



# KERN HEALTH SYSTEMS

<b>KERN HEALTH SYSTEMS</b>					
<b>POLICY AND PROCEDURES</b>					
SUBJECT: Claims Submission and Reimbursement				POLICY #: 6.01-P	
DEPARTMENT: Claims					
Effective Date: 08/2000	Review/Revised Date: 08/03/2023	DMHC	X	PAC	
		DHCS	X	QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

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Emily Duran  
Chief Executive Officer

Date \_\_\_\_\_

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Chief Financial Officer

Date \_\_\_\_\_

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Chief Operating Officer

Date \_\_\_\_\_

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Chief Compliance and Fraud Prevention Officer

Date \_\_\_\_\_

\_\_\_\_\_  
Director of Claims

Date \_\_\_\_\_

**POLICY:**

Kern Health System (KHS) guidelines for claims submission shall be communicated to KHS contracted providers, and to non-contracted providers upon request, to provide for timely and accurate claims submission and reimbursement.

KHS shall reimburse 90% of clean claims from providers who are in individual or group practices or who practice in shared health facilities, within 30 calendar days of the date of receipt and 99% of all clean claims within 90 days. KHS shall reimburse each completed claim, or portion thereof, as soon as possible, but no later than 45 working days after the date of receipt of the complete claim. In accordance with State regulations, KHS will pay interest on clean claims not paid within 45 working days of receipt<sup>1</sup>. See 1.1, 1.1.1 and 1.1.2. The date of receipt shall be the date KHS receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date of the check

or the form of payment.

The KHS Claims Department (Claims) will make every effort to identify members that are covered under any other State or Federal Medical Care Program or under other contracted or legal entitlement including, but not limited to, a private group or indemnification program. Claims staff will make every effort to recover any monies paid for services provided to members prior to identifying such other coverage.

Claims will identify cases which involve Casualty Insurance, Tort Liability, or Workers' Compensation. KHS will notify the Department of Health Care Services (DHCS) or its designated contractor of all such cases involving Medi-Cal Product members.

- Claims will be processed in accordance with the statutory, regulatory, and contractual requirements outlined in the following sources: California Health and Safety Code §1371, 1371.35, 1371.36, 1371.37, and 1371.39
- CCR Title 28 §1300.71, 1300.71.38; and 1300.77.4

**DEFINITIONS:**

<b>Information necessary to determine payer liability<sup>2</sup></b>	The minimum amount of material information in the possession of third parties related to a provider's billed services that is required by a claims adjudicator or other individuals with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost if applicable, and extent of the plan's liability, if any, and to comply with governmental information requirements.
<b>Reasonably relevant information<sup>3</sup></b>	The minimum amount of itemized, accurate and material information generated by or in the possession of the provider related to the billed services that enables a claims adjudicator with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and extent of the plan's liability, if any, and to comply with governmental information requirements.
<b>Working Days<sup>4</sup></b>	Monday through Friday, excluding recognized federal holidays. Recognized federal holidays are as follows <sup>5</sup> : A. New Year's Day: closest weekday to January 1 <sup>st</sup> B. ML King's Birthday: 3 <sup>rd</sup> Monday in January C. Washington's Birthday: 3 <sup>rd</sup> Monday in February (aka Presidents' Day) D. Memorial Day: last Monday in May E. Juneteenth: closest weekday to 6/19 F. Independence Day: closest weekday to July 4 <sup>th</sup> G. Labor Day: 1 <sup>st</sup> Monday in September H. Columbus Day: 2 <sup>nd</sup> Monday in October I. Veteran's Day: Closest weekday to November 11 <sup>th</sup> (aka Armistice Day)

J. Thanksgiving Day: 4 <sup>th</sup> Thursday in November K. Christmas Day: Closest weekday to December 25 <sup>th</sup>
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## **PROCEDURES:**

### **1.0 CLAIMS SUBMISSION**

The preferred method of claim submission is Electronic billing. Electronic billing may be used to bill KHS for any claims that do not require an attachment. All electronic transactions with KHS must be HIPAA compliant. Providers utilizing electronic billing should submit electronic claims through Change Healthcare (Emdeon, Relay Health), Cognizant, SSI, or Office Ally. Providers requiring assistance in submitting electronic claims through any of the clearinghouses listed above, should contact the KHS Provider Relations Department.

Should an attachment be required for claim submissions, such as PM330, Invoice pricing, requested records; Claims should be mailed to the following address:

Claims Department  
Kern Health Systems  
PO Box 85000  
Bakersfield, CA 93380

KHS prohibits providers from using members Social Security Numbers (SSN) on claims submitted for reimbursement<sup>6</sup>. Providers shall use the member Client Identification Number (CIN) or the KHS Member Identification Number when submitting claims to reduce the fraudulent use of SSNs in the Medi-Cal program.

Hospitals, long term care facilities, licensed primary care clinics and emergency medical transportation are excluded from the SSN billing restriction. However, these excluded entities are required to make a good faith effort to obtain the member's CIN information for billing.

Providers shall restrict the use of the member's SSN whenever possible, especially as an identifier in the processing of claims.

### **1.1 Deadlines**

Claims received after 3:00 PM are opened and scanned as received the following day. Claims submission deadlines for contracted and non-contracted providers differ as described below. Providers may submit a provider dispute regarding a claim that was denied as a late submission. If good cause for the delay is demonstrated, the 180 calendar day deadline will be waived, and the claim adjudicated as if it was submitted within 180 calendar days following the provision of covered services.<sup>7</sup>

#### **1.1.1 Contracted Providers**

In order to receive full compensation, contracted providers should submit to KHS a complete, written bill for all covered services rendered within one hundred and eighty (180) calendar days

following the provision of the covered services.

Claims received after 180 calendar days<sup>8</sup> following the provision of the covered services are denied with the following exceptions:

- A. Other Primary Insurance: Claims submitted within 90 calendar days<sup>9</sup> of the date of the primary carrier's Explanation of Benefits (EOB). Any such claims received after the 90 calendar day deadline and are also beyond 180 calendar days are denied.
- B. California Children's Services: Claims must be submitted within 90 calendar days of the CCS denial letter. Any such claims received after the 90 calendar day deadline and are also beyond 180 calendar days are denied.

### **1.1.2 Non-Contracted Providers**

Claims received after six (6) months<sup>10</sup> following the provision of the covered services are denied with the following exceptions:

- A. Failure of the patient to identify himself or herself as a Medi-Cal beneficiary within four months after the month of service.
- B. If a provider has submitted a bill to a liable third party, the provider has one year after the month of service to submit the bill for payment.
- C. If a legal proceeding has commenced in which the provider is attempting to obtain payment from a third party, the provider has one year to submit the bill after the month in which the services have been rendered.
- D. The director finds that the delay in submission of the bill was caused by circumstances beyond the control of the provider.
- E. Other Primary Insurance: Claims submitted within 90 calendar days<sup>11</sup> of the date of the primary carrier's Explanation of Benefits (EOB). Any such claims received after the 90 calendar day deadline and are also beyond six (6) months are denied.
- F. California Children's Services: Claims submitted within 90 calendar days of the CCS denial letter. Any such claims received after the 90 calendar day deadline and are also beyond six (6) months are denied.

All non-emergency services by non-contracted providers, except for Covid 19 Testing, STD and family planning services require prior authorization. See *KHS Policies and Procedures #3.21 Family Planning Services and #3.17 STD Treatment*.

## **1.2 Format for Paper Submissions**

Appropriate claim forms or electronic data formats should be used. The red

*Health Insurance Claim Form (CMS 1500)* with sensor block must be used to bill for professional/supplier services. It should be used by physicians, laboratories, and allied health professionals to submit claims for medical services. Durable medical equipment and blood products should also be billed using this form. Pharmacies may also use this form to bill for supplies not billable through the on-line pharmacy claims processing service.

The red *UB-04* Claim Form should be used to submit claims for inpatient Hospital accommodations and ancillary charges and for hospital outpatient services.

### **1.3 Content**

The billed amount should be based on the same fee schedule used to bill other third party payers. Any copayment or coordination of benefits (COB) payments collected should be indicated in the appropriate data field of the claim. Providers should follow the Medi-Cal instructions for completing the *CMS 1500* and *UB-04* Forms, with the exception of Box 24J as indicated on page 7 of this policy. This includes the use of an alternative member identification number in lieu of the member's SSN<sup>12</sup>. KHS prohibits any use of the member's SSN when filing claims to KHS for KHS reimbursement. Paper claims will be denied, and EDI claims will be rejected.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

Form with multiple sections: 1. MEDICARE/MEDICAID/TRICARE/CHAMPVA/OTHER; 2. PATIENT'S NAME; 3. PATIENT'S BIRTH DATE; 4. INSURED'S NAME; 5. PATIENT'S ADDRESS; 6. PATIENT RELATIONSHIP; 7. INSURED'S ADDRESS; 8. RESERVED FOR NUCC USE; 9. OTHER INSURED'S NAME; 10. IS PATIENT'S CONDITION RELATED TO; 11. INSURED'S POLICY GROUP OR FECA NUMBER; 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE; 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE; 14. DATE OF CURRENT ILLNESS; 15. OTHER DATE; 16. DATES PATIENT UNABLE TO WORK; 17. NAME OF REFERRING PROVIDER; 18. HOSPITALIZATION DATES; 19. ADDITIONAL JUSTIFICATION; 20. OUTSIDE LAB?; 21. DIAGNOSIS OR NATURE OF ILLNESS; 22. RESUBMISSION CODE; 23. PRIOR AUTHORIZATION NUMBER; 24. A. DATE(S) OF SERVICE; 25. FEDERAL TAX I.D. NUMBER; 26. PATIENT'S ACCOUNT NO.; 27. ACCEPT ASSIGNMENT?; 28. TOTAL CHARGE; 29. AMOUNT PAID; 30. Rsvd for NUCC Use; 31. SIGNATURE OF PHYSICIAN OR SUPPLIER; 32. SERVICE FACILITY LOCATION INFORMATION; 33. BILLING PROVIDER INFO & PH #.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Submitted claims must include a full itemization of charges and the following information:

<b>Information</b>	<b>CMS 1500 Box</b>	<b>UB92 Box</b>
Patient's KHS identification number or CIN (not SSN)	1a	60
Patient's name	2	8b
Patient's date of birth	3	10
Patient's home address	5	9a-e
Other insurance coverage, including Medicare (if applicable)	11a-d	50a, 58a, 59a, 60a, 61a, and/or 62a
Rendering/Ordering NPI number	17b	76
Diagnosis Code	21	66a-q <b>DIAGNOSIS CODE HEADER.</b> For claims with dates of service/dates of discharge on or after October 1, 2015, enter the ICD indicator "0" in the white space below the <i>Diagnosis Code</i> field (Box 66). No ICD indicator is required if the claim is submitted without a diagnosis code.
ICD Indicator 9 or 0	21 ICD ind.	
Resubmission code (claim Frequency Code) 1 for an original encounter submission, 7 for a replacement submission (note replacement will replace the full previous claim)	22	
KHS Authorization Number (if applicable)	23	63a
Date of service, Place of service	24a, 24b	6, 12 and 45
CPT/HCPCS Code (including appropriate modifier), Medi-Cal defined codes	24d	42, 44
Diagnosis Pointer	24E	NA
CHARGES. In full dollar amount, enter the usual and customary fee for service(s). Do not enter a decimal point (.) or dollar sign (\$). Enter full dollar amount and cents even if the amount is even (for example, if billing for \$100, enter 10000, not 100).	24F	47

If an item is a taxable medical supply, include the applicable state and county sales tax.		
Days or Units	24G	46
RENDERING PROVIDER ID NUMBER. Enter the NPI for a rendering provider (unshaded area), if the provider is billing under a group NPI. The rendering provider instructions apply to services rendered by the following providers: Acupuncturist                      Physicians Chiropractors                      Podiatrists Licensed audiologists      Portable X-ray providers Occupational therapists      Prosthetists Ophthalmologists              Psychologists Orthopedists                      Radiology labs Physical therapists              Speech pathologists Physician groups	24J	76
Vendor Federal tax identification number	25	5
Total Charge	28	47 line 23
SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS. The claim must be signed and dated by the provider, or a representative assigned by the provider. Use <u>black</u> ballpoint pen only. An <u>original</u> signature is required on all paper claims. The signature must be written, not printed. Stamps, initials or facsimiles are not acceptable.	31	NA
<b>INFORMATION.</b> Enter the provider's name. Enter the provider address, without a comma between the city and state, and a nine-digit ZIP code, without a hyphen. Enter the telephone number of the facility where services were rendered, if other than home or office. <b>NOTE:</b> Not required for clinical laboratories when billing for their own services	32	NA
Enter the NPI of the facility where the services were rendered.	32A	NA
Billing Provider Information and Phone Number	33	NA
Entering the billing provider's NPI	33A56	
	33a	1
	24J	56

For further clarification refer to the Medi-Cal Manual

#### 1.4 Pre-payment and Post-Payment Claims Review

KHS reviews claims on a pre-payment and Post-Payment basis. All claims are submitted through an automated Medi-Cal NCCI editing program prior to processing. Internal KHS programs also edit for appropriateness of Provider, member, and covered services validation..



Any claims with identified issues are further reviewed on a manual basis by Claim Examiners.

**1.4.1 Unbundling**

KHS requires procedure codes to be bundled as outlined in the *American Medical Association Current Procedural Terminology (CPT) Guidebook*. Providers will not be reimbursed more for performing portions of a bundled group than they would be reimbursed for performing the complete group.

KHS uses a code auditing tool to assist claims processors in identifying claims that are potentially unbundled. Information regarding unbundling policies for specific CPT or HCPCS procedure codes may be obtained by submitting a written request to the Claims Department or calling the Claims Department at 1-800-391-2000.

**1.4.2 Supporting Documentation**

Claims are processed according to the guidelines listed in the table below.

<b>Procedure Code or Claim Type</b>	<b>Description / Explanation</b>	<b>Restriction/Requirement</b>
Ambulance services	See <i>KHS Policy and Procedure #3.50 – Ambulance Transportation Services</i> for details.	For Non-participating providers a trip sheet may be required. Claims received without the necessary documentation are denied. Claims may be resubmitted with required documentation.
By report procedures		Narrative Medical Summary is required. Claims received without the necessary documentation are denied. Claims may be resubmitted with required documentation. Invoice for supplies.

Procedure Code or Claim Type	Description / Explanation	Restriction/Requirement
DME	Items that do not have established Medi-Cal rates	Invoice is required. Claims received without the necessary documentation are denied. Claims may be resubmitted with required documentation. Invoice for supplies.
Other insurance primary	Includes Medicare See KHS Policy #6.08 - <i>Coordination of Benefits</i>	EOB from primary insurance is required. Claims received without the necessary documentation are denied. Claims may be resubmitted with required documentation. Note: Electronic claim submission requires appropriate fields completed. Actual EOB is not required for electronic claims.
Sterilization	See <i>KHS Policy #2.19 – Sterilization Consent</i> for details.	Sterilization consent form is required. Claims received without the necessary documentation are denied. Claims may be resubmitted with required documentation.
Surgical procedures		By Report Surgical procedures, need to be submitted with necessary documentation or they will be denied. Claims may be resubmitted with required documentation.
99284	Non-Contracted Providers only. Emergency Department visit (detailed history, detailed examination, and medical decision making of moderate complexity)	Medical review of ER report may be required.
99285	Non-Contracted Providers only. Emergency Department visit (comprehensive history, comprehensive examination, and medical decision making of high complexity)	Medical review of ER report may be required. .

**1.5 Claims are audited on a pre and post payment basis. Random sample auditing by examiner is done on a pre-payment basis. High Dollar Claims may be sent to an external vendor for detailed claim review as well on a post payment basis. Special audits are also completed on a Pre or post payment basis, i.e. PM330 validation, MOT claims, etc. Target audits are completed on a requested basis.**

## **2.0 MISDIRECTED CLAIMS**

Claims involving Emergency Services shall be forwarded to the appropriate payer within 10 working days of receipt of the claim.

Claims not involving Emergency Services:

- If the provider that filed the claim is contracted with the plan's capitated provider, the Plan has 10 working days of the receipt of the claim to: Send the claimant a notice of denial, with instructions to bill the capitated provider, or forward the claim to the appropriate capitated provider.
- In all other cases, the plan has 10 working days of the receipt of the claim incorrectly sent to the plan to forward the claim to the appropriate payer.

## **3.0 ER SERVICES**

KHS will reimburse all medically necessary emergency claims according to the eligibility of the member at the time of service. KHS reserves the right to review all ER claims to determine if it meets the definition of emergency as defined in 42 CFR 438.114. KHS does not determine emergency medical conditions based on a list of diagnoses or symptoms; and does not require notification to PCP or KHS as a condition for reimbursement. No authorization is required for emergency care. Emergent services by a non-contracted provider will be paid at the Medi-Cal FFS rate for rendered services. Contracted providers will be reimbursed pursuant to contracted rate. At a minimum, reimbursement for an MSE is made to all emergency room providers, (professional and facility component and hospital based urgent care facilities). Members are not held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Member. Note that if a KHS representative instructs the member to see Emergency Services, , the services are payable as emergencies. See *KHS Policy and Procedure #3.31 Emergency Services Section 5.0*.

3.1 Disputes involving Emergency Services and/or Post Stabilization Care Services may be submitted for resolution under provisions of W&I Code section 14454 and 22 CCR sections 53620 et.seq. (except section 53698) to:

Department of Health Care Services  
Office of Administrative Hearing and Appeals  
3831 North Freeway Blvd., Suite 200  
Sacramento, CA 95834

KHS will implement DHCS' determination and reimburse the Provider within 30 calendar days of the effective date of a decision. Proof of payment will be provided to the DHCS as requested. Failure to do so within the 30 day time frame will result in capitation offsets in accordance with W&I code sections 14454 (c) and 14115.5 and 22 CCR section 53702 and may subject KHS to sanctions pursuant to W&I Code section

#### **4.0 CLAIMS RESUBMISSION**

Claims may be resubmitted for reprocessing within 45 business days of the date of payment/denial. Claims resubmitted after the 45 business day deadline are denied.

Simple resubmission of a claim does not initiate the provider dispute process. To initiate the dispute process, providers must follow the procedure outlined in *KHS Policy and Procedure #6.04 – Practitioner/Provider Disputes Regarding Claims Payment*.

#### **5.0 REIMBURSEMENT**

KHS reimburses contracted providers based on the compensation agreement specified in their contract. KHS rates are based on the Medi-Cal fee schedule identified in the applicable provider contract. Providers may view an electronic fee schedule at [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov). Case rates and per diem rates are stipulated in the provider contract. Non-Contracted providers are reimbursed at Medi-Cal rates.

##### **5.1 Emergency Services & Urgent Care**

If the group or site is PAR and the attending provider is Non PAR, reimbursement is at the group/site contract rate.

If the group or site is Non PAR and the attending provider is Non PAR, reimbursement is at Medi-Cal rates.

##### **5.2 PT/OT/ST, Lab, Pathology & Radiology Services**

If the group or site is PAR and the attending provider is Non-PAR, if Non-PAR provider is authorized reimbursement is at Medi-Cal rates otherwise claim is denied.

##### **5.3 Hospitalist Providers**

If the group or site is PAR and the attending provider in Non PAR, reimbursement is at the Medi-Cal rate.

If the group or site is Non PAR and the attending provider is Non PAR, reimbursement is at the Medi-Cal rate.

If the group or site is PAR and the attending provider is PAR reimbursement is at the contract rate.

##### **5.4 SNF - Long Term Care Facility Claims**

Effective 01/01/2023, KHS will process SNF Long Term Care Facility Claims. In accordance with WIC Section 14184.201 (b)(2), and WIC Section 14184.102(d), SNF LTC claims that are authorized will be paid at the State Fee schedule rate determined at the time of service. The State fee schedule rate applies to both contracted and non-contracted facilities. These services are also subject to Coordination of Benefit rules, as KHS will always be the payer of last resort. For those members who are dually eligible for medi-Cal and Medicare, KHS will pay the full deductible and coinsurance in accordance with

Additional reimbursement guidelines are contained in the following KHS policies:

- A. *KHS Policy and Procedure #3.05-P: Preventive Medical Care*
- B. *KHS Policy and Procedure #3.12 – Urgent Care Services*
- C. *KHS Policy and Procedure #3.23-P: Emergency Services*
- D. *KHS Policy and Procedure #3.24-P: Pregnancy and Maternity Care*
- E. *KHS Policy and Procedure #3.46 – Tuberculosis Treatment*
- F. *KHS Policy and Procedure #6.09-P: Assistant Surgeon*
- G. *KHS Policy and Procedure #6.18 – Laboratory Billing Guidelines and Restrictions*
- H. *KHS Policy and Procedure #6.19 – DME Billing Guidelines*
- I. *KHS Policy and Procedure #6.21 – Infusion Billing Guidelines*

KHS uses Medi-Cal billing criteria unless otherwise specified in a KHS policy. The Medi-Cal Provider Manual is available online at [www.medi-cal.gov](http://www.medi-cal.gov). The Medi-Cal Provider Manual includes but is not limited to the following:

- A. Policies and procedures which provide detailed payment policies and rules and non-standard coding methodologies used to adjudicate claims. These documents clearly and accurately describe all global payment provisions<sup>13</sup>
- B. Information regarding reimbursement for the administration of injectable medications
- C. Policy regarding consolidation of multiple services or charges and payment adjustment due to coding changes
- D. Policy regarding reimbursement for multiple procedures
- E. Policy regarding recognition of CPT modifiers

Complete claims or portions thereof are reimbursed or denied within 45 working days of receipt.<sup>14</sup> Only members for whom a premium is paid by the State to KHS are entitled to health services and benefits provided hereunder and only for services rendered or supplies received during the period for which the member is enrolled.<sup>15</sup>

As stated in the provider contract, except for applicable copayments, providers may not invoice or balance bill KHS members for the difference between billed charges and the reimbursement paid by KHS for any covered benefit.<sup>16</sup>

#### **5.4 Coordination of Benefits and Third Party Liability**

If the member has other medical coverage, the provider must file the claim with the other primary insurance carrier before filing with KHS. Upon receipt of partial payment or denial from the other carrier, the provider should submit the claim to KHS along with documentation of payment or denial from the primary carrier. The Claims Department requires a copy of the other Plan's payment determination prior to releasing payment for those members covered by another Plan.

KHS secondary payment for eligible services is limited to the maximum that KHS would compensate providers as specified in the provider's contract. The primary and secondary payments may not add up to more than 100% of eligible

charges.

KHS does not pay claims for services provided to a Member whose Medi-Cal eligibility record indicates either third party coverage, designated by the Other Health Coverage (OHC) code, or Medicare coverage without proof that the provider has first exhausted all other sources of payment. An exception to this guideline exists for services and OHC codes which request post-payment recovery. Proof of third party billing is not required prior to payment for services provided to Members with OHC codes A, M, X, Y or Z.

The Claims Department does not attempt recovery in circumstances involving Casualty Insurance, Tort Liability, or Workers' Compensation awards to Medi-Cal members. Circumstances which may result in Casualty Insurance payments, Tort Liability payments, or Worker's Compensation awards are reported, in writing, to DHCS as appropriate within 10 (ten) calendar days after discovery by KHS.

## **6.0 MODIFIERS**

### **6.1 25 Significant, Separately Identifiable E&M Service Description**

This policy does not apply to facilities (hospitals, surgery centers, kidney centers, etc.)

CPT modifier -25 is used when, on the day a procedure or service was performed, the patient's condition required a significant, separately identifiable evaluation and management (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.

#### **Policy Statement**

KHS does not deny payment for CPT evaluation and management (E&M) codes with a CPT modifier -25 appended when submitted with surgical or other procedure codes for the same patient on the same date of service based solely on the existence of the modifier -25.

The submission of modifier -25 appended to an E&M code indicates that documentation is available in the patient's records for review upon request that will support the significant and separately identifiable nature of the E&M service.

All surgical procedures and some procedural services include a certain degree of physician involvement or supervision which is integral to that service. For those procedures and services, a separate E&M service is not normally reimbursed. However, a separate E&M service may be considered for reimbursement if the patient's condition required services above and beyond the usual care associated with the procedure or service provided. To identify these circumstances, modifier -25 is attached to the E&M code.

### Example of Proper Use of Modifier -25

An established patient is seen for a 2.0cm finger laceration. The patient also asks the physician to evaluate swelling of his right knee that is causing pain.  
Correct Codes – 12001 and 99213-25

### Example of Improper Use of Modifier -25

An established patient is seen for left knee pain. After evaluating the knee, the physician performs arthrocentesis.

Correct Code – 20610

It would not be appropriate to bill an E&M code because the focus of the visit was the knee pain which precipitated the arthrocentesis.

### Multiple E&M Services

Only one E&M service code per patient, per physician, per day is eligible for reimbursement unless:

- the visits were for unrelated problems that could not be provided during the same encounter (i.e., scheduled office visit in the morning for ear pain and 4 hours later an unscheduled visit for a broken wrist).

In this cases, modifier -25 should be attached to the E&M codes.

### **References**

American Medical Association. “Appendix A: Modifiers”. Current Procedural Terminology (CPT). Chicago: AMA Press. 2008.

NCCI Policy Manual for Medicare Services, current version Chapter 1.

## **6.2 53; Discontinued Procedure**

### **Definitions**

This policy does not apply to facilities (hospitals, surgery centers, kidney centers, etc. see modifier 73 & 74)

CPT Modifier -53 is appended to a code when a physician elects to terminate a surgical or diagnostic procedure due to extenuating circumstances.

### **Policy Statement**

CPT Modifier -53 is valid only when a physician elects to terminate a surgical or diagnostic procedure due to extenuating circumstances that threaten the wellbeing of the patient.

Modifier -53 is eligible to attach to one code per operative session.

When modifier -53 is valid, the discontinued procedure may be reimbursed at a rate reduced from the usual allowable for the procedure.

Modifier -53 is not valid when used for elective cancellation of a procedure

prior to anesthesia induction and/or surgical preparation in the operating suite.

Modifier -53 is not valid when a laparoscopic or endoscopic procedure is converted to an open procedure or when a procedure is changed or converted to a more extensive procedure.

### References

1. American Medical Association. "Appendix A – Modifiers." Current Procedural Terminology (CPT). Chicago: AMA Press.
2. American Medical Association. "Modifiers." CPT Assistant. Chicago: AMA Press, November 1996, p. 19.

Grider, Deborah J. Coding with Modifiers: A Guide to Correct CPT and HCPCS Level II Modifier Usage. Chicago: AMA Press, 2004, pp. 109 – 114.

## 6.3 57; Decision for Surgery

This policy does not apply to facilities (hospitals, surgery centers, kidney centers, etc.)

### Definitions

This policy does not apply to facilities (hospitals, surgery centers, kidney centers, etc.)

CPT modifier - 57 is used when the initial decision to perform a major surgical procedure is made during an E&M service provided the day before or the day of a major surgery.

Major surgery is defined as any code having a 90 day global period.

### Policy Statement

KHS will not require a physician to submit clinical information of their patient encounters solely because the physician seeks payment for both surgical procedures and E&M services for the same patient on the same date of service, provided that the correct E&M code, surgical code and modifier (e.g., CPT modifiers 25 or 57) are included on the initial claim submission.

An E&M service provided the day before or the day of a major surgery that resulted in the initial decision to perform surgery is eligible for reimbursement if modifier -57 is appended to the E&M code.

Modifier -57 should not be used when the E&M service is associated with a minor surgical procedure (defined as having a 0 or 10 day global period).

Modifier -57 should not be used when the E&M service was for the preoperative evaluation.

### References

1. American Medical Association. "Appendix A – Modifiers". Current



#### **6.4 59; Distinct Procedural Service**

This policy does not apply to facilities (hospitals, surgery centers, kidney centers, etc.)

##### **Definitions**

CPT modifier -59 represents a procedure or service that is distinct or independent from other services performed on that same day. Modifier -59 identifies procedures or services, other than E&M services, that are not normally reported together but are appropriate under the circumstances.

##### **Policy Statement**

CPT codes submitted with modifier 59 attached are considered appropriate coding to the extent they follow the AMA CPT book, and they designate a distinct or independent procedure performed on the same day by the same physician, but only to the extent that:

- 1) although such procedures or services are not normally reported together, they are appropriately reported together under the particular presenting circumstances; and
- 2) it would not be more appropriate to append any other CPT recognized modifier to such CPT codes.

KHS does not deny payment for services with a CPT modifier -59 appended based solely on the existence of the modifier -59.

The submission of modifier -59 appended to a procedure code indicates that documentation is available in the patient's records for review upon request that will support the distinct or independent identifiable nature of the service submitted with modifier -59.

CPT codes submitted with modifier 59 attached will be eligible for payment to the extent they not only follow the AMA CPT book, but additionally are not considered a bundled component of a more comprehensive code or two codes that should not be reported together based on NCCI edits or NCCI coding guidelines.

Valid use of modifier -59:

- Differing anatomical site (e.g., skin lesions on separate body sites), different organ system (e.g., laparoscopy on separate organ systems), contralateral structures (e.g., bilateral knees although use of HCPCS modifiers –RT and –LT would be clearer.)
- Separate surgical operative session on the same date of service.

Invalid use of modifier -59:

- Procedures in the same ipsilateral joint (including differing compartments)

performed by open, scope, or combined open/scope technique, including added port or incisional sites.

- Procedures in the same anatomical site (e.g., digit, breast, etc.), even with incision lengthening or contiguous incision.
- CPT identified “separate” procedures performed in the same session, same anatomic site, or orifice.
- Scope procedure converted to open procedure.
- Incisional repairs are part of the global surgical package, including deliveries.
- Contiguous structures in the same anatomic site, organ system, or joint.

**References**

NCCI Policy Manual for Medicare Services, current version Chapter 1.

**6.5 Payment of Interest on Late Claims<sup>17</sup>**

Interest is automatically paid on late claims in accordance with *KHS Policy and Procedure #60.05-I Payment of Interest on Late Claims*.

**7.0 PROVIDER PREVENTABLE CONDITIONS**

Provider Preventable Conditions (PPCs) are either Health Care-Acquired Conditions (HCACs) or Other Provider-Preventable Conditions (OPPCs) as defined under 42 CFR 447.26 and must be reported to the Department of Health Care Services (DHCS) and KHS upon discovery in any health care setting. KHS’ Quality Department will provide the information to KHCS via the on-line portal at [Security Code \(ca.gov\)](https://www.cdph.ca.gov/Programs/OPA/Pages/SecurityCode.aspx).

**7.1 Reimbursement**

KHS will not reimburse providers for PPC-related health care services.

**7.2 Billing Guidelines**

The following guidelines apply to outpatient hospital providers, freestanding ambulatory surgery centers, and acute outpatient hospital provider billing for acute outpatient hospital-based physician services.

<b>Outpatient Hospitals and Freestanding Ambulatory Surgery Centers</b>	
<b>UB-04 or 837I institutional claims</b>	<b>CMS-1500 or 837P professional claims</b>
Acute outpatient hospitals and hospitals licensed health centers (HLHCs)	Acute outpatient hospital and HLHC claims for acute outpatient hospital-based physician services
Privately-owned chronic disease and rehabilitation outpatient hospitals	Freestanding ambulatory surgery centers (FASCs)
Psychiatric outpatient hospitals	
State-owned non-acute outpatient hospitals operated by the Department of Mental Health (DMH) state-owned non-acute outpatient hospitals operated by	

the Department of Public Health (DPH)	
Substance abuse treatment outpatient hospitals	

The following guidelines apply to inpatient hospital providers and acute inpatient hospital providers billing for acute inpatient hospital-based physician services.

<b>UB-04 or 837I institutional claims:</b>	<b>CMS-1500 or 837P professional claims:</b>
Acute inpatient hospitals	Acute inpatient hospital claims for acute inpatient hospital-based physician services
Privately-owned chronic disease and rehabilitation inpatient hospitals	
Psychiatric inpatient hospitals	
State-owned non-acute inpatient hospitals operated by the Department of Mental Health (DMH)	
State-owned non-acute inpatient hospitals operated by the Department of Public Health (DPH)	
Substance abuse treatment inpatient hospitals	

All inpatient hospital claims related to a PPC must include the appropriate Present on Admission (POA) indicator.

<b>POA Indicator Reporting Description and PPC Payment Criteria for Inpatient Hospitals</b>		
POA Value on UB-04 or 837I	Description	Payment adjustments
Y	Diagnosis was present at time of inpatient admission.	Payment is made for the condition.
N	Diagnosis was not present at time of inpatient admission.	Applicable PPC payment adjustments will be made
U	Documentation is insufficient to determine if the condition was present at the time of inpatient admission.	Applicable PPC payment adjustments will be made.
W	Clinically undetermined. The provider was unable to clinically determine whether the condition was present at the time of inpatient admission.	Payment is made for condition.

Leave field blank	Effective January 1, 2011, the POA field will be left blank for codes exempt from POA reporting. Note: The number “1” is no longer valid on claims submitted under the 5010 format, effective January 1, 2011. Refer to CMS change request 7024 <a href="http://www.cms.gov/transmittals/downloads/R756OTN.pdf">www.cms.gov/transmittals/downloads/R756OTN.pdf</a>	Exempt from POA
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## 8.0 RECOVERY OF OVERPAYMENTS<sup>18</sup>

KHS pursues recovery of overpayments that meet cost-benefit guidelines. When recovery is pursued, KHS sends a refund request letter to the provider. Within 30 working days of receipt of the letter, the provider must submit to KHS either a complete refund of the overpayment or a provider dispute. Disputes must be submitted and will be processed in accordance with *KHS Policy and Procedure # 6.04 – Practitioner/Provider Disputes Regarding Claims Payment*.<sup>19</sup> As stipulated in the provider contract, if a dispute is not received within 30 working days or the full repayment amount, the overpayment will be offset against additional amounts due to the provider.

Overpayment process will be reviewed by the Claims Director or designee on a bi annual basis for accuracy. All documentation of Overpayment/refund requests are kept for a minimum of 10 years in our MFILES online storage. 2 years are available for review, and 8 years are archived.

Any recovery of an overpayment to a provider of \$25 million or more, KHS and DHCS will share equally. Sixty (60) days after the date that the overpayment was identified, KHS will report the overpayment to the DHCS Contract Manager. KHS will submit the overpayment amount recovered, provider information, reason for the overpayment, services related to the overpayment, and steps taken to prevent future occurrences. This will not include any recoveries retained under the False claims Act or other investigations not covered under APL 17-003. Any recovery of an overpayment to a provider of less than \$25 million will be retained by KHS with the exception of any OHC recovery over 13 months old.

KHS will report annually to DHCS on all recoveries of overpayments, including network providers excluded from participation in Medicaid program and those made to a network provider due to fraud, waste or abuse. Documentation will include retention policies, processes, timeframes, and documentation required for reporting the recovery of all overpayments, will be provided upon request by DHCS. Report will be submitted through the DHCS Contract Manager.

KHS shall require network providers to report to KHS when it has received an overpayment, to return the overpayment to KHS within sixty (60) calendar days after the date on which the overpayment was identified, and to notify KHS in writing of the reason for the overpayment.

Any identification or recoveries of overpayments due to potential Fraud, Waste or Abuse, will be communicated to the DHCS Audits and Investigations Intake Unit within 10 days of identification via the Compliance Department.

## **9.0 INQUIRIES REGARDING UNPAID CLAIMS<sup>20</sup>**

Providers may confirm the date of receipt of paper claims within 15 working days of receipt by calling 1-800-391-2000. Providers receive an electronic acknowledgement of the receipt of electronic claims within 2 working days of the date of receipt.

## **10.0 UNFAIR BILLING PATTERNS<sup>21</sup>**

Providers who engage in an unfair billing pattern may be reported to the Department of Managed Health Care. Unfair billing patterns include, but are not limited to, demonstrable and unjust patterns of unbundling and up-coding. KHS will make efforts to work with providers to distinguish billing errors from unfair billing patterns and to help providers correct billing errors. Providers will only be reported to DMHC after efforts to resolve such billing issues have failed.

Additionally, Providers need to be aware that Kern Health Systems is contractually obligated to conduct, complete, and report to the Department of Health Care Services the results of a preliminary investigation of suspected fraud and/or abuse within ten (10) working days of the date that KHS first becomes aware of, or is on notice of, such activity.

## **11.0 MENTAL HEALTH AND SUBSTANCE USE DISORDERS**

Pursuant to APL 22-005 and 22-006, KHS will cover all initial mental health assessments by network providers without a referral/authorization. KHS will not deny reimbursement for Non Serious Mental Health Services (NSMHS) provided during the assessment process if the assessment determined that the member does not meet the criteria for NSMHS or meets the criteria to Serious Mental Health Services (SMHS). KHS will not deny reimbursement for NSMHS provided to a member who meets NSMHS criteria on the basis of the member having a co-occurring SUD, when all other Medi-Cal and services requirements are met. KHS will not deny reimbursement for NSMHS provided to a member on the basis of the member also meeting SMHS criteria and/or also received SMHS services provided that the concurrent services are clinically appropriate, coordinated and not duplicative.

## **12.0 COMMUNICATIONS REGARDING CLAIM PAYMENTS**

Once a claim has been paid or denied, Providers will receive an Explanation of Provider Payment (EPP) showing how the claim was adjudicated. The EPP uses standard Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) for denial explanations for any portions of the claim that may have been non-paid. KHS will also use more explanatory comments on the EPP when necessary. Providers can access the EPP from the Payment Portal. If additional communication is needed, Providers can call KHS at any time.

### **13.0 Prohibited Claims**

Kern Health Systems adheres to 22 CCR sections 53866, 53220 and 53222; and does not submit a claim, demand or any other type of collection request to a member or persons acting on behalf of a member for any services provided under this program except to collect: Third-party payments in accordance with Section 53222(a), or Payment for services provided pursuant to Section 53210(d). KHS does not attempt recovery in circumstances involving casualty insurance, tort liability, or worker's compensation, but rather reports that to DHCS within 10 days of discovery by KHS.

13.1 KHS holds harmless and indemnifies members for any debt to providers for services rendered and billed to Members.

#### 14.0 Non-Contracted Certified Nurse Midwives and Certified Nurse Practitioners and Free Standing Birthing Centers

If the KHS network does not include a Free Standing Birthing Center(FBC) in its network at any time, KHS will reimburse out of network FBCs for services provided to its members at the Medi-Cal FFS rate for the services. Also, if the KHS network at any domes does not include a Certified Nurse Midwife or Licensed Midwife, KHS will reimburse out of network providers at the Medi-Cal FFS rate.

#### 15.0 Long Term Care: SNF and NF

In accordance with W&I Code section 14184.201(b), effective 01/01/2023, KHS will reimburse covered Long Term Care services at Skilled Nursing and Nursing facilities that are authorized, at the Medi-Cal FFS rates established at the time of service. This includes contracted and non-contracted providers. Services of Long Term Care at Subacute facilities or Intermediate Care facilities are still the responsibility of the Medi-Cal FFS plan and will become the responsibility of KHS on 01/01/2024.

## REFERENCE:

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**Revision 2024-06: Policy revised by Director of Claims to comply with technical changes made to DHCS APL23-011.**  
**Revision 2023-08:** Policy revised by Director of Claims to comply with DHCS APL 23-011 **Revision 2023-04:** Policy revised by Director of Claims to comply with DHCS 2024 Operations Readiness **Revision 2022-11:** Revised by Claims Director to comply with DHCS APL 22-018. DMHC approval received on 12/28/2022 and DHCS approval received on 2/22/2023. <sup>1</sup> **Revision 2022-06:** Revised by Claims Director to comply with DHCS APL 22-006 and 22-005, revisions approved by the DHCS on 7/26/2022 and by DMHC on 11/10/2022, Filing No 202223746. **Revision 2021-09:** Added Juneteenth as declared a new federal holiday in 2021. **Revision 2021-08:** Director of Claims added additional required language of 99% of all clean claims are processed in 90 days for ILOS review of P&P. **Revision 2017-05: Added additional required language and processes to comply with APL-17-003 effective 7/1/17.** **Revision 2016-05:** Revisions to ICD codes. Updated Health Insurance Claim Form provided by Claims Director. **Revision 2016-03:** Policy revised to comply with All Plan letter (APL) 15-006 regarding provider preventable conditions. Additional language added by Director of Claims on reimbursement. **Revision 2014-03:** Revised to comply with DHCS Medical Audit review 2013. Section 3.5 new language to include stipulation that misdirected claims are sent to appropriate payer within ten (10) days. References to Healthy Families removed. **Revision 2013-10:** New language added for various modifiers. Contractual requirements for KHS added regarding reporting to the DHCS. **Revision 2011-11:** Revised to comply with new DHCS Contract requirements and made changes to comply with MMCD Policy Letter 08-002. Added clarifying language that Providers may use the KHS Member Identification Number. **Revision 2010-05:** Policy revised to comply with DHCS Deliverable 7.B. Policy updates provided by Director of Claims. **Revision 2009-01:** Policy revised to comply with MMCD 08-002. **Revision 2008-11:** Revised mailing address for Claims submission, process returned to Bakersfield, CA. Policy Revision date not changed and signatures not required per CCO. **Revision 2008-06:** Routine revision initiated by Claims Manager. Policy reviewed against MMCD All Plan Letter 07-020 Medi-Cal Billing Restriction on the Use of Social Security Numbers 12/26/07 **Revision 2005-08:** Routine review initiated by Director of Claims. Policy reviewed against DHS Contract 03-76165 (Effective 5/1/2004). **Revision 2004-04:** Revised to include 30 business day deadline for claims resubmission. Should have been included in Revision 2003-12. Also updated with new addresses and phone numbers. **Revision 2003-12:** Revised to comply with AB1455 Claims Settlement Regulations; effective 01/01/2004. Revised per request of Claims Manager. Policy #6.03 – Unbundled Claims (2001-03) is deleted and incorporated into this policy. Policy #60.06 – Third Party Liability (2001-08) is deleted and incorporated into this policy and the associated internal policy. **Revision 2002-05:** Revised per DHS request. Clarify that 90 submission deadline applies only to contracted providers. Also added Processing Guidelines section. Revised per Amendment to 2002 Service Agreements (11/8/01). **Revision 2001-03:**

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Changes made per Provider Relations request. Changed submission deadline from 60 to 90 days to match contract; added HFAM PO Box. Issue date changed to correct previous error.

<sup>1</sup> Health and Safety Code Sections 1371, 1371.35

<sup>2</sup> CCR Title 28 §1300.71(a)(11)

<sup>3</sup> CCR Title 28 §1300.71(a)(10)

<sup>4</sup> CCR Title 28 §1300.71(a)(13)

<sup>5</sup> Title 5 USC 6103 specifies the federal holiday schedule. See [www.canb.uscourts.gov/canb/genifo.nsf](http://www.canb.uscourts.gov/canb/genifo.nsf) (click on “general information”; click on “search”; enter “federal holidays” in the search box) for a yearly schedule.

<sup>6</sup> MMCD All Plan Letter 07-020 Medi-Cal Billing Restriction on the Use of Social Security Numbers 12/26/07

<sup>7</sup> CCR Title 28 §1300.71(b)(4)

<sup>8</sup> KHS may not impose a deadline less than 90 days after the date of service (CCR Title 28 §1300.71(b)(1).

<sup>9</sup> KHS may not impose a deadline less than 90 days after the date of payment or date of contest, denial or notice from the primary payer (CCR Title 28 §1300.71(b)(1).

<sup>10</sup> MMCD All Plan Letter 08-002

<sup>11</sup> KHS may not impose a deadline less than 90 days after the date of payment or date of contest, denial or notice from the primary payer (CCR Title 28 §1300.71(b)(1).

<sup>12</sup> MMCD All Plan Letter 07-020

<sup>13</sup> CCR Title 28 §1300.71(o)(1)(B). Also must be electronic.

<sup>14</sup> CCR Title 28 §1300.71(g) and (h); HSC §1371

<sup>15</sup> HFAM Contract 05MHF016 Exhibit B, II B(1). Inclusion requested by B. Davenport.

<sup>16</sup> DHS Contract 03-76165 Exhibit A-08 (6). Non contracting emergency providers are not allowed to balance bill. (DMHC Letters May 12, 2003 and July 2, 2003. See AB1455 information).

<sup>17</sup> HSC §1371

<sup>18</sup> CCR Title 28 §1300.71(d)(3) through (6)

<sup>19</sup> CCR Title 28 §1300.71(d)(4)

<sup>20</sup> CCR Title 28 §1300.71(c)

<sup>21</sup> HSC §1371.39(b)