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Kaiser Foundation Health Plan of Washington
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TRAUMA ACTIVATION, INPATIENT ADMISSIONS AND PRE-PAYMENT BILLING REIMBURSEMENT CHANGES

Dear Provider,

Effective March 1, 2020, Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. (Kaiser Permanente) are making the changes listed below regarding reimbursement of services for the following: 1.) trauma activation charges, 2.) three day payment window for services "incidental to" inpatient admissions and 3.) prepayment billing review criteria for inpatient and outpatient claims.

1. Trauma activation charges

Payment for trauma activation will be allowed only when all National Uniform Billing Guidelines (NUBG) criteria for trauma activation is met. Documentation may be required to validate billing, e.g. licensure as a certified trauma facility, appropriate certified trauma level, and that pre-notification occurred.

- Charges for trauma activation, Revenue Code 68X billed with G0390, will be considered for payment when a facility has received a pre-notification from EMS or someone who meets either local, state, or ACS field criteria and EMS or other party meeting the ACS criteria are given the appropriate team response,
- The admission type is trauma center indicated by admit type code "05", and
- 99291 is billed with Revenue Code 450.

When Revenue Code series 68X is billed in association with services other than critical care, payment for trauma activation is bundled into the other services provided on that day.

Reference: Medicare Claims Processing Manual Chapter 4 - Part B Hospital, found at

https://www.cms.gov/Regulations-and Guidance/Guidance/Manuals/Downloads/clm104c04.pdf

2. Three day payment window for services "incident to" inpatient admissions

Currently when commercial inpatient reimbursement is based on a Per Diem Rate, Diagnosis-Related Group (DRG), or Case Rate, certain incidental services provided within 1 calendar day of the inpatient admission are included in the inpatient reimbursement and not paid separately.

Services that are considered incidental to an inpatient admission include:

- Surgical day care
- Observation stays
- Emergency room care
- Diagnostic and/or testing services

The payment window for commercial claims will be extended from "within 1 calendar day of the inpatient admission" to "within 3 calendar days of the inpatient admission". If the outpatient service does not meet criteria for separate payment, payment is considered bundled into the inpatient claim.

Resource: CMS MLN Matters - Clarification of Payment Window for Outpatient Services Treated as Inpatient Services, found at

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7142.pdf

Resource: Kaiser Permanente Services Incidental to Inpatient Admissions Payment Policy, found at

https://wa-provider.kaiserpermanente.org/static/pdf/provider/billing-claims/services-incidental-inpatient.pdf

3. **Pre-payment billing review criteria for inpatient and outpatient claims**

   Currently pre-payment billing review occurs on some inpatient claims with billed charges of $50,000 and greater. Effective for dates of service March 1, 2020 and after, billed charges threshold for pre-payment review will be decreased to $40,000 and greater. Outpatient claims meeting this threshold will also be subject to review, as will claims for Self-Funded members.

If you have any questions about specific claims or this process, please contact the Provider Assistance Unit at 509-241-7206 or toll-free at 1-888-767-4670, Monday – Friday from 8 am to 5 pm.

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