Code Editing and Coding Policy

General | Code Editing | Coding Policy

General

Code Editing and Coding Policy are based on industry standard guidelines.

Kaiser Permanente variations for facility claims:

- Health plan variations from the general NCCI policy, PTP (procedure to procedure) code edits, OCE, or MCE guidelines will be made transparent to contracted providers.

Kaiser Permanente variations for professional claims:

- Kaiser Permanente has adopted the Best Practice Recommendation (BPR) for professional claims, Claim coding policy and edits: Standardization & transparency, as outlined in Washington state Senate Bill 5346 and published through the administration simplification work of Washington Healthcare Forum.

- Kaiser Permanente is committed to following all recommendations outlined in the BPR. We strive to make any variations to the BPR (e.g., general NCCI policy, Procedure to Procedure code edits, defined payment rule indicators in MPFSDB) transparent to our contracted providers when they are put into production or as soon as we become aware of them.

Code Editing

Review Process | Reconsideration Process

Review Process

Kaiser Permanente's code editing logic — including general NCCI policy, PTP (procedure to procedure) edits, and the defined payment rule indicators in MPFSDB — is applied to selected professional claims for all lines of business unless:

- Regulations are specific to a particular Line of Business (e.g., LCD/NCD logic is applied to Medicare claims only).
- Kaiser Permanente plan benefits take precedence over an industry standard policy (e.g., Kaiser Permanente's preventative care benefits may be richer than Medicare, which could change how code edits are applied).
- Provider contract terms require an exception (proprietary information).

Kaiser Permanente reserves the right to determine criteria for the selection of claims which are subject to code editing application. Criteria might include, but not limited to, claim type of service, CPT code, or diagnosis code.

If selection criteria prevented a claim from being analyzed by our code editing software, it would result in the provider not receiving industry standard code editing denials when appropriate. This outcome would be to the provider's benefit.

Kaiser Permanente has a claims code editing process in place which assures:

- Provider claims are coded based on recognized industry standard guidelines.
- Kaiser Permanente code edits are applied based on industry standard guidelines.
- We are meeting coding requirements of Medicare and other regulatory entities.
- Costs for administration of claims are reduced for both providers and Kaiser Permanente.
- Our consumers' claims are submitted and processed consistently and appropriately based on the services they received.

Kaiser Permanente's code editing logic is applied to claims for all lines of business unless:

- Regulations are specific to a particular line of business (e.g., LCD/NCD logic is applied to Medicare claims only).
- Health plan benefits take precedence over an industry standard policy (e.g., Kaiser Permanente's preventative care benefits might be richer than Medicare, which could change how code edits are applied).
- Contract terms require an exception.
- Variations to coding policy or specific code edits are specifically called out as required by the BPR.

General code editing logic applied includes, but is not limited to:

- CMS guidelines are used as the basis for applying coding policy.
- NCCI coding policy which explains the rationale for the PTP (procedure to procedure).
- PTP (procedure to procedure) code edits (i.e., Column One/Column Two Correct Coding Edit Table, Mutually Exclusive Table).
- MPFSDB indicators called out in the BPR.
- Other indicators listed in the MPFSDB that are industry standard; including but not limited to:
    - Professional/technical component indicators (modifier 26/modifier TC).
    - Other status codes.
    - Global surgery indicators.
    - Pre-operative, intra-operative, post-operative percentages.
- Medically Unlikely Edits (MUE), Units of Service edits.
- American Medical Association (AMA) CPT guidelines where applicable (e.g., add-on codes, E&M code requirements, separate procedures, modifiers, unlisted procedures etc.).
- Local Coverage Determinations (LCD) edits – Medicare.
- National Coverage Determinations (NCD) edits – Medicare.
- Maternity Coding – AMA CPT coding with additional logic published by American College of Obstetricians and Gynecologists (ACOG).
- Procedure vs. Age Edits.
- Procedure vs. Gender Edits.
- Diagnosis vs. Age Edits.
- Diagnosis vs. Gender Edits.
- Diagnosis codes should be coded to the highest specificity required for each code based on ICD-10 guidelines.
- Refer to ICD-10 guidelines in determining if a diagnosis code can be billed in the primary position, secondary position, or either position.

- Each diagnosis code should be "pointed" to the correct procedure code. Incorrect pointing could result in claim line denials.
- For laboratory or pathology claims, the requesting physician must supply the initial diagnosis. For lab services interpreted by a physician/pathologist, they are responsible for correcting that diagnosis, if necessary, when the final results of the test are available. The final diagnosis should be billed on the claim.

Kaiser Permanente may review a provider's claims in more detail, either through the code editing process or claims audit process. Factors that may prompt a detailed review or audit include, but are not limited to:

- Codes with modifier 22 or 59.
- Unlisted or unspecified codes.
- High level Evaluation and Management codes.
- Codes billed with an unusual number of units.
- An unusual combination of procedures performed.
- Coding trends.

In order to complete these reviews/audits, it may be necessary to request the medical record documentation which supports the services billed/coded. If medical records documentation is required, you will receive written notification requesting medical records.

Reconsideration Process

If you disagree with the application of the code edit, are requesting the edit's source information, or have additional information regarding the services billed, you can request a reconsideration by:

- Calling the Provider Assistance Unit (PAU) at 1-888-767-4670.
- Mailing your request with attachments to:
  Kaiser Foundation Health Plan of Washington
  Attn: CEU - Code Editing
  PO Box 30766
  Salt Lake City, UT 84130

Please be sure to indicate the following information:

- Indicate you are requesting a reconsideration of the code edit denial.
- A brief description of what and why you are asking us to reconsider (specific denial).
- Relevant codes or code combinations if appropriate
- Source documentation supporting your position or links to where this information can be found.
- Your expected outcome
- Name, mailing address, and phone number of the point of contact within your organization.

Your reconsideration request will be reviewed by our Coding Specialists, RN Auditors, or the Medical Director of Kaiser Permanente Claims Administration. You will be contacted if any additional supporting documentation is needed during our review. Examples of supporting documentation may include (**Note** You will have fourteen calendar days to supply the requested information):

- An operative report

- Medical chart notes
- Radiology report
- Maternity records

We will respond to a reconsideration request of a code edit denial within thirty calendar days unless additional information is needed from you. This could delay our response time up to forty-five calendar days.

If your reconsideration request results in the code edit denial being overturned, we will reprocess the claim. If your request results in our upholding the code edit denial, you will receive a written response outlining how we arrived at the decision and any source information we used which supports the decision.

The process of submitting a final level of appeal is addressed under the "Provider Dispute Resolution Process" found in your provider contract.

Coding Policy

Review Process | Reconsideration Process

Review Process

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. (Kaiser Permanente) payment policies are designed to assist you when submitting claims to Kaiser Permanente. They are consistently updated to promote accurate coding and policy clarification.

The Code Editing policy and full list of Kaiser Permanente Policies can be accessed here:

https://wa-provider.kaiserpermanente.org/static/pdf/provider/billing-claims/code-editing.pdf

https://wa-provider.kaiserpermanente.org/provider-manual/billing-claims/claims/payment-policy

Reconsideration Process

Kaiser Permanente has a process for providers to request a reconsideration of a code editing policy where:

- The provider and Kaiser Permanente are using different nationally recognized sources.
- The provider and Kaiser Permanente have a different interpretation of a nationally recognized source.

This BPR provides guidelines for a provider to request a reconsideration of a code editing policy. Refer to the BPR to determine what is in the scope of this process. Examples in scope include but are not limited to:

- Column 1 / Column 2 code edits (unbundling)
- Modifier validity
- Assistant surgeon necessity

To submit a reconsideration of a coding policy, please include:

- Description of the issue/concern
- Explanation of why you do not agree with Kaiser Permanente's policy or the interpretation of a policy.
- Relevant codes or code combinations if appropriate
- Source documentation supporting your position or links to where this information can be found.
- Your expected outcome
- Name, mailing address, and phone number of the point of contact within your organization.
- Mail your request with attachments to:
  Kaiser Foundation Health Plan of Washington
  PO Box 30766
  Salt Lake City, UT 84130

The policy reconsideration request will be reviewed by our Payment Policy Committee. You will be contacted if any additional supporting documentation is needed during our review. Examples of supporting documentation may include (**Note** You will have fifteen calendar days to supply the requested information):

- Information regarding denied claims.
- Operative reports
- Medical chart notes

We will respond to a reconsideration request of a coding policy within sixty calendar days unless additional information is needed from you. This could delay our response time up to seventy-five calendar days. There could be situations where Kaiser Permanente and a provider are constructively engaged in a discussion about a reconsideration request, and it is mutually agreed that they will extend the response time.

If the decision is made that Kaiser Permanente will not revise the coding policy, a written notification will be sent to the provider. The correspondence will include an explanation of the rationale behind the decision and any related source information.

If the decision is made that Kaiser Permanente will revise the coding policy, a written notification will be sent to the provider. The correspondence will include information regarding:

- Kaiser Permanente's expectations as to when and how the new policy will take effect.
- Any system changes that need to occur along with the projected implementation date
- Kaiser Permanente's plan for any related denials prior to the new policy taking effect.
- Any special instructions for provider claim prior to the new policy implementation.

Once a request for reconsideration of a coding policy has been reviewed and a decision has been communicated to the provider, additional requests related to this policy will not be reviewed unless:

- The provider submits new and/or significantly different information.
- New source information has been published that has not been addressed.