier '-62' to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once the same procedure code. If additional procedure(s), including add-on procedure(s), are performed during the same surgical session, separate code(s) can also be reported with the modifier '-62' added. Note: If a co-surgeon acts as an assistant in the performance of additional procedure(s) during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or 82 added.

Modifier 76

Repeat Procedure or Service by Same Physician: It may be necessary to indicate that a procedure or service was repeated after the original procedure or service. Report this circumstance by adding modifier 76 to the repeated procedure or service.

Modifier 78

Return to the Operating Room for a Related Procedure During the Postoperative Period: Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period: It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first and requires the use of an operating or procedure room, report it by adding modifier 78

to the related procedure. (For repeat procedures, see modifier 76).

Durable Medical Equipment (DME) Modifiers

NU= new equipment

RP= replacement and repair

RR= rental of DME equipment

This list is not all-inclusive.

5.35 Modifier Review

Kaiser Permanente reserves the right to review use of modifiers to ensure accuracy and appropriateness using industry standard guidelines. Invalid or ineligible modifiers might be corrected if possible or rejected if it isn't possible to determine correct code modifier. Our code editing process will help evaluate the accuracy of the coding of the procedure(s), not their medical necessity, and will identify inappropriate use of modifiers, which could cause claims to pend and/or be returned for correction.

5.36 Coding Edit Rules

Kaiser Permanente applies coding edit rules to all claims submitted. The following descriptions outline some major categories of our coding edit rules, some of which ClaimsXten® applies automatically as part of coding and billing validation.

These rules are subject to change and may be edited from time to time. There may be situations where your contract supersedes these rules. If you have questions about your contract and code editing, please contact your contract manager or Provider Relations.

Major Categories of Claim Coding Errors/Inconsistencies: AMA, CMS guidelines, and ClaimsXten® will identify input codes without valid modifiers and flag potential errors while accepting coding practices judged to be conventional by the AMA and the Centers for Medicare & Medicaid Services (CMS). The CPT and HCPCS manuals explicitly detail and outline many of the rules included in ClaimsXten®.

HCPCS codes related to CPT codes: ClaimsXten® also evaluates the combination of HCPCS codes and CPT codes. These codes are cross-walked to identify where a HCPCS code is related to one or many CPT codes, and are evaluated based on the existing CPT rules. Unnecessary or disallowed codes are then rejected.

Example: HCPCS code D7872 is defined as "diagnostic arthroscopy of the temporomandibular joint, with or without biopsy." D7872 is related to the CPT code 29800, "diagnostic arthroscopy of temporomandibular joint." Since both codes have the same narrative, the CPT code should be used. If both codes are submitted for the same service date, ClaimsXten® denies the HCPCS code as part of the CPT code. In addition, additional rules regarding CPT and HCPCS codes will be applied, so in this example, if 90781 (IV infusion) were also on the claim, they would be denied as part of the global services.

HCPCS codes not related to CPT codes: ClaimsXten® also detects situations where HCPCS codes aren't related to CPT codes. Rules developed as appropriate that are the result of the review of non-CPT related HCPCS codes are part of the knowledge base supporting ClaimsXten® and do not conflict with the Correct Coding Initiative (CCI) and National Correct Coding Initiative (NCCI).

Example: E1050 is denied in conjunction with E1060. The description for E1050 is “fully reclining wheelchair, fixed full length arms, swing away detachable elevating leg rests.” The description for E1060 is “fully reclining wheelchair, detachable arms, swing away detachable elevating leg rests.”

HIPPS Codes: Health Insurance Prospective Payment System (HIPPS) rate codes represent specific sets of patient characteristics (or case-mix groups) on which payment determinations are made under several prospective payment systems. Case-mix groups are developed based on research into utilization patterns among various provider types. For payment systems that use HIPPS codes, clinical assessment data is the basic input used to determine which case-mix group applies to a particular patient. A standard patient assessment instrument is interpreted by case-mix grouping software algorithms, which assign the case mix group. For payment purposes, at least one HIPPS code is defined to represent each case-mix group. These HIPPS codes are reported on claims to insurers. Institutional providers use HIPPS codes on claims in association with special revenue codes. One revenue code is defined for each prospective payment system that requires HIPPS codes. HIPPS codes are placed in data element SV202 on the electronic 837 institutional claims transaction or in Form Locator (FL) 44 ("HCPCS/rate") on a paper UB-04 claims form. The associated revenue code is placed in data element SV201 or in FL 42. In certain circumstances, multiple HIPPS codes may appear on separate lines of a single claim.

Procedure Unbundling: Procedure unbundling occurs when two or more procedure codes are used to describe a procedure performed, when a single, more comprehensive, procedure code exists that accurately describes the entire procedure performed.

Example 1: Laboratory unbundling occurs when certain lab tests are billed separately when a predefined panel exists that contains all of the individual tests billed. These tests should not be billed separately, but should be billed using one panel code.

Example 2: Billing the following two codes together is considered “unbundling.” 93005 Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report 93010 Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only.

When 93005 and 93010 are performed on the same day, the correct comprehensive procedure code would be 93000.

Incidental Procedures: An incidental procedure is typically performed at the same time as a more complex primary procedure. However, the incidental procedure requires little additional physician resources, and/or is clinically integral to the performance of the primary procedure. Therefore, incidental procedures are not reimbursed separately.

Separate procedures designated as a “separate procedure” in the CPT code book are commonly performed as an integral part of a total, larger procedure, and normally don’t warrant separate identification. Therefore, these services are typically included as part of the “global” charges submitted for the related, larger procedure.

However, when the procedure is performed as a separate, independent service not in conjunction with any normally related procedure, it can be billed as a “separate procedure.” If the procedure is performed alone for a specific purpose, it may be eligible for separate reimbursement.

Mutually Exclusive Procedures: Mutually exclusive procedures are two or more procedures not usually performed at the same operative session on the same member on the same date of

service. Mutually exclusive rules may also include different procedure code descriptions for the same type of procedure(s), for which the physician should be submitting only one of the procedure codes.

Age and Gender (Sex) Conflicts: An age conflict occurs when the contracted provider bills an age-specific procedure code for a member outside of the designated age range. Similarly, a gender conflict occurs when a gender-specific procedure is assigned to a member of the opposite gender.

Example 1: The contracted provider assigns the code for surgical opening of the stomach, for newborns (43831), to a 45-year-old member.

Example 2: Code 58150 Total abdominal hysterectomy is submitted for a male member.

Exception: Initial Newborn Care codes (99431, 99432, 99435) are payable under the mother's contract and are excluded from the age processing rules.

The following age are examined for conflicts: Newborn (less than 1 year old), Pediatric (1-17 years old), Maternity (12-55 years old), Adult (over 14 years old)

Obsolete/Deleted Codes: If obsolete or deleted codes cannot be cross-walked to current or updated codes, we may deny the claim. Obsolete or deleted codes are updated each calendar year and we don't accept them past the end date specified by CMS. Medicare claims with outdated codes will be subject to denial per CMS guidelines.

Multiple/Duplicate Component Billing: When procedures are billable for professional and technical components (i.e., with Modifiers 26 and TC), Kaiser Permanente monitors that the total amount paid for the service does not exceed what would have been paid if the procedure had been billed without the modifier(s). Kaiser Permanente reserves the right to adjust claims that are paid in excess of the total.

ClaimsXten® helps the claims examiner and UM staff (medical nurse auditors, Kaiser Permanente physicians) evaluate the coding accuracy of the procedure(s), not their medical necessity.

5.37 Retrospective Claim Review

Retrospective reviews occur after the member has received care and after he/she or their provider has submitted a claim for payment. Staff in the Claims Department review and make benefit decisions on claims. Staff in the Resource Stewardship department support the Claims Department in reviewing claims without a referral or authorization if there is an issue of medical necessity. This same staff review claims for appropriate coding and billing where clinical expertise is necessary. Issues such as unbundling, up coding, and undocumented services are reviewed in the Post Service area. Physician reviewers review all issues related to medical necessity decisions before we issue a denial.

The following resources are used during the Post Service Review process. Associated review rules for a particular claim are based on thorough reviews of a variety of sources including, but not limited to:

- Centers for Medicare and Medicaid Services (CMS) policies
- Kaiser Permanente medical policy

- AMA guidelines (i.e., Current Procedural Terminology, CPT®)
- Professional specialty organizations (e.g., American College of Surgeons, American Academy of Orthopaedic Surgeons, American Society of Anesthesiology)
- State and/or federal mandates
- Subscriber benefit contracts
- Provider contracts
- Specialty expert consultants

Therefore, our policies and review rules are developed with information gleaned from many sources, not just a single source. Our review rules are designed to verify the clinical accuracy of procedure code relationships to claims.

It's important to note that while all codes may be acceptable to report, separate reimbursement may not be made. Reimbursement is based on many factors, such as the member's coverage, coding rules outlined by CMS, CPT and other nationally recognized entities like those listed above, and federal and state mandates and regulations.

This ensures that our members receive the right care at the right time at the appropriate level. To accurately adjudicate claims and administer subscriber benefits, it's often necessary to request medical records. Here are claims categories from which we may require submission of clinical information, before or after adjudication of a claim:

- Procedures or services that require precertification/preauthorization but did not go through the normal process before services were rendered
- Procedures or services involving determination of medical necessity, including but not limited to those outlined in medical policies/criteria
- Procedures or services that are or might be considered cosmetic or experimental/ investigational
- Claims for which we can't determine if the claim involves a covered service and therefore must review medical records to make a benefit determination
- Procedures or services reported with "unlisted," "not otherwise classified," or "miscellaneous" codes
- Procedures or services reported with CPT® modifiers 22, 62, 66, and 78
- Quality of care and/or quality improvement activities (e.g., data collection as required by accrediting agencies, such as NCQA)
- Claims involving coordination of benefits
- Claims being appealed
- Claims being investigated for fraud and abuse or potential inappropriate billing practices
- Claims for which services reported appear to have been unbundled

Some of these are discussed in more detail in this manual.

This list is not intended to limit the ability of Kaiser Foundation Health Plan of the Northwest to request clinical records. There may be additional individual circumstances when we may request these records.

Services classified under the Humanitarian Device Exemption (HDE) must have an authorization prior to usage. Once authorized, the reimbursement would be based on invoice unless otherwise contracted. Medical Necessity Review does monitor claims for usage and reimbursement of such devices.

5.38 Other Party Liability (OPL)

Other Party Liability (OPL) is a way of determining the order in which benefits are paid and the amounts that are payable when a claimant is covered under more than one plan (individual or group). It's intended to prevent duplication of benefits when an individual is covered by multiple plans or payers providing benefits or services for medical, dental, or other treatment. OPL includes Coordination of Benefits (COB), Third Party Liability (TPL), Worker's Compensation (WC), TRICARE (also known as CHAMPUS), and Medicare primary and dual coverage.

Kaiser Permanente follows the National Association of Insurance Commissioners (NAIC) model regulations for coordinating benefits, except when NAIC model regulations differ from Oregon or Washington state law, which supersedes the NAIC model regulations.

If you have questions on the **coordination of benefits**, please call the Provider Inquiry Line at 503-735-2727 or 1-866-441-1221.

5.39 Workers' Compensation

If you have questions, please call 503-735-2727 or 1-866-441-1221.

5.40 Provider Claims Disputes

If your office/facility has questions or concerns about the way a particular claim was processed by Kaiser Permanente, please contact our Provider Inquiry Unit at 503-735 2727 or 1-866-441-1221. Many questions and issues regarding claim payments, coding, and submission policies can be resolved quickly over the phone or via fax.

If your issue can't be resolved through this initial contact, you will be instructed as follows:

Provider Claim Payment Appeals Process:

If your concern is determined to be a claim payment appeals issue, submit your concern in writing to:

Kaiser Permanente
National Claims Administration
P.O. Box 370050
Denver, CO 80237-9998

All claim payment appeal requests must be filed within 365 days of the date the claim was originally processed or denied, to be considered for payment by Kaiser Permanente.

5.41 Services

5.41.1 Evaluation Management (E/M) Services

837 P or a CMS-1500 (2/12)

Field 19: When covering for another physician, enter the name of the physician you are covering for.

Note: If a **non-participating** practitioner/provider will be covering for you, please notify that individual of this requirement.

Inpatient E/M Services

If a patient is admitted for observation following the performance of a major/minor "surgical package" procedure, do not report hospital observation service codes, because all post-operative E/M services are included as part of the global surgical package.

Consultations

- Kaiser Permanente will reimburse for **initial** consultations when billed with any surgical procedure done on the same day of service.
- *For office/outpatient:* If the consultant assumes patient management responsibilities following the **initial** consultation, use office E/M (established patient) visit codes for all subsequent patient encounters, **NOT** office consultation codes.
- *For inpatient:* If the consultant assumes patient management responsibilities, use subsequent hospital care codes (**NOT** follow-up inpatient consultation codes) to report all additional E/M encounters with the patient.

Surgery and E/M Services

- Reimbursement will generally **NOT** be made for a pre- or post-operative E/M visit provided on the same day as major/minor surgery, or an endoscopic procedure, unless we agree there was a significant, separately identifiable E/M service provided in addition to the procedure. In these instances, the provider must bill for the E/M visit using the appropriate modifier.
- If E/M services are performed during the post-operative period for a reason unrelated to the original procedure (such as for other disease or injuries), you can bill for these services using modifier 24 (Unrelated E/M service by the same physician during a post-operative period), and you must list a corresponding diagnosis code that shows the E/M services were for a problem other than the surgical diagnosis.

Urgent or Emergency Services Provided in the Office

For urgent or emergency services provided in the office setting, use code *Office services provided on an emergency basis* in addition to the appropriate E/M office visit code.

Non-Surgical Procedure that Includes E/M Services:

Sometimes, Kaiser Permanente will deny medical visits when they're billed with certain non-surgical procedures, because the codes for these procedures include admission to the hospital and/or daily visits. The non-surgical procedures in this category include:

- Clinical brachytherapy

- End stage renal disease services
- Allergy immunotherapy services

Preventive Medicine Services:

Use preventive medicine codes--**not** office evaluation/management codes—to report the routine evaluation and management of adults and children, in the absence of patient complaints. For example, use preventive medicine codes for:

- Well-baby check-ups
- Routine pediatric visits
- Camp or school physicals
- Routine, annual gynecological exams.

5.41.2 Emergency Rooms

837 I or a UB-04

- **Loop2300 CL101, 102 and 104, field 15 (UB-04):** Enter the code indicating the source of the admission or outpatient registration
- **Loop 2400 SV201, 202-202.7 field 44:** Use the emergency department E/M visit codes **ONLY** if the patient is seen in the emergency department.

Use emergency department E/M visit codes for E/M services provided in the emergency department, even for non-emergency services. The only requirement for using "emergency department" codes is that the patient must be registered in the emergency department. Use office visit E/M codes if the patient is seen in the ER as a convenience to the physician and/or patient but isn't registered in the emergency department.

5.41.3 Durable Medical Equipment (DME)

Description:

Durable medical equipment (DME) is medically necessary equipment that is:

- Appropriate for use at home
- Primarily and customarily used to serve a medical purpose
- Not useful to a person in absence of an illness
- Able to withstand repeated use

Professional

Loop 2400, SV101, field 24d: CPT codes are required for all professional services. Use HCPCS Level II codes to define DME. Use modifiers, if applicable. If using a generic code on EDI submission, add description to Loop 2400 NTE

Institutional

- **Loop 2400, SV201, field 42:** Enter the appropriate revenue code
- **Loop 2400 SV201, 202-202.7, field 44:** HCPCS/Rates required

- **Loop 2400, SV204, field 46:** Number of rental months

5.41.4 Injection/Immunizations

CPT codes are required for all professional services. Use HCPCS Level II codes to define injections/immunizations.

> **Note:** If there was no identifiable E/M service rendered by the nurse or the provider, and the patient received only an injection during the encounter, you can report an injection administration code in lieu of the E/M visit code and the appropriate HCPCS code (specifying the drug administered).

Unlike injections, *immunization procedures include the supply of materials*. Additionally, injection administration fees aren't eligible for reimbursement when billed with immunization codes.

5.41.5 Newborn Services

For professional and institutional claims, each newborn must have their own medical record number (MRN). Submit the claim using the newborn as the subscriber.

Note: If the MRN isn't established, contact Member Services at 503-813-2000 or 1-800-813-2000.

5.41.6 Do Not Bill Events

Do Not Bill Events (DNBEs) are occurrences where the fees for all or part of the health care services directly related to the occurrences might be waived. Please see Section 8 of this manual for further definitions of DNBEs.

The sections of this manual that address DNBE are solely for the purpose of determining compensation to provider and shall not constitute or imply any admission of liability.

DNBE Claims Submission: If you submit claims using an 837I or a CMS 1450 (UB-04) form, (i) include on all inpatient claims the present on admission ("POA") indicators in the manner required by CMS for Medicare fee-for-service claims and (ii) for any DNBEs recognized before submitting a claim, include on all claims the applicable International Classification of Diseases ("ICD") codes and all applicable standard modifiers—including CMS National Coverage Determination ("NCD") modifiers for SEs)—in the manner required by CMS for Medicare fee-for-services claims.

If you submit claims using 837P or a CMS 1500 (2/12) form and recognize that a DNBE has occurred before submitting a claim, include on all claims the applicable ICD codes and all applicable standard modifiers (including CMS NCD modifiers for SEs) for any DNBE in the manner required by CMS for Medicare fee-for-service claims.

If you recognize that a DNBE has occurred before submitting a claim, the claim should reflect all services provided (including those related to the DNBE) and all associated fees (including those related to the DNBE), with an adjustment in fees to reflect the waiver of fees directly related to the DNBE.

For example, when billing for inpatient stays, you must submit a no-pay claim (Type of Bill 110) to report all charges associated with a DNBE. More specifically, if services or procedures unrelated to the DNBE are provided during the same stay as the DNBE, providers billing for inpatient stays are required to submit two claims, one claim with services or procedures unrelated to the DNBE and the other with the services or procedures related to the DNBE as a

no-pay claim. Non-covered Type of Bill 110 must have one of the diagnosis codes listed below in the diagnosis position 2-9 on the UB-04 form to identify the type of DNBE performed. Do not transmit via the External Cause of Injury (E-code) located on the UB-04 form.

- E876.5: Performance of wrong operation (surgical procedure) on correct patient (existing code)
- E876.6: Performance of operation (surgical procedure) on patient not scheduled for surgery
- E876.7: Performance of correct operation (surgical procedure) on wrong side/body part

Present on Admission (POA) field is required on all primary and secondary diagnosis for inpatient discharges for all applicable bill types.

Providers billing for hospital outpatient encounters, ambulatory surgery centers, or other health care professionals must use one of these HCPCS modifier(s) when the associated charges on all lines related to a DNBE:

PA: Surgery Wrong Body Part

PB: Surgery Wrong Patient

PC: Wrong Surgery on Patient

Waive or Reimburse Fees: You should waive fees otherwise owed by payors and members (or reimburse any fees that may have already been paid by payors and members) that are directly related to the DNBE, whether the event has already been reported by you or if it is later discovered by Kaiser Permanente.

In addition, you will consider, on a case-by-case basis at your discretion, waiving (or later reimbursing) fees otherwise owed by payors or members for medically necessary health care services required to treat the DNBE after the encounter when the DNBE occurred.

Resolving DNBE Reimbursement Issues: We'll collaborate with you to quickly resolve DNBE determinations and corresponding reimbursement issues. Any disputes related to DNBE reimbursement shall be resolved according to the dispute resolution process set forth in your provider Agreement.

Reimbursement by you to payors or members for fees directly related to a DNBE that were already paid to you will be deemed an overpayment subject to the Adjustment to Payment clause of your provider Agreement and made within thirty (30) days of the parties' resolution of DNBE determinations and reimbursement issues, unless otherwise required by law.

5.41.7 Anesthesia

Global Anesthesia Package

The "global" anesthesia package includes:

- The performance of a pre-anesthetic exam and evaluation (even if the exam is done on a date different from the date of surgery)
- The administration of the anesthetic
- The administration of fluids and/or blood incidental to the delivery of anesthesia (or the procedure being performed)

- The usual monitoring services (ECG, blood pressure, etc.)
- The provision of post-operative anesthesia care (post-operative visit)

Office-Based Surgical Procedures

When an office-based surgical procedure is performed, reimbursement for the procedure includes reimbursement for anesthesia services as part of the global surgical fee, because it's expected that appropriate anesthesia will be administered with the office-based procedure.

Anesthesia Reporting Requirements and Reimbursement

Kaiser Permanente reimburses participating providers for anesthesia services based on nationally recognized criteria for reporting of anesthesia services, including:

- American Medical Association (AMA) CPT codes *(00100 – 01999)*
- American Society of Anesthesiologists (ASA) Relative Value Guide (RVG)

Medicare guidelines

Base Units

Do not indicate the ASA base unit values in the Days/Units field (Item 24, Box G). Base units are determined as defined by the American Society of Anesthesiologists RVG. The base units assigned to a procedure are intended to demonstrate the relative complexity of a specific procedure and include the value of all anesthesia services, except the value of the actual time spent administering the anesthesia. Kaiser Permanente stores the base unit value within our claims system and will calculate the anesthesia payment of the base units according to the information provided on the claim.

Reporting of Anesthesia Time

Anesthesia time begins when the anesthesiologist starts to prepare the patient for the induction of anesthesia in the operating room or in an equivalent area. Anesthesia time ends when the anesthesiologist is no longer in personal attendance, which is when the patient may be safely placed under postoperative supervision. Time units are calculated by allowing 1 unit for each 15-minute interval or remaining fraction thereof. Providers are to show time as total number of minutes in the Units field (Item 24, Box G).

Reimbursement

Payment for most anesthesia services is based on:

- The base unit value
- Plus anesthesia time units
- Multiplied by the fee schedule conversion factor, as appropriate

Other services are reimbursed based upon the CPT code.

Multiple Surgical Procedures

When multiple surgical procedures are performed during a single anesthetic administration, the anesthesia code representing the most complex procedure is reported. The time reported is the combined total of all procedures reported on the primary procedure.

5.41.8 Exceptions to Billing Anesthesia Codes

Anesthesiologists should bill using **anesthesia codes only**, unless one or more of the following services was performed by the anesthesiologist—in which case the appropriate "non-anesthesia" CPT code(s) may be reported and billed in accordance with CMS guidelines:

- Evaluation and management services
- Hospital inpatient services
- Consultations
- Critical care services
- Pain management
- Nerve blocks
- Destruction by neurolytic agents
- Services not included in the global anesthesia fee
- Other miscellaneous services

Qualifying Circumstances

CPT codes 99100, 99116, 99135, and 99140 represent various patient conditions that may impact the anesthesia service provided. You can bill such codes in addition to the anesthesia being billed. Show the charges for these codes on the same line as the CPT Qualifying Circumstances Code in Item 24, Box F.

Patient-Controlled Analgesia (PCA)

Benefits may be available for the administration of patient-controlled analgesia (PCA) following a surgical procedure. PCA billed by a **surgeon** is covered as part of the global surgical package and is **not** separately reimbursable. PCA reimbursements are limited to **anesthesiologists** only.

Submit the anesthesiologist's services for PCA as a **single line** on the claim form as follows:

- **Span the dates** to include the entire care for the PCA *(reimbursement will be made as a global allowance and will include the entire course of PCA).*
- Any hospital care provided by the anesthesiologist **after** the initial day of PCA will be considered covered under the global PCA fee.
- Use CPT code **01996** when billing for PCA services.

Conscious Sedation:

Sedation with or without analgesia (conscious sedation)—intravenous, intramuscular, or inhalation(CPT code 99143-99145) is considered eligible for reimbursement when billed by an anesthesiologist, pain management, or certified registered nurse anesthetist.

Anesthesia Modifiers

Personally Performed or Medically Directed/Supervised Anesthesia Services

Use an appropriate HCPCS anesthesia modifier to denote whether the anesthesia services were **personally performed**, **medically directed**, or **medically supervised**:

AA - Anesthesia service **performed personally** by the anesthesiologist

AD - Medical supervision by a physician of **more than four** concurrent procedures

QK - Medical direction of **two**, **three**, or **four** concurrent anesthesia procedures involving qualified individuals

QX - CRNA service **with** medical direction by a physician

QY - Medical direction of one CRNA by the physician

QZ - CRNA service **without** medical direction by a physician

QS - Monitored anesthesia care service *(can be billed by a CRNA or a physician)*

Physical Status Modifiers

As indicated in the CPT book, the following **physical status** modifiers should be appended to the CPT anesthesia code to distinguish between the various levels of **complexity** of the anesthesia service(s) provided:

P1 - A normal **healthy** patient

P2 - A patient with **mild** systemic disease

P3 - A patient with **severe** systemic disease

P4 - A patient with severe systemic disease that is a **constant threat to life**

P5 - A **moribund** patient who is not expected to survive without the operation

P6 - A declared **brain-dead** patient whose organs are being removed for donor purposes

Do not enter additional minutes for the Physical Status modifier. If eligible for reimbursement, the additional unit(s) will be calculated by our claims system. The patient cannot be billed for Physical Status modifiers not allowed by Kaiser Permanente.

Other CPT Modifiers/Qualifying Circumstances Codes

You can use other modifiers and "qualifying circumstances" codes as appropriate. Follow the instructions in the CPT/HCPCS books when reporting these additional modifiers and/or codes.

5.42 Coordination of Benefits

Coordination of Benefits (COB) is a method for determining the order in which benefits are paid and the amounts that are payable when a member is covered under more than one plan. It's intended to prevent duplication of benefits when an individual is covered by multiple plans providing benefits or services for medical or other care and treatment.

Kaiser Permanente contracted providers are responsible for determining the primary payor and for billing the appropriate party.

5.43 How to Determine the Primary Payor

The benefits of the plan that covers an individual as an employee, member, or subscriber other than as a dependent are determined before those of a plan that covers the individual as a dependent.

When both parents cover a child, the “birthday rule” applies—the payor for the parent whose birthday falls earlier in the calendar year (month and day) is the primary payor.

When determining the primary payor for a child of separated or divorced parents, ask about the court agreement or decree. In the absence of a divorce decree/court order stipulating parental health care responsibilities for a dependent child, insurance benefits for that child are applied according to the following order:

Insurance carried by the:

- Natural parent with custody pays first
- Step-parent with custody pays next
- Natural parent without custody pays next
- Step-parent without custody pays last

If the parents have joint custody of the dependent child, then benefits are applied according to the birthday rule referenced above. If this doesn’t apply, call the Member Services Department at 503-813-2000 or 1-800-813-2000.

- Kaiser Permanente is generally primary for working Medicare-eligible members when the CMS Working Aged regulation applies.
- Medicare is generally primary for retired Medicare members over age 65, and for employee group health plan (EGHP) members with end stage renal disease (ESRD) for the first thirty (30) months of dialysis treatment. This doesn’t apply to direct pay members.
- In cases of work-related injuries, Workers’ Compensation is primary unless coverage for the injury has been denied.

In cases of services for injuries sustained in vehicle accidents or other types of accidents, primary payor status is determined on a jurisdictional basis. If the auto insurance is primary, claims will require an EOB.

5.44 Description of COB Payment Methodologies

Kaiser Permanente COB allows benefits from multiple carriers to be added on top of each other so that the member receives the full benefits from their primary carrier and the secondary carrier pays their entire benefit up to 100% of allowed charges. When Kaiser Permanente has been determined as the secondary payor, we pay the difference between the payment by the primary payor and the amount that would’ve been paid if Kaiser Permanente was primary, less any amount for which the member has financial responsibility.

Benefit carve-out calculations are based on whether or not the provider accepts Medicare assignment for the provider contract corresponding to the claim. Medicare assignment means the provider has agreed to accept the Medicare allowed amount as payment.

5.45 COB Claims Submission Requirements and Procedures

Whenever Kaiser Permanente is the **secondary** payor, claims can be submitted **either** electronically or on one of the standard paper claim forms:

Electronic

If Kaiser Permanente is the secondary payor, send the completed electronic claim with the payment fields from the primary insurance carrier entered as follows:

Loops 2320 and 2330 contain information about the subscriber and other insurance information, Loop 2400 is the original claim billed amounts, Loop 2430 provides the information from the primary payor.

For example: **SVD*PAYER ID*100*HC:C**1~** (Loop ID-2430)

Payor ID = ID of the payor who adjudicated this service line

100 = Payor amount approved for payment for the line

HC = HCPCS qualifier

C = HCPCS code for bundled procedure

1 = Service units

CAS*PR*2*20~

PR = Patient responsibility

2 = Adjustment reason—Co-insurance amount

20 = Amount of adjustment

Paper

If Kaiser Permanente is the secondary payor, send the completed claim form with a copy of the corresponding Explanation of Benefit (EOB) or Explanation of Medicare Benefits (EOMB)/Medicare Summary Notice (MSN) from the primary insurance carrier attached to the paper claim to ensure efficient claims processing/adjudication. We can't process a claim without an EOB or EOMB/MSN from the primary insurance carrier.

CMS-1500 (2/12) claim form: Complete Field 29 (Amount Paid)

CMS-1450 (UB-04) claim form: Complete Field 54 (Prior Payments)

5.46 Members Enrolled in Two Kaiser Permanente Plans

Some members might be enrolled under two separate Kaiser Permanente plans. In these dual-coverage situations, providers need submit only **one** claim under the primary plan to Kaiser Permanente for processing.

5.47 COB Claims Submission Timeframes

If Kaiser Permanente is the secondary payor, any Coordination of Benefits (COB) claims must be submitted for processing within 365 days of the date of the Explanation of Benefits (EOB) or EOMB/MSN.

5.48 Explanation of Payment

EOPs are sent to all providers when a claim is finalized in our system. There are two kinds of EOP available:

- **Paper**: These paper-generated EOPs are sent to the provider when a claim has completed the system's check cycle. It includes all required information in compliance with HIPAA. This can be sent to the secondary or tertiary payor.
- **835 Electronic Remittance Advice (ERA)**: This is an electronic transaction in compliance with HIPAA. Providers would use this as they would a paper EOP to submit COB to a secondary or tertiary payor. This contains all the information needed to tie back to a check or EFT transaction.

You can choose either or both. If you're currently on paper EOP and want to move to 835 ERA the information below will link you to CAQH (you can also sign up for EFT). If you choose to receive 835, Kaiser is required to send paper EOP and 835 for four check cycles or 30 days. We then move you to 835 ERA-only unless you choose to receive both.

Visit https://solutions.caqh.org for information and to create your secure account.

Or, speak with the CAQH EnrollHub Helpline **at 1-844-815-9763.** Representatives are available 7a.m.–9p.m. ET Monday–Thursday and 7a.m.–7p.m. ET Friday.

835 ERA Example:

Scenario:

Dollars and data are being sent together through the banking system to pay Medicare Part A institutional claims.

This scenario depicts the use of the ANSI ASC X12 835 in a governmental institutional environment. The electronic transmission of funds request and the remittance detail are contained within this single 835. In this scenario, one or more depository financial institutions is involved in transferring information from the sender to the receiver.

Assumptions:

The following assumptions pertain this scenario:

- The dollars move using the ACH network from the Bank of Payorea, ABA# 999999992, account number 123456 to the Bank of No Return, ABA# 999988880, checking account number 98765. The money moves on September 13, 2002.
- The Insurance Company of Timbuktu, Federal tax ID # 512345678 and Medicare Intermediary ID# 999, is paying Regional Hope Hospital, National Provider Number 6543210903. This is for one inpatient and one outpatient claim.
- For the inpatient claim, the patient's name is Sam O. Jones. The Health Insurance Claim Number is 666-66-6666A. The claim submitter's identifier is 666123. The date of the hospitalization was August 16, 2002 to August 24, 2002. Total charges reported are $211,366.97. Paid amount is $138,018.40. There is no patient responsibility. Contractual adjustment is $73,348.57. No service line detail is provided.
- For the outpatient claim, the patient's name is Liz E. Border, Health Insurance Claim Number 996-66-9999B. The claim submitter's identifier is 777777. The date of service is

May 12, 2002. Total charges reported are $15,000. Paid amount is $11,980.33. Contractual adjustment is $3,019.67. There is no service line information.

- There is a Capital Pass Through Amount (CV) payment to the provider for $1.27.

The 835 Transmission:

ST*835*1234~

BPR*C*150000*C*ACH*CTX*01*999999992*DA*123456*1512345678*

***01*999988880*DA*98765*20020913~**

TRN*1*12345*1512345678~

DTM*405*20020916~

N1*PR*INSURANCE COMPANY OF TIMBUCKTU~

N3*1 MAIN STREET~

N4*TIMBUCKTU*AK*89111~

REF*2U*999~

N1*PE*REGIONAL HOPE HOSPITAL*XX*6543210903~

LX*110212~

TS3*6543210903*11*20021231*1*211366.97**138018.4**73348.57~**

TS2*2178.45*1919.7156.82*197.69*4.23~**

CLP*666123*1*211366.97*138018.4MA*1999999444444*11*1~**

CAS*CO*45*73348.57~

NM1*QC*1*JONES*SAM*O*HN*666666666A~**

MIA*0*138018.4~**

DTM*232*20020816~

DTM*233*20020824~

QTY*CA*8~

LX*130212~

TS3*6543210909*13*19961231*1*15000**11980.33**3019.67~**

CLP*777777*1*15000*11980.33MB*1999999444445*13*1~**

CAS*CO*45*3019.67~

NM1*QC*1*BORDER*LIZ*E*HN*996669999B~**

MOA*MA02~**

DTM*232*20020512~

PLB*6543210903*20021231*CV:CP*-1.27~

SE*28*1234~

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NORTHWEST CLAIMS ADMINISTRATION
NORTHWEST
KAISER FOUNDATION HEALTHPLAN,INC
PO Box 370050
Denver, CO 80327-9998

Questions? Call Customer Service at (866) 441-1221
Weekdays Mon - Fri 9:00AM - 4:00PM PST
Weekends Sat - Sun 8:00AM - 6:00PM PST

Check / EFT #: 0000005000
Remittance Number: EOPVEN123456
Payment Date: 08/20/2015
Total Payment Amt: 10.10
Vendor Tax ID No: 99999999
Vendor ID No: 9999999
Vendor NPI No: 123456789

Provider 123
PO BOX 1234
PORTLAND, OR 97201-1234

ACCOUNT SUMMARY	# of Claims	Billed Amount / Allowed Amount	Disallowed Amount/Discount	Not Cov'd Amount	Applied to Deductible	CoPay / Coins	Other Ins	Plan Pays
Claims Payment Total	2	927.00	910.17	0.00	0.00	0.00		10.10
		16.83				6.73		
Total Payment Amount								**10.10**
Method of Payment:								
Check/EFT Amount								**10.10**
Total Payment Amount								**10.10**
Other / Claims Related Transactions								0.00

Payment was made electronically (EFT) - 0000005000

Payment Date: 08/20/2015

Explanation of Payment

#	Service Dates	Service Code	Service Mod	Billed Amount Allowed Amount	Disallowed Amount/Discount	Not Cov'd Amount	Applied to Deductible	CoPay CoIns	Other Ins	Plan Pays	Remark Code(s)
Patient Name: Patient ID / MRN:				Provider: Provider NPI:		POS: 21 TOB: LOB: MDC - MEDICAID		Patient Acct No (Provider): Vendor TIN:			Claim #: 2559414 Auth #:
1	05/31/2015 05/31/2015	99223		485.00 0.00	485.00					0.00	243
2	06/02/2015 06/02/2015	99232		172.00 0.00	172.00					0.00	243
3	06/01/2015 06/01/2015	99233		248.00 0.00	248.00					0.00	243
	Total			**905.00** **0.00**	**905.00**	**0.00**	**0.00**	**0.00** **0.00**	**0.00**	**0.00**	
	Claim Payment Total									**0.00**	
Patient Name: Patient ID / MRN:				Provider: Provider NPI:		POS: 22 TOB: LOB: TPN - TIERED PRODUCT NON		Patient Acct No (Provider): Vendor TIN:			Claim #: 2559415 Auth #:
1	06/10/2015 06/10/2015	73110	26RT76	22.00 16.83	5.17			 6.73		10.10	45, 2
	Total			**22.00** **16.83**	**5.17**	**0.00**	**0.00**	**0.00** **6.73**	**0.00**	**10.10**	
	Claim Payment Total									**10.10**	
	Method of Payment:										
	Total Payment Amount									**10.10**	

Remark Codes

Code	Description
2	Coinsurance Amount
45	Chg exceeds fee sched/max allowbl or contrctd/legisltd fee,use only with Group Codes PR/CO
243	Services not authorized by network/primary care providers.

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UNDERSTANDING YOUR EXPLANATION OF PAYMENT (EOP) STATEMENT

*** *Please retain for your records* ***

*[Line Number]* - The line number that coincides with the line number on the submitted claim.

of claims *[Number of Claims]* - The total number of claims covered by this Explanation of Payment (EOP).

Allowed Amount -The total allowable amount as determined by contract, other provider agreement, or reasonable and customary payment guidelines.

Applied to Deductible - The amount of member's deductible applied to the claim.

Auth # *[Authorization Number]* - An assigned number that identifies the authorization for approved services identified on the claim.

Billed Amount - The amount billed by the provider for a specific service or set of services.

Check/EFT Amount *[Check/Electronic Funds Transfer Amount]* - The net amount of the check/EFT payment.

Check/EFT No *[Check/Electronic Funds Transfer Number]* - The payment instrument number issued on a check/EFT paid to the vendor or member/subscriber.

Claim # *[Claim Number]* - A number assigned by Kaiser Permanente to an individual claim.

Claim Payment Amount - The sum of the individual claims Total amounts covered by this Explanation of Payment (EOP).

Claim Payment Total - The total amount of the claim, interest, and penalty paid by the Health Plan.

CoIns *[Coinsurance]* - A percentage of the payment amount the insured pays against a claim.

CoPay - A fixed amount the insured pays against a claim.

Disallowed Amount/ Discount - Reflects contractual allowances, usual and customary (U&C) charges, provider responsibility/not covered, and discounts.

Interest Amount - The interest penalty amount required under governing rules for the specific Line of Business.

LOB *[Line of Business]* - The relevant rules under which the patient is enrolled as Kaiser Foundation Health Plan member.

Method of Payment - Describes the method of payment for the Claim Payment Total or Total Payment Amount (e.g. check/EFT, recoupment, prepayment, etc., as applicable) .

Not Cov'd Amount *[Not Covered Amount]* - Services not included under the terms of the insured's health care coverage.

Other Claim Related Transactions - Includes reversal claims,refunds received, recoupments applied, prepayments, write-ons and write-offs.

Other Ins *[Other Insurance]* - The amount paid by another financially responsible insurance carrier as primary on the claim, under Coordination of Benefits, Third Party Liability or Workers' Compensation.

Patient Acct No (Provider) *[Patient Account Number (Provider)]* - Your account number for the patient.

Patient ID/MRN *[Patient Identification Number/Medical Record Number]* - The Kaiser Permanente identification number or medical record number for the patient.

Patient Name - The name of the patient to whom the services were provided on this claim.

Patient Out of Pocket - Remaining cost share from the amount determined by primary coverage that the patient owes after additional payment by Kaiser Permanente on non-primary claims

Payment Date - The date that the claims represented on this Explanation of Payment (EOP) were paid.

Penalty Amount - A payment amount other than interest that may be required to pay the provider under governing rules for the specific Line of Business.

Plan Pays - The total amount paid by Kaiser Permanente for all payable services on the individual claim or total of all claims.

POS *[Place of Service]*- The location where the service was provided.

Prepayments - Funds paid to provider in advance of services used to satisfy liability of submitted claims consistent with the terms of the provider's contractual agreement.

Provider - The provider of services associated with the claim.

Provider NPI *[Provider National Provider Identification Number]* - A CMS number assigned to the vendor for billing and identification purposes.

Recoupments - Funds resulting from overpayments used to offset payment of claims.

Refunds Received - Funds received from the vendor for identified overpaid claims.

Remark Code - Codes describing how the claim was processed.

Remittance Number - A unique number identifying this Explanation of Payment (EOP).

Reversal Claims - Used to account for adjusted claims.

Service Code - A code used to describe the medical services and procedures provided.

Service Dates - The dates on which the services were provided.

Service Mod *[Service Modifier]* - An alpha and/or numeric code appended to a CPT/HCPCS procedure code to clarify the services or procedures being billed.

Total Payment Amount - The sum of the individual claims Total amounts covered by this Explanation of Payment (EOP). Total Payment Amount = Claims Payment Amount + Interest Amount + Penalty Amount.

TOB *[Type of Bill]* - A three digit code located on a claim form that describes the type of bill a provider is submitting.

Vendor ID No *[The Vendor Identification Number]* -The internal account number that Kaiser Permanente assigns each vendor.

Vendor NPI No *[Vendor National Provider Identification Number]* - A CMS number assigned to the vendor for billing and identification purposes.

Vendor Tax ID No *[Vendor Tax Identification Number/Vendor TIN]* - Federally issued tax identification number.

Withheld Amount - Payments made to 3rd parties/ lien holders on behalf of the vendor.

Write Offs - Vendor balance forgiven by Kaiser Permanente

Write Ons - Used to account for existing overpayment balances.

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DENIALS DUE TO MISSING INFORMATION

If a claim was denied due to missing information, you may resubmit the claim with the complete information. The information needed to perfect this claim is described in the Explanation of Payment (EOP) remarks section. Please submit the claim in writing with comments, documents, records and other supporting information for review. Submit in writing to:

Kaiser Permanente
National Claims Administration
PO Box 370050
Denver, CO 80237-9998

ADDITIONAL INFORMATION AVAILABLE

You are entitled to receive, upon request and free of charge:

- An explanation of the scientific or clinical judgment used for determining medical necessity, experimental or investigative treatment or similar exclusions/limits.
- A copy of any internal rule, guideline, protocol or similar criterion relied upon in making the determination.

You may contact our Claims Inquiries Representatives for assistance.
If you need additional information or explanation please call the Kaiser Permanente Provider Claims line at (503) 735-2727 or 1-(866)-441-1221. If your issue is not resolved with the Kaiser Permanente Provider Claims line you may file a written appeal.

APPEAL PROCEDURE

Please review your EOP carefully. If you don't agree with this decision in whole or in part you may submit a signed written appeal within 180 days from the date of this notice to:

Kaiser Permanente
National Claims Administration
ATTN: Provider Appeals
PO Box 370050
Denver, CO 80237-9998

Contracted Providers:

You have the right to appeal our decision
Please review your EOP carefully. If you don't agree with this decision, in whole or in part you may submit a signed written appeal within 180 days from the date of this notice to:

Kaiser Permanente
National Claims Administration
ATTN: Provider Appeals
PO Box 370050
Denver, CO 80237-9998

NonContracted Providers:

You have the right to appeal our decision

You have the right to ask Kaiser Permanente to review our decision by asking for an appeal.
Appeal: Ask Kaiser Permanente for an appeal within **60 days** of the date of this notice. We can give you more time if you have a good reason for missing the deadline.

Important Information About Your Appeal Rights

Standard Appeal - We'll give you a written decision on a standard appeal within **30 days** after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We'll tell you if we're taking extra time and will explain why more time is needed. If your appeal is for payment of a service you've already received, we'll give you a written decision within **60 days**.

How to ask for an appeal with Kaiser Permanente

Step 1: Your written request must include:

- Your name & address
- Waiver of liability form
- Reasons for appealing
- Any evidence you want us to review, such as clinical records or other information that explains why you should be reimbursed for the item or service.

Step 2: Mail your appeal.

Kaiser Permanente
National Claims Administration
ATTN: Provider Appeals
PO Box 370050
Denver, CO 80237-9998

What happens next?

If you ask for an appeal and we continue to deny your request for payment of a service, we'll send you a written decision and automatically send your case to an independent reviewer. **If the independent reviewer denies your request, the written decision will explain if you have additional appeal rights.**

Get help & more information

- Kaiser Permanente Toll Free: (877) 221-8221 TTY users call: 711
  8:00 a.m. - 8:00 p.m., 7 days a week
- 1-800-MEDICARE (1-800-633-4227) TTY users call: 1-877-486-2048
  24 hours, 7 days a week