KAISER PERMANENTE®

PAYMENT POLICY

PREPAYMENT REVIEW – LINE ITEM DEDUCTION (LID)

Scope

This policy applies to:

☒ Kaiser Permanente Health Plan of Washington

☒ Kaiser Permanente Health Plan of Washington Options, Inc.

☒ Commercial

☒ Medicare

☐ Medicaid

Policy

Original Effective Date: 09/01/2019

This policy provides information on rules that govern processes related to determining payment for claims under review. Kaiser Permanente (KP) 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.

Kaiser Permanente 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.

Kaiser Permanente (KP) will not separately reimburse items and services as defined below.

Charges for use of **capital equipment**, whether rented or purchased, are not separately payable. The use of such equipment is part of the administration of a service. KP 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.

Charges for IV flushes (for example, heparin and 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. KP will review claims for these charges and provide instructions to Claims staff to deny these services as not payable. Examples include: use of local anesthesia, 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.

Charges for hydration are not separately payable unless the hydration services are therapeutic, based on patient medical records. KP will review claims for these charges, along with

supporting medical records, to determine whether the services are therapeutic and therefore payable.

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. KP will 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.

Under the OPPS (Outpatient Prospective Payment System), charges for line items or Healthcare Common Procedure Coding System (HCPCS) codes that are packaged into a 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 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 Ambulatory Payment Classification (APC) were applicable, the packaged services are not separately payable.

Packaged services are identified in the OPPS Addendum B with Status indicator of “N”.

Personal Care Items These items do not contribute to the meaningful treatment of the patient's condition. KP 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, footsies/slippers.

Charges for respiratory therapy services provided at a **Specialty Care Unit** (such as ICU, Pediatric ICU, CCU, or ED, 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. KP will review claims for these charges and provide instructions to Claims staff to deny these services as not payable. Examples include: ventilator supplies, heated aerosol/heated treatments while patient is on ventilator, oxygen, oximetry reading or trending, CO2 monitoring/trending, arterial punctures, endotracheal suctioning, and intubation/extubation.

KPWA will allow the following:

One daily ventilator management charge or BiPAP while the patient is in the specialty care unit.

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

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

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: nebulizers, heated aerosol and oxygen, Chest percussions if done by a respiratory therapist, demonstration of MDI use or use of respiratory equipment by a respiratory therapist.

Telemetry units
Medical surgical units

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. KP will review claims for these charges and provide instructions to Claims staff to deny these services as not payable.

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. KP will review claims for these charges and provide instructions to Claims staff to deny these services as not payable.

In accordance with CMS, Kaiser Permanente will apply reductions to the secondary and subsequent technical component of imaging procedures when multiple services are furnished by the same physician to 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%.

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 percent of the contracted/allowed rate.

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.

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 Printed documentation 5 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.

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).

Billing/Coding Guidelines

All claims must be billed according to Centers for Medicare & Medicaid Services (CMS) guidelines.

KP 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.

KP 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.

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

Policy Definitions

CMS – Centers for Medicare & Medicaid Services

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

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.

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.

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.

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.

Prerequisite(s)

Not applicable

References

Centers for Medicare & Medicaid Services; CMS

National Correct Coding Initiative (CCI) Standards

Frequently Asked Questions

Not applicable

Revision History

01/08/2024 – Annual Review

04/22/2022 – Updated to correct hyperlinks and formatting

10/13/2020 – Additional language omitted, which was included in error

06/29/2020 – Removed duplicate effective dates

05/28/2020 – Previous effective dates: 4/19/2018, 10/5/2018, 6/15/2019, 9/1/2019

06/02/2019 – Only one daily vent management charge will be allowed while the patient is in a Specialty Care Unit