

## CLAIMS SETTLEMENT PRACTICES & PROVIDER DISPUTE RESOLUTION MECHANISMS

As required by Assembly Bill 1455, the California Department of Managed Health Care has set forth regulations establishing certain claim settlement practices and the process for resolving claims disputes for managed care products regulated by the Department of Managed Health Care. This information notice is intended to inform you of your rights, responsibilities, and related procedures as they relate to claim settlement practices and claim disputes for Kaiser Foundation Health Plan, Inc. (KP) members, to include Medi-Cal.

### I. CLAIMS SUBMISSION

KP encourages providers to submit electronic claims (837I/P transaction). Information or questions regarding EDI are addressed at: <https://kpnationalclaims.my.site.com/EDI/s/>

Detailed instructions regarding filing requirements and your EDI options are also available in the Provider Manuals posted for your convenience on the Community Provider Portal at:

**Southern California**  
**Northern California**

<http://kp.org/providers/scal/>  
<http://kp.org/providers/ncal/>

#### A. Sending Claims to Kaiser Permanente

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

**Southern California**

Kaiser Foundation Health Plan, Inc.  
Claims Administration Department  
P.O. Box 7004  
Downey, California 90242-7004

**Northern California**

**Emergency Claims**

Kaiser Foundation Health Plan, Inc.  
National Claims Administration  
P.O. Box 12923  
Oakland, CA 94604-2923

**Referred Service Claims**

Kaiser Referral Invoice Service Center (RISC)  
2829 Watt Avenue, Suite #130  
Sacramento, CA 95821-6242

**DME, SNF, CBAS, ICF/DD, ICF/DD-H, ICF/DD-N,  
Home Health, and Hospice Service Claims**

Kaiser Foundation Health Plan, Inc.  
National Claims Administration  
P.O. Box 12923  
Oakland, CA 94604-2923

**Northern California**  
**Transplant Case Claims**

Kaiser Permanente  
Transplant Claims Processing Unit  
1950 Franklin St., 7th Floor  
Oakland, CA 94612

**B. Claims Submission Requirements**

The following is a listing of claim submission requirements (including timeliness standards and required supporting documentation), as well as supplemental information we believe is important for you to know in submitting claims to KP. You are required to submit "complete claims" as defined in Title 28, California Code of Regulations, Section 1300.71(a)(2) for the services provided. A "complete claim" must include the following information, as applicable:

- **Correct Form:** All professional claims should be submitted using preprinted red OCR CMS-1500 or the EDI 837P file, and all facility claims (or appropriate ancillary services) should be submitted using preprinted red OCR UB-04 or EDI 8371 file based on CMS guidelines.
- **Standard Coding:** All fields should be completed using industry-standard coding, including the use of ICD-10 code sets.
- **Applicable Attachments:** Attachments should be included in the submission when circumstances require additional information.
- **Completed Field Elements for CMS Form 1500 or CMS Form UB04:** All applicable data elements of CMS forms should be completed, including correct loops and segments on electronic submissions.

Contracted providers must submit claims within 90 calendar days or according to your agreement terms. Non-contracted providers have 180 calendar days after the date of service to submit a claim. Claims submitted outside of these time frames may be denied as untimely.

**C. Claims Receipt Verification**

Kaiser Permanente will acknowledge claims received electronically (EDI) within two (2) working days of receipt of the claim. Paper claims received will be acknowledged within fifteen (15) working days of receipt of the claim.

**D. Clinical Review Payment Determination Policy**

Kaiser Permanente is responsible for reviewing facility and professional claims to ensure that providers comply with billing and coding standards. This includes confirming services rendered are appropriate and medically necessary, and that payment is made in accordance with applicable contract and/or provider manual requirements. The Clinical Review Payment Determination Policy outlines Kaiser Permanente's review processes, including Itemized Bill Review (IBR), Post Stabilization, and Trauma Activation, among others. The policy can be accessed in the provider portal in the claims section as follows:

- **Southern California** click here: [Claims | Community Provider Portal | Kaiser Permanente](#);
- **Northern California** click here: [Claims | Community Provider Portal | Kaiser Permanente](#).

**E. Contacting Kaiser Permanente Regarding Claims**

For claim filing requirements, you may refer to the Billing and Payment section in the Provider Manual located in the KP Community Provider Portal or contact Kaiser Permanente by calling: 1-800-390-3510.

For status inquiries, you may visit KP Online Affiliate's self-service portal or contact Kaiser Permanente by calling: 1-800-390-3510.

## **II. Provider Dispute Resolution Process**

As required by California Assembly Bill 1455, KP has established a fast, fair and cost-effective dispute resolution mechanism that complies with the DMHC requirements.

### **A. Types of Disputes**

The following describes the most common types of payment disputes:

- Claims Payment Disputes: challenging, appealing or requesting reconsideration of a claim (or bundled group of claims) that has been denied, adjusted or contested by KP.
- Responding to Requests for Overpayment Reimbursements: disputing a request initiated by KP for reimbursement by you of overpayment of a claim.

### **B. Provider Dispute Requirements**

A Provider Dispute must contain at least the information listed below, as applicable to your dispute. If the Provider Dispute does not contain all the applicable information listed below, we may return the Provider Dispute to you, and we will identify in writing the missing information necessary for us to consider the dispute.

Required Information:

- Provider Name
- Provider Tax ID Number
- Contact Information
- Kaiser Claim Number
- Member Medical Record Number
- Date(s) of Service
- Reason for the Dispute

Substantially similar multiple payment disputes may be filed in batches, provided that such disputes include the above-mentioned information.

### **C. Time Period for Submission of Provider Disputes**

Subject to any longer period specifically permitted under your agreement or required under applicable law, the Provider Dispute must be received by KP within 365 calendar days from our action (or the most recent action if there are multiple actions) that led to the dispute, or in the case of inaction, the Provider Dispute must be received by KP within 365 calendar days after our time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.

### **D. Timeframes for Acknowledgement of Receipt & Determination of Provider Disputes**

KP will acknowledge receipt of your Provider Dispute submitted in accordance with the above requirements within fifteen (15) working days after KP's receipt of hardcopy submission, or within two (2) working days after KP's receipt of online submission.

KP will issue a resolution letter explaining the reasons for our determination, to the extent required by applicable law, within forty-five (45) working days after the date of receipt of the complete Provider Dispute.

#### **E. Submitting Provider Disputes**

Provider Disputes are encouraged to be submitted electronically through Online Affiliate:

##### **Southern California**

<https://healthy.kaiserpermanente.org/southern-california/community-providers/online-provider-tools>

##### **Northern California**

<https://healthy.kaiserpermanente.org/northern-california/community-providers/online-provider-tools>

Disputes may also be mailed to the following:

##### **Southern California**

Kaiser Foundation Health Plan, Inc.  
Claims Administration Department  
P.O. Box 7006  
Downey, California 90242-7006

##### **Northern California**

##### **Emergency Claims**

Kaiser Foundation Health Plan, Inc.  
National Claims Administration  
P.O. Box 12923  
Oakland, CA 94604-2923

##### **Referred Outside Medical Service Claims**

Kaiser Referral Invoice Service Center (RISC)  
2829 Watt Avenue, Suite #130  
Sacramento, CA 95821-6242

### **III. Claim Overpayments**

#### **A. Notice of Overpayment of a Claim**

If KP determines that we have overpaid a claim, we will notify you in writing through a separate notice clearly identifying the claim, the name of the patient, the date(s) of service and a clear explanation of the basis upon which we believe the amount paid on the claim was in excess of the amount due. The refund request will include interest and penalties on the claim where applicable.

#### **B. Contested Notice**

If you contest our notice of overpayment of a claim, we ask that you send us a letter within thirty (30) business days of your receipt of the notice of overpayment to the address indicated by KP in the overpayment notice. Such letter should include the basis upon which you believe the claim was not overpaid. If your contest notice to KP does not include the basis upon which you believe the claim was not overpaid, then that basis must be provided in writing no more than 365 calendar days following your initial receipt of the KP notice of overpayment. We will process the completed letter of contest in accordance with the KP payment dispute resolution process described in Section II above.

#### **C. No Contest**

If you do not contest our notice of overpayment of a claim, you must reimburse us within thirty (30) business days of your receipt of our notice of overpayment of a claim. Interest will begin to accrue at the rate of 10 (ten) percent per annum on the amount due beginning with the first business day following the initial 30 business day period.

#### **D. Offsets to Payments**

We will only offset an uncontested notice of overpayment of a claim against a provider's current claim submission when: (i) the provider fails to reimburse KP within the timeframe set forth in Section III.C, above, and (ii) KP's contract with the provider specifically authorizes KP to offset an uncontested overpayment of a claim from the provider's current claims submissions or KP has obtained other written offset authorization from the provider. In the event an overpayment of a claim or claims is offset, the Evidence of Payment (EOP) includes a Recoupment Detail Report. This report provides additional details about your vendor balance and offset, including which claims the offset was applied to.



## PROVIDER DISPUTE RESOLUTION REQUEST

**NOTE: WE STRONGLY URGE NON-CONTRACTED PROVIDERS NOT TO BILL HEALTH PLAN MEMBERS DURING THE DISPUTE RESOLUTION PROCESS.**

PROVIDER NAME \_\_\_\_\_

PROVIDER TAX ID \_\_\_\_\_

PROVIDER TYPE (CHECK ALL THAT APPLY)

Contracted       Professional Provider  
 Non-Contracted       Institutional Provider  
 Other Provider: (please specify)

### CLAIM INFORMATION

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

### DETAILED DESCRIPTION OF REASON FOR DISPUTE

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

**SUMMARY OF SERVICES PROVIDED**

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Contact Name (Please Print)

Title

Signature

Phone Number

Date



## **POL-020 Clinical Review Payment Determination Policy – California**

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This policy applies to California for all lines of business.

### **1.0 Business Policy**

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This policy provides information on rules that govern National Payment Integrity (NPI) Clinical Review processes related to determining payment for claims under review. NPI Clinical Review is responsible for reviewing facility and professional claims to ensure that providers comply with billing and coding standards, that services rendered are appropriate and medically necessary, and that payment is made in accordance with applicable contract and/or provider manual requirements.

### **2.0 Rules**

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#### **2.1 Itemized Bill Review (IBR)**

**2.1.1** National Claims Administration will not reimburse providers for items or services that are considered inclusive of, or an integral part of, another procedure or service, rather, non-separately payable services will be paid as part of the larger related service and are not eligible for separate reimbursement.

**2.1.1.1** NPI Clinical Review will apply commonly accepted standards to determine what items or services are eligible for separate reimbursement. Commonly accepted standards include CMS guidelines, National Uniform Billing Committee (NUBC) standards, National Correct Coding Initiative (CCI) standards, and professional and academic journals and publications.

**2.1.1.2** NCA staff will submit a request for information (RFI) to the provider to request an itemized bill and/or medical records if financial liability cannot be determined based on the submitted claim.

**2.1.1.3** NCA intake staff will scan and attach itemized bills to related claims in order to complete claims processing.

**2.1.2** National Claims Administration will not separately reimburse items and services as defined below.

**2.1.2.1** Charges for use of [capital equipment](#), whether rented or purchased, are not to be separately payable. The use of such equipment is part of the administration of a service. NPI Clinical Review will review claims for these charges and provide instructions to Claims staff to deny these services as not payable. Examples include: automatic blood pressure machines/monitors,



anesthesia machines, cameras, cardiac monitors, fetal monitors, EMG, temperature monitor, apnea monitors, cautery machines, cell savers, instruments, IV/feeding pumps, lasers, microscopes, neuro monitors, oximetry monitors, scopes, specialty beds, thermometers, ventilators, balloon pumps, EKG machines, and hemodynamic monitoring catheters.

**2.1.2.2** Charges for IV flushes (for example, heparin and/or saline) and solutions to dilute or administer substances, drugs, or medications, are not separately payable. The use of these is part of the administration of a service. NPI Clinical Review will review claims for these charges and provide instructions to Claims staff to deny these services as not payable. Examples include IV start, access of indwelling catheter, subcutaneous catheter or port, flush at the end of an infusion, standard tubing/syringes/supplies, and preparation of chemotherapy agents.

**2.1.2.3** Charges for hydration are not separately payable unless the hydration services are therapeutic, based on patient medical records. NPI Clinical Review will review claims for these charges, along with supporting medical records, to determine whether the services are therapeutic and therefore payable.

**2.1.2.4** Charges for services that are necessary or otherwise integral to the provision of a specific service and/or delivery of services in a specific location are considered routine services and are not separately payable. This applies to both the inpatient and outpatient settings. These services are part of the room and board charges. NPI Clinical Review must review claims for these charges and provide instructions to Claims staff to deny these services as not payable. Examples include: IV insertion, saline flushes, infusion of IV fluids, administration of medications (IV, PO, IM), urinary catheterization, dressing changes, tube feeding, respiratory treatment or care such as (but not limited to): sputum induction, airway clearance (ex: suctioning), incentive spirometer, nebulizer treatment, if a potent drug was administered, point of care testing, nasogastric tube (NGT) insertion, incremental nursing care, measuring blood oxygen levels, and specimen collection.

**2.1.2.5** Under the OPSS (Outpatient Prospective Payment System), any charges for line items or Healthcare Common Procedure Coding System (HCPCS) codes that are bundled together under a single payment for surgical procedure should not be paid separately. This is because the cost of these items and services is already included in the overall payment for the associated service. These bundled and/or packaged items are considered an essential component of the procedure and included in the Ambulatory Payment Classification (APC) payment for the service of which they are an integral part. For instances when the claim contains services payable under cost reimbursement or services payable under a fee schedule, in addition to services that would be packaged if an APC were applicable, the packaged services are not separately payable. Packaged services are identified in the OPSS Addendum B with Status indicator of "N."

**2.1.2.6** [Personal Care Items](#) These items do not contribute to the meaningful treatment of the patient's condition. NPI Clinical Review will review claims for these charges and provide instructions to Claims staff to deny these services as

not payable. Examples include but are not limited to admission kits, oral swabs/mouthwash, footies/slippers.

**2.1.2.7** Charges for respiratory therapy services provided at a [Specialty Care Unit](#) (such as ICU, Pediatric ICU, CCU, ED, or intermediate intensive care units) are not separately payable. The use of these services is part of the administration of care at a Specialty Care Unit. NPI Clinical Review will review claims for these charges and provide instructions to Claims staff to deny these services as not payable. Examples include but are not limited to ventilator supplies, heated aerosol/heated aerosol treatments while patient on ventilator, oxygen, oximetry reading or trending, CO2 monitoring/trending, arterial punctures, endotracheal suctioning, and extubation.

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

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

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

**2.1.2.7.4** Charges for respiratory services provided in the inpatient setting other than at a specialty care unit are limited to 1 unit/charge per date of service regardless of the number of respiratory treatments and/or procedures provided. Examples include but are not limited to CPT if done by a respiratory therapist, nebulizers, heated aerosol and oxygen, chest percussions if done by a respiratory therapist, and demonstration of MDI use or respiratory equipment by a respiratory therapist. Examples of non-specialty care units:

- Telemetry units
- Medical surgical units

**2.1.2.8** Charges for [Routine Floor Stock](#) items and supplies necessary or otherwise integral to the provision of a specific service or delivery of service in a specific location are considered routine and are not separately payable. The use of these services is part of the administration of care at a hospital or skilled nursing facility and are used during the normal course of treatment, which may be related to and/or part of a separately payable treatment. NPI Clinical Review will review claims for these charges and provide instructions to Claims staff to deny these services as not payable.

**2.1.2.9** Charges for [Point of Care \(POC\)](#) tests are not separately payable. These tests are performed at the site where the patient care is provided by the nursing staff at the facility as part of the room and board services. Under the Clinical Laboratory Amendments of 1988 (CLIA), a POC must have a Certificate of Waiver license in order for the site to allow POC testing. NPI Clinical Review will review claims for these charges and provide instructions to Claims staff to deny these services as not payable.

**2.1.2.10** The following Multiple Procedure Payment Reduction (MPPRs) are applied specifically to the technical component of diagnostic imaging for cardiovascular and ophthalmology services if procedure is billed with another imaging procedure in the same family.

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

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

**2.1.2.11** Multiple Procedure Payment Reduction (MPPR). Kaiser Permanente will reimburse the highest-valued procedure at the full fee schedule or contracted/negotiated rate and will reduce payment for the second and subsequent procedures. The National Correct Coding Initiative (NCCI) policy states, "Most medical and surgical procedures include pre-procedure, intra-procedure, and post-procedure work. When multiple procedures and/or surgeries are performed at the same patient encounter, there is often overlap of the pre-procedure and post-procedure work. The payment methodologies for surgical procedures account for the overlap of the pre-procedure and post-procedure work."

The primary or highest valued procedure will be reimbursed at 100% of the fee schedule value or contracted/negotiated rate. Second and/or subsequent procedures will be reimbursed at 50% of the fee schedule value or contracted/negotiated rate.

**2.1.2.12** Kaiser Permanente will apply reductions to the secondary and subsequent technical component of imaging procedures when multiple services are ordered by the same physician for the same patient in the same session on the same day. The technical component is for the use of equipment, facilities, non-physician medical staff and supplies. The imaging procedure with the highest technical component is paid at 100% and the technical components for additional less-technical services in the same code family are reduced by 50%.

**2.1.2.13** When more than one surgical procedure is performed during the same operative session by the same provider, all procedures should be billed on the same claim. Payment for multiple surgeries is based on whether the surgical procedure itself may be subject to a multiple surgery reduction. If the multiple surgery reduction applies, the procedure with the highest allowed amount will be allowed at 100% of the contracted/allowed rate. The multiple surgery reduction will be applied to the procedure(s) with a lesser allowed amount at 50% of the contracted/allowed rate.

**2.1.2.14** Implants. According to the Food and Drug Administration (FDA), implants are devices or materials placed surgically inside or surface of the body. Implants can be permanent or removed when no longer needed. Many implants

are intended to replace body parts, deliver medication, monitor body functions or provide support to organs or tissues.

**2.1.2.14.1** A medical device must meet the following requirements to be eligible for reimbursement:

If required by the FDA, the device must have received FDA approval or clearance (except for a device that has received an FDA investigational device exemption (IDE) and has been classified as a Category B device by the FDA in accordance with §§405.203 through 405.207 and 405.211 through 405.215 of the regulations) or another appropriate FDA exemption.

The device is reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body part (as required by section 1862(a)(1)(A) of the Social Security Act).

The device is an integral and subordinate part of the service furnished, is used for one patient only, comes in contact with human tissue, is surgically implanted or inserted through a natural or surgically created orifice or surgical incision in the body, and remains in the patient when the patient is discharged from the hospital.

**2.1.2.14.2** The device is not any of the following:

Equipment, an instrument, apparatus implement, or item of this type for which depreciation and financing expenses are recovered as depreciable assets as defined in Chapter 1 of the Medicare Provider Reimbursement Manual (CMS Pub. 15-1).

A material or supply furnished to a service such as sutures, surgical clip, other than a radiological site marker.

A medical device that is used during a procedure or service and does not remain in the patient when the patient is released from the hospital.

Material that may be used to replace human skin (for example, a biological or synthetic material).

## **2.2 Trauma Activation**

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

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

**2.2.1.1.1** Have received a pre-notification from EMS or someone who meets either local, state, or ACS field criteria and are given the appropriate team response.

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

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

**2.2.1.1.4** Evaluation and Management codes for critical care must be billed under Revenue Code 450 in order to receive trauma activation reimbursement. When revenue code series 68x trauma response is billed in association with services other than critical care, payment for trauma activation is bundled into the other services provided on that day.

### **2.3 Diagnosis Related Group (DRG) Payment**

**2.3.1** The purpose of DRG validation is to ensure diagnostic and procedural information and discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician's description and the information contained in the beneficiary's medical records.

**2.3.2** Clinical Review performs DRG reviews on claims with payment based on DRG reimbursement to determine the diagnosis and procedural information leading to the DRG assignment is supported by the medical record.

**2.3.3** Validation must ensure diagnostic and procedural information and discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician's description and the information contained in the beneficiary's medical record.

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

**2.3.5** The comprehensive review of the patient's medical records will be conducted to validate:

- Physician-ordered inpatient status.
- Accuracy of diagnostic code assignment.
- Accuracy of the procedural code assignments.
- Accuracy of the sequencing of the principal diagnosis and procedure codes.
- Accuracy of present-on-admission (POA) indicator assignment.
- Accuracy of DRG grouping assignment and associated payment.
- Accuracy of Discharge Disposition Status Code assignment.

- Other factors that may impact DRG assignment and/or claim payment.
- Compliance with KP's payment policies including but not limited to those policies that address DRG inpatient facility, never events, hospital-acquired conditions, and readmissions or transfers to another acute care hospital.

## **2.4 Medical Necessity Review**

**2.4.1** A decision by Clinical Review may be made that a request for benefit coverage under the patient's plan does not meet the requirements for Medical Necessity. Such requests are reviewed for: appropriateness of treatment, levels of care billed, or the request may be determined to be cosmetic in nature, experimental, or investigational. The requested benefit may therefore be denied, reduced, or payment not provided or made, in part or in whole.

**2.4.2** Determinations of medical necessity should adhere to the standard of care and always be made on a case-by-case basis that applies to the actual direct care and treatment of the patient. Considerations include:

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

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

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

## **2.5 Level of Care Review**

**2.5.1** Level of Care (LOC) Review applies to inpatient claims. Review of facility claims ensure that the level of care being billed matches the LOC that was authorized so that appropriate reimbursement is made.

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

**2.5.3** If provider bills for additional days on a higher level of care than what is authorized, the claim will be denied, and provider will submit a corrected claim for payment.

## **2.6 Short Stay/2 Midnight Rule**

**2.6.1** Kaiser Permanente will reimburse a provider for an inpatient admission if the medical records support inpatient admission and if at time of or before admission, the admitting physician reasonably expects the patient's hospital care would cross two midnights.

**2.6.2** Exceptions to the 2 Midnight Rule:

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

**2.6.2.2** For admissions not meeting 2 Midnight Rule, inpatient admission less than 2 days will be considered on a case-by-case basis where the medical records support the physician's determination that the patient requires inpatient care despite the lack of a two-midnight expectation.

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

## **2.7 Post Stabilization**

**2.7.1 (California)** A member who has an urgent/emergent condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.

**2.7.2 (California)** Non-Plan treating providers or the member are required to contact Kaiser Permanente to request prior authorization for post-stabilization care. After receiving a request for authorization, Kaiser Permanente must either authorize care or arrange for transfer to a Plan provider. Kaiser Permanente does not reimburse for unauthorized post-stabilization services.

## **2.8 Neonatal Intensive Care Level of Care (NICU)**

**2.8.1** This medical criteria provides guidance for NICU and neonatal care levels 2 through 4. Level 1 admission and discharge criteria as coupling or mother/baby care was intentionally omitted as it now replaces routine nursery care.

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

## **2.9 Emergency Department (ED) Facility Evaluation and Management (E&M) Coding**

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

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

**2.9.3** Certain claims are excluded from review:

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

**2.9.3.2** Claims for children under 2.

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

**2.9.3.4** Claims for patients who received critical care services.

**2.9.4** The review is based upon presenting problems as defined by the ICD 10 reason for visit, intensity of the diagnostic workup as measured by the diagnostic CPT codes, and based upon the complicating conditions as defined by the ICD 10 principal, secondary, and external cause of injury diagnosis codes.

**2.9.5** To learn more about the EDC Analyzer TM tool, see: [EDC Analyzer.com](http://EDC Analyzer.com).

**2.10 Provider Preventable Conditions (PPC) review applies to the Medicaid line of business. Per CMS guidelines, reimbursement is prohibited to providers for services which meet certain conditions, for example, surgery performed on the wrong body parts.**

**2.10.1** The Clinical Review department reviews claims that have been pended for review to determine whether the claim contains any PPC services based upon a defined list of Health Care Acquired Conditions (HAC) and Other Provider Preventable Conditions (OPPCs).

**2.10.2** The Clinical Review department will determine if the service provided meets the clinical guidelines set forth by CMS to ensure PPC services are not reimbursed.

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

**2.11 Do Not Bill Events (DNBE)**

**2.11.1** Per CMS guidelines, providers will not be reimbursement for certain DNBE also known as "never events." DNBEs (never events), are errors in medical care that are of concern to both the public and health care. Examples include, but are not limited to, the below. KP may reduce payment for services directly related to a Do Not Bill Event.

- Wrong surgery or invasive procedure on patient
- Surgery or invasive procedure on wrong patient
- Surgery or invasive procedure on wrong body part

**2.11.2** Hospital Acquired Condition is a condition that could reasonably have been prevented through the application of evidence-based guidelines. The charges for these events will be disallowed. Medical records are used to confirm the DNBE/HAC/Sentinel Event and an Itemized Statement is used to identify related charges.

**3.0 Guidelines**

N/A

**4.0 Definitions**

**4.1 Capital equipment** - Items that are used by multiple patients during the lifetime of that piece of equipment.



**4.2 Center for Medicare and Medicare Services (CMS)** - Part of the Department of Health and Human Services (HHS) who administers programs such as Medicare, Medicaid, and Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace.

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

**4.4 Medical Necessity** - Medical Necessity is the standard terminology that all health care professionals and entities use for the review process to determine whether medical care is appropriate and essential and is an appropriate health care service and supply provided by health care entities, appropriate to the evaluation and treatment of a disease, condition, illness or injury, and is consistent with the applicable standard of care. Criteria used to determine whether services are medically necessary are evidence based.

**4.5 Personal Care Items** - Items used by the patient for non-medical use such as hygiene and comfort. Examples include: admission kits, pillows/blankets/linens/towels, cosmetics/cleansers/soap/deodorizers, diapers/wipes, lotions/creams, oral swabs/mouthwash/shaving supplies/toothpaste/toothbrush, nutritional supplies, bath comfort kits (shampoo, conditioner, hairspray), slippers/footies, hairbrush/comb, and facial tissues.

**4.6 Point of Care (POC) Tests** - Tests that are performed at site where patient care is provided. Point of care (POC) tests do not require the equipment nor the skills of licensed or certified technicians or technologists.

**4.7 Post Stabilization Care** - Medically necessary services related to the member's emergency condition that the member receives after the treating physical determines the member's condition is stabilized.

**4.8 Routine Floor Stock** - Supplies that are available to all patients in the floor or area of a hospital or skilled nursing facility. These are supplies provided to a patient during the normal course of treatment. Personal care items are non-chargeable because they do not contribute to the meaningful treatment of the patient's condition. Examples of routine supplies or floor stock include: thermometers, respiratory supplies such as oxygen masks/ambu bags, suction tips, tubing, oxygen, preparation kits, irrigation solutions (sterile water, normal saline), gauze/sponge sterile or non-sterile, oximeters/oximeter probes, syringes, gloves/masks, supplies used ordinarily for surgery such as surgery drapes/sutures, sequential compression socks, bedpans/urinals, hypo/hyperthermia blankets, EKG electrodes, lab supplies, hypodermic needles, and personal care items.

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

## 5.0 References

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N/A

## 6.0 Frequently Asked Questions (FAQs)

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N/A

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[Revision History](#)



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