# KERN HEALTH SYSTEMS

## POLICY AND PROCEDURES

<table>
<thead>
<tr>
<th>SUBJECT: Claims Submission and Reimbursement</th>
<th>POLICY #: 6.01-P</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEPARTMENT: Director of Claims</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Effective Date:</th>
<th>Review/Revised Date:</th>
<th>DMHC</th>
<th>PAC COMMITTEE</th>
<th>DHCS</th>
<th>QI/UM COMMITTEE</th>
<th>BOD</th>
<th>FINANCE COMMITTEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>08/2000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date: **10/18/13**

Douglas A. Hayward  
Chief Executive Officer

Date: **10/18/13**

Chief Financial Officer

Date: **8-13-13**

Chief Operating Officer

Date: **10-10-13**

Director of Compliance  
Director of Claims

**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. 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. See 1.1, 1.1.1 and 1.1.2. The date of receipt shall be the date KHS receives the claim, as indcuted 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  

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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. Benefits for Healthy Families members shall only be provided in such cases if the member agrees to reimburse and provides a lien to KHS to the extent of the reasonable value of services provided.

- 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:**

<table>
<thead>
<tr>
<th>Information necessary to determine payer liability²</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reasonably relevant information³</td>
<td>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.</td>
</tr>
</tbody>
</table>
| Working Daysiv                                    | Monday through Friday, excluding recognized federal holidays. Recognized federal holidays are as follows⁵:  
A. New Year’s Day: closest week day to January 1st  
B. ML King’s Birthday: 3rd Monday in January  
C. Washington’s Birthday: 3rd Monday in February (aka Presidents’ Day)  
Memorial Day: last Monday in May  
D. Independence Day: closest week day to July 4th  
E. Labor Day: 1st Monday in September  
F. Columbus Day: 2nd Monday in October  
G. Veteran’s Day: Closest week day to November 11th (aka Armistice Day)  
H. Thanksgiving Day: 4th Thursday in November  
I. Day After Thanksgiving  
J. Christmas Day: Closest week day to December 25th |

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PROCEDURES:

1.0 CLAIMS SUBMISSION
Claims should be mailed to the following address:

Claims Department  
Kern Health Systems  
PO Box 25003  
Bakersfield, CA  93311

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 Emdeon, Relay Health or Office Ally. Providers requiring assistance in submitting electronic claims through Emdeon, Relay Health or Office Ally, should contact the KHS Provider Relations Department.

KHS prohibits providers from using members Social Security Numbers (SSN) on claims submitted for reimbursement. 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.

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 following the provision of the covered services are denied with the following exceptions:

A. Other Primary Insurance: Claims submitted within 90 calendar days 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.
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 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 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 after 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 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
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 SSNxii. 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.

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

<table>
<thead>
<tr>
<th>Information</th>
<th>CMS 1500 Box</th>
<th>UB92 Box</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s KHS identification number or CIN (not SSN)</td>
<td>1a</td>
<td>60</td>
</tr>
<tr>
<td>Patient’s name</td>
<td>2</td>
<td>8b</td>
</tr>
<tr>
<td>Patient’s date of birth</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Patient’s home address</td>
<td>5</td>
<td>9a-e</td>
</tr>
<tr>
<td>Other insurance coverage, including Medicare (if applicable)</td>
<td>11a-d</td>
<td>50a, 58a, 59a, 60a, 61a, and/or 62a</td>
</tr>
<tr>
<td>Rendering/Ordering NPI number</td>
<td>17b</td>
<td>76</td>
</tr>
<tr>
<td>ICD-(- Code)</td>
<td>21</td>
<td>66a-q</td>
</tr>
<tr>
<td>KHS Authorization Number (if applicable)</td>
<td>23</td>
<td>63a</td>
</tr>
<tr>
<td>Date of service, Place of service</td>
<td>24a, 24b</td>
<td>6, 12 and 45</td>
</tr>
<tr>
<td>CPT/HCPCS Code (including appropriate modifier), Medi-Cal defined codes</td>
<td>24d</td>
<td>42, 44</td>
</tr>
<tr>
<td>Diagnosis Pointer</td>
<td>24E</td>
<td>NA</td>
</tr>
<tr>
<td>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). If an item is a taxable medical supply, include the applicable state and county sales tax.</td>
<td>24F</td>
<td>47</td>
</tr>
<tr>
<td>Days or Units</td>
<td>24G</td>
<td>46</td>
</tr>
<tr>
<td>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:</td>
<td>24J</td>
<td>76</td>
</tr>
<tr>
<td>Acupuncturist</td>
<td>Physicians</td>
<td></td>
</tr>
<tr>
<td>Chiropractors</td>
<td>Podiatrists</td>
<td></td>
</tr>
<tr>
<td>Licensed audiologists</td>
<td>Portable X-ray providers</td>
<td></td>
</tr>
<tr>
<td>Occupational therapists</td>
<td>Prosthettists</td>
<td></td>
</tr>
<tr>
<td>Ophthalmologists</td>
<td>Psychologists</td>
<td></td>
</tr>
<tr>
<td>Orthostists</td>
<td>Radiology labs</td>
<td></td>
</tr>
<tr>
<td>Physical therapists</td>
<td>Speech pathologists</td>
<td></td>
</tr>
<tr>
<td>Physician groups</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vendor Federal tax identification number</td>
<td>25</td>
<td>5</td>
</tr>
<tr>
<td>Total Charge</td>
<td>28</td>
<td>47 line 23</td>
</tr>
<tr>
<td>SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS.</td>
<td>31</td>
<td>NA</td>
</tr>
</tbody>
</table>

The claim must be signed and dated by the provider or a representative assigned by the provider. Use black ballpoint pen only. An original signature is required on all paper claims.
The signature must be written, not printed. Stamps, initials or facsimiles are not acceptable.

**INFORMATION.** Enter the provider 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. **NOTE:** Not required for clinical laboratories when billing for their own services

| 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

### 1.3.1 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 Supporting Documentation

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

<table>
<thead>
<tr>
<th>Procedure Code or Claim Type</th>
<th>Description / Explanation</th>
<th>Restriction/Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance services</td>
<td>See <em>KHS Policy and Procedure #3.50 – Ambulance Transportation Services</em> for details.</td>
<td>For Healthy Families Providers and Non-participating providers a trip sheet is required. Claims received without the necessary documentation are denied. Claims may be resubmitted with required documentation.</td>
</tr>
<tr>
<td>Procedure Code or Claim Type</td>
<td>Description / Explanation</td>
<td>Restriction/Requirement</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>---------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>By report procedures</td>
<td></td>
<td>Narrative Medical Summary is required. Claims received without the necessary documentation are denied. Claims may be resubmitted with required documentation. Invoice for supplies.</td>
</tr>
<tr>
<td>DME</td>
<td>Items that do not have established Medi-Cal rates</td>
<td>Invoice is required. Claims received without the necessary documentation are denied. Claims may be resubmitted with required documentation. Invoice for supplies.</td>
</tr>
<tr>
<td>Other insurance primary</td>
<td>Includes Medicare See KHS Policy #6.08 -Coordination of Benefits</td>
<td>EOB from primary insurance is required. Claims received without the necessary documentation are denied. Claims may be resubmitted with required documentation.</td>
</tr>
<tr>
<td>Sterilization</td>
<td>See KHS Policy #2.19 - Sterilization Consent for details.</td>
<td>Sterilization consent form is required. Claims received without the necessary documentation are denied. Claims may be resubmitted with required documentation.</td>
</tr>
<tr>
<td>Surgical procedures</td>
<td></td>
<td>By Report Surgical procedures, need to be submitted with necessary documentation or they will be denied. Claims may be resubmitted with required documentation.</td>
</tr>
<tr>
<td>99284</td>
<td>Non-Contracted Providers only. Emergency Department visit (detailed history, detailed examination, and medical decision making of moderate complexity)</td>
<td>Medical review of ER report may be required. Claims received without the report are reimbursed at the 99283 level, if a report is necessary.</td>
</tr>
<tr>
<td>Procedure Code or Claim Type</td>
<td>Description / Explanation</td>
<td>Restriction/Requirement</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>---------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>99285</td>
<td>Non-Contracted Providers only. Emergency Department visit (comprehensive history, comprehensive examination, and medical decision making of high complexity)</td>
<td>Medical review of ER report may be required. Claims received without the report are reimbursed at the 99283 level, if a report is necessary.</td>
</tr>
</tbody>
</table>

2.0 ER SERVICES
KHS will reimburse all medically necessary emergency claims according to the eligibility of the member at the time of service. KHS will not provide payment for services unless the clinical situation causing the patient to present to the facility is a life threatening emergency. At a minimum, reimbursement for an MSE is made to all emergency room providers, (professional and facility component and hospital based urgent care facilities). See KHS Policy and Procedure #3.31 Emergency Services Section 5.0.

3.0 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.

4.0 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. Case rates and per diem rates are stipulated in the provider contract. Non-Contracted providers are reimbursed at Medi-Cal rates.

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
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. 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.

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. 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.

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.

4.1 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.

5.0 Modifiers

5.1 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

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

**References**


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

5.2 **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**

5.3 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

5.4 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 more clear.)
- 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.

5.5 Payment of Interest on Late Claims
KHS pays interest on clean claims not paid within 45 working days of receipt. KHS calculates and pays interest automatically without requiring the provider to make a request.
Interest on each claim is accrued at the rate of 15% per annum beginning with the first calendar day following the 45th working day and ending with the anticipated date when the payment checks will be issued and sent to applicable providers. Claims for emergency services are paid a minimum interest of $15 for each 12-month period or portion thereof on a non-prorated basis.\textsuperscript{xix}

6.0 \textbf{RECOVERY OF OVERPAYMENTS}\textsuperscript{xxi}
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 \textit{KHS Policy and Procedure \# 6.04 – Practitioner/Provider Disputes Regarding Claims Payment}.\textsuperscript{xxii} As stipulated in the provider contract, if a dispute is not received within 30 working days, the overpayment will be offset against additional amounts due to the provider.

7.0 \textbf{INQUIRIES REGARDING UNPAID CLAIMS}\textsuperscript{xxiii}
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.

8.0 \textbf{UNFAIR BILLING PATTERNS}\textsuperscript{xxiv}
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.

\textbf{REFERENCE:}

\textsuperscript{i} \textit{Revision 2013-10:} New language added for various modifiers. Contractual requirements for KHS added regarding reporting to the DHCS. \textit{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. \textit{Revision 2010-05:} Policy revised to comply with DHCS Deliverable 7.B. Policy updates provided by Director of Claims. \textit{Revision 2009-01:} Policy revised to comply with MMCD 08-002. \textit{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. \textit{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 \textit{Revision 2005-08:} Routine review initiated by Director of Claims. Policy reviewed against DHCS Contract 03-76165 (Effective 5/1/2004). \textit{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. \textit{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

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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:** 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.

1. Health and Safety Code Sections 1371, 1371.35
2. CCR Title 28 §1300.71(a)(11)
3. CCR Title 28 §1300.71(a)(10)
4. CCR Title 28 §1300.71(a)(13)

*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.*

v. MMCD All Plan Letter 07-020 Medi-Cal Billing Restriction on the Use of Social Security Numbers 12/26/07
vi. CCR Title 28 §1300.71(b)(4)

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

viii. 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)).

ix. MMCD All Plan Letter 08-002

x. 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)).

xi. MMCD All Plan Letter 07-020

xii. CCR Title 28 §1300.71(o)(1B). Also must be electronic.

xiii. CCR Title 28 §1300.71(g) and (n); HSC §1371

xiv. HFAM Contract 05MHFO16 Exhibit B, II B(1). Inclusion requested by B. Davenport.

xv. 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).

xvi. HSC §1371

xvii. Health and Safety Code Sections 1371, 1371.35

xviii. Health and Safety Code §1371

xix. Health and Safety Code §1371.36(e); CCR Title 28 §1300.71(i)(1)

xx. CCR Title 28 §1300.71(d)(3) through (6)

xxi. CCR Title 28 §1300.71(d)(4)

xxii. CCR Title 28 §1300.71(c)

xxiii. HSC §1371.39(b)

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