It is our pleasure to welcome you as a contracted provider (Provider) participating under HMO plans offered by the Kaiser Permanente Medical Care Program Affiliated Payors. We want this relationship to work well for you, your medical support staff, and our Members.

This Provider Manual was created to help guide you and your staff in working with Kaiser Permanente’s various systems and procedures applicable to our HMO products in Northern California. It is an important part of your relationship with Kaiser Permanente, but this Provider Manual does not cover all aspects of your relationship with us. Please continue to consult your Provider agreement with Kaiser Permanente.

During the term of such agreement, Providers are responsible for (i) maintaining copies of the Provider Manual and its updates as provided by Kaiser Permanente, (ii) providing copies of the Provider Manual to its subcontractors and (iii) ensuring that Provider and its practitioners and subcontractors comply with all applicable provisions. The Provider Manual, including but not limited to all updates, shall remain the property of Kaiser Permanente and shall be returned to Kaiser Permanente or destroyed upon termination of the obligations under such agreement.

If you have questions or concerns about the information contained in this HMO Provider Manual, you can reach our Medical Services Contracting Department by calling (844) 343-9370.

Additional resources can also be found on our Community Provider Portal website at: http://providers.kaiserpermanente.org/nca/.
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**Introduction**

This Northern California HMO Provider Manual applies to you as a Provider for HMO products offered by Kaiser Permanente Medical Care Program Affiliated Payors, as referenced in your Agreement with a Kaiser Permanente entity.

To the extent provided in your Agreement, if there is a conflict between this Provider Manual and your Agreement, the terms of the Agreement will control. The term "Member" as used in this Provider Manual refers to currently eligible enrollees of HMO plans offered by Kaiser Permanente Medical Care Program Affiliated Payors, including Kaiser Foundation Health Plan, and their beneficiaries. The term “Provider” as used in this Provider Manual refers to the practitioner, facility, hospital, or contractor subject to the terms of the Agreement. Additionally, “you” or “your” in the Provider Manual refers to the practitioner, facility, hospital, or contractor subject to the terms of the Agreement and “we” or “our” in the Provider Manual refers to Kaiser Permanente. Operational instructions in this Provider Manual specifically relate to the HMO product. Capitalized terms used in this Provider Manual may be defined within the Provider Manual or if not defined herein, will have the meanings given to them in your Agreement.
1. Kaiser Permanente Medical Care Program (KPMCP)

1.1 History

Kaiser Permanente was founded in the late 1930's by an innovative physician, Sidney R. Garfield, MD, and an industrialist, Henry J. Kaiser, as a comprehensive affordable alternative to “fee-for-service” medical care. Initially, the health care program was only available to construction, shipyard, and steel mill workers employed by the Kaiser industrial companies during the late 1930’s and 1940’s. The program was opened for enrollment to the general public in 1945.

Today, Kaiser Foundation Health Plan is one of the country’s largest nonprofit, independent, prepaid group practice health maintenance organizations. We are proud of our over 60-year history of providing quality health care services to our Members and of the positive regard we’ve earned from our Members, peers, and others within the health care industry.

1.2 Organizational Structure

Kaiser Permanente Northern California Region (KPNC) is comprised of 3 separate entities that share responsibility for providing medical, hospital and business management services. This group of entities is referred to in this Provider Manual as Kaiser Permanente (KP). The entities are:

- Kaiser Foundation Health Plan, Inc. (KFHP): KFHP is a California nonprofit, public benefit corporation that is licensed as a health care service plan under the Knox-Keene Act. KFHP offers HMO plans. KFHP contracts with Kaiser Foundation Hospitals and The Permanente Medical Group to provide or arrange for the provision of medical services.

- Kaiser Foundation Hospitals (KFH): KFH is a California nonprofit public benefit corporation that owns and operates community hospitals and outpatient facilities. KFH provides and arranges for hospital and other facility services, and sponsors charitable, educational, and research activities.

- The Permanente Medical Group, Inc. (TPMG): TPMG is a professional corporation of physicians in KPNC that provides and arranges for professional medical services.

1.3 KPNC Service Area

The KPNC was the first of KP’s 8 regions. Currently covering an area from south of Fresno to El Dorado in the Sierra foothills, from San Jose (Gilroy) to Sonoma on the Pacific coast, KPNC spans more than twenty counties.
1.4 **Integration**

KP is unique. We integrate the elements of health care providers, hospitals, home health, support functions and health care coverage into a cohesive health care delivery system. Our integrated structure enables us to coordinate care to our Members across the continuum of care settings.

1.5 **Nondiscrimination**

The KPMCP in Northern California does not discriminate in the delivery of health care based on race/ethnicity, color, national origin, ancestry, religion, sex (including gender, gender identity, or gender related appearance/behavior whether or not stereotypically associated with the person’s assigned sex at birth), marital status, veteran’s status, sexual orientation, age, genetic information, medical history, medical conditions, claims experience, evidence of insurability (including conditions arising out of acts of domestic violence), or source of payment.

It is also the policy of KPMCP to require that facilities and services be accessible to individuals with mental or physical disabilities in compliance with the Americans with Disabilities Act of 1990 (“ADA”) including but not limited to the service animal requirements set forth in 28 C.F.R. § 36.302(c), and Section 504 of the Rehabilitation Act of 1973 (“Section 504”) and other applicable federal and state laws and regulations that prohibit discrimination on the basis of disability.

As a Provider for HMO products offered by KP, you are expected to adhere to KP’s “Nondiscrimination In the Delivery of Health Care Policy” and to all other federal and state laws and regulations that prohibit discrimination.

1.6 **Preventative Health Care**

KP continues to influence the practice of medicine by focusing on keeping the patient healthy and on treating illness and injuries. We encourage Members to seek care on a regular and preventive basis.

1.7 **Other Products**

In addition to our core HMO plans, KP also offers the fully insured and self-funded products, administered by KP Insurance Company (KPIC). Fully insured and Self-Funded Exclusive Provider Organization, Point-of-Service, and Preferred Provider Organization (PPO) options are addressed in a separate manual.
1.7.1 Exclusive Provider Organization (EPO)
- Mirrors our HMO product, offered on a fully insured or self-funded basis
- EPO Members choose a KP primary care provider (PCP) and receive care at KP or (contracted) plan medical facilities
- Except when referred by a TPMG physician or designee (Plan Physician), EPO Members will be covered for non-emergency care only at designated plan medical facilities and from designated plan practitioners

1.7.2 Point of Service (POS)—Two-Tier
- Tier 1 is the EPO provider network
- Tier 2 is comprised of all other contracted Providers
- POS Members incur greater out-of-pocket expenses in the form of higher co-payments, co-insurance and/or deductibles when they use Tier 2 benefits
- The POS—Two Tier product is offered on a fully insured or self-funded basis

1.7.3 Point of Service (POS)—Three-Tier
- Tier 1 is the EPO provider network
- Tier 2 is comprised of our contracted PPO network providers
- Tier 3 includes non-contracted providers
- POS Members incur greater out-of-pocket expenses in the form of higher co-payments, co-insurance and/or deductibles when they self-refer to a contracted PPO network provider (Tier 2)
- Generally, the out-of-pocket costs will be highest for self-referred services received from non-contracted providers (Tier 3)
- The POS—Three Tier product is offered on a fully insured or self-funded basis

1.7.4 Out of Area Preferred Provider Organization (PPO)
- The PPO is offered to Members living outside the KP EPO service area. Members receive care from our PPO provider network, e.g. PHCS.
- PPO Members may choose to receive care from a non-network provider; however, their out-of-pocket costs may be higher
- There are no requirements for PCP selection
- The Out of Area PPO is offered on a fully insured or self-funded basis
Each Member is issued a Health Identification Card (Health ID Card) that shows his/her unique medical record number (MRN). Members should present their Health ID Card and photo identification when they seek medical care. If a replacement card is needed, the Member can order a Health ID Card online at www.kp.org or call Member Services.

1.8 Identification Cards and Medical Record Number (MRN)

Each Member is issued a Health Identification Card (Health ID Card) that shows his/her unique MRN. Members should present their Health ID Card and photo identification when they seek medical care. If a replacement card is needed, the Member can order a Health ID Card online at www.kp.org or call Member Services.

The Health ID Card is for identification only and does not give a Member rights to services or other benefits unless he/she is eligible. Anyone who is not eligible at the time of service is responsible for paying for services provided.

For record-keeping purposes, your business office may wish to photocopy the front and back of a Member’s Health ID card and place it in the Member’s medical records file.

The MRN is used by KP to identify the Member’s medical record, eligibility, and benefit level. If a Member’s enrollment terminates and the Member re-enrolls at a later date, the Member retains the same MRN even though employer or other information may change. The MRN enables medical records/history to be tracked for all periods of enrollment.

The MRN should be used as the “Patient ID” when submitting bills and encounter data.

Sample Health ID Cards:

Northern California
Southern California

Kaiser Foundation Health Plan, Inc.
Southern California Region

Prefix       Medical Record No.       Date of Birth

Name: First M Last                      Gender

For information about your Health Plan benefits:
1-800-464-4000/TTY 1-800-777-1370

kp.org

After-hours nurse advice: 1-888-576-5225/TTY 1-888-880-0833
If you think you have a medical or psychiatric emergency, call 911 or go to the nearest hospital. If you receive emergency care in a non-Plan hospital, please call us at 1-800-225-8683/
TTY 1-800-777-1370 as soon as your condition is stabilized so that a Kaiser Permanente physician can access your medical information to discuss your care with the treating physician. Your call to obtain authorization for post-stabilization care may also help protect you from financial responsibility.

This card is for identification only. Possession of this card confers no right to services or benefits unless the holder is a member complying with all provisions of an applicable agreement.
2. Key Contacts

2.1 Northern California Region Key Contacts

<table>
<thead>
<tr>
<th>Department</th>
<th>Area of Interest</th>
<th>Contact Information</th>
</tr>
</thead>
</table>
| KP Member Services                 | Membership Information  
General enrollment questions  
Eligibility and benefit verification  
Co-pay, deductible and co-insurance information  
Members presenting without KP identification number  
Verifying Member’s PCP assignment  
Member grievance and appeals  
Payment status on submitted claims | (888) 576-6789 (Member cost share and eligibility verification)  
Weekdays: 8a-5p Pacific  
IVR System available  
24 hours / 7 days a week |
| Medical Services Contracting       | Contract Management and Provider Relations  
• Updates to Provider demographics, such as Tax ID and ownership changes, address changes  
• Practitioner additions/terminations to/from your group  
• Provider education and training  
• Contract interpretation  
• Form requests | (844) 343-9370  
(510) 987-4138 (fax)  
P.O. Box 23380  
Oakland, CA 94623-2338 |
| Quality & Operations Support       | Practitioner Credentialing                                                                                                                                                                                      | (510) 625-5608 |
| Medical Services Contracting       | Facility/Organizational Provider Credentialing                                                                                                                                                               | (844) 343-9370 |
| Medical Staff Office               | Kaiser Foundation Hospital Privileges                                                                                                                                                                           | Facility Listing – Section 2.4 |
| Outside Medical Services           | Authorizations, Referrals by Service  
• Authorizations, referrals & billing questions for referred services  
• Coordination of Benefits  
• Third Party Liability  
• Workers’ Compensation | Referral Coordinators - Facility Listing - Section 2.4 |
| National Claims Administration     | Emergency Medical Claims (non-Medicare)  
Billing questions for emergency (non-referred) services                                                                                                                                                         | (800) 390-3510  
P.O. Box 12923  
Oakland, CA 94604-2923 |

National Claims Administration     | Emergency Medical Claims (Medicare)  
Billing questions for emergency (non-referred) services                                                                                                                                                         | (800) 390-3510  
PO. Box 24010  
Oakland, CA 94623 |
### Section 2: Key Contacts

<table>
<thead>
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<th>Department</th>
<th>Area of Interest</th>
<th>Contact Information</th>
</tr>
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<td>Case Management by Service</td>
<td>Facility Listing - Section 2.4</td>
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<td>Department of Research</td>
<td>Clinical Studies</td>
<td>(510) 987-1000</td>
</tr>
<tr>
<td>Clinical Reviews</td>
<td>UM Reconsiderations and Appeals</td>
<td>(888) 987-7247</td>
</tr>
<tr>
<td></td>
<td>72 Hour Expedited Appeals</td>
<td>(888) 987-2252 (fax)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>M-F 7am-7pm; Sat 9am-1pm</td>
</tr>
<tr>
<td>Emergency Prospective Review Program (EPRP)</td>
<td>Emergency Notification</td>
<td>(800) 447-3777</td>
</tr>
<tr>
<td>CA Statewide Service</td>
<td></td>
<td>Available 24 hours a day, 7 days a week</td>
</tr>
<tr>
<td>The “HUB”</td>
<td>Non-Emergency Ambulance and Medical</td>
<td>(800) 438-7404</td>
</tr>
<tr>
<td></td>
<td>Transportation</td>
<td></td>
</tr>
<tr>
<td>Nephrology Specialty Department</td>
<td>Management of Adult Kidney Transplant patients</td>
<td>San Francisco: (415) 833-8726</td>
</tr>
<tr>
<td></td>
<td>91 days and beyond after transplant</td>
<td>So. Sacramento: (916) 688 6985</td>
</tr>
<tr>
<td>National Transplant Network</td>
<td>Transplants: All Other</td>
<td>(510) 625-4134</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(510) 625-5605</td>
</tr>
</tbody>
</table>

#### 2.2 Member Services Interactive Voice Response System (IVR)

KP Member Services IVR can assist you with a variety of questions. Call **(888) 576-6789** to use this service. Please have the following information available when you call into the system to provide authentication:

- Provider Tax ID or National Provider Identifier (NPI)
- Member's MRN
- Member's date of birth
- Date of service for claim in question

The IVR can assist you with status of a Member's accumulator (amount applied toward deductible); claims and payment status; or connect you to a Member Services representative. Follow the prompts to access these services.

#### 2.3 KP Outside Services

Referral Coordinators and Outside Services Case Managers located at KP facilities throughout the Northern California Region work closely with health care professionals who contract with KP.
Referral Coordinators are your first contact for questions about authorized referrals and billing information. Referral Coordinators:

- Process and distribute authorization document(s)
- Verify status of authorizations
- Process invoices received from Providers for referred services
- Act as liaisons between the Provider and KP physicians

Referral Coordinators may be reached by calling the telephone number that is provided on the authorization document. If you have not received an authorization document from us, contact the Referral Coordinator in your Service Area.

Outside Services Case Managers address specific services and are your first contact to address patient care issues involving:

- Concurrent review and UM
- Discharge planning

2.4 **KP Facility Listing**

KP Facilities, Referral Coordinators and Outside Services Case Managers may be reached at the telephone numbers listed on the following pages.
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<th>RENAL CASE MANAGERS</th>
<th>UTILIZATION MANAGEMENT</th>
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<tr>
<td>East Bay</td>
<td>Oakland</td>
<td>(510) 752-1000</td>
<td>(510) 752-6610</td>
<td>(510) 752-7153</td>
<td>(510) 752-7645</td>
</tr>
<tr>
<td></td>
<td>Richmond</td>
<td>(510) 307-1500</td>
<td>(510) 307-2496</td>
<td>(510) 752-7118</td>
<td>(510) 307-2943</td>
</tr>
<tr>
<td></td>
<td>San Leandro</td>
<td>(510) 454-1000</td>
<td>(510) 675-6758</td>
<td>(510) 784-2082</td>
<td>(510) 454-4892</td>
</tr>
<tr>
<td></td>
<td>Fremont</td>
<td>(510) 795-3000</td>
<td>(510) 675-6758</td>
<td>(510) 248-3345</td>
<td>(510) 248-7039</td>
</tr>
<tr>
<td>Marin/Sonoma</td>
<td>San Rafael</td>
<td>(415) 444-2000</td>
<td>(415) 491-3118</td>
<td>(415) 482-6892</td>
<td>(415) 444-2638</td>
</tr>
<tr>
<td></td>
<td>West Marin/Coastal</td>
<td>(415) 899-7525</td>
<td>(415) 491-3118</td>
<td>(415) 482-6892</td>
<td>(415) 444-2638</td>
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<tr>
<td></td>
<td>Coastal Health</td>
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<td>Alliance</td>
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<tr>
<td></td>
<td>Santa Rosa</td>
<td>(707) 393-4000</td>
<td>(707) 571-3900</td>
<td>(707) 393-4301</td>
<td>(707) 393-3169</td>
</tr>
<tr>
<td>Greater San Francisco Service Area</td>
<td>San Francisco</td>
<td>(415) 833-2000</td>
<td>(415) 833-4792</td>
<td>(415) 833-8890</td>
<td>(415) 833-2801</td>
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<tr>
<td></td>
<td>So. San Francisco</td>
<td>(650) 742-2000</td>
<td>(650) 742-2587</td>
<td>(650) 742-3141</td>
<td>(650) 742-2332</td>
</tr>
<tr>
<td>San Mateo</td>
<td>Redwood City</td>
<td>(650) 299-2000</td>
<td>(650) 299-3245</td>
<td>(650) 299-3726</td>
<td>(650) 299-3290</td>
</tr>
<tr>
<td>South Bay</td>
<td>Santa Clara</td>
<td>(408) 851-1000</td>
<td>(408) 851-3720</td>
<td>(408) 851-1045</td>
<td>(408) 851-7050</td>
</tr>
<tr>
<td></td>
<td>San Jose</td>
<td>(408) 972-3000</td>
<td>(408) 972-7184</td>
<td>(408) 363-4544</td>
<td>(408) 972-7208</td>
</tr>
<tr>
<td>Diablo</td>
<td>Walnut Creek</td>
<td>(925) 295-4000</td>
<td>(925) 295-7635</td>
<td>(925) 295-4315</td>
<td>(925) 295-5175</td>
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<td></td>
<td>Antioch</td>
<td>(925) 813-6500</td>
<td>(925) 295-7635</td>
<td>(925) 295-6333</td>
<td>(925) 813-3720</td>
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<tr>
<td>Napa/Solano</td>
<td>Vacaville</td>
<td>(707) 624-4000</td>
<td>N/A</td>
<td>N/A</td>
<td>(707) 624-2950</td>
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<tr>
<td></td>
<td>Vallejo</td>
<td>(707) 651-1000</td>
<td>(707) 651-2520</td>
<td>(707) 651-4028</td>
<td>(707) 651-2061</td>
</tr>
<tr>
<td></td>
<td>Vallejo Rehab-KFRC</td>
<td>(707) 651-2311</td>
<td>N/A</td>
<td>N/A</td>
<td>(707) 651-2313</td>
</tr>
<tr>
<td>North Valley/S. Sacramento</td>
<td>Sacramento</td>
<td>(916) 973-5000</td>
<td>(916) 784-5558</td>
<td>(916) 973-5855</td>
<td>(916) 973-6903</td>
</tr>
<tr>
<td></td>
<td>Roseville</td>
<td>(916) 784-4000</td>
<td>(916) 784-5558</td>
<td>(916) 973-5855</td>
<td>(916) 784-4802</td>
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<tr>
<td></td>
<td>So. Sacramento</td>
<td>(916) 688-2000</td>
<td>(916) 525-3162</td>
<td>(916) 688-6458</td>
<td>(916) 688-2585</td>
</tr>
<tr>
<td>Central Valley</td>
<td>Manteca</td>
<td>(209) 825-3700</td>
<td>(209) 858-7902</td>
<td>(209) 476-5099</td>
<td>(209) 825-2441</td>
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<tr>
<td></td>
<td>St. Joseph's Medical</td>
<td>(209) 943-2000</td>
<td>N/A</td>
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<td></td>
<td>Center</td>
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<tr>
<td></td>
<td>Modesto</td>
<td>(209) 557-1000</td>
<td>(209) 858-7900</td>
<td>(209) 735-4348</td>
<td>(209) 735-5600</td>
</tr>
<tr>
<td>Fresno</td>
<td>Fresno</td>
<td>(559) 448-4500</td>
<td>(559) 448-4606</td>
<td>(559) 448-5149</td>
<td>(559) 448-3352</td>
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<td>Out of Service Area</td>
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<td>(877) 520-4773</td>
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<tr>
<td>SERVICE AREA</td>
<td>FACILITY</td>
<td>OUTSIDE SERVICES CASE MANAGEMENT HUBS</td>
<td>SKILLED NURSING FACILITY COORDINATOR Mon - Fri (8:30a - 5:00p)</td>
<td>SKILLED NURSING FACILITY COORDINATOR Evenings, Weekends &amp; Holidays</td>
<td>HOME HEALTH CASE MANAGERS</td>
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<td><strong>East Bay</strong></td>
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<tr>
<td>Richmond</td>
<td>(925) 926-7303</td>
<td>(510) 675-5539</td>
<td>(877) 233-6752</td>
<td>(510) 752-6295</td>
<td>(510) 752-6390</td>
</tr>
<tr>
<td>San Leandro</td>
<td>(925) 926-7303</td>
<td>(510) 675-5539</td>
<td>(877) 233-6541</td>
<td>(510) 675-6620</td>
<td>(510) 675-5777</td>
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<tr>
<td>Fremont</td>
<td>(925) 926-7303</td>
<td>(510) 675-5539</td>
<td>(877) 233-6541</td>
<td>(510) 675-6620</td>
<td>(510) 675-5777</td>
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<td><strong>Marin/Sonoma</strong></td>
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<tr>
<td>San Rafael</td>
<td>(925) 926-7303</td>
<td>(415) 893-4046</td>
<td>(877) 829-8615</td>
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3. Eligibility and Benefits Determination

3.1 Eligibility and Benefit Verification

Providers are responsible for verifying Members’ eligibility and benefits. Each time a Member presents at the office for services, Providers should:

- Verify the patient’s current eligibility status
- Verify covered benefits
- Obtain necessary authorizations (if applicable)

Do not assume that eligibility is in effect because a person has a Health ID Card. Please check a form of photo identification to verify the identity of the Member. Except in an emergency situation, the Provider must verify that the Member has a benefit for the service prior to providing services.

Contact KP Member Services to verify the Member's eligibility and benefits. It is important to verify the availability of benefits for services before rendering the service so the Member can be informed of any potential payment responsibility. If services are provided to a Member and the service is not a benefit or the benefit has been exhausted, denied or not authorized, KP may not be obligated to pay for those services.

KP Member Services Contact Center
and
Self-Service is available in the IVR System
24 hours / 7 days a week

(888) 576-6789
Monday - Friday from 8 A.M. to 5 P.M.
Pacific Time Zone (PT)

To verify Member eligibility, benefits or PCP assignment, speak with a Member Services representative by calling the KP Member Services Contact Center. Please provide the Member’s name and MRN which is located on the Health ID card.

Please be aware KP maintains Online Affiliate, an online resource for lookup of Members' eligibility and benefits. For additional information on this option, please contact our Provider Relations Department

3.1.1 After Hours Eligibility Requests

A Member who requests medical care after normal business hours must have his/her eligibility verified during the next business day. During the interim, request that the patient
complete a financial responsibility form that places payment responsibility on the patient in the event that he or she is found to be ineligible as a Member or the care provided is not a covered benefit. A financial responsibility form is not required for provision of emergency services; however KP will not pay for emergency or other unauthorized services provided if the person is not a Member.

3.1.2 Benefit Coverage Determination

In addition to eligibility, Providers must confirm that the Member has coverage for the services at issue prior to providing such services to a Member, usually by requesting an authorization or receiving a referral from KP. Section 4.3 of this Provider Manual provides further details on the process for obtaining referrals and authorizations, except in cases of emergency.

3.2 Membership Types

The table below generally describes the different HMO membership types.

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<th>Covered Benefits Defined By:</th>
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<td>Commercial</td>
<td>Members who purchase HMO coverage on an individual basis (other than Medicare)</td>
<td>Evidence of Coverage (EOC)</td>
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<td>Members who are covered as part of an employer group and are not Medicare-eligible</td>
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<td>Medicare + Choice) (aka Senior Advantage)</td>
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<td>Employer group retirees or otherwise Medicare-eligible employees who are also</td>
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<td>Medicare beneficiaries and have assigned their Medicare benefits to KP by enrolling the KP Senior Advantage Program</td>
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<td>Medicare Cost</td>
<td>Members who are enrolled under a Medicare Cost contract between Health Plan or entities participating in the KP Medical Care Program and Centers for Medicare &amp; Medicaid Services (CMS) and/or for whom Medicare is the primary payor for purposes of the Agreement</td>
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<td>Regular Medicare (Medicare unassigned)</td>
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<td>Dual Coverage: Two separate plans – the primary Medicare benefits are defined by Medicare; the HMO benefits are defined by the EOC</td>
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<td>Contact Member Services for detailed information specific to your geographic area.</td>
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### 3.3 Benefit Exclusions and Limitations

KP benefit plans may be subject to limitations and exclusions. Before rendering services, it is important to contact KP Member Services to obtain information on, and verify the availability of, Member benefits for services so the Member can be informed of any potential payment responsibility.

If services are provided to a Member and the service is not a benefit, the benefit has been exhausted, denied or was not authorized, KP will not be obligated to pay for those services, except to the extent required by law.

### 3.4 Drug Benefits

The drug benefits vary based on the benefit plan. To verify if a Member has a drug benefit, please contact Member Services.
4. Utilization Management/Resource Management (UM)

4.1 Overview of Utilization Management/Resource Management Program

KFHP, KFH, and TPMG share responsibility for Utilization Management/Resource Management (UM). KFHP, KFH, and TPMG work together to provide and coordinate UM for Members by reviewing and monitoring the full range of outpatient and inpatient services delivered by physicians, hospitals, and other health care practitioners and providers. UM is a process that determines whether a health care service recommended by your treating provider is medically necessary. If it is medically necessary, the service will be authorized and the Member will receive the services in a clinically appropriate place consistent with the terms of the Member’s health coverage. UM activities and functions include the prospective, retrospective, or concurrent review of health care service requests submitted by providers and the decisions to approve, modify, delay, or deny the request based in whole or in part on medical necessity. Kaiser’s utilization review program is subject to direct regulation under the Knox-Keene Act and must adhere to managed care accreditation standards. The determination of whether a service is medically necessary is based upon criteria that are consistent with sound clinical principles and processes, which are reviewed and approved annually by the Plan.

4.1.1 Data Collection and Surveys

KP collects UM data to comply with state and federal regulations and accreditation requirements. Evaluation of UM data identifies areas for improvement in inpatient and outpatient care.

KP conducts Member and practitioner satisfaction surveys on a regular basis. Survey results are reviewed to identify patterns, trends, success of interventions, and opportunities for performance and UM process improvements.

UM staff also collects information about the medical necessity of health care services and the appropriateness of benefits-based coverage decisions. Appropriately licensed health care professionals supervise all UM processes.

The success of KP UM programs depends on the cooperation and commitment of Providers who provide care to Members working to ensure successful outcomes and cost-effective treatment.

4.2 Medical Appropriateness

Kaiser Permanente uses written objective criteria based on sound clinical evidence in making utilization management (UM) decisions. We have policies that establish how such clinical criteria are developed, adopted, and reviewed. When we make a UM decision that
denies or modifies provider requested services, we will communicate that decision to you in writing. That notification will include a concise explanation of the reasons for our decision and the criteria or guidelines we used. UM decisions are always independently based on clinical criteria or scientific literature; they are never made on the basis of a financial incentive or reward.

Qualified physicians or other appropriately qualified health care professionals review all prior authorization denials. Physicians who make UM decisions may be physician leaders for Outside Referral Services, physician experts, and/or Members of physician specialty boards. They have current, unrestricted licenses and have appropriate education, training, and clinical experience related to the services being requested. When necessary, they will consult board certified physicians in the associated specialty to assist them in making a UM decision.

4.3 “Referral” and “Authorization” – General Information

Prior authorization must be obtained before rendering certain services unless it can be demonstrated that the Member was suffering from an “emergency medical condition” at the time treatment was rendered. An emergency medical condition means any of the following (i) a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (a) serious jeopardy to the Member’s health, or in the case of a pregnant woman, the health of the woman or her unborn child, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part; or (ii) a mental disorder that manifests itself by acute symptoms of sufficient severity that such either the Member is an immediate danger to themselves or others, or the Member is not immediately able to provide for or use food, shelter, or clothing, due to the mental disorder, or (iii) with respect to a pregnant woman who is having contractions (a) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (b) that transfer may pose a threat to the health or safety of the woman or her unborn child, or (iv) as otherwise defined by applicable law (including California law or Emergency Medical Treatment and Active Labor Act (EMTALA)), or as otherwise required by law.

KP Plan Physicians offer primary medical, behavioral, pediatric, and OB-GYN care as well as specialty care. A KP Plan Physician may refer a Member to a non-plan Provider when the Member requires covered services and supplies that are not available from us, or cannot be provided in a timely manner. The outside referrals process is managed at the facility level and the Assistant Physicians-In-Chief (APICs) for Outside Services (Referrals) are responsible for reviewing the medical necessity and availability of services for which a referral has been requested.

Additionally, there are service-specific authorization processes for externally referred services for durable medical equipment (DME), solid organ and bone marrow transplants, transgender surgery and behavioral health treatment for autism spectrum disorder. These processes involve specialty boards and physician experts.
When KP approves outside services for a Member, KP issues an Authorization for Medical Care form, which details the level and scope of services, number of visits and/or duration of treatment that have been pre-approved. The Member receives a letter that indicates a referral has been approved for the Member to see a specific outside Provider. Any further services must be pre-approved by KP. To receive approval, the outside Provider must contact the referring physician.

Authorized services must be rendered before the expiration date stated in the Authorization for Medical Care form or Patient Transfer Referral form or notification from KP of authorization cancellation. An additional authorization must be obtained for care that may exceed the scope of the original authorization, including any limits in the number of services (i.e., visits, etc.) or may extend beyond the expiration date of the authorization.

For assistance in resolving administrative and patient related issues, including clarification of the authorization or referral process, please contact a Referral Coordinator from the referring KP facility.

4.4 Authorization of Services

Prior authorization is a prerequisite before payment can be made for any inpatient and outpatient services that would otherwise be covered by a Member’s benefit plan, except for emergency services and any other situations expressly allowed by the Agreement or this Provider Manual.

Notwithstanding that services were provided to a Member without prior authorization (other than investigational or experimental therapies or other non-covered services), the Provider will be paid for the provision of such services in a licensed acute care hospital if related to services that were previously authorized and when all of the following conditions are met: (1) the services were medically necessary at the time they were provided; (2) the services were provided after KP normal business hours; and (3) a system that provides for the availability of a KP representative or an alternative means of contact through an electronic system, including voice mail or electronic mail, was not available, such that KP could not respond to a request for authorization within 30 minutes after the request was made.

Authorization can be requested from KP by contacting the appropriate Referral Coordinator.

NOTE: Authorization from KP is required even when KP is the secondary payor.

4.4.1 Hospital Admissions Other Than Emergency Services

A KP Plan physician or KP designated specialist may refer a Member for a hospital admission without prior authorization. The RM staff conducts an initial review within 24 hours of admission to determine medical necessity, appropriate level of care and the provision of services, except for emergency services for all admissions and the provision of
services, except for emergency services. Such authorization can be requested as described above by contacting the appropriate Referral Coordinator.

4.4.2 Admission to Skilled Nursing Facility (SNF)

If the medical necessity of hospitalization or other care is an issue or other services better meet the Member’s clinical condition and needs, the Outside Services Case Managers will notify the appropriate physician to discuss alternative treatment plans.

A KP Plan Physician or KP designated specialist may refer a Member for skilled level of care at a SNF. Such authorization will include a description of specific, approved therapies and other medically necessary skilled nursing services per Medicare Guidelines.

The initial skilled care authorizations or denials are based on the Member’s medical needs at the time of admission, and the Member’s benefits and eligibility status. The Member is informed by the Care Coordinator what his or her authorized anticipated length of stay will be.

The Care Coordinator conducts telephonic or onsite reviews at least weekly to evaluate the Member’s clinical status and level of care needs and to determine if continuation of the authorization is appropriate. The SNF may request extension of an authorization for continued stay from the Care Coordinator. Based on the Member’s skilled care needs and benefit eligibility, more SNF days may be approved. If additional days are authorized, then the SNF will receive an authorization from KP.

Other services in connection with a SNF stay are authorized when either the Member’s Plan Physician or other KP designated specialist expressly orders such services. These services may include, but are not limited to, the following items:

- Laboratory and radiology services
- Special supplies or DME
- Ambulance transport (when patient meets medical necessity)

Kaiser requires that authorization numbers be included on all claims submitted by not only SNFs, but all ancillary providers that provide services to Kaiser Members.

These authorization numbers must be provided by the facility that requests the services, preferably at time of service. Because authorization numbers change frequently it is critical that the authorizations be valid for the date of service provided. Please note that the correct authorization number for the ancillary service providers may not be the latest authorization you have.

It is the responsibility of the SNF to provide the correct authorization number(s) to all ancillary service providers at time of service. If you are not sure of the correct authorization number, please contact Kaiser’s authorization department for confirmation.
4.4.3 Home Health/Hospice Services

All home health and hospice services must be authorized by KP prior to providing services. Home health or hospice services are provided subject to the following criteria:

- A KP Plan Physician must order and direct the requests for home health and hospice services
- The patient is an eligible Member
- Services are provided in accordance with benefit guidelines
- The patient requires the care in the patient’s place of residence. Any place that the patient is using as a home is considered the patient’s residence
- The home environment is a safe and appropriate setting to meet the patient’s needs and provide home health or hospice services
- There is a reasonable expectation that the patient’s clinical needs can be met by the Provider

4.4.3.1 Home Health Only

- The services are medically necessary for the Member’s clinical condition
- The patient is homebound, which is defined as an inability to leave home without the aid of supportive devices, special transportation or the assistance of another person. A patient may be considered homebound if absences from the home are infrequent and of short distances. A patient is not considered homebound if lack of transportation or inability to drive is the reason for being confined to the home
- The patient and/or caregiver(s) are willing to participate in the plan of care and work toward specific treatment goals

4.4.3.2 Hospice Only

- The patient is certified as being terminally ill and meets the criteria of the benefit guidelines for hospice services

4.4.4 Durable Medical Equipment (DME)/ Prosthetics and Orthotics (P&O)

Prior Authorization is required for DME and P&O. KP evaluates authorization requests for appropriateness based on, but not limited to:

- The Member’s care needs
- The application of specific benefit guidelines
- DME and Soft Goods formulary guidelines and P&O Clinical Criteria which are available at the Clinical library: http://clm.kp.org
4.4.5 Psychiatric Hospital Services

Initial verbal authorizations will be made to the psychiatric facility by a KP Psychiatry Department/Call Center Referral Coordinator at the direction of a KP Plan Physician or clinician. When a Member is admitted to your facility for psychiatric services, you must notify KP at the appropriate facility number to activate the initial authorization. You may be asked to complete supplemental documentation, such as an “Insurance Admission Information” form.

4.4.6 Non-Emergent Transportation

To serve our Members and coordinate care with our Providers, KP has a 24 hour, 7 day per week, centralized medical transportation department called the “HUB”, to coordinate and schedule non-emergency medical transportation.

4.4.6.1 Non-Emergency Medical Transport (Gurney Van/Wheelchair Van)

Providers must call KP to arrange for KP physician-authorized non-emergency medical transportation through the HUB.

Non-emergency medical transportation may or may not be a covered benefit for the Member. Payment may be denied for the medical transportation of a Member that is not coordinated through the HUB and not properly documented as an authorized referral.

4.4.6.2 Non-Emergency Ambulance Transportation

If a Member requires non-emergency ambulance transportation to a KP Medical Center or any other location designated by KP, Providers may contact KP to arrange the transportation of the Member through the HUB. Providers should not contact any ambulance company directly to arrange an authorized non-emergency ambulance transportation of a Member.

Non-emergency ambulance transportation may or may not be a covered benefit for the Member. Payment may be denied for ambulance transport of a Member that is not coordinated through the HUB and not properly documented as an authorized referral.

4.4.7 Authorization for KP Emergency Department Visits

If, due to a change in a Member’s condition, the Member requires a more intensive level of care than your facility can provide, you can request a transfer of the Member to a KP Medical Center. The Care Coordinator or designee will arrange the appropriate transportation through KP’s medical transportation HUB.

Transfers to a KP Medical Center should be made by the facility after verbal communication with the appropriate KP staff, such as a TPMG SNF physician or the Emergency
Department physician. Contact a Care Coordinator for a current list of telephone numbers for emergency department transfers.

If a Member is sent to the Emergency Department via a 911 ambulance and it is later determined by KP that the 911 ambulance transport or emergency department visit was not medically necessary, KP may not be obligated to pay for the ambulance transport.

4.4.7.1 Required Information for Transfers to KP

Please send the following written information with the Member:

1. Name of Member’s contact person (family member or surrogate) and telephone number
2. Completed inter-facility transfer form
3. Brief history (history and physical; discharge summary; and/or admit note)
4. Current medical status, including presenting problem, current medications and vital signs
5. A copy of the patient’s Advance Directive/Physician Orders for Life Sustaining Treatment (POLST)
6. Any other pertinent medical information, i.e., lab/x-ray

If the Member is to return to the sending facility, KP will provide the following written information:

1. Diagnosis (admitting and discharge)
2. Medications given; new medications ordered
3. Labs and x-rays performed
4. Treatment(s) given
5. Recommendations for future treatment; new orders

4.5 Emergency Admissions and Services; Hospital Repatriation Policy

Consistent with applicable law, KP Members are covered for emergency care needed to clinically stabilize their situation. An emergency medical condition means any of the following (i) a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: (a) serious jeopardy to the Member’s health, or in the case of a pregnant woman, the health of the woman or her unborn child, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part; or (ii) a mental disorder that manifests itself by acute symptoms of sufficient severity such that either the Member is
an immediate danger to themselves or others, or the Member is not immediately able to provide for or use food, shelter, or clothing, due to the mental disorder, or (iii) with respect to a pregnant woman who is having contractions (a) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (b) that transfer may pose a threat to the health or safety of the woman or her unborn child, or (iv) as otherwise defined by applicable law (including California law or EMTALA).

Services provided to Members to screen and stabilize a patient suffering from an emergency medical condition as defined above do not require prior authorization.

**EMERGENCY SERVICES**

- If emergency services are provided to screen and stabilize a patient, they are covered in situations when a prudent layperson would have believed that an emergency condition existed
- Once a patient is stabilized, the treating physician is required to communicate with KP for approval to provide further care or to effect transfer

**EMERGENCY CLAIM**

The following circumstances will be considered when the bill is processed for payment:

- Whether services and supplies are covered under the Member's benefit plan
- Whether services have been ordered, authorized, prescribed, or directed by a KP Plan Physician
- Whether services provided were immediately required because of unforeseen illness or injury

Payment is dependent on the advice of the treating physician, as well as the KP determination of the situation in which care was provided and in consideration of the prudent layperson guideline as stated above. Members have varying benefit plans, and some benefit plans may not cover continuing or follow-up treatment at a non-plan facility. Therefore, the Provider should contact KP’s Emergency Prospective Review Program (EPRP) prior to furnishing post-stabilization services.

### 4.5.1 Emergency Prospective Review Program (EPRP)

EPRP provides a statewide notification system relating to emergency services for Members. It also provides authorization for requested post-stabilization care and must be contacted prior to a stabilized Member's admission to a facility. KP may make arrangements for necessary continued hospitalization or for transferring the Member to a designated hospital after the Member is stabilized.

When a Member presents in an emergency room for treatment, we expect the Provider to triage and treat the Member in accordance with EMTALA requirements, and to contact EPRP once the Member has been stabilized or stabilizing care has been initiated.*
Provider may contact EPRP at any time, including prior to stabilization to the extent legally and clinically appropriate, to receive relevant patient-specific medical history information which may assist the Provider in its stabilization efforts and any subsequent post-stabilization care. EPRP has access to Member medical history, including recent test results, which can help expedite diagnosis and inform further care. In addition, EPRP can authorize post-stabilization care at the facility, subject to the requirements under the Member’s benefit plan, in order for non-emergency care to be a covered service, or can assist in making other appropriate care arrangements.

* Please note: Under the EMTALA regulations Providers may, but are not required to contact EPRP once stabilizing care has been initiated but prior to the patient’s actual stabilization, if such contact will not delay necessary care or otherwise harm the patient.

EPRP

(800) 447-3777
Available 7 days a week
24 hours a day

EPRP is available 24 hours a day, every day of the year and provides:

- Access to clinical information to help the Provider in evaluating a Member’s condition and to enable our physicians and the treating physicians at the facility to quickly determine the appropriate treatment for the Member
- Emergency physician to emergency physician discussion regarding a Member’s condition
- Authorization of post-stabilization care or assistance with making appropriate alternative care arrangements

4.5.2 Post-Stabilization Care

If there is mutual agreement at the time of the phone call as to the provision of post-stabilization services, EPRP will authorize the Provider to provide the agreed-upon services and issue a confirming authorization number. If requested, EPRP will also provide, by fax or other electronic means, a written confirmation of the services authorized and the confirmation number. KP will send a copy of the authorization to the facility’s business office within 24 hours of the authorization decision. This authorization number must be included with the claim for payment for the authorized services. The authorization number is required for payment, along with all reasonably relevant information relating to the post-stabilization services on the claim submission consistent with the information provided to EPRP as the basis for the authorization.

EPRP must have confirmed that the Member was eligible for and had benefit coverage for the authorized post-stabilization services provided prior to the provision of post-stabilization services.
If EPRP authorizes the admission of a clinically stable Member to the facility, KP’s Outside Services Case Manager will follow that Member’s care in the facility until discharge or transfer.

EPRP may request that the Member be transferred to a KP-designated facility for continuing care or EPRP may authorize certain post-stabilization services in your facility. In many cases, such post-stabilization services will be rendered under the management of a physician who is a member of your facility’s medical staff and who has contracted with KP to manage the care of our Members being treated in community hospitals.

EPRP may deny authorization for some or all post-stabilization services. The verbal denial of authorization will be confirmed in writing. If EPRP denies authorization for requested post-stabilization care, KP shall not have financial responsibility for services if the Provider nonetheless chooses to provide the care. If the Member insists on receiving such unauthorized post-stabilization care from the facility, we strongly recommend that the facility require that the Member sign a financial responsibility form acknowledging and accepting his or her sole financial liability for the cost of the unauthorized post-stabilization care and/or services.

If the Member is admitted to the facility as part of the stabilizing process and the facility has not yet been in contact with EPRP, the facility must contact the local Outside Services Case Manager at the appropriate number in order to discuss authorization for continued admission as well as any additional appropriate post-stabilization care once the Member’s condition is stabilized.

### 4.6 Concurrent Review

The Outside Utilization Review Services Case Management Hub for Northern California (OURS-NCAL) and KP Plan Physicians will conduct concurrent review in collaboration with contracted facilities. The review may be done telephonically or on site in accordance with the facility's protocols and KP's onsite review policy and procedure, as applicable.

If the Member needs continued services, OURS-NCAL will either confirm or obtain authorization from a KP Plan Physician or licensed clinician (as appropriate for mental health services) for continued stay/services. If continued stay/services are not authorized, the Provider will be notified of the reasons for the denial and appeal procedures.

When utilization problems are identified, we will work with the facility to develop and implement protocols that are intended to improve the provision of services for our Members. A joint monitoring process will be established to observe for continued improvement and cooperation.

OURS-NCAL and the Providers collaborate on concurrent review activities that include, but are not limited to:

- monitoring length of stay/visits
• providing day/service authorization, recertification, justification
• attending patient care conferences and rehabilitation meetings
• utilizing community benchmarking for admissions and average length of stay (ALOS)
• setting patient goal for Members
• conducting visits or telephonic reports, as needed
• developing care plans

4.7 Case Management Hub Contact Information

The specific contact information for OURS-NCAL is as follows:

Main Phone Line: (925) 926-7303
Toll free phone line: 1-888-859-0880
eFax: 1-877-327-3370

The office is located in Walnut Creek, providing support for all Northern California Kaiser Permanente Members admitted in any non-KP hospital, including those admitted Members out of the KP service area and out of the country.

4.8 Denials And Provider Appeals

Information about a denial or the appeal procedures is available by contacting OURS-NCAL or Member Services.

When a denial is made, the Provider is sent a UM denial letter accompanied by the name and direct telephone number of the decision-maker. All medical necessity decisions are made by physicians or licensed clinicians (as appropriate for mental health services). Physician decision-makers include, but are not limited to, DME physician champions, APICs for Outside Services, Pediatric Developmental Disabilities Office, other board-certified physicians or behavioral health practitioners.

If the physician or behavioral health practitioner does not agree with a medical necessity decision, the Provider may contact the UM decision-maker on the cover page of the letter or the Physician-in-Chief for discussion at the local facility. Providers may also contact the issuing department that is identified in the letter for additional information.

4.9 Discharge Planning

Providers such as hospitals, SNFs, psychiatric facilities, home health and hospice agencies are expected to provide discharge planning services for Members, and to cooperate with KP to assure timely and appropriate discharge.
Providers should designate staff to provide proactive, ongoing discharge planning. Discharge planning services should begin upon the Member's admission and be completed by the medically appropriate discharge date. The Provider's discharge planner will identify barriers to discharge and determine an estimated date of discharge. Upon request by KP, Provider will submit documentation of the discharge planning process.

The Provider's discharge planner, in consultation with the Care Coordinator, will arrange and coordinate transportation, DME, follow-up appointments, appropriate referrals to community services and any other services requested by KP.

Unless the Provider has received prior authorization to furnish follow-up care, the Provider must contact KP to arrange for and to coordinate covered medically necessary care after discharge.

### 4.10 UM Information

The Provider may be requested to provide information for the KP UM activities concerning Members in the Provider’s facility. Such additional information may include, but is not limited to, the following data:

- Number of inpatient admissions
- Number of inpatient readmissions within the previous 7 days
- Number of emergency department admissions
- Type and number of procedures performed
- Number of consults
- Number of deceased Members
- Number of autopsies
- ALOS
- Quality Assurance/Peer Review process
- Number of cases reviewed
- Final action taken for each case reviewed
- Committee Membership (participation as it pertains to Members and only in accordance with the terms of your contract)
- Utilization of psychopharmacological agents
- Other relevant information KP may request

### 4.11 Case Management

Care Coordinators work with treating Providers to develop and implement plans of care for acutely ill, chronically ill or injured Members. KP case management staff may include nurses and social workers, who assist in arranging care in the most appropriate setting and help coordinate other resources and services.
While any Provider may request authorization for services, or may seek a Member’s inclusion in a particular KP UM program (for example, case management), the PCP continues to be responsible for managing the Member’s overall care. It is the Provider’s responsibility to send a report to the referring physician, regardless of whether the referring physician is the Member’s PCP, of any consultation with, or treatment rendered to, the Member.

4.12 Clinical Practice Guidelines (CPGs)

Clinical Practice Guidelines (CPGs) are developed to support clinical decisions by practitioners at the point of care in the provision of acute, chronic and behavioral health services. The use of CPGs by practitioners assists KFHP by ensuring that the care provided to members is evidence-based and consistent with professionally recognized standards of care. Development of CPGs is prioritized based on established criteria, which include: number of patients affected by a particular condition/need, quality of care concerns and excessive clinical practice variation, regulatory issues, payor interests, cost, operational needs, leadership mandates and prerogatives.

Physicians and other practitioners are involved in the identification of CPG topics, as well as the development, review, and endorsement of all CPGs. The CPG team includes a core, multi-disciplinary group of physicians representing the medical specialties most affected by the CPG topic, as well as health educators, pharmacists, or other medical professionals.

The CPGs are sponsored and approved by one or more Clinical Chiefs groups, as well as by the Guidelines Medical Director. Established guidelines are routinely reviewed and updated at least every two years or earlier when new evidence emerges. CPGs are distributed to practitioners and are available on two internal Kaiser Permanente intranet websites.

4.13 Pharmacy Services / Drug Formulary

KP has developed a quality, cost effective pharmaceutical program which includes therapeutics and formulary management. The Regional Pharmacy and Therapeutics (P&T) Committee reviews and promotes the use of the safest, most effective, and cost-effective drug therapies, and shares “Best Practices” with all KP Regions. The Regional P&T Committee’s Formulary evaluation process is used to develop the applicable KP Drug Formulary (Formulary) and the National Medicare Part D Formulary for use by KP practitioners. Contracted practitioners are encouraged to use and refer to the Regional Drug Formulary when prescribing medication for Members (available at http://kp.org/formulary).
4.13.1 Pharmacy Benefits

Pharmacy services are available for Members who have benefit plans that provide coverage for a prescription drug program. For information on specific member benefit plans, please contact Member Services.

4.13.2 Filling Prescriptions

The Formulary can be accessed online in a searchable format. It provides the list of drugs approved for general use by prescribing practitioners. For access to the online version of the Formulary on the Internet or to request a paper copy, please refer to the instructions at the end of this section.

KP pharmacies do not cover prescriptions written by non-Plan Physicians unless an authorization for care by that non-Plan Physician has been issued. In order to avoid confusion, when writing the prescription, please remind Members to bring a copy of their authorizations to the KP pharmacy when filling the prescription.

Practitioners are expected to prescribe drugs included in the Formulary unless at least one of the exceptions listed under “Prescribing Non-Formulary Drugs” in this section is met. If there is a need to prescribe a non-Formulary drug, the exception reason must be indicated on the prescription.

A Member may request an exception by contacting their physician directly through secure messaging or the Member Services Contact Center for referral to their physician and should usually receive a response, including the reason for any denial, within 2 Business Days from receipt of the request.

Members will be responsible for paying the full price of their medication if the drugs requested are (i) non-Formulary drugs not required by their health condition, (ii) excluded from coverage (i.e., cosmetic use) or (iii) not prescribed by an authorized or Plan Provider. Any questions should be directed to Member Services.

4.13.2.1 Prescribing Non-Formulary Drugs

Non-Formulary drugs are those that have not yet been reviewed, and those drugs that have been reviewed but given non-Formulary status by the Regional P&T Committee. However, the situations outlined below may allow a non-Formulary drug to be covered by the Member’s drug benefit.

- **New Members**
  If needed and the Member's benefit plan provides, new Members may be covered for an interim supply (up to 100 days) of any previously prescribed “non-Formulary” medication to allow the Member time to make an appointment to see a KP provider. If the Member does not see a KP provider within the 100 days, he or she must pay the full price for any refills of non-Formulary medications.
• **Existing Members**
  A non-Formulary drug may be prescribed for a Member if he or she has an allergy, or intolerance to, or treatment failure with all Formulary alternatives or has a special need that requires the Member to receive a non-Formulary drug. In order for the Member to continue to receive the non-Formulary medication covered under their drug benefit, the exception reason must be provided on the prescription.

**NOTE:** Generally, non-Formulary drugs are not stocked at KP pharmacies. Therefore, before prescribing a non-Formulary drug, call the pharmacy to verify the drug is available at that site.

4.13.2.2 **Pharmacies**

KP pharmacies provide a variety of services including: the filling of new prescriptions, transferring prescriptions from another pharmacy, providing refills and consulting about new medications.

4.13.2.3 **Telephone and Internet Refill Lines**

Members may request refills on their prescriptions, with or without refills remaining, by calling the 24-hour Refill Recorder at the facility of choice for prescription pick up. The phone number is listed in the KP Health Care directory or by calling the facility operator. All telephone requests should be accompanied by the Member's name, MRN, daytime phone number and prescription number.

Members may also refill their prescriptions online by accessing the KP Member website at https://healthy.kaiserpermanente.org/.

4.13.2.4 **Mail Order**

Members with a prescription drug benefit are eligible to use the KP “Prescription by Mail” service. For more information regarding mail order prescriptions or to request an order form, please contact the Mail Order Pharmacy at (888) 218-6245.

Only maintenance medications should be ordered through the mail. Acute prescriptions such as antibiotics or pain medications should be obtained through a KP pharmacy to avoid delays in treatment.

The complete list of restricted use drugs may be found at http://pharmacy.kp.org/.

4.13.2.5 **Restricted Use Drugs**

Some drugs (i.e., chemotherapy) are restricted to prescribing only by approved KP specialists. Restricted drugs are noted in the Formulary. If you have any questions regarding prescribing restricted drugs, please call the main pharmacy at the local facility.
4.13.2.6 Emergency Situations

If emergency medication is needed when KP pharmacies are not open, Members may use pharmacies outside of KP. Since the Member will have to pay the full retail price in this situation, he or she should be instructed to call Customer Service at (800) 464-4000 to obtain a claim form in order to be reimbursed for the cost of the prescription less any co-pays that may apply.

It is your responsibility to submit itemized claims for services provided to Members in a complete and timely manner in accordance with your Agreement, this Provider Manual and applicable law. KP is responsible for payment of claims in accordance with your Agreement. Please note that this Provider Manual does not address submission of claims for fully insured or self-funded products underwritten or administered by KPIC.
5. Billing and Payment

It is your responsibility to submit itemized claims for services provided to Members in a complete and timely manner in accordance with your Agreement, this Provider Manual and applicable law. KP is responsible for payment of claims in accordance with your Agreement. Please note that this Provider Manual does not address submission of claims for fully insured or self-funded products underwritten or administered by KPIC.

5.1 Whom to Contact with Questions

If you have any questions relating to the submission of claims for services to Members for processing, please see Sections 5.4.1 and 5.4.2 below.

5.2 Methods of Claims Submission

Claims may be submitted by mail or electronically. Whether submitting claims on paper or electronically, only the UB-04 form will be accepted for facility services billing and only the CMS-1500 form, which will accommodate reporting of the individual (Type 1) NPI, will be accepted for professional services billing. Submitting claims that are handwritten, faxed or photocopied will be subject to processing delay and/or rejection.

When CMS-1500 or UB-04 forms are updated by NUCC/CMS, KP will notify Provider when the KP systems are ready to accept the updated form(s) and Provider must submit claims using the updated form(s).

5.3 Claims Filing Requirements

5.3.1 Record Authorization Number

All services that require prior authorization must have an authorization number reflected on the claim form or a copy of the authorization form may be submitted with the claim.

5.3.2 One Member and One Provider per Claim Form

Separate claim forms must be completed for each Member and for each Provider.

- Do not bill for different Members on the same claim form
- Do not bill for different Providers on the same claim form
5.3.3 Submission of Multiple Page Claim (CMS-1500 Form and UB-04 Form)

If you must use a second claim form due to space constraints, the second form should clearly indicate that it is a continuation of the first claim. The multiple pages should be attached to each other. Enter the TOTAL CHARGE on the last page of your claim submission.

5.3.4 Billing Inpatient Claims That Span Different Years

When an inpatient claim spans different years (for example, the patient was admitted in December and was discharged in January of the following year), it is NOT necessary to submit 2 claims for these services. Bill all services for this inpatient stay on one claim form (if possible), reflecting the actual date of admission and the actual date of discharge.

5.3.5 Interim Inpatient Bills

For inpatient services only, we will accept separately billable claims for services in an inpatient facility on a bi-weekly basis, to the extent required by 28 CCR 1300.71(a)(7)(B). Interim hospital billings should be submitted under the same Member account number as the initial bill submission.

5.3.6 Bills from Dialysis Providers for Non-Dialysis Services

If your facility provides non-dialysis services to a Member (ex: non-dialysis/wound antibiotic administration, vaccines excluding flu), such services must be billed on a paper claim separate from the bill for dialysis related services.

5.3.7 Psychiatric and Recovery Services Provided to MediCal Members

Depending upon the county in which a MediCal Member resides, claims for such Member’s psychiatric and recovery services may be processed directly by the county. Providers will be notified at the time a Member is referred to the Provider of the Member’s MediCal status, and whether the claim will be processed by KP or by the county agency. Additionally, KP will give the Provider a telephone number to obtain authorization and billing information from the county for these Members.

5.3.8 Services Provided to Medicare Cost Members

Unless otherwise directed in your Agreement, claims for services provided to Medicare Cost Members must first be submitted to the Centers for Medicare and Medicaid Services (CMS). All secondary claims may be submitted via EDI for Coordination of Benefits (COB). In most cases an EOB/EOMB from the primary payor (CMS) is not required and will be requested by KP only if necessary.
5.4 **Paper Claims**

5.4.1 **Submission of Paper Claims**

Unless otherwise indicated on the written Authorization for Medical Care or Patient Transfer Referral form, claims for referred services should be sent to:

**Kaiser Referral Invoice Service Center (RISC)**
2829 Watt Avenue, Suite #130
Sacramento, CA 95821
Phone: 1-888-420-6222

Claims for **DME, SNF, Home Health, and Hospice** Services should be sent to:

**KP Continuum Claims Processing Center**
320 Lennon Lane
Walnut Creek, CA 94598
Phone: 1-800-337-0115

Claims as part of a **transplant** case should be sent to:

**Kaiser Permanente**
Transplant Claims Processing Unit
1950 Franklin St., 16th Floor
Oakland, CA 94612

5.4.1.1 **Calling KP Regarding Referred Services Claims**

For claims submission requirements or claims status inquiries regarding referred services, you may contact KP by calling **(800) 390-3510.**

5.4.2 **Submission of Paper Claims – Emergency Services**

Claims for emergency services for Members should be sent to:

**Kaiser Foundation Health Plan, Inc.**
National Claims Administration
P.O. Box 12923
Oakland, CA 94604-2923
Claims for emergency services provided to Members may be physically delivered (e.g., by courier) to:

Kaiser Foundation Health Plan, Inc.
National Claims Administration
1800 Harrison Street, 12th Floor
Oakland, CA 94612

5.4.2.1 Calling KP Regarding Emergency Claims

For submission requirements or status inquiries regarding claims for emergency services, you may contact KP by calling (800) 390-3510.

5.4.3 Supporting Documentation for Paper Claims

In general, the Provider must submit, in addition to the applicable billing form, all supporting documentation and information that is reasonably relevant and necessary to determine payment. At a minimum, supporting documentation that may be reasonably relevant may include the following, to the extent applicable to the services provided:

- Authorization if necessary
- Admitting face sheet
- Discharge summary
- Operative report(s)
- Emergency room records with respect to all emergency services
- Treatment and visit notes as reasonably relevant and necessary to determine payment
- A physician report relating to any claim under which a physician is billing a CPT-4 code with a modifier, demonstrating the need for the modifier
- A physician report relating to any claim under which a physician is billing an “Unlisted Procedure”, a procedure or service that is not listed in the current edition of the CPT codebook
- Physical status codes and anesthesia start and stop times whenever necessary for anesthesia services
- Therapy logs showing frequency and duration of therapies provided for SNF services

Under certain circumstances, KP is required by law to report and verify appropriate supporting documentation for Member diagnoses, in accordance with industry-standard coding rules and practices. As a result, KP may from time to time, in accordance with your Agreement, request that you provide, or cause to be provided by any subcontractors or other parties, copies of or access to (including on-site or remote access by KP personnel)
medical records, books, materials, notes, paper or electronic files, and any other items or data to verify appropriate documentation of the diagnoses and other information reflected on claims or invoices submitted to KP. It is expected that the medical records properly indicate the diagnoses in terms that comply with industry-standard coding rules and practices. Further, it is essential that access to, or copies of, this documentation is promptly provided, and in no event should you do so later than 5 Business Days after a request has been made, so that KP may make any necessary corrections and report to appropriate governmental programs in a timely fashion.

If additional documentation is deemed to be reasonably relevant information and/or information necessary to determine payment, we will notify you in writing.

5.4.4 Ambulance Services

Ambulance claims should be submitted directly to Employers Mutual Inc. (EMI). EMI accepts paper claims on the CMS-1500 (08/05) claim form at the following address:

EMI Attn: Kaiser Ambulance Claims
PO Box 853915
Richardson, TX  75085-3915

Customer Claims Service Department
Monday through Friday 8:00 am to 5:00 pm Pacific
1-888-505-0468

5.5 Submission of Electronic Claims

5.5.1 Electronic Data Interchange (EDI)

KP encourages Providers to submit electronic claims (837I/P transaction). Electronic claim transactions eliminate the need for paper claims. Electronic Data Interchange (EDI) is an electronic exchange of information in a standardized format that adheres to all Health Insurance Portability and Accountability Act (HIPAA) requirements. KP requires all EDI claims be HIPAA compliant.

For information or questions regarding EDI with KP call the NCAL EDI helpline (866) 285-0362.
5.5.2 Where to Submit Electronic Claims

Providers must submit their EDI claim via a clearinghouse. Clearinghouses frequently supply the required PC software to enable direct data entry in the Provider’s office. Providers may use their existing clearinghouse if their clearinghouse is able to forward the EDI to one of KP's direct clearinghouses.

Each clearinghouse assigns a unique identifier for KFHP. Payer IDs for KP’s direct clearinghouses are listed below:

<table>
<thead>
<tr>
<th>Clearinghouse</th>
<th>NCAL Payer IDs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capario</td>
<td>KS003</td>
</tr>
<tr>
<td>Emdeon</td>
<td>94135</td>
</tr>
<tr>
<td>Office Ally</td>
<td>94135</td>
</tr>
<tr>
<td>Relay Health</td>
<td>94135</td>
</tr>
<tr>
<td>SSI</td>
<td>94135</td>
</tr>
</tbody>
</table>

When a Provider sends an EDI claim to their clearinghouse, the clearinghouse receives the claim, may edit the data submitted by the Provider in order for it to be HIPAA compliant, and then sends it on to KP or one of KP’s direct clearinghouses.

5.5.3 EDI Claims Acknowledgement

When KP receives an EDI claim we transmit an electronic acknowledgement (277P transaction) back to the clearinghouse. This acknowledgement includes information about whether claim was accepted or rejected. The Provider's clearinghouse should forward this confirmation for all claims received or rejected by KP. Electronic claim acknowledgement reports also identify specific errors on rejected claims. Once the claims listed on the reject report are corrected, the Provider may resubmit these claims electronically. Providers are responsible for reviewing clearinghouse acknowledgment reports. If the Provider is unable to resolve EDI claim errors they may submit a paper claim.

NOTE: If you are not receiving electronic claim receipts from the clearinghouse, contact your clearinghouse to request them.

5.5.4 Supporting Documentation for Electronic Claims

If submitting claims electronically, the 837 transaction contains data fields to house supporting documentation through free-text format (exact system data field within your billing application varies). If supporting documentation is required to process an EDI claim, KP will request the supporting documentation and let you know where to send the information.
5.5.5 HIPAA Requirements

All electronic claim submissions must adhere to all HIPAA requirements. The following websites (listed in alphabetical order) include additional information on HIPAA and electronic loops and segments. HIPAA Implementation Guides can also be ordered by calling Washington Publishing Company (WPC) at (301) 949-9740.


5.6 Complete Claim

You are required to submit “complete claims” as defined in 28 CCR 1300.71(a)(2) for the services provided. A “complete claim” must include the following information, as applicable:

- **Correct Form**: All professional claims should be submitted using the CMS-1500 and all facility claims (or appropriate ancillary services) should be submitted using the UB-04 based on CMS guidelines.
- **Standard Coding**: All fields should be completed using industry standard coding, including the use of ICD-10 code sets for outpatient dates of service and inpatient discharge dates on/after October 1, 2015.
- **Applicable Attachments**: Attachments should be included in the submission when circumstances require additional information.
- **Completed Field Elements for CMS-1500 or UB-04**: All applicable data elements of CMS forms should be completed.

In addition, depending on the claim, additional information may be necessary if it is “reasonably relevant information” and “information necessary to determine payer liability” (as each such term is defined in 28 CCR 1300.71(a)(10) and (11)).

A claim is not considered to be complete or payable if one or more of the following exists:

- The format used in the completion or submission of the claim is missing required fields or codes are not active
- The eligibility of a Member cannot be verified
- The service from and to dates are missing
- The rendering Provider information is missing
- The billing Provider is missing
- The diagnosis is missing or invalid
- The place of service is missing or invalid
- The procedures/services are missing or invalid
• The amount billed is missing or invalid
• The number of units/quantity is missing or invalid
• The type of bill, when applicable, is missing or invalid
• The responsibility of another payor for all or part of the claim is not included or sent with the claim
• Other coverage has not been verified
• Additional information is required for processing such as COB information, operative report or medical notes (these will be requested upon denial or pending of claim)
• The claim was submitted fraudulently

NOTE: Failure to include all information will result in a delay in claim processing and payment and will be returned for any missing information. A claim missing any of the required information will not be considered a complete claim.

For further information and instruction on completing claims forms, please refer to the CMS website (www.cms.hhs.gov), where manuals for completing both the CMS-1500 and UB-04 can be found in the “Regulations and Guidance/Manuals” section.

5.7 Claims Submission Timeframes

Claims for services provided to Members should be submitted for payment within 90 days of such service. However, all claims and encounter data should be sent to the appropriate address no later than 180 days (or any longer period specified in your Agreement or required by law) after the date of service or date of discharge, as applicable.

To the extent required by law, claims that are denied because they are filed beyond the applicable claims filing deadline shall, upon a Provider’s submission of a provider dispute notice as described in Section 6 of this Provider Manual and the demonstration of good cause for the delay, be accepted and adjudicated in accordance with the applicable claims adjudication process.

5.8 Proof of Timely Claims Submission

Claims submitted for consideration or reconsideration of timely filing must be reviewed with information that indicates the claim was initially submitted within the appropriate time frames. KP will consider system generated reports that indicate the original date of claim submission. Please note that handwritten or typed documentation is not acceptable proof of timely filing.
Section 5: Billing and Payment

5.9 Claims Receipt Verification and Status

There are 2 methods to verify that KP has received your claim. There are two methods to verify that KP has received your claim. When KP receives an EDI claim we transmit an electronic acknowledgement (277P transaction) back to the clearinghouse. This acknowledgement includes information about whether claim was accepted or rejected. Your clearinghouse should forward this confirmation for all claims received or rejected by KP. Electronic claim acknowledgement reports also identify specific errors on rejected claims. For paper claims, you can obtain acknowledgment of receipt by calling our Member Services Contact Center. During that call, the representative will be able to tell you the date the claim was received and the KP identification number assigned to your claim should you need to contact us again regarding some aspect of the claim’s status. Please allow at least 15 Business Days after you submit your paper claim before telephoning to verify our receipt.

5.10 Claim Corrections

A claim correction can be submitted via the following procedures:

Paper Claims - Write “CORRECTED CLAIM” in the top (blank) portion of the CMS-1500 or UB-04 claim form. Attach a copy of the corresponding page of the Explanation of Payment (EOP) to each corrected claim. Mail the corrected claim(s) to the appropriate address at KP.

- When lost claims are subsequently replaced by a copy, claims should be boldly marked “DUPLICATE CLAIM” or “TRACER”. To reduce unnecessary paperwork and expense in the billing office, please do not submit follow-up/tracer claims until 60 days after the original claim was mailed, not from the date the services were rendered. When follow-up claims are submitted prior to this time, in addition to the work created for the Provider’s office, KP must spend time reviewing duplicate claims. This can result in unnecessary payment delays. Additionally, pursue follow-up/tracer claims submitted if the claim is not resolved timely.

- Late charges (late posting of billed charges) must be submitted with appropriate documentation, including the following: copy of late charges and itemized statement; copy of the original itemized statement; claim for late charges, and medical records associated with late charges.

Electronic Claims (CMS 1500) - Corrections to CMS-1500 claims that were already accepted (regardless whether these claims were submitted on paper or electronically) should be re-submitted on paper claim forms only. If corrected claims for CMS-1500 are submitted electronically, Providers should contact KP to identify the corrected claim electronic submission. Corrections submitted electronically may inadvertently be denied as a duplicate claim.

Electronic Claims (UB-04) - Please include the appropriate Type of Bill code when electronically submitting a corrected UB-04 claim for processing. IMPORTANT: Claims submitted without the appropriate 3rd digit (xxx) in the “Type of Bill” code may be denied.
5.11 Incorrect Claims Payments

Most questions regarding claim payments can be resolved quickly over the phone. Contact KP at the number indicated on the Explanation of Payment (EOP) to discuss any questions you have on the payments made. The Member Services Contact Center (888) 576-6789 can also assist with all claims payment inquiries.

5.11.1 Underpayments

If an underpayment has been confirmed, KP will issue a supplemental payment to the Provider. See also Section 5.10 of this Provider Manual.

5.11.2 Overpayments

5.11.2.1 Overpayment Identified by Provider

If you receive an overpayment directly from KP or as a result of coordination of benefits, you must notify KP promptly upon discovery and return the overpayment to the appropriate address below as soon as possible.

- You may return the original, KP-issued check, the EOP, and a note regarding the erroneous payment to KP and a check will be reissued less the erroneous payment, or
- You may issue a refund check payable to Kaiser Permanente and return it to the address listed below along with a copy of the EOP and a note explaining the erroneous payment

Please include the following information when returning uncontested overpayments:

- Name of each Member who received care for which an overpayment was received
- Copy of each applicable remittance advice
- Each applicable Member’s MRN
- Authorization number(s) for all applicable non-emergency services

To return overpayments for referred (non-emergency) services, either send the original, KP-issued check to:

Kaiser Permanente
TPMG Claims Referral Refund, NCAL
P.O. Box 743375
Los Angeles, CA 90074-3375
or, send your **Provider-issued refund check** to:

Kaiser Permanente  
Attn: TPMG Claims Operations, NCAL  
1950 Franklin St. 16th floor  
Oakland, CA 94612

To return overpayments for **emergency services**, either send the **original, KP-issued check** to:

KP National Claims Administration  
1800 Harrison Street, 12th Floor  
Oakland, CA 94612

or, send your **Provider-issued refund check** to:

KP Claims Recovery, NCAL  
P.O. Box 742120  
Los Angeles, CA 90074-2120

### 5.11.2.2 Overpayment Identified by KP

If KP determines that we have overpaid a claim, we will notify you in writing through a separate notice clearly identifying the claim, the name of the patient, the date(s) of service and a clear explanation of the basis upon which we believe the amount paid on the claim was in excess of the amount due. The refund request will include interest and penalties on the claim where applicable.

### 5.11.2.3 Contested Notice

If you contest our notice of overpayment of a claim, we ask that you send us a letter within 30 Business Days of your receipt of the notice of overpayment to the address indicated by KP in the notice of overpayment. Such letter should include the basis upon which you believe that the claim was not overpaid. If your contest notice to KP does not include the basis upon which you believe the claim was not overpaid, then that basis must be provided in writing no more than 365 calendar days following your initial receipt of the KP notice of overpayment. We will process the completed letter of contest in accordance with the KP payment dispute resolution process described in this Provider Manual.

### 5.11.2.4 No Contest

If you do not contest our notice of overpayment of a claim, you must reimburse us within 30 Business Days of your receipt of our notice of overpayment of a claim. Interest will begin to accrue at the rate of 10% percent per annum on the amount due beginning with the first business day following the initial 30 business day period.
5.11.2.5 Offset to Payments

We will only offset an uncontested notice of overpayment of a claim against a Provider’s current claim submission when: (i) the Provider fails to reimburse KP within the timeframe set forth above, and (ii) KP’s contract with the Provider specifically authorizes KP to offset an uncontested overpayment of a claim from the Provider’s current claims submissions or KP has obtained other written offset authorization from the Provider. In the event that an overpayment of a claim or claims is offset, we will supply you with a detailed written explanation identifying the specific overpayment(s) that have been offset against the specific current claim(s).

5.11.3 Inconsistent Payments

If you identify a consistent and large number of tracer/follow-up claims or payment errors every month, a potential problem in the workflow/processing cycle—whether in the billing process or payment operation—may exist.

If the payment issue involves claims submitted for Referred Services, contact the Referral Coordinator or Outside Services Case Manager at the referring KP facility.

If the payment issues involve claims submitted for Emergency Services, contact National Claims Administration.

The responsible department will work with the Provider’s office to identify and correct the source of the problem. Before contacting KP in either of these situations, please consider the following items in the Provider’s billing process:

- Are the original claims being submitted in a timely fashion?
- Are follow-up dates based on the date the original claim was mailed to KP versus the date-of-service?
- Have all payments been posted to patient accounts?
- Is the information (health plan, patient name, etc.) correct on the claim?
- Did the payment received match the expected reimbursement rate?
5.12 **Member Cost Share**

Please verify applicable Member Cost Share at the time of service by contacting Member Services. Depending on the benefit plan, Members may be responsible to share some cost of the services provided. Co-payments, co-insurance and deductibles (collectively, “Member Cost Share”) are the fees a Member is responsible to pay a Provider for certain covered services. Member Cost Share information varies by plan and can be obtained from:

<table>
<thead>
<tr>
<th>KP Claims and Referrals Member Services</th>
<th>(800) 390-3510</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday - Friday from 8 A.M. to 5 P.M.</td>
<td>Pacific Time Zone (PT)</td>
</tr>
<tr>
<td>Self-Service is available in the IVR System</td>
<td>(888) 576-6789</td>
</tr>
<tr>
<td>24 hours / 7 days a week</td>
<td></td>
</tr>
</tbody>
</table>

Please be aware KP maintains Online Affiliate, an online resource for lookup of Members’ eligibility and benefits. For additional information on this option, please contact our Provider Relations Department

- Providers are responsible for collecting Member Cost Share as explicitly required by your Agreement and in accordance with Member benefits
- Claims submitted by Providers who are responsible for collecting Member Cost Share will be paid at the applicable rate(s) under your Agreement, less the applicable Member Cost Share amount due from the Member
- You must not waive any Member Cost Share you are required to collect, except as expressly permitted under applicable law and your Agreement
- When a Medicare Advantage Member is also enrolled in Medi-Cal (or another State’s Medicaid program) and any such Medicaid program is responsible for the Member’s Medicare Advantage Cost Share, Providers should either accept payment pursuant to their Agreement as payment in full or bill the applicable Medicaid program for the Member’s Cost Share. In no event should you bill the Member for the Member Cost Share under these circumstances
5.13 Billing for Service Provided to Visiting Members

The claim submission process for services provided to Members visiting from other KP regions is the same as for all other Members. Reimbursement for visiting Members will reflect the visiting Member's benefits.

NOTE: At least the MRN displayed on the Health ID Card must be identified on the submitted claim.

5.14 Coding for Claims

It is the Provider’s responsibility to ensure that billing codes used on claim forms are current and accurate, that codes reflect the services provided and they are in compliance with KP’s coding standards. Incorrect and invalid coding may result in delays in payment or denial of payment. All coding must follow commonly accepted standards adopted by KP, including those specified in Section 5.15 below. Claims that use nonstandard, outdated or deleted CPT, HCPCS, ICD-10, or Revenue codes or are otherwise outside the coding standard adopted by KP will be subject to processing delay and/or rejection.

5.15 Coding Standards

All fields should be completed using industry standard coding as outlined below, as applicable.

ICD-10
To code diagnoses and hospital procedures on inpatient claims, use the International Classification of Diseases- 10th Revision-Clinical Modification (ICD-10-CM) and International Classification of Diseases – 10th Revision – Procedure Coding System (ICD-10-PCS) maintained by the ICD-10-CM and ICD-10-PCS Coordination and Maintenance Committee which includes the 4 cooperating parties: the American Hospital Association (AHA), the CMS, the National Center for Health Statistics (NCHS) and the American Health Information Management Association (AHIMA). ICD-10-CM codes appear as three-, four-, five-, six-, or seven-digit codes, depending on the specific disease or injury being described. ICD-10-PCS hospital inpatient procedure codes appear as seven-digit codes.

CPT-4
The Physicians’ Current Procedural Terminology (CPT), Fourth Edition code set is a systematic listing and coding of procedures and services performed by Providers. CPT codes are developed by the American Medical Association (AMA). Each procedure code or service is identified with a five-digit code.

HCPCS
The Health Care Common Procedure Coding System (HCPCS) Level 2 identifies services
and supplies. HCPCS Level 2 begin with letters A–V and are used to bill services such as home medical equipment, ambulance, orthotics and prosthetics, drug codes and injections.

Revenue Code
Consult your NUBC UB-04 Data Specifications Manual for a complete listing.

NDC (National Drug Codes)
Codes for prescribed drugs, maintained and distributed by the U.S. Department of Health and Human Services

ASA (American Society of Anesthesiologists)
Anesthesia services, the codes maintained and distributed by the American Society of Anesthesiologists

DSM-IV (American Psychiatric Services)
For psychiatric services, codes distributed by the American Psychiatric Association

5.16 **Modifiers Used in Conjunction with CPT and HCPCS Codes**

Modifiers submitted with an appropriate procedure code further define and/or explain a service provided. Valid modifiers and their descriptions can be found in the most current CPT or HCPCS coding book. When submitting claims, assign modifiers according to the current CPT guidelines.

5.17 **Modifier Review**

KP will review modifier usage based on CPT guidelines. Providers are required to use modifiers according to standards and codes set forth in CPT manuals.

KP reserves the right to review use of modifiers to ensure accuracy and appropriateness. Improper use of modifiers may cause claims to be pended and/or returned for correction.

5.18 **Claims Adjustments, Coding & Billing Validation**

KP reviews codes and adjusts claims in accordance with your Agreement, the provisions below, and applicable law.

Claims adjustments are made in connection with claims review, as described in more detail below, and as otherwise set forth in your Agreement.

If you believe we have made an incorrect adjustment to a claim that has been paid, please contact the office that issued the payment identified on the remittance advice and EOP. Staff at the office can explain how the payment was computed and can make payment adjustments, if required. Additionally, you may refer to Section 6.2 of this Provider Manual for information on how to dispute such adjustment. When submitting the dispute
resolution documentation, please clearly state the reason(s) you believe the claim adjustment was incorrect.

### 5.18.1 Claims Review

Billed items will be reviewed and/or corrected as described in your Agreement and as permitted by applicable law. Final payment will be based on such reviewed (and, if necessary, corrected) information.

### 5.18.2 Code Review

The terms of your Agreement govern the amount of payment for services provided under your Agreement. The following general rules apply to our payment policies.

KP’s claims payment policies for provider services generally follow industry standards as defined by the American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS). Our claims adjudication systems accept and identify all active CPT and HCPCS codes as well as all coding modifiers. We use Medicare’s parameters to define global surgery periods. When necessary to clarify billed charges, supporting documentation is requested and, in addition, we request procedure reports for bills with “unlisted” procedure codes and the application of Modifier 26.

We do not allow code unbundling for procedures for which Medicare requires all-inclusive codes and we will re-bundle the procedures and pay according to Medicare’s all-inclusive codes.

Payment for services such as multiple procedures, bilateral procedures, assistant surgeons, and co-surgeons and application of modifiers are adjudicated in accordance with CMS guidelines. Billing as a co-surgeon with Modifier 62 or for increased services with Modifier 22 requires submission of a separate operative report.

KP will not reimburse for any professional component of clinical diagnostic laboratory services, such as automated laboratory tests, billed with a Modifier 26 code, whether performed inside or outside of the hospital setting; provided that (consistent with CMS payment practices), reimbursement for such services, if any, is included in the payment to the appropriate facility responsible for providing the laboratory services.
### 5.18.3 Coding Edit Rules

The table below identifies common edit rules.

<table>
<thead>
<tr>
<th>Edit Category</th>
<th>Description</th>
<th>Edit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rebundling</td>
<td>Use a single comprehensive CPT code when 2 or more codes are billed</td>
<td>Apply</td>
</tr>
<tr>
<td>Incidental</td>
<td>Procedure performed at the same time as a more complex primary procedure</td>
<td>Deny if procedure deemed to be incidental</td>
</tr>
<tr>
<td></td>
<td>Procedure is clinically integral component of a global service</td>
<td>Deny if procedure deemed to be incidental</td>
</tr>
<tr>
<td></td>
<td>Procedure is needed to accomplish the primary procedure</td>
<td>Deny if procedure deemed to be incidental</td>
</tr>
<tr>
<td>Mutually Exclusive</td>
<td>Procedures that differ in technique or approach but lead to the same outcome</td>
<td>Deny procedure that is deemed to be mutually exclusive</td>
</tr>
<tr>
<td>Duplicate Procedures</td>
<td>Category I--Bilateral: Shown twice on submitted claim</td>
<td>Allow one procedure per date of service; second procedure denied</td>
</tr>
<tr>
<td></td>
<td>Category II- Unilateral/Bilateral shown twice on submitted claim</td>
<td>Allow only one procedure per date of service; second procedure denied</td>
</tr>
<tr>
<td></td>
<td>Category III- Unilateral/single CPT shown twice</td>
<td>Replace with corresponding Bilateral or multiple code</td>
</tr>
<tr>
<td></td>
<td>Category IV- Limited by date of service, lifetime or place of service</td>
<td>Allow/deny based on Plan's Allowable Limits</td>
</tr>
<tr>
<td>Medical Visits/Pre- &amp; Post-Op Visits</td>
<td>Based on Surgical Package guidelines; Audits across dates</td>
<td>Deny E&amp;M services within Pre- and Post-op Timeframe</td>
</tr>
<tr>
<td>Cosmetic</td>
<td>Identifies procedures requiring review to determine if they were performed for cosmetic reasons only</td>
<td>Review for medical necessity</td>
</tr>
<tr>
<td>Experimental</td>
<td>Codes defined by CMS and AMA in CPT and HCPCS manuals to be experimental</td>
<td>Pend for Review</td>
</tr>
<tr>
<td>Obsolete</td>
<td>Procedures no longer performed under prevailing medical standards</td>
<td>Review for medical necessity</td>
</tr>
</tbody>
</table>

### 5.18.4 Clinical Review

In addition to code review, claims may be reviewed by a physician or other appropriate clinician.
5.18.5 Compensation Methodologies

Depending on your specific Agreement provisions, KP utilizes various compensation methodologies including, but not limited to case rates, fee schedules, the Average Wholesale Price from the most recently published Red Book by Thomson Healthcare, and/or Medicare guidelines. KP calculates anesthesia units in 15 minute increments. KP also uses Medicare Prospective Payment System (PPS) rates. Notwithstanding the effective date of any rate or rate exhibit to the Agreement, and unless provided otherwise in the Agreement, inpatient services for which the episode of care spans multiple days are generally paid in accordance with the rate(s) in effect on the date the episode began (i.e. the admit date or first date of service). This may include application of compensation methodologies such as per diems, percentage of charges, case rates, etc. Outpatient services are generally paid in accordance with the applicable rate in effect on the date of service. Please refer to your Agreement for more detailed information on the reimbursement method that applies to you.

5.18.6 Do Not Bill Events (DNBE)

Depending on the terms of your Agreement, you may not be compensated for Services directly related to any Do Not Bill Event (as defined below) and may be required to waive Member Cost Share associated with, and hold Members harmless from, any liability for services directly related to any DNBE. KP expects you to report every DNBE as set forth in Section 9.5.5 of this Provider Manual. KP will reduce compensation for services directly related to a DNBE when the value of such services can be separately quantified in accordance with the applicable payment methodology. DNBE shall mean the following:

In any care setting, the following surgical errors identified by CMS in its National Coverage Determination issued June 12, 2009¹ (SE):

- Wrong surgery or invasive procedure² on patient
- Surgery or invasive procedure on wrong patient
- Surgery or invasive procedure on wrong body part

² ‘Surgical and other invasive procedures’ is defined by CMS as “operative procedures in which skin or mucous membranes and connective tissue are incised or an instrument is introduced through a natural body orifice. ‘Invasive procedures’ include a “range of procedures from minimally invasive dermatological procedures (biopsy, excision, and deep cryotherapy for malignant lesions) to extensive multi-organ transplantation. They include all procedures described by the codes in the surgery section of the Current Procedural Terminology (CPT) and other invasive procedures such as percutaneous transluminal angioplasty and cardiac catheterization. They include minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through needle or trocar.”
Specifically in an acute care hospital setting, the following hospital acquired conditions initially identified by CMS on August 19, 2008\(^3\) and later expanded (together, with RFO-HAC, as defined below (HACs)) if not present upon admission:

- Intravascular air embolism
- Blood incompatibility (hemolytic reaction due to administration of ABO/HLA incompatible blood or blood products)
- Pressure ulcer (stage three or four)
- Falls and trauma (fracture, dislocation, intracranial injury, crushing injury, burn, electric shock)
- Catheter-associated urinary tract infection
- Vascular catheter-associated infection
- Manifestation of poor glycemic control (diabetic ketoacidosis, nonketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, secondary diabetes with hyperosmolarity)
- Surgical site infection, mediastinitis, following coronary artery bypass graft
- Surgical site infection following orthopedic procedures (spine, neck, shoulder, elbow)
- Surgical site infection following bariatric surgery for obesity (laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery)
- Deep vein thrombosis or pulmonary embolism following orthopedic procedures (total knee or hip replacement)
- Any new Medicare fee-for-service HAC later added by CMS

In any care setting, the following HAC if not present on admission for inpatient services or if not present prior to provision of other Services (RFO-HAC):

- Removal (if medically indicated) of foreign object retained after surgery

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5.18.7 Claims for Do Not Bill Events

You must submit Claims for Services directly related to a DNBE according to the following requirements and in accordance with the other terms of your Agreement and this Provider Manual related to Claims.

- **CMS 1500** – If you submit a CMS 1500 Claim (or its successor) for any inpatient or outpatient professional Services provided to a Member wherein a SE or RFO-HAC has occurred, you must include the applicable ICD-10 codes and modifiers as set forth in the following table and as otherwise required for the Medicare fee-for-service program.

- **UB-04** – If you submit a UB-04 Claim (or its successor) for inpatient or outpatient facility Services provided to a Member wherein a HAC (Including a RFO-HAC) has occurred, you must include the following information:
  - **DRG.** If, under the terms of your Agreement, such Services are reimbursed on a DRG basis, you must include the applicable ICD-10 codes, present on admission indicators, and modifiers as set forth in the following table and as otherwise required for the Medicare fee-for-service program.
  - **Other Payment Methodologies.** If, under the terms of your Agreement, such Services are reimbursed on a payment methodology other than a DRG and the terms of your Agreement state that you will not be compensated for Services directly related to a DNBE, you must split the Claim and submit both a Type of Bill (TOB) ‘110’ (no-pay bill) setting forth all Services directly related to the DNBE including the applicable ICD-10 codes, present on admission indicators, and modifiers as set forth in the following table and as otherwise required for the Medicare fee-for-service program, and a TOB ‘11X (with the exception of 110)’ setting forth all Covered Services not directly related to the DNBE.

Completion of the Present on Admission (POA) field is required on all primary and secondary diagnoses for inpatient Services for all bill types. Any condition labeled with a POA indicator other than ‘Y’ shall be deemed hospital-acquired. All claims must utilize the applicable HCPCS modifiers with the associated charges on all lines related to the surgical error, as applicable.

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4 POA Indicators: ‘Y’ means diagnosis was present at time of inpatient admission, ‘N’ means diagnosis was not present at time of inpatient admission, ‘U’ means documentation insufficient to determine if condition present at time of inpatient admission, and ‘W’ means provider unable to clinically determine whether condition present at time of inpatient admission. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are deemed present on admission. However, if such an outpatient event causes, or increases the complexity or length of stay of, the immediate inpatient admission, the charges associated with the Services necessitated by the outpatient event may be denied.

## 5.19 CMS-1500 (02/12) Field Descriptions

The fields identified in the table below as “Required” must be completed when submitting a CMS-1500 (02/12) claim form for processing:

<table>
<thead>
<tr>
<th>Field Number</th>
<th>Field Name</th>
<th>Required Fields for Claim Submissions</th>
<th>Instructions/Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>MEDICARE/ MEDICAID/ TRICARE / CHAMPVA/ GROUP HEALTH PLAN/FECA BLK LUNG/OTHER</td>
<td>Not Required</td>
<td>Check the type of health insurance coverage applicable to this claim by checking the appropriate box.</td>
</tr>
<tr>
<td>1a</td>
<td>INSURED’S I.D. NUMBER</td>
<td>Required</td>
<td>Enter the patient’s Kaiser Permanente Medical Record Number (MRN)</td>
</tr>
<tr>
<td>2</td>
<td>PATIENT’S NAME</td>
<td>Required</td>
<td>Enter the patient’s name. When submitting newborn claims, enter the newborn’s first and last name.</td>
</tr>
<tr>
<td>3</td>
<td>PATIENT’S BIRTH DATE AND SEX</td>
<td>Required</td>
<td>Enter the patient’s date of birth and gender. The date of birth must include the month, day and FOUR DIGITS for the year (MM/DD/YYYY). Example: 01/05/2006</td>
</tr>
<tr>
<td>4</td>
<td>INSURED’S NAME</td>
<td>Required</td>
<td>Enter the name of the insured, i.e., policyholder (Last Name, First Name, and Middle Initial), unless the insured and the patient are the same—then the word “SAME” may be entered.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If this field is completed with an identity different than that of the patient, also complete Field 11.</td>
</tr>
<tr>
<td>5</td>
<td>PATIENT’S ADDRESS</td>
<td>Required</td>
<td>Enter the patient’s mailing address and telephone number. On the first line, enter the STREET ADDRESS; the second line is for the CITY and STATE; the third line is for the nine digits ZIP CODE and PHONE NUMBER.</td>
</tr>
<tr>
<td>6</td>
<td>PATIENT’S RELATIONSHIP TO INSURED</td>
<td>Required</td>
<td>Check the appropriate box for the patient’s relationship to the insured.</td>
</tr>
<tr>
<td>7</td>
<td>INSURED’S ADDRESS</td>
<td>Required if Applicable</td>
<td>Enter the insured’s address (STREET ADDRESS, CITY, STATE, and nine digits ZIP CODE) and telephone number. When the address is the same as the patient’s—the word “SAME” may be entered.</td>
</tr>
<tr>
<td>8</td>
<td>RESERVED FOR NUCC USE</td>
<td>Not Required</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>9</td>
<td>OTHER INSURED’S NAME</td>
<td>Required if Applicable</td>
<td>When additional insurance coverage exists, enter the last name, first name and middle initial of the insured.</td>
</tr>
<tr>
<td>Field Number</td>
<td>Field Name</td>
<td>Required Fields for Claim Submissions</td>
<td>Instructions/Examples</td>
</tr>
<tr>
<td>--------------</td>
<td>------------</td>
<td>--------------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>9a</td>
<td>OTHER INSURED’S POLICY OR GROUP NUMBER</td>
<td>Required if Applicable</td>
<td>Enter the policy and/or group number of the insured individual named in Field 9 (Other Insured’s Name) above. NOTE: For each entry in Field 9a, there must be a corresponding entry in Field 9d.</td>
</tr>
<tr>
<td>9b</td>
<td>RESERVED FOR NUCC USE</td>
<td>Not Required</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>9c</td>
<td>RESERVED FOR NUCC USE</td>
<td>Not Required</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>9d</td>
<td>INSURANCE PLAN NAME OR PROGRAM NAME</td>
<td>Required if Applicable</td>
<td>Enter the name of the “other” insured’s INSURANCE PLAN or program.</td>
</tr>
<tr>
<td>10a-c</td>
<td>IS PATIENT’S CONDITION RELATED TO</td>
<td>Required</td>
<td>Check “Yes” or “No” to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. NOTE: If “yes” there must be a corresponding entry in Field 14 (Date of Current Illness/Injury). Place (State) - enter the State postal code.</td>
</tr>
<tr>
<td>10d</td>
<td>CLAIM CODES (Designated by NUCC)</td>
<td>Not Required</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>11</td>
<td>INSURED’S POLICY NUMBER OR FECA NUMBER</td>
<td>Required if Applicable</td>
<td>Enter the insured’s policy or group number.</td>
</tr>
<tr>
<td>11a</td>
<td>INSURED’S DATE OF BIRTH</td>
<td>Required if Applicable</td>
<td>Enter the insured’s date of birth and sex, if different from Field 3. The date of birth must include the month, day, and FOUR digits for the year (MM/DD/YYYY). Example: 01/05/2006</td>
</tr>
<tr>
<td>11b</td>
<td>OTHER CLAIM ID (Designated by NUCC)</td>
<td>Not Required</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>11c</td>
<td>INSURANCE PLAN OR PROGRAM NAME</td>
<td>Required if Applicable</td>
<td>Enter the insured’s insurance plan or program name.</td>
</tr>
<tr>
<td>11d</td>
<td>IS THERE ANOTHER HEALTH BENEFIT PLAN?</td>
<td>Required</td>
<td>Check “yes” or “no” to indicate if there is another health benefit plan. For example, the patient may be covered under insurance held by a spouse, parent, or some other person. If “yes” then fields 9 and 9a-d must be completed.</td>
</tr>
<tr>
<td>Field Number</td>
<td>Field Name</td>
<td>Required Fields for Claim Submissions</td>
<td>Instructions/Examples</td>
</tr>
<tr>
<td>--------------</td>
<td>--------------------------------------------------------</td>
<td>---------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>12</td>
<td>PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE</td>
<td>Required if Applicable</td>
<td>Have the patient or an authorized representative SIGN and DATE this block, unless the signature is on file. If the patient’s representative signs, then the relationship to the patient must be indicated.</td>
</tr>
<tr>
<td>13</td>
<td>INSURED’S OR AUTHORIZED PERSON’S SIGNATURE</td>
<td>Required</td>
<td>Have the patient or an authorized representative SIGN this block, unless the signature is on file.</td>
</tr>
<tr>
<td>14</td>
<td>DATE OF CURRENT ILLNESS, INJURY, PREGNANCY (LMP)</td>
<td>Required if Applicable</td>
<td>Enter the date of the current illness or injury. If pregnancy, enter the date of the patient’s last menstrual period. The date must include the month, day, and FOUR DIGITS for the year (MM/DD/YYYY). Example: 01/05/2006</td>
</tr>
<tr>
<td>15</td>
<td>OTHER DATE</td>
<td>Not Required</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>16</td>
<td>DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</td>
<td>Not Required</td>
<td>Enter the “from” and “to” dates that the patient is unable to work. The dates must include the month, day, and FOUR DIGITS for the year (MM/DD/YYYY). Example: 01/05/2003</td>
</tr>
<tr>
<td>17</td>
<td>NAME OF REFERRING PHYSICIAN OR OTHER SOURCE</td>
<td>Required if Applicable</td>
<td>Enter the FIRST and LAST NAME of the KP referring or KP ordering physician.</td>
</tr>
<tr>
<td>17a</td>
<td>OTHER ID #</td>
<td>Not Required</td>
<td></td>
</tr>
<tr>
<td>17b</td>
<td>NPI NUMBER</td>
<td>Required</td>
<td>Enter the NPI number of the KP referring provider.</td>
</tr>
<tr>
<td>18</td>
<td>HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</td>
<td>Required if Applicable</td>
<td>Complete this block when a medical service is furnished as a result of, or subsequent to, a related hospitalization.</td>
</tr>
<tr>
<td>19</td>
<td>ADDITIONAL CLAIM INFORMATION (Designated by NUCC)</td>
<td>Not Required</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>20</td>
<td>OUTSIDE LAB CHARGES</td>
<td>Not Required</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>DIAGNOSIS OR NATURE OF ILLNESS OR INJURY</td>
<td>Required</td>
<td>Enter the diagnosis/condition of the patient, indicated by an ICD-10 code number. Enter up to 12 diagnosis codes, in PRIORITY order (primary, secondary condition). Enter the ICD indicator in the upper right corner of this field (“9”=ICD9; “0”=ICD10)</td>
</tr>
<tr>
<td>22</td>
<td>RESUBMISSION</td>
<td>Not Required</td>
<td></td>
</tr>
<tr>
<td>Field Number</td>
<td>Field Name</td>
<td>Required Fields for Claim Submissions</td>
<td>Instructions/Examples</td>
</tr>
<tr>
<td>--------------</td>
<td>---------------------------------</td>
<td>---------------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>23</td>
<td>PRIOR AUTHORIZATION NUMBER</td>
<td>Required if Applicable</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>For ALL inpatient and outpatient claims, enter the KP referral number, if applicable, for the episode of care being billed. NOTE: this is a 10-digit alphanumeric identifier.</td>
</tr>
<tr>
<td>24A-J</td>
<td>SUPPLEMENTAL INFORMATION</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Supplemental information can only be entered with a corresponding, completed service line. The top area of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 lines of service. When reporting additional anesthesia services information (e.g., begin and end times), narrative description of an unspecified code, NDC, VP – HIBCC codes, OZ – GTIN codes or contract rate, enter the applicable qualifier and number/code/information starting with the first space in the shaded line of this field. Do not enter a space, hyphen, or other separator between the qualifier and the number/code/information. The following qualifiers are to be used when reporting these services: 7 – Anesthesia information, ZZ – Narrative description of unspecified code, N4 – National Drug Codes (NDC), VP – Vendor Product Number Health Industry Business Communications Council (HIBCC) Labeling Standard, OZ – Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN), CTR – Contract rate.</td>
</tr>
<tr>
<td>Field Number</td>
<td>Field Name</td>
<td>Required Fields for Claim Submissions</td>
<td>Instructions/Examples</td>
</tr>
<tr>
<td>--------------</td>
<td>------------</td>
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<td>----------------------</td>
</tr>
<tr>
<td>24A</td>
<td>DATE(S) OF SERVICE</td>
<td>Required</td>
<td>Enter the month, day, and year (MM/DD/YY) for each procedure, service, or supply. Services must be entered chronologically (starting with the oldest date first). For each service date listed/billed, the following fields must also be entered: Units, Charges/Amount/Fee, Place of Service, Procedure Code, and corresponding Diagnosis Code. IMPORTANT: Do not submit a claim with a future date of service. Claims can only be submitted once the service has been rendered (for example: durable medical equipment).</td>
</tr>
<tr>
<td>24B</td>
<td>PLACE OF SERVICE</td>
<td>Required</td>
<td>Enter the place of service code for each item used or service performed.</td>
</tr>
<tr>
<td>24C</td>
<td>EMG</td>
<td>Required if Applicable</td>
<td>Enter Y for &quot;YES&quot; or leave blank if &quot;NO&quot; to indicate an EMERGENCY as defined in the electronic 837 Professional 4010A1 implementation guide.</td>
</tr>
<tr>
<td>24D</td>
<td>PROCEDURES, SERVICES, OR SUPPLIES: CPT/HCPCS, MODIFIER</td>
<td>Required</td>
<td>Enter the CPT/HCPCS codes and MODIFIERS (if applicable) reflecting the procedures performed, services rendered, or supplies used. IMPORTANT: Enter the anesthesia time, reported as the “beginning” and “end” times of anesthesia in military time above the appropriate procedure code.</td>
</tr>
<tr>
<td>24E</td>
<td>DIAGNOSIS POINTER</td>
<td>Required</td>
<td>Enter the diagnosis code reference number (pointer) as it relates the date of service and the procedures shown in Field 21. When multiple services are performed, the primary reference number for each service should be listed first, and other applicable services should follow. The reference number(s) should be a 1, or a 2…or a 12; or multiple numbers as explained. IMPORTANT: ICD-10 diagnosis codes must be entered in Item Number 21 only. Do not enter them in 24E.</td>
</tr>
<tr>
<td>Field Number</td>
<td>Field Name</td>
<td>Required Fields for Claim Submissions</td>
<td>Instructions/Examples</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------------------</td>
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<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| 24F          | $ CHARGES             | Required                              | Enter the FULL CHARGE for each listed service. Any necessary payment reductions will be made during claims adjudication (for example, multiple surgery reductions, maximum allowable limitations, co-pays etc).  
Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number. |
| 24G          | DAYS OR UNITS         | Required                              | Enter the number of days or units in this block. (For example: units of supplies, etc.)  
IMPORTANT: As noted in the instructions for Field Number 24D, enter the total anesthesia time in minutes, reported as the “beginning” and “end” times, in military.  
When entering the NDC units in addition to the HCPCS units, enter the applicable NDC ‘units’ qualifier and related units in the shaded line. The following qualifiers are to be used:  
F2 - International Unit  
ML - Milliliter  
GR – Gram  
UN – Unit  
ME – Milligram |
<p>| 24H          | EPSDT FAMILY PLAN     | Not Required                           |                                                                                                                                                                                                                      |</p>
<table>
<thead>
<tr>
<th>Field Number</th>
<th>Field Name</th>
<th>Required Fields for Claim Submissions</th>
<th>Instructions/Examples</th>
</tr>
</thead>
</table>
| 24I          | ID. QUAL                    | Required, if Applicable                | Enter the qualifier of the non-NPI identifier. The Other ID# of the rendering provider is reported in 24j in the shaded area. The NUCC defines the following qualifiers:  
0B - State License Number  
1B - Blue Shield Provider Number  
1C - Medicare Provider Number  
1D - Medicaid Provider Number  
1G - Provider UPIN Number  
1H - CHAMPUS Identification Number  
EI - Employer’s Identification Number  
G2 - Provider Commercial Number  
LU - Location Number  
N5 - Provider Plan Network Identification Number  
SY - Social Security Number (The social security number may not be used for Medicare.)  
X5 - State Industrial Accident Provider Number  
ZZ - Provider Taxonomy                                                                 |
| 24J          | RENDERING PROVIDER ID #     | Required if Applicable                 | Enter the non-NPI identifier in the shaded area of the field, if applicable. Enter the NPI number in the non-shaded area of the field, if applicable.  
Report the Identification Number in Items 24i and 24j only when different from data recorded in Fields 33a and 33b.                                                                                     |
| 25           | FEDERAL TAX ID NUMBER       | Required                               | Enter the physician/supplier federal tax I.D. number or Social Security number of the billing provider identified in Field 33. Enter an X in the appropriate box to indicate which number is being reported. Only one box can be marked.  
IMPORTANT: The Federal Tax ID Number in this field must match the information on file with the IRS.                                                                                                        |
| 26           | PATIENT’S ACCOUNT NO.       | Required                               | Enter the patient’s account number assigned by the Provider’s accounting system, i.e., patient control number.  
IMPORTANT: This field aids in patient identification by the Provider.                                                                                                                                         |
<p>| 27           | ACCEPT ASSIGNMENT           | Not Required                           |                                                                                                                                                                                                                        |</p>
<table>
<thead>
<tr>
<th>Field Number</th>
<th>Field Name</th>
<th>Required Fields for Claim Submissions</th>
<th>Instructions/Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>28</td>
<td>TOTAL CHARGE</td>
<td>Required</td>
<td>Enter the total charges for the services rendered (total of all the charges listed in Field 24f).</td>
</tr>
<tr>
<td>29</td>
<td>AMOUNT PAID</td>
<td>Required if Applicable</td>
<td>Enter amount paid by other payer. Do not report collections of patient cost share.</td>
</tr>
<tr>
<td>30</td>
<td>RESERVED FOR NUCC USE</td>
<td>Not Required</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>31</td>
<td>SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS</td>
<td>Required</td>
<td>Enter the signature of the physician/supplier or his/her representative, and the date the form was signed. For claims submitted electronically, include a computer printed name as the signature of the health care Provider or person entitled to reimbursement.</td>
</tr>
<tr>
<td>32</td>
<td>SERVICE FACILITY LOCATION INFORMATION</td>
<td>Required if Applicable</td>
<td>The name and address of the facility where services were rendered (if other than patient’s home or physician’s office). Enter the name and address information in the following format: 1st Line – Name 2nd Line – Address 3rd Line – City, State and Zip Code Do not use commas, periods, or other punctuation in the address (e.g., “123 N Main Street 101” instead of “123 N. Main Street, #101). Enter a space between town name and state code; do not include a comma. When entering a 9 digit zip code, include the hyphen.</td>
</tr>
<tr>
<td>32a</td>
<td>NPI #</td>
<td>Required if Applicable</td>
<td>Enter the NPI number of the service facility if it is an entity external to the billing provider.</td>
</tr>
<tr>
<td>32b</td>
<td>OTHER ID #</td>
<td>Required if Applicable</td>
<td>Enter the two digit qualifier identifying the non-NPI identifier followed by the ID number of the service facility. Do not enter a space, hyphen, or other separator between the qualifier and number.</td>
</tr>
<tr>
<td>33</td>
<td>BILLING PROVIDER INFO &amp; PH #</td>
<td>Required</td>
<td>Enter the name, address and phone number of the billing entity.</td>
</tr>
<tr>
<td>33a</td>
<td>NPI #</td>
<td>Required if Applicable</td>
<td>Enter the NPI number of the billing provider.</td>
</tr>
<tr>
<td>Field Number</td>
<td>Field Name</td>
<td>Required Fields for Claim Submissions</td>
<td>Instructions/Examples</td>
</tr>
<tr>
<td>--------------</td>
<td>---------------</td>
<td>--------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>33b</td>
<td>OTHER ID #</td>
<td>Required if Applicable</td>
<td>Enter the two digit qualifier identifying the non-NPI number followed by the ID number of the billing provider. Do not enter a space, hyphen, or other separator between the qualifier and number. If available, please enter your unique provider or vendor number assigned by KP.</td>
</tr>
</tbody>
</table>
**5.20 UB-04 (CMS-1450) Field Descriptions**

The fields identified in the table below as “Required” must be completed when submitting a UB-04 claim form for processing:

<table>
<thead>
<tr>
<th>Field Number</th>
<th>Field Name</th>
<th>Required Fields for Claim Submissions</th>
<th>Instructions/Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>PROVIDER NAME and ADDRESS</td>
<td>Required</td>
<td>Enter the name and address of the billing provider which rendered the services being billed.</td>
</tr>
<tr>
<td>2</td>
<td>PAY-TO NAME, ADDRESS, CITY/STATE, ID #</td>
<td>Required if Applicable</td>
<td>Enter the name and address of the billing provider’s designated pay-to entity.</td>
</tr>
<tr>
<td>3a</td>
<td>PATIENT CONTROL NUMBER</td>
<td>Required</td>
<td>Enter the patient’s account number assigned by the Provider’s accounting system, i.e., patient control number. IMPORTANT: This field aids in patient identification by the Provider.</td>
</tr>
<tr>
<td>3b</td>
<td>MEDICAL / HEALTH RECORD NUMBER</td>
<td>Required if Applicable</td>
<td>Enter the number assigned to the patient’s medical/health record by the Provider. Note: this is not the same as either Field 3a or Field 60.</td>
</tr>
<tr>
<td>4</td>
<td>TYPE OF BILL</td>
<td>Required</td>
<td>Enter the appropriate code to identify the specific type of bill being submitted. This code is required for the correct identification of inpatient vs. outpatient claims, voids, etc.</td>
</tr>
<tr>
<td>5</td>
<td>FEDERAL TAX NUMBER</td>
<td>Required</td>
<td>Enter the federal tax ID of the hospital or person entitled to reimbursement in NN-NNNNNNNN format.</td>
</tr>
<tr>
<td>6</td>
<td>STATEMENT COVERS PERIOD</td>
<td>Required</td>
<td>Enter the beginning and ending date of service included in the claim.</td>
</tr>
<tr>
<td>7</td>
<td>BLANK</td>
<td>Not Required</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>8</td>
<td>PATIENT NAME / ID</td>
<td>Required</td>
<td>Enter the patient’s name, together with the patient ID (if different than the insured’s ID).</td>
</tr>
<tr>
<td>9</td>
<td>PATIENT ADDRESS</td>
<td>Required</td>
<td>Enter the patient’s mailing address.</td>
</tr>
<tr>
<td>10</td>
<td>PATIENT BIRTH DATE</td>
<td>Required</td>
<td>Enter the patient’s birth date in MM/DD/YYYY format.</td>
</tr>
<tr>
<td>11</td>
<td>PATIENT SEX</td>
<td>Required</td>
<td>Enter the patient’s gender.</td>
</tr>
<tr>
<td>12</td>
<td>ADMISSION DATE</td>
<td>Required if Applicable</td>
<td>For inpatient and Home Health claims only, enter the date of admission in MM/DD/YYYY format.</td>
</tr>
<tr>
<td>13</td>
<td>ADMISSION HOUR</td>
<td>Required</td>
<td>For either inpatient OR outpatient care, enter the 2-digit code for the hour during which the patient was admitted or seen.</td>
</tr>
<tr>
<td>Field Number</td>
<td>Field Name</td>
<td>Required Fields for Claim Submissions</td>
<td>Instructions/Examples</td>
</tr>
<tr>
<td>--------------</td>
<td>----------------------------------</td>
<td>--------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>14</td>
<td>ADMISSION TYPE</td>
<td>Required</td>
<td>Indicate the type of admission (e.g. emergency, urgent, elective, and newborn).</td>
</tr>
<tr>
<td>15</td>
<td>ADMISSION SOURCE</td>
<td>Required</td>
<td>Enter the code for the point of origin of the admission or visit.</td>
</tr>
<tr>
<td>16</td>
<td>DISCHARGE HOUR (DHR)</td>
<td>Required if Applicable</td>
<td>Enter the two-digit code for the hour during which the patient was discharged.</td>
</tr>
<tr>
<td>17</td>
<td>PATIENT STATUS</td>
<td>Required</td>
<td>Enter the discharge status code as of the “Through” date of the billing period.</td>
</tr>
<tr>
<td>18-28</td>
<td>CONDITION CODES</td>
<td>Required if Applicable</td>
<td>Enter any applicable codes which identify conditions relating to the claim that may affect claims processing.</td>
</tr>
<tr>
<td>29</td>
<td>ACCIDENT (ACDT) STATE</td>
<td>Not Required</td>
<td>Enter the two-character code indicating the state in which the accident occurred which necessitated medical treatment.</td>
</tr>
<tr>
<td>30</td>
<td>BLANK</td>
<td>Not Required</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>31-34</td>
<td>OCCURRENCE CODES AND DATES</td>
<td>Required if Applicable</td>
<td>Enter the code and the associated date (in MM/DD/YYYY format) defining a significant event relating to this billing period that may affect claims processing.</td>
</tr>
<tr>
<td>35-36</td>
<td>OCCURRENCE SPAN CODES AND DATES</td>
<td>Required if Applicable</td>
<td>Enter the occurrence span code and associated dates (in MM/DD/YYYY format) defining a significant event relating to this billing period that may affect claims processing.</td>
</tr>
<tr>
<td>37</td>
<td>BLANK</td>
<td>Not Required</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>38</td>
<td>RESPONSIBLE PARTY</td>
<td>Not Required</td>
<td>Enter the name and address of the financially responsible party.</td>
</tr>
<tr>
<td>39-41</td>
<td>VALUE CODES and AMOUNT</td>
<td>Required if Applicable</td>
<td>Enter the code and related amount/value which is necessary to process the claim.</td>
</tr>
<tr>
<td>42</td>
<td>REVENUE CODE</td>
<td>Required</td>
<td>Identify the specific accommodation, ancillary service, or billing calculation, by assigning an appropriate revenue code to each charge.</td>
</tr>
<tr>
<td>43</td>
<td>REVENUE DESCRIPTION</td>
<td>Required if Applicable</td>
<td>Enter the narrative revenue description or standard abbreviation to assist clerical bill review.</td>
</tr>
<tr>
<td>44</td>
<td>PROCEDURE CODE AND MODIFIER</td>
<td>Required if Applicable</td>
<td>For ALL outpatient claims, enter BOTH a revenue code in Field 42 (Rev. CD.), and the corresponding CPT/HCPCS procedure code in this field.</td>
</tr>
<tr>
<td>Field Number</td>
<td>Field Name</td>
<td>Required Fields for Claim Submissions</td>
<td>Instructions/Examples</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------------------------</td>
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<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>45</td>
<td>SERVICE DATE</td>
<td>Required</td>
<td><strong>Outpatient Series Bills:</strong> A service date must be entered for all outpatient series bills whenever the “from” and “through” dates in Field 6 (<strong>Statement Covers Period: From/Through</strong>) are not the same. Submissions that are received without the required service date(s) will be rejected with a request for itemization. <strong>Multiple/Different Dates of Service:</strong> Multiple/different dates of service can be listed on ONE claim form. List each date on a separate line on the form, along with the corresponding revenue code (<strong>Field 42</strong>), procedure code (<strong>Field 44</strong>), and total charges (<strong>Field 47</strong>).</td>
</tr>
<tr>
<td>46</td>
<td>UNITS OF SERVICE</td>
<td>Required</td>
<td>Enter the units of service to quantify each revenue code category. <strong>IMPORTANT:</strong> SNF Providers billing for Supportive Services and Home Health Providers billing for Services in excess of a 2-hour visit should enter the <strong>total number of 15 minute units</strong> of authorized Services provided to Members, regardless of the time unit assigned to the applicable payment rate in your contract (e.g., rate per hour).</td>
</tr>
<tr>
<td>47</td>
<td>TOTAL CHARGES</td>
<td>Required</td>
<td>Indicate the total charges pertaining to each related revenue code for the current billing period, as listed in Field 6.</td>
</tr>
<tr>
<td>48</td>
<td>NON COVERED CHARGES</td>
<td>Required if Applicable</td>
<td>Enter any non-covered charges.</td>
</tr>
<tr>
<td>49</td>
<td>BLANK</td>
<td>Not Required</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>50</td>
<td>PAYER NAME</td>
<td>Required</td>
<td>Enter (in appropriate ORDER on lines A, B, and C) the NAME and NUMBER of each payer organization from which you are expecting payment towards the claim.</td>
</tr>
<tr>
<td>51</td>
<td>HEALTH PLAN ID</td>
<td>Not Required</td>
<td>Enter the Plan Sponsor identification number.</td>
</tr>
<tr>
<td>52</td>
<td>RELEASE OF INFORMATION (RLS INFO)</td>
<td>Required if Applicable</td>
<td>Enter the release of information certification indicator(s).</td>
</tr>
<tr>
<td>53</td>
<td>ASSIGNMENT OF BENEFITS (ASG BEN)</td>
<td>Required</td>
<td>Enter the assignment of benefits certification indicator.</td>
</tr>
<tr>
<td>Field Number</td>
<td>Field Name</td>
<td>Required Fields for Claim Submissions</td>
<td>Instructions/Examples</td>
</tr>
<tr>
<td>--------------</td>
<td>----------------------------------</td>
<td>--------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>54A-C</td>
<td>PRIOR PAYMENTS</td>
<td>Required if Applicable</td>
<td>If payment has already been received toward the claim by one of the payers listed in Field 50 (Payer) prior to the billing date, enter the amounts here.</td>
</tr>
<tr>
<td>55</td>
<td>ESTIMATED AMOUNT DUE</td>
<td>Required if Applicable</td>
<td>Enter the estimated amount due from patient. Do not report collection of patient’s cost share.</td>
</tr>
<tr>
<td>56</td>
<td>NATIONAL PROVIDER IDENTIFIER (NPI)</td>
<td>Required</td>
<td>Enter the billing provider’s NPI.</td>
</tr>
<tr>
<td>57</td>
<td>OTHER PROVIDER ID</td>
<td>Required</td>
<td>Enter the service Provider’s Kaiser-assigned Provider ID, if any.</td>
</tr>
<tr>
<td>58</td>
<td>INSURED’S NAME</td>
<td>Required</td>
<td>Enter the insured's name, i.e. policyholder.</td>
</tr>
<tr>
<td>59</td>
<td>PATIENT’S RELATION TO INSURED</td>
<td>Required</td>
<td>Enter the patient’s relationship to the insured.</td>
</tr>
<tr>
<td>60</td>
<td>INSURED’S UNIQUE ID</td>
<td>Required</td>
<td>Enter the patient’s Kaiser Medical Record Number (MRN).</td>
</tr>
<tr>
<td>61</td>
<td>INSURED’S GROUP NAME</td>
<td>Required if Applicable</td>
<td>Enter the insured’s group name.</td>
</tr>
<tr>
<td>62</td>
<td>INSURED’S GROUP NUMBER</td>
<td>Required if Applicable</td>
<td>Enter the insured’s group number. For Prepaid Services claims enter &quot;PPS&quot;.</td>
</tr>
<tr>
<td>63</td>
<td>TREATMENT AUTHORIZATION CODE</td>
<td>Required if Applicable</td>
<td>For ALL inpatient and outpatient claims, enter the KP referral number, if applicable, for the episode of care being billed. NOTE: this is a 10-digit alphanumeric identifier</td>
</tr>
<tr>
<td>64</td>
<td>DOCUMENT CONTROL NUMBER</td>
<td>Not Required</td>
<td>Enter the document control number related to the patient or the claim as assigned by KP.</td>
</tr>
<tr>
<td>65</td>
<td>EMPLOYER NAME</td>
<td>Required if Applicable</td>
<td>Enter the name of the insured’s (Field 58) employer.</td>
</tr>
<tr>
<td>66</td>
<td>DX VERSION QUALIFIER</td>
<td>Required</td>
<td>Indicate the ICD version indicator of codes being reported. (“9”=ICD9; “0”=ICD10)</td>
</tr>
<tr>
<td>67</td>
<td>PRINCIPAL DIAGNOSIS CODE</td>
<td>Required</td>
<td>Enter the principal diagnosis code, on all inpatient and outpatient claims. Enter POA (Present on Admit) indicator in the shaded area on the right side of the principal ICD</td>
</tr>
<tr>
<td>Field Number</td>
<td>Field Name</td>
<td>Required Fields for Claim Submissions</td>
<td>Instructions/Examples</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------------------------------------</td>
<td>---------------------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>67A-Q</td>
<td>OTHER DIAGNOSES CODES</td>
<td>Required if Applicable</td>
<td>Enter other diagnoses codes corresponding to additional conditions that coexist or develop subsequently during treatment. Diagnosis codes must be carried to their highest degree of detail. Enter POA (Present on Admit) indicator (for each ICD entered) in the shaded area on the right side for each ICD</td>
</tr>
<tr>
<td>68</td>
<td>BLANK</td>
<td>Not Required</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>69</td>
<td>ADMITTING DIAGNOSIS</td>
<td>Required</td>
<td>Enter the admitting diagnosis code on all inpatient claims.</td>
</tr>
<tr>
<td>70a-c</td>
<td>REASON FOR VISIT (PATIENT REASON DX)</td>
<td>Required if Applicable</td>
<td>Enter the diagnosis codes indicating the patient’s reason for outpatient visit at the time of registration.</td>
</tr>
<tr>
<td>71</td>
<td>PPS CODE</td>
<td>Required if Applicable</td>
<td>Enter the DRG number to which the procedures group, even if you are being reimbursed under a different payment methodology.</td>
</tr>
<tr>
<td>72</td>
<td>EXTERNAL CAUSE OF INJURY CODE (ECI)</td>
<td>Required if Applicable</td>
<td>Enter an ICD-10 “VWXYZ” code in this field (if applicable).</td>
</tr>
<tr>
<td>73</td>
<td>BLANK</td>
<td>Not required</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>74</td>
<td>PRINCIPAL PROCEDURE CODE AND DATE</td>
<td>Required if Applicable</td>
<td>Enter the ICD-10 procedure CODE and DATE on all inpatient AND outpatient claims for the principal surgical and/or obstetrical procedure which was performed (if applicable).</td>
</tr>
<tr>
<td>74a-e</td>
<td>OTHER PROCEDURE CODES AND DATES</td>
<td>Required if Applicable</td>
<td>Enter other ICD-10 procedure CODE(S) and DATE(S) on all inpatient AND outpatient claims (in fields “A” through “E”) for any additional surgical and/or obstetrical procedures which were performed (if applicable).</td>
</tr>
<tr>
<td>75</td>
<td>BLANK</td>
<td>Not required</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>Field Number</td>
<td>Field Name</td>
<td>Required Fields for Claim Submissions</td>
<td>Instructions/Examples</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------------------------------</td>
<td>---------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| 76           | ATTENDING PHYSICIAN / NPI / QUAL / ID | Required                          | Enter the NPI and the name of the attending physician for inpatient bills or the KP physician that requested the outpatient services.  
Inpatient Claims—Attending Physician  
Enter the full name (first and last name) of the physician who is responsible for the care of the patient.  
Outpatient Claims—Referring Physician  
For ALL outpatient claims, enter the full name (first and last name) of the KP physician who referred the Patient for the outpatient services billed on the claim. |
| 77           | OPERATING PHYSICIAN / NPI/QUAL/ID   | Required If Applicable               | Enter the NPI and the name of the lead surgeon who performed the surgical procedure.                                                                         |
| 78-79        | OTHER PHYSICIAN/ NPI/QUAL/ID       | Required if Applicable               | Enter the NPI and name of any other physicians.                                                                                                                                 |
| 80           | REMARKS                            | Not Required                         | Special annotations may be entered in this field.                                                                                                                                 |
| 81           | CODE-CODE                          | Required if Applicable               | Enter the code qualifier and additional code, such as marital status, taxonomy, or ethnicity codes, as may be appropriate.                                      |
Form UB-04

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Date of Admission</th>
<th>Date of Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/01/2017</td>
<td>01/01/2017</td>
<td>01/01/2017</td>
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<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>123</td>
<td>456</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Insurance Card Number</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Doe</td>
<td>123-456</td>
<td>01/01/1980</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Provider Name</th>
<th>NPI Number</th>
<th>Address</th>
<th>City</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Smith</td>
<td>123-456</td>
<td>123 Main St</td>
<td>City</td>
<td>State</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service</th>
<th>Quantity</th>
<th>Rate</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 1</td>
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<td>$10</td>
<td>$1000</td>
</tr>
<tr>
<td>Item 2</td>
<td>50</td>
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<td>$1000</td>
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<table>
<thead>
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<th>Code</th>
<th>Description</th>
<th>Itemized Statement</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Test A</td>
<td>$500</td>
<td>$500</td>
</tr>
<tr>
<td>B</td>
<td>Test B</td>
<td>$300</td>
<td>$300</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DCN</th>
<th>Code</th>
<th>Description</th>
<th>E&amp;M Code</th>
<th>Date of Service</th>
<th>Provider Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>C</td>
<td>Test C</td>
<td>99213</td>
<td>01/01/2017</td>
<td>John Smith</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Quantity</th>
<th>Rate</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Test A</td>
<td>100</td>
<td>$10</td>
<td>$1000</td>
</tr>
<tr>
<td>B</td>
<td>Test B</td>
<td>50</td>
<td>$20</td>
<td>$1000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Quantity</th>
<th>Rate</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Test A</td>
<td>100</td>
<td>$10</td>
<td>$1000</td>
</tr>
<tr>
<td>B</td>
<td>Test B</td>
<td>50</td>
<td>$20</td>
<td>$1000</td>
</tr>
</tbody>
</table>
5.21 **Coordination of Benefits (COB)**

Coordination of Benefits (COB) is a method for determining the order in which benefits are paid and the amounts which are payable when a Member is covered under more than one health benefit plan. It is intended to prevent duplication of benefits when an individual is covered by multiple health benefit plans providing benefits or services for medical or other care and treatment.

Providers are responsible for identifying the primary payor and for billing the appropriate party. If a Member’s KP plan is not the primary payor, then the claim should be submitted to the primary payor as determined via the process described below. If a Member’s Kaiser plan is the secondary payor, then the primary payor payment must be specified on the claim, and an Explanation of Payment (EOP) needs to be submitted as an attachment to the claim.

5.21.1 **How to Determine the Primary Payor**

Primary coverage is determined using the guidelines established under applicable California law. Examples are:

- The benefits of the plan that covers an individual as an employee or subscriber other than as a dependent are determined before those of a plan that covers the individual as a dependent.

- When both parents cover a child, the “birthday rule” applies – the payor for the parent whose birthday falls earlier in the calendar year (month and day) is the primary payor.

Please call or contact Members Services with any questions you may have about COB.

- The commercial benefit plan is generally primary for working Medicare-eligible Members when the CMS Working Aged regulation applies

- Medicare is generally primary for retired Medicare Members over age 65, and for active, employee group health Members with End Stage Renal Disease (ESRD) after the first 30 months of dialysis treatment (the coordination period)

- In cases of work-related injuries, Workers Compensation is primary unless coverage for the injury has been denied

- In cases of services for injuries sustained in vehicle accidents or other types of accidents, primary payor status is determined on a jurisdictional basis. Submit the claim as if the benefit plan is the primary payor
5.21.2 Description of COB Payment Methodology

Coordination of Benefits allows benefits from multiple health benefit plans to be added on top of each other so that the Member receives the maximum benefit from their primary and the secondary health benefit plans together.

Please note that the primary payor payment must be specified on the claim, and an EOP needs to be submitted as an attachment to the claim.

When KP is secondary to another payor, KP will coordinate benefits and determine the payable amount to the Provider in accordance with the applicable Agreement.

5.21.3 COB Claims Submission Requirements and Procedures

If a claim is submitted to KP when another payor is primary without the EOP by the primary payor, KP will deny payment of the claim. The Provider will need to submit a claim to the other (primary) payor. Within 90 Business Days (or longer period if required under applicable law or expressly permitted under your Agreement) after the primary payor has paid its benefit, please resubmit to KP the claim with the EOP that accompanied payment by the primary payor. The claim will be reviewed and the amount of payment due, if any, will be determined.

5.21.4 Direct Patient Billing

Members may be billed only for Member Cost Share where applicable according to the Member’s benefit coverage and your Agreement, which payments may be subject to an out-of-pocket maximum.

The circumstances above are the only situations in which a Member can be billed directly for covered services.

5.22 Third Party Liability (TPL)

Unless and to the extent your Agreement expressly provides to the contrary, KP has the exclusive right of recovery for TPL claims. TPL for health care costs may arise from sickness or injury caused or alleged to be caused by a third party. In order to prevent duplicate payments for health care costs that are also paid by another responsible party, Providers are required to assist KP in identifying all potential TPL situations and to provide KP with information that supports KP’s TPL inquiries.
5.22.1 Third Party Liability Guidelines

Providers are asked to assist and cooperate with KP’s efforts to identify TPL situations by doing the following:

- Provide full information in applicable fields on the billing form. If one or more payors is (are) named, KP will contact the Member for potential TPL information
- Enter ICD-10 diagnosis data in applicable fields on the billing form

KP retains the right to investigate TPL recoveries through retrospective review of ICD-10 and CPT-4 codes from the billing forms where a possible TPL is indicated.

5.23 Workers' Compensation

If a Member indicates that his or her illness or injury occurred while the Member was "on the job", you should do the following:

- Document that the Member indicates the illness or injury occurred "on the job" on the claim
- Complete applicable fields on the billing form indicating a work related injury
- Submit the claim to the patient’s Workers’ Compensation carrier/plan

If the Member's Workers' Compensation carrier/plan ultimately denies the Workers’ Compensation claim, you may submit the claim for covered services to KP in the same manner as you submit other claims for services.

If you have received an authorization to provide such care to the Member, you should submit your claim to KP in the same manner as you submit other claims for services. Your Agreement may specify a different payment rate for these services.

5.24 Prohibited Billing Practices

Providers may not bill, charge, collect a deposit from, impose surcharges, or have any recourse against a Member or a person acting on a Member’s behalf for covered services provided under the terms of the Agreement. Balance billing Members for services covered by KFHP is prohibited by California and Federal law and under your Agreement.

Except for Member Cost Share, and as otherwise expressly permitted in your Agreement and under applicable law, Providers must look solely to KP or other responsible payor (e.g., Medicare) for compensation of covered services provided to Members.

As long as the Provider has clearly informed the Member in writing that KP may not cover or continue to cover a specific service, the Provider and Member may agree that the Member is solely responsible for paying for continued services and non-covered services.
Claims received beyond the applicable filing period will be denied for untimely submission. In these instances, the provider of service may not bill the Member, but may resubmit the claim as a provider dispute. The resubmitted claim must include the reason for initial late submission of the claim, along with the other required information and submission requirements described in Section 6.2.2 of this Provider Manual.

5.25 Explanation of Payment and Remittance Advice

Payment is made to the Provider within 45 Business Days of receipt of a properly submitted complete claim or as otherwise stated in your Agreement or allowed by applicable law. The Explanation of Payment (EOP) information is located on the remittance advice or “check skirt” received.

If the billing codes submitted and are not paid, the Provider will receive a denial letter under separate cover. The letter provides the rationale for denial of payment.

5.26 Invoices

Some Providers are contracted to perform certain services which are not appropriately billed on a form like the UB-04 or the CMS-1500. Often such services are provided at a KP facility or clinic, or other location and are not billed based upon a specific procedure performed, or on a per Member basis, rather, the Provider may be required to bill for such services using an invoice. Billing for services using an invoice is not subject to certain Knox-Keene Act or Medicare provisions related to standard claims for services that are traditionally billed on the UB-04 or the CMS-1500. Following are the billing requirements for submitting invoices for payment:

All invoices for services furnished at a KP facility, clinic or other location must be submitted on letterhead or other pre-printed invoice with the Provider’s name, address, and tax identification number on a monthly basis, within 30 calendar days of the end of the month in which services were rendered, or such other frequency as may be communicated to the Provider by KP. In addition, all invoices must:

- Reflect the amount due, dates of service, and, if applicable, patient names and MRNs. Any supplies that are being furnished by the Provider and invoiced to KP should be specifically identified
- Include a unique invoice number. KP will create a unique number if one is not provided
- Identify each KP facility where services were provided, as applicable
- Be marked “Duplicate” or “Tracer”, when the original invoice is lost or subsequently replaced by a copy
- Be accurate, complete and in the form directed by the applicable KP administrative personnel or as established in the Agreement. Balance forward invoicing and interim
invoicing will not be approved or accepted by the facility chief of service/designee or other appropriate KP administrative personnel as a condition of payment

5.26.1 Other Contracted Functions Related to Professional Services

In addition to the invoice requirements described above, invoices for professional services delivered for TPMG can be submitted electronically or on paper. Regardless of the method of submission, all invoices must be produced on letterhead or other pre-printed invoice with the following information:

- Provider’s name, address and tax identification number
- The amount due and the pay-to address
- The KP contact name, KP reference number, KP general ledger (GL) number that is provided by KP to Contractor. Contractor shall ensure that it has the most current information prior to submitting invoices for payment
- Date(s) on which Services provided
- Patient’s name and MRN, if applicable
- Dated signature of Contractor

Electronic invoices (as a PDF file) may be submitted via email to:

<table>
<thead>
<tr>
<th>Medical Center Name</th>
<th>Locations</th>
<th>Email Address for Invoices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Valley (CVL)</td>
<td>Stockton, Manteca, Tracy, Modesto</td>
<td><a href="mailto:TPMG-AP-Central-Valley@kp.org">TPMG-AP-Central-Valley@kp.org</a></td>
</tr>
<tr>
<td>Diablo Service Area (DSA)</td>
<td>Walnut Creek, Livermore, Pleasanton, Martinez, Antioch</td>
<td><a href="mailto:TPMG-AP-Diablo-Service-Area@kp.org">TPMG-AP-Diablo-Service-Area@kp.org</a></td>
</tr>
<tr>
<td>East Bay (EBA)</td>
<td>Oakland, Alameda, Richmond, Pinole</td>
<td><a href="mailto:TPMG-AP-East-Bay@kp.org">TPMG-AP-East-Bay@kp.org</a></td>
</tr>
<tr>
<td>Fresno (FRS)</td>
<td>Fresno, Clovis, Oakhurst, Selma</td>
<td><a href="mailto:TPMG-AP-Fresno@kp.org">TPMG-AP-Fresno@kp.org</a></td>
</tr>
<tr>
<td>Greater So Alameda (GSA)</td>
<td>San Leandro, Union City, Fremont</td>
<td><a href="mailto:TPMG-AP-Greater-Southern-Alameda-Area@kp.org">TPMG-AP-Greater-Southern-Alameda-Area@kp.org</a></td>
</tr>
<tr>
<td>Napa Solano (NSA)</td>
<td>Vallejo, Napa, Vacaville, Fairfield</td>
<td><a href="mailto:TPMG-AP-Napa-Solano@kp.org">TPMG-AP-Napa-Solano@kp.org</a></td>
</tr>
<tr>
<td>North Valley (NVL)</td>
<td>Sacramento, Roseville, Folsom, Lincoln, Davis, Rancho Cordova</td>
<td><a href="mailto:TPMG-AP-North-Valley@kp.org">TPMG-AP-North-Valley@kp.org</a></td>
</tr>
<tr>
<td>Redwood City (RWC)</td>
<td>Redwood City, San Mateo</td>
<td><a href="mailto:TPMG-AP-Redwood-City@kp.org">TPMG-AP-Redwood-City@kp.org</a></td>
</tr>
<tr>
<td>Regional Offices</td>
<td>Regional Depts</td>
<td><a href="mailto:TPMG-AP-Regional-Office@kp.org">TPMG-AP-Regional-Office@kp.org</a></td>
</tr>
<tr>
<td>San Francisco (SFO)</td>
<td>San Francisco, French Campus</td>
<td><a href="mailto:TPMG-AP-San-Francisco@kp.org">TPMG-AP-San-Francisco@kp.org</a></td>
</tr>
<tr>
<td>San Jose (SJO)</td>
<td>San Jose, Gilroy</td>
<td><a href="mailto:TPMG-AP-San-Jose@kp.org">TPMG-AP-San-Jose@kp.org</a></td>
</tr>
<tr>
<td>San Rafael (SRF)</td>
<td>San Rafael, Petaluma, Novato</td>
<td><a href="mailto:TPMG-AP-San-Rafael@kp.org">TPMG-AP-San-Rafael@kp.org</a></td>
</tr>
<tr>
<td>Santa Clara (SCL)</td>
<td>Santa Clara, Mountain View, Campbell, Milpitas</td>
<td><a href="mailto:TPMG-AP-Santa-Clara@kp.org">TPMG-AP-Santa-Clara@kp.org</a></td>
</tr>
<tr>
<td>Medical Center Name</td>
<td>Locations</td>
<td>Email Address for Invoices</td>
</tr>
<tr>
<td>--------------------------</td>
<td>------------------------------------------------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td>Santa Rosa (SRO)</td>
<td>Santa Rosa, Rohnert Park</td>
<td><a href="mailto:TPMG-AP-Santa-Rosa@kp.org">TPMG-AP-Santa-Rosa@kp.org</a></td>
</tr>
<tr>
<td>South Sacramento (SSC)</td>
<td>So Sacramento, Elk Grove</td>
<td><a href="mailto:TPMG-AP-South-Sacramento@kp.org">TPMG-AP-South-Sacramento@kp.org</a></td>
</tr>
<tr>
<td>South San Francisco (SSF)</td>
<td>So San Francisco, San Bruno, Daly City</td>
<td><a href="mailto:TPMG-AP-South-San-Francisco@kp.org">TPMG-AP-South-San-Francisco@kp.org</a></td>
</tr>
</tbody>
</table>

To submit paper invoices, please direct mail to:

TPMG Accounts Payable
{Insert Name of KP Medical Center}
P.O. Box 214269
Sacramento, CA 95821-214269

Inquiries on payments or receipt of invoices may be made by emailing the Customer Service staff at the appropriate email address at the medical center listed above.

5.26.2 Other Contracted Functions Related to Services Delivered at KFH (Non-Professional)

In addition to the invoice requirements described above, invoices for services delivered at KFH can be submitted electronically or on paper. Regardless of the method of submission, all invoices must be produced on letterhead or other pre-printed invoice with the following information:

- Provider’s name, address and tax identification number
- The amount due and the pay-to address
- The KP contact name, KP reference number, KP general ledger (GL) number that is provided by KP to Contractor. Contractor shall ensure that it has the most current information prior to submitting invoices for payment
- Date(s) on which Services provided
- Patient’s name and MRN, if applicable
- Dated signature of Contractor
Electronic invoices (as a PDF file) may be submitted via email to:

KP-AP-Invoice@kp.org

The Subject Line of the email must contain the phrase “VENDOR INVOICE”. The rest of the subject line may then be typed.

To submit paper invoices, please direct mail to:

KP—Accounts Payable
PO Box 12929
Oakland, CA  94604-3010

Inquiries on payments or any other questions may be made by contacting the Customer Service line either by mailing KP-AP-Customer@kp.org with the subject line “Supplier Inquiry”, or by calling (866) 858-2226.

5.26.3 1099 Tax Documents

KP mails 1099 forms to the TIN address identified by Providers and in accordance with state and federal regulations controlling timeliness of tax documents. Duplicate copies of 1099 forms may be obtained by sending a written request to 1099misc@kp.org, or by calling KP at (510) 627-2798. To avoid errors, email requests are preferred. All requests, either by email or phone, must include all the following detail to allow KP to validate requests:

- Federal Tax Identification Number (TIN)
- Legal Name of entity to which TIN belongs
- TIN address
- Full name of person making the request
- Phone number of the person making the request
6. Provider Dispute Resolution Process

KP actively encourages our contracted Providers to utilize Member Services staff to resolve billing and payment issues.

If you remain unable to resolve your billing and payment issues, KP makes available to all Providers a fast, fair and cost-effective dispute resolution mechanism for disputes regarding invoices, billing determinations, or other contract issues. This dispute resolution mechanism is handled in accordance with applicable law and your Agreement. Please note that the process described in this section applies to disputes subject to the Knox-Keene Act. While we expect to use this process for other types of disputes, we are not required to do so.

This section of the Provider Manual gives you information about our dispute resolution process, but it is not intended to be a complete description of the law or the provisions of your Agreement. Please make sure that you review your Agreement and the applicable law for a complete description of the dispute resolution process. To the extent your Agreement expressly sets forth any longer time frame or additional process than as described below, the contractual provisions will apply to the extent not prohibited under applicable law.

6.1 Types of Disputes

The following describes the most common types of disputes:

- **Claims Payment Disputes:** Challenging, appealing or requesting reconsideration of a claim (or bundled group of claims) that has been denied, adjusted or contested by KP

- **Responding to Requests for Overpayment Reimbursements:** Disputing a request by KP for reimbursement by you of overpayment of a claim

- **Other Disputes:** Seeking resolution of a contract dispute (or bundled group of contract disputes) between you and KP

6.2 Submitting Payment Disputes

You must submit a written notice to KP by U.S. Mail or other physical delivery if you have a dispute relating to the adjudication of a claim or a billing determination (collectively referred to herein as “payment dispute”). Your written notice of a payment dispute is referred to in this Provider Manual as a “Provider Dispute Notice”.
6.2.1 Directions for Delivery and Mailing of Payment Disputes

6.2.1.1 Payment Disputes Related to Referred Service Claims

If the payment dispute is related to a claim for a service covered by your Agreement and that was referred to you by a Plan Physician, the dispute must be sent to the following address:

By U.S. Mail and
By Physical Delivery: KP Referral Invoice Service Center (RISC)
Attn: Provider Disputes
2829 Watt Avenue, Suite 130
Sacramento, CA  95821-6242

To inquire about filing a payment dispute and/or the status of previously submitted disputes, contact the Provider Relations Coordinator at the number shown on the acknowledgement letter you received, or call Provider Relations at (510) 987-4102.

6.2.1.2 Payment Disputes Related to Emergency Services Claims

Payment disputes regarding claims for emergency services provided to Members must be sent to the following address:

By U.S. Mail: Kaiser Foundation Health Plan, Inc.
National Claims Administration
Attention: Provider Dispute Services Unit
P.O. Box 23100
Oakland, CA 94623

By Physical Delivery
Other Than By U.S. Mail: Kaiser Foundation Health Plan, Inc.
National Claims Administration
1800 Harrison Street, 8th Floor
Oakland, CA 94612

For payment dispute inquiries and filing information for claims for emergency services, you may contact KP by calling: (800) 390-3510.

6.2.2 Required Information for Provider Payment Dispute Notices

Your Provider Dispute Notice must contain at least the information listed below, as applicable to your payment dispute. If your Provider Dispute Notice does not contain all of the applicable information listed below, we will return the Provider Dispute Notice to you and identify in writing the missing information necessary for us to consider the payment dispute. You must resubmit an amended dispute to us within 30 Business Days from the
date of such notification letter, making sure to include all elements noted therein as missing from your payment dispute. If KP does not receive your amended payment dispute within this time, our previous decision will be considered final and you will have exhausted our provider payment dispute process.

Required Information

- Your name, the tax identification number under which services were billed and your contact information
- If the payment dispute concerns a claim or a request for reimbursement of an overpayment of a claim, a clear identification of the disputed item, using KP’s original claim number, the date of service, and a clear explanation of the basis upon which you believe that the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect
- If the payment dispute involves a Member or a group of Members, the name(s) and MRN(s) of the Member(s) must be included in addition to the information above

Your Provider Dispute Notice may be submitted by you or by a representative (for example, a billing service, a collection agency or an attorney) authorized by you to perform this function. If your authorized representative submits your Provider Dispute Notice, that representative will be required to provide confirmation that an executed business associate agreement between you, as the provider of health care services, and such representative is in place and that it complies with HIPAA. If the copy of the business associate agreement is not included, the dispute documentation will be returned to the submitting third party/representative until the business associate agreement is included.

6.2.3 Time Period for Submission of Provider Dispute Notices

Subject to any longer period specifically stipulated under your Agreement or required under applicable law, Provider Dispute Notices must be received by KP within 365 days from our action (or the most recent action if there are multiple actions) that led to the dispute, or in the case of inaction, Provider Dispute Notices must be received by KP within 365 days after our time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.
6.2.4 Timeframes for Acknowledgement of Receipt and Determination of Provider Dispute Notices

We will acknowledge receipt of your Provider Dispute Notice submitted in accordance with the above requirements within 15 Business Days after the date of receipt by the office designated above. We will return to you any payment dispute you submit that does not include all required information as described above as an incomplete payment dispute and will take no further action on that incomplete submission unless it is resubmitted completely as required above and within the applicable time frames. KP will issue a resolution letter explaining the reasons for our determination, to the extent required by applicable law, within 45 Business Days after the date of receipt of the complete Provider Dispute Notice.

6.2.5 Instructions for Resolving Substantially Similar Payment Disputes

If you are considering submitting in excess of 20 substantially similar disputes, you are encouraged to reach out to our Provider Relations unit at (510) 987-4102. We may be able to identify a root cause and streamline the resolution process.

If you proceed with filing substantially similar multiple payment disputes they may be filed in writing in batches as a single dispute, provided that such disputes are submitted with the following information:

Each claim being disputed must be individually numbered and contain the provider’s name, the provider’s tax identification number, the provider’s contact information, the original KP claim number (if the dispute is claim related), the Health Plan member’s medical record number (if the dispute concerns care provided to a specific Health Plan member or members), date(s) of service, clear identification of the item(s) being disputed for each claim and an explanation of the basis for each dispute.

The submission must include all of these data elements as well as any documentation you wish to submit to support your dispute. Any submission of substantially similar provider payment disputes that does not include all required elements will be returned to you as incomplete and will need to be re-submitted with all necessary information. We will consider ten (10) or more disputes submitted within five (5) working days for substantially the same dispute reason (whether for the same or different claims) as a single dispute under this provision for the filing of substantially similar provider payment disputes.

6.3 Disputing Requests for Overpayment Reimbursements

Follow the instructions of this Section 6, Provider Dispute Resolution Process.
6.4 **Other Disputes**

For disputes not based on claim adjudication or billing determination(s), refer to your KP Medical Services Agreement.
7. Member Rights and Responsibilities

KP recognizes that Members have both rights and responsibilities in the management of their health care.

Members have certain rights to which they are entitled when they interact with representatives of KP: Providers, and the employees of those Providers, as well as KP employees and physicians.

Members are also expected to be responsible for knowing about their health care needs and coverage. They are also responsible for maintaining appropriate attitudes and behavior when receiving health care as a Member.

This section addresses our Members’ rights and responsibilities as well as their opportunities to address any situation where they may believe that they have not received appropriate services, care, or treatment.

7.1 Member Rights and Responsibilities Statement

KP has developed a statement of Member rights which includes a Member’s right to participate in the Member’s own medical care decisions. These decisions range from selecting a PCP to making informed decisions regarding recommended treatment plans.

The Member Rights and Responsibilities Statement also includes a Member’s responsibility to understand the extent and limitations of his/her health care benefits, to follow established procedures for accessing care, to recognize the impact lifestyle has on physical condition, to provide accurate information to caregivers, and to follow agreed upon treatment plans.

Upon enrollment and annually thereafter, KP provides notification to each subscriber that a Member Rights and Responsibilities Statement is located in “Your Guidebook to Kaiser Permanente Services”. The Guidebook includes the following statement:

Active communication between you and your physician as well as others on your health care team helps us to provide you with the most appropriate and effective care. We want to make sure you receive the information you need about your Health Plan, the people who provide your care, and the services available, including important preventive care guidelines. Having this information contributes to your being an active participant in your own medical care.

We also honor your right to privacy and believe in your right to considerate and respectful care.

This section details your rights and responsibilities as a Kaiser Permanente member and gives you information about member services, specialty referrals, privacy and confidentiality, and the dispute resolution process.
As an adult member, you exercise these rights yourself. If you are a minor or are unable to make decisions about your medical care, these rights will be exercised by the person with the legal responsibility to participate in making these decisions for you.

**YOU HAVE THE RIGHT TO:**

**Receive information about Kaiser Permanente, our services, our practitioners and providers, and your rights and responsibilities.**

We want you to participate in decisions about your medical care. You have the right, and should expect to receive as much information as you need to help you make decisions. This includes information about:

- Kaiser Permanente
- The services we provide, including behavioral health services
- The names and professional status of the individuals who provide you with service or treatment
- The diagnosis of a medical condition, its recommended treatment, and alternative treatments
- The risks and benefits of recommended treatments
- Preventive care guidelines
- Ethical issues
- Complaint and grievance procedures

We will make this information as clear and understandable as possible. When needed, we will provide interpreter services at no cost to you.

**Participate in a candid discussion of appropriate or medically necessary treatment options for your condition(s), regardless of cost or benefit coverage.** You have the right to a candid discussion with your Plan Physician about appropriate or medically necessary treatment options for your condition(s), regardless of cost or benefit coverage. Ask questions, even if you think they’re not important. You should be satisfied with the answers to your questions and concerns before consenting to any treatment. You may refuse any recommended treatment if you don’t agree with it or if it conflicts with your beliefs.

Kaiser Permanente does not discriminate on the basis of age, race, ethnicity, color, national origin, cultural background, ancestry, religion, sex, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, source of payment, genetic information, citizenship, primary language, or immigration status.

Medical emergencies or other circumstances may limit your participation in a treatment decision. However, in general, you will not receive any medical treatment
before you or your representative gives consent. You and, when appropriate, your family will be informed about the outcomes of care, treatment, and services that have been provided, including unanticipated outcomes.

**Participate with practitioners and providers in making decisions about your health care.** You have the right to choose an adult representative, known as your agent, to make medical decisions for you if you are unable to do so and to express your wishes about your future care. Instructions may be expressed in advance directive documents such as an advance health care directive. See the “Guidebook” for more information about advance directives.

For more information about these services and resources, please contact our Member Service Contact Center 24 hours a day, 7 days a week (closed holidays) at 1-800-464-4000 (English), 1-800-788-0616 (Spanish), 1-800-757-7585 (Chinese dialects), or TTY: 711.

**Have ethical issues considered.** You have the right to have ethical issues that may arise in connection with your health care considered by your health care team. Kaiser Permanente has a Bioethics/Ethics Committee at each of our medical centers to assist you in making important medical or ethical decisions.

**Receive personal medical records.** You have the right to review and receive copies of your medical records, subject to legal restrictions and any appropriate copying or retrieval charge(s). You can also designate someone to obtain your records on your behalf. Kaiser Permanente will not release your medical information without your written consent, except as required or permitted by law.

To review, receive, or release copies of your medical records, you’ll need to complete and submit an appropriate written authorization or inspection request to our Medical Secretaries Department at the facility where you get your care. They can provide you with these forms and tell you how to request your records. Check your medical facility in the “Guidebook” or visit kp.org to find addresses and phone numbers for these departments. If you need help getting copies of your medical records, call our Member Services Contact Center at 1-800-464-4000 or TTY: 711.

**Receive care with respect and recognition of your dignity.** We respect your cultural, psychosocial, spiritual, and personal values; your beliefs; and your personal preferences.

Kaiser Permanente is committed to providing high-quality care for you and to building healthy, thriving communities. To help us get to know you and provide culturally competent care, we collect race, ethnicity, language preferences (spoken and written) and religion data. This information can help us develop ways to improve care for our members and communities. This information is kept private and confidential and not used in underwriting, rate setting, or benefit determination. We believe that providing quality health care includes a full and open discussion.
regarding all aspects of medical care and want you to be satisfied with the health care you receive from Kaiser Permanente.

Use interpreter services. When you call or come in for an appointment or call for advice, we want to speak with you in the language you are most comfortable using. For more about our interpreter services, please refer to the “Guidebook” or call our Member Services Contact Center at 1-800-464-4000 or TTY: 711.

Be assured of privacy and confidentiality. All Kaiser Permanente employees and physicians, as well as practitioners and providers with whom Kaiser Permanente contracts, are required to keep your protected health information (PHI) confidential. PHI is information that includes your name, Social Security number, or other information that reveals who you are, such as race, ethnicity, and language data. For example, your medical record is PHI because it includes your name and other identifiers.

Kaiser Permanente has strict policies and procedures regarding the collection, use, and disclosure of member PHI that includes the following:

- Kaiser Permanente’s routine uses and disclosures of PHI
- Use of authorizations
- Access to PHI
- Internal protection of oral, written, and electronic PHI across the organization
- Protection of information disclosed to Plan sponsors or employers
- Please review the section titled “Privacy Practices” in the “Guidebook”

For more information about your rights regarding PHI as well as our privacy practices, please refer to our Notice of Privacy Practices on our website kp.org, or call our Member Services Contact Center at 1-800-464-4000 or TTY: 711.

Participate in physician selection without interference. You have the right to select and change your personal physician within the Kaiser Permanente Medical Care Program without interference, subject to physician availability. To learn more about nurse practitioners, physician assistants, and selecting a primary care practitioner, please refer to the “Guidebook”.

Receive a second opinion from an appropriately qualified medical practitioner. If you want a second opinion, you can either ask your Plan physician to help you arrange for one, or you can make an appointment with another Plan physician. Kaiser Foundation Health Plan, Inc., will cover a second opinion consultation from a non-Permanente Medical Group physician only if the care has been pre-authorized by a Permanente Medical Group. While it is your right to consult with a physician outside the Kaiser Permanente Medical Care Program without prior authorization, you will be responsible for any costs you incur.
Receive and use member satisfaction resources, including the right to voice complaints or make appeals about Kaiser Permanente or the care we provide. You have the right to resources such as patient assistance and member services, and the dispute-resolution process. These services are provided to help answer your questions and resolve problems.

A description of your dispute-resolution process is contained in your Evidence of Coverage booklet, Certificate of Insurance, or the Federal Employees Health Benefits Program materials. If you need a replacement, contact your local Member Services Department or our Member Service Contact Center to request another copy. If you receive your Kaiser Permanente coverage through an employer, you can also contact your employer for a current copy. When necessary, we will provide you with interpreter services, including Sign Language, at no cost to you.

For more information about our services and resources, please contact our Member Service Contact Center at 1-800-464-4000 (English), 1-800-788-0616 (Spanish), 1-800-757-7585 (Chinese dialects), or 1-800-777-1370 or TTY: 711.

Make recommendations regarding Kaiser Permanente’s member rights and responsibilities policies. If you have any comments about these policies, please contact our Member Services Contact Center at 1-800-464-4000 or TTY: 711.

YOU ARE RESPONSIBLE FOR THE FOLLOWING:

Knowing the extent and limitations of your health care benefits. A detailed explanation of your benefits is contained in your Evidence of Coverage booklet, Certificate of Insurance, or the Federal Employees Health Benefits Program materials. If you need a replacement, contact your local Member Services office to request another copy. If you receive your Kaiser Permanente coverage through your employer, you can also contact your employer for a current copy of your Evidence of Coverage booklet or Certificate of Insurance.

Notifying us if you are hospitalized in a non–Kaiser Permanente Hospital. If you are hospitalized in any hospital that is not a Plan Hospital, you are responsible for notifying us as soon as reasonably possible so we can monitor your care. You can contact us by calling the number on your Kaiser Permanente ID card.

Identifying yourself. You are responsible for carrying your KP identification (ID) card and photo identification with you at all times to use when appropriate, and for ensuring that no one else uses your ID card. If you let someone else use your card, we may keep your card and terminate your membership.

Your Kaiser Permanente ID card is for identification only and does not give you rights to services or other benefits unless you are an eligible member of our Health Plan. Anyone who is not a member will be billed for any services we provide.
Keeping appointments. You are responsible for promptly canceling any appointment that you do not need or are unable to keep.

Supplying information (to the extent possible) that Kaiser Permanente and our practitioners and providers need in order to provide you with care. You are responsible for providing the most accurate information about your medical condition and history, as you understand it. Report any unexpected changes in your health to your physician or medical practitioner.

Understanding your health problems and participating in developing mutually agreed treatment goals to the highest degree possible. You are responsible for telling your physician or medical practitioner if you don’t clearly understand your treatment plan or what is expected of you. You are also responsible for telling your physician or medical practitioner if you believe you cannot follow through with your treatment plan.

Following the plans and instructions for care you have agreed on with your practitioners. You are responsible for following the plans and instructions that you have agreed to with your physician or medical practitioner.

Recognizing the effect of your lifestyle on your health. Your health depends not only on care provided by Kaiser Permanente but also on the decisions you make in your daily life—poor choices such as smoking or choosing to ignore medical advice or positive choices such as exercising and eating healthy foods.

Being considerate of others. You are responsible for treating physicians, health care professionals, and your fellow Kaiser Permanente members with courtesy and consideration. You are also responsible for showing respect for the property of others and of Kaiser Permanente.

Fulfilling financial obligations. You are responsible for paying on time any money owed to Kaiser Permanente.

Knowing about and using the member satisfaction resources available to you, including the dispute-resolution process.

For more about the dispute resolution process, see the “Guidebook”. A description of your dispute-resolution process is also contained in your Evidence of Coverage booklet, Certificate of Insurance, or the Federal Employees Health Benefits Program materials. If you need a replacement, contact our Member Services Contact Center to request a copy. If you receive your Kaiser Permanente coverage through an employer, you can also contact your employer for a current copy of your Evidence of Coverage booklet or Certificate of Insurance. Our Member Services Contact Center can also give you information about the various resources available to you and about Kaiser Permanente’s policies and procedures. If you have any recommendations or comments about these policies, please contact our Member Services Contact Center.
Providers and their staff are expected to accept and honor these principles.

7.2 Non-Compliance with Member Rights and Responsibilities

Failure to act in a way that is consistent with the Member Rights and Responsibilities Statement can result in action against the Member, the Provider, or KP, as appropriate.

7.2.1 Members

In the event a Member has a complaint or grievance, the Member is instructed in “Your Guidebook” and their EOC, or Certificate of Insurance, to discuss the situation with Member Services. Members can file a grievance for any issue, including complaints against the Provider and/or the Provider’s staff. Resolution of the problem or concern is processed through the Member Complaint and Grievance procedure that is described later in this section.

Although the Member should contact Member Services about a grievance, you may be approached directly by the Member. If you do receive a complaint from or on behalf of a Member which, in your reasonable judgment, is not resolvable within 2 Business Days, you must notify Provider Relations as soon as possible.

7.2.2 Providers

If a Member fails to meet an obligation as outlined in the Member Rights and Responsibilities Statement and you have attempted to resolve the issue, please contact Member Services.

You should advise Member Services if a Member:

- Displays disruptive behavior or is not able to develop a positive provider/patient relationship
- Unreasonably and persistently refuses to follow your instructions/recommendations to the extent that you believe it is jeopardizing the patient’s health
- Commits a belligerent act or threatens bodily harm to physicians, physician staff, hospital personnel, and/or home health/hospice/SNF staff
- Purposely conceals or misrepresents medical history or treatment
- Uses documents with your signature without proper authorization or forges/falsifies your name to documents, including prescriptions
- Allows someone to misrepresent the Member as a KFHP Member
KP reserves the right at its discretion to:

- Conduct informal mediation to resolve a relationship issue
- Move the Member to another provider
- Pursue termination of the individual’s membership or take other appropriate action, as allowed under that Member’s specific EOC

### 7.3 Health Care Decision-Making

KP and contracted hospitals, physicians, and health care professionals make medical decisions based on the appropriateness of care for Members’ medical needs. KP does not compensate anyone for denying coverage or services, nor does KP use financial incentives to encourage denials. In order to maintain and improve the health of Members, all Providers should be especially vigilant in identifying any potential underutilization of care or service.

KP encourages open Provider-patient communication regarding available treatment alternatives. We do not penalize Providers for discussing all available care options with our Members.

Our Members have the right to choose among treatment or service options, regardless of benefit coverage limitations. Providers are expected to inform our Members of appropriate care options, even when one or more of the options are not covered benefits under the Member’s benefit plan. If the Provider and the patient decide upon a course of treatment that is not covered in the Member’s EOC, the Member must be advised they are responsible for the cost of that care.

If the Member is dissatisfied with this arrangement, the Member should be advised to contact Member Services for an explanation of the Member’s benefit plan. If the Member persists in requesting non-covered services and the Provider is willing to provide such service, the Provider should make payment arrangements with the Member in advance of any non-emergent treatment to be provided.

KP’s UM program and procedures are:

- Based on objective guidelines adopted by KP
- Used to determine medical necessity and appropriateness of care
- Designed to establish whether services provided or to be provided are covered under a Member’s benefit plan

Please refer to Section 4 and Section 9 of this Provider Manual for more details.

The ultimate decision on whether to proceed with treatment rests with the Provider and the Member.
7.4 Advance Directives

An Advance Directive is a written instruction recognized under California and/or federal law, such as a living will or a Durable Power of Attorney for Health Care. An Advance Directive allows Members to appoint a representative to make personal health care decisions on their behalf. A Member’s representative must be at least 18 years old. The Member’s representative is referred to as a Health Care Agent. To avoid potential conflicts of interest, KPMCP personnel, volunteers, and physicians may not serve as witnesses for a Member’s Advance Directive.

KP requires that all Providers comply with the federal Patient Self-Determination Act of 1990, which mandates that a patient must have the opportunity to participate in determining the course of his/her medical care, even when the patient is unable to speak for him or herself. The federal law applies to emancipated minors, but does not apply to all other minors. Providers must also comply with California’s Health Care Decisions law and any other California State Laws concerning Advance Health Care Directives.

To ensure compliance with governing law, the existence of any Advance Directive must be documented in a prominent place in the medical record. An institutional Provider is required to provide written information regarding Advance Directives to all Members admitted to the facility, and provide staff and patient education regarding Advance Directives.

Members should be encouraged to provide copies of their completed Advance Directives to all Providers of their medical care. Members should also be informed that they can register their Advance Directive with California Secretary of State’s Office. The State will provide the Member with a Registry Card that the Member can carry with him/her.

If a Member who is a patient wishes to execute or modify an Advance Directive, the attending physician should be notified so that the physician has an opportunity to discuss the decision with the Member. The attending physician must document any changes to an Advance Directive in the Member’s medical record.

An Advance Directive may be revoked by the Member at any time, orally or in writing, as long as the Member is capable of doing so. Upon divorce, if the spouse was designated as the surrogate decision-maker, the chosen agent is invalidated unless the patient specifically states to the contrary in their Advance Directive. If a Member has more than one written Advance Directive, then the most recently executed document should be recognized. Please note: revoked forms should not be discarded, but remain a part of the Member’s Medical Record.

Members are provided with information regarding Advance Directives in the Evidence of Coverage, “Your Guidebook”, and the website at http://lifecareplan.wpengine.com/advance-health-care-directive-guide/. Members may also contact Member Services regarding Advance Directives for an informational brochure and appropriate forms.
7.4.1 Physician Orders for Life Sustaining Treatment (POLST)

A POLST form is a document that the Member’s physician completes with the Member’s input (or Member’s decision-maker’s input). It documents the Member’s choices about resuscitation, medical interventions, use of antibiotics, and use of artificially administered fluids and nutrition.

POLST is a physician’s order form that outlines a plan of care that reflects the Member’s wishes concerning end-of-life care. It is voluntary, and is intended only for people who are seriously ill. It can be revoked by the Member at any time. This form can assist physicians, nurses, health care facilities, and emergency personnel in honoring the Member’s wishes for life-sustaining treatment.

The POLST form complements the advance directive and is not intended to replace that document. Information on the POLST form will be incorporated into the medical record when presented to the individual's Provider.

For more information on POLST, visit [http://www.capolst.org](http://www.capolst.org).

7.5 Member Grievance Process

Members are assured a fair and equitable process for addressing their complaints, grievances and appeals (“grievances”) against Providers, their staff, and KP employees. This review process is designed to evaluate all aspects of the situation and arrive at a solution that strives to be mutually satisfactory to the Member and the organization, including you, our Provider. Members are notified of the processes available for resolving grievances in their Evidence of Coverage, and “Guidebook”.

A Member grievance may relate to dissatisfaction with quality of care, access to services, Provider or staff attitude, operational policies and procedures, benefits, eligibility and requests for services and care they believe are available under their coverage. Valid Member complaints and grievances against a Provider are included in the Provider’s quality file at KP and reviewed as part of the recredentialing process. Grievances are tracked and trended on an ongoing basis to identify potential problems with a Provider or with our own policies and procedures.

The grievance information provided in this Provider Manual is a general overview and is not all inclusive. There are variations to the Member’s rights and remedies depending on the membership type (e.g., Medicare, Medi-Cal, etc.), Therefore, Members should be referred to Member Services or to their Evidence of Coverage brochure for more information.
7.5.1 Provider Participation in Member Grievance Resolution

The established procedures for resolving Member grievances may require the Provider’s participation under certain circumstances. KP will advise you of any involvement required or information that must be provided. Grievances about clinical issues will be reviewed by at least one practitioner provided by KP and practicing in the same or a similar specialty that typically manages the related medical condition, procedure or treatment who was not previously involved in the patient’s care. As a result of this review, you may be asked as part of the investigation to respond by email or by an Investigative Review Form to Member Services with your clinical opinion regarding the Member's concern or request.

7.5.2 Member Grievance Resolution Procedure

One of the rights that Members are apprised of in “Guidebook” is that they have the right to participate in a candid discussion with the Provider of all available options regardless of cost or benefit coverage. Members are told, “You have the right to a candid discussion with your Plan Physician about appropriate or medically necessary treatment options for your condition(s), regardless of cost or benefit coverage. Ask questions, even if you think they’re not important. You should be satisfied with the answers to your questions and concerns before consenting to any treatment. You may refuse any recommended treatment if you do not agree with it or if it conflicts with your beliefs.”

If the issue cannot be resolved this way, we encourage the Member to contact a Patient Assistance Coordinator or a Member Services representative at the local KP facility. If the Provider presents a grievance on behalf of a Member, and the issue is felt to be of an emergent nature, one that could seriously jeopardize the Member’s life, health, or ability to regain maximum function, the Provider or the Member may contact the Expedited Review Unit (ERU) through the Member Service Contact Center to request a review.

7.5.3 Processes for Grievance Resolution

If the problem is not amenable to immediate resolution at the point of service, the Member may submit a grievance through any of the following methods:

- in person to a Patient Assistance Coordinator or Member Services Representative in the Member Services Department at the local KP facility
- via our website at http://www.kp.org
- by calling the Member Service Contact Center at (800) 464-4000 (English), 1-800-788-0616 (Spanish), 1-800-757-7585 (Chinese dialects), or TTY: 711
- by completing a Grievance Form or writing a letter and mailing it to a Member Services office at a Plan Facility (member can refer to the “Guidebook” for addresses)
Our representatives will advise the Member about the resolution process and ensure that the appropriate parties review the complaint.

Sample Medicare and Non-Medicare Grievance Forms can be found at the end of this section.

Grievances reviewed through the standard process are generally acknowledged within 5 days, and resolved as quickly as the member’s health requires, but no longer than regulatory timeframes. Depending on the issue and the applicable regulatory requirements, the resolution time frame is generally within 30 days.

**NOTE:** For expedited processing, see Section 7.5.3.2.

### 7.5.3.1 Quality of Care Grievances

Members’ grievances which contain potential quality of care concerns are forwarded by Member Services to the Member Services Clinical Consultants for case review. Clinical Consultants will forward cases to the responsible Quality departments as appropriate.

For Medicare members, the written response to a quality of care grievance will inform the Member of the right to file the quality of care complaint with the Quality Improvement Organization (QIO). The QIO is an organization comprised of practicing doctors and other health care experts under contract with the federal government to monitor and improve the care given to Medicare members. In California, the QIO is Livanta.

### 7.5.3.2 Expedited Review

A Member who believes that his/her health status would be seriously jeopardized by submitting an issue through the standard process may request an expedited review.

The ERU handles Part C organization determinations and redeterminations meeting the expedited review criteria. The PDU addresses expedited Part D coverage determinations and redeterminations. Part C or D payment issues or post-service may not be expedited. When a Member’s expedited Part C case or Part D case is received by Member Services, it is the responsibility of the program representative to screen the request to immediately identify whether the request meets the established qualifying criteria for expedited review. Requests that meet these criteria are immediately referred to the ERU or PDU for review.

The ERU and PDU physicians determine if the request meets the criterion for expedited review, which includes screening against regulatory requirements. If a Plan or non-Plan Physician states that an expedited review is required for reasons of clinical urgency, an expedited review will be automatically granted.

Requests meeting expedited criteria are reviewed by a designated ERU/PDU physician in consultation, as needed, with the appropriate specialist(s). If the physicians deny the request, in whole or in part, the Member is informed of the reason for the denial and given information for the next steps to take to have the determination reconsidered.
The Member will be notified of the expedited decision verbally and also in writing, as quickly as the member’s health requires but no later than the required expedited timeframes – generally within 72 hours.

Requests that do not meet the qualifying criteria for expedited review will be processed in accordance with standard review timeframes.

**7.5.3.3 Instructions for Filing a Grievance**

The following instructions are to be included with any Grievance Form supplied by Providers to our Members. Providers may reproduce this page and the forms immediately following for that purpose.

**HOW TO FILE A GRIEVANCE**

KP is committed to providing Members with quality care and with a timely response to their concerns. Members can discuss their concerns with our Member Services representatives at most Plan Facilities, or they can call our Member Service Contact Center.

Members can file a grievance for any issue. Their grievance must explain the issue, such as the reasons why they believe a decision was in error or why they are dissatisfied about Services they received. Members must submit their grievance orally or in writing within 60 days (Medicare) or 180 days (Non-Medicare) of the date of the incident that caused their dissatisfaction as follows:

- To a Member Services representative at their local Member Services Department at a Plan Facility (Member should refer to “Guidebook” for locations), or by calling our Member Service Contact Center:
  
  - English: 1-800-464-4000
  - Spanish: 1-800-788-0616
  - Chinese dialects: 1-800-757-7585
  - TTY: 711

- Through our website at: http://www.kaiserpermanente.org

We will acknowledge receipt of a Member’s grievance after receiving it, and provide a resolution as soon as their health requires but no later than regulatory time frames allow, which is generally within 30 days. If we do not approve a Member’s request, we will tell them the reason and inform them about additional dispute resolution options.

**NOTE:** If we resolve a Member’s issue by the end of the next business day after we receive their grievance and Member Services representative notifies them orally about our decision, we will not send them a written decision unless their grievance involves a quality of care issue, breach of privacy, Hospital grievances, coverage dispute, a dispute about whether a service is medically necessary, an experimental or investigational treatment, or those grievances for which they request a written response.
# Sample Grievance Form—Medicare

**Grievance/Appeal FORM - Medicare**

<table>
<thead>
<tr>
<th>Member/Patient Name:</th>
<th>Medical Record Number:</th>
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<thead>
<tr>
<th>Address</th>
<th>Street</th>
<th>City</th>
<th>Zip Code</th>
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<tr>
<th>Daytime Telephone Number:</th>
<th>Alternate Telephone Number:</th>
<th>Birth Date:</th>
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<tr>
<th>Name of Person Filing: (if different than above, a Statement of Authorized Representative form will be mailed to the member for completion):</th>
<th>Relationship:</th>
<th>Daytime Telephone Number:</th>
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<table>
<thead>
<tr>
<th>Department/Location and Medical Facility where issue occurred:</th>
<th>Date Issue Occurred:</th>
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Please describe the nature of the issue *(attach additional sheets if needed)*:

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Please explain how you have tried to resolve this issue.

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What would you consider a proper solution to this issue?

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**Signature:**

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<th>Date:</th>
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**For Program Representative Use Only**

<table>
<thead>
<tr>
<th>Name of Program Representative:</th>
<th>Facility:</th>
<th>Date Received:</th>
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<tbody>
<tr>
<td>Medicare</td>
<td>Coverage</td>
<td></td>
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<tr>
<td>Medicare</td>
<td>Redetermination</td>
<td></td>
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<tr>
<td>Medicare</td>
<td>Organization</td>
<td></td>
</tr>
<tr>
<td>Medicare</td>
<td>Reconsideration</td>
<td></td>
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<tr>
<td>Medicare</td>
<td>Med-Med</td>
<td></td>
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<tr>
<td>Medicare</td>
<td>Fed-Med</td>
<td></td>
</tr>
<tr>
<td>Medicare</td>
<td>PERS-Med</td>
<td></td>
</tr>
</tbody>
</table>

*You will be advised of any additional procedural and appeal rights to which you are entitled as we move forward with your issue.*

**DO NOT FILE IN PATIENT CHART**

Return this form in the pre-addressed envelope provided you, OR return it to your local Kaiser Permanente Member Services or Member Relations department for processing.

*Revised: 10.05.05 [Medicare Compliance]*
Sample Grievance Form—Non-Medicare

Department of Managed Health Care Complaint Process

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone Kaiser Foundation Health Plan at 1 (800) 464-4000 and use your health plan’s grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-686-9391) for the hearing and speech impaired. The department’s internet website hmohelp.ca.gov has complaint forms, IMR application forms, and instructions online.

If you have an issue that involves an imminent and serious threat to your health (such as severe pain or potential loss of life, limb, or major bodily function), you can contact the California Department of Managed Health Care directly at any time without first filing a grievance with us.

DO NOT FILE IN PATIENT CHART

Please return this form to your local Kaiser Permanente Member Services department for processing. You may deliver the form in person or by mail. If you prefer, you may file a grievance online at kaiserpermanente.org, in person at your local Member Service office, or by phone by calling 1-800-464-4000.
7.5.4 Department of Managed Health Care Complaint Process—Non-Medicare

The DMHC is responsible for regulating health care service plans. If a Member has a grievance against KP, the Member should notify Kaiser Foundation Health Plan at **(800) 464-4000** (English), **1-800-788-0616** (Spanish), **1-800-757-7585** (Chinese dialects), or TTY: **711** to lodge the grievance with Member Services. The Member will have the opportunity to seek resolution of the problem using KP’s grievance process. If the Member is not satisfied with the outcome of the grievance process, or if the grievance has remained unresolved for more than 30 calendar days, the Member may contact the DMHC for assistance. The DMHC will determine whether the Member is eligible to participate in the Independent Medical Review Program, described below.

7.5.4.1 Independent Medical Review Program Availability—Non-Medicare

California law requires health plans to offer an independent medical review program to Members who have been denied services because the services were deemed not medically necessary, or considered experimental or investigational. This includes denial of emergency and urgent care services from non-KP providers. The Independent Medical Review Program ("IMR") is administered by the California DMHC. If the DMHC determines that the Member’s case qualifies for an IMR, medical experts not affiliated with KP will conduct the review. KP will honor the DMHC decision.

A Member may qualify for IMR if the issue has been denied or is unresolved after 30 days, or 3 days for requests that meet expedited review criteria, if KP:

- Denies, changes, or delays a service or treatment because the plan determines it is not medically necessary
- Will not cover an experimental or investigational treatment for a serious medical condition
- Will not pay for emergency or urgent medical services that you have already received

Members can request an IMR by completing an IMR Application Form, which comes with a grievance resolution letter. Along with the Application, Members should attach copies of letters or other documents about the treatment or service that KP denied. Members can Mail or fax the form and any attachments to:

**Department of Managed Health Care**
**980 9th Street Suite 500**
**Sacramento CA 95814-2725**
Help Center FAX: **(916) 255-5241**

The numbers to the DMHC are: **(888) 466-2219** and **(877) 688-9891** (TDD). The DMHC web address is [http://www.hmohelp.ca.gov](http://www.hmohelp.ca.gov).
7.5.5 Demand for Arbitration

Under certain circumstances, a Member may file a demand for arbitration after receiving an appeal decision, or at any earlier step in the process. For more information on arbitration procedures, please advise the Member to contact the Member Services Department at the local KP facility or contact our Member Services Contact Center at (800) 464-4000 (English), 1-800-788-0616 (Spanish), 1-800-757-7585 (Chinese dialects), or TTY: 711.

NOTE: The complaint and appeals information provided in this Provider Manual may not address the rights and remedies of every category of Member, for example, Medicare, MediCal, as well as Members employed/retired from the State of California and/or the Federal Government, each of whom may have different rights and remedies. Members in these categories should be directed to contact Member Services for applicable grievance and appeal provisions, or they may refer to their Evidence of Coverage brochure for more information.
8. Provider Rights and Responsibilities

As a Provider, you are responsible for understanding and complying with terms of your Agreement and this section. If you have any questions regarding your rights and responsibilities under the Agreement and as described in this section of the Provider Manual, we encourage you to call the Provider Relations Department.

8.1 Providers’ Rights and Responsibilities

All Providers are responsible for:

- Providing health care services without discriminating on the basis of health status or any other unlawful category
- Upholding all applicable responsibilities outlined in the Member Rights & Responsibilities Statement in this Provider Manual
- Maintaining open communication with a Member to discuss treatment needs and recommended alternatives, without regard to any covered benefit limitations or KP administrative policies and procedures. KP encourages open provider-patient communication regarding appropriate treatment alternatives and does not restrict Providers from discussing all available care options with Members
- Providing all services in a culturally competent manner
- Providing for timely transfer of Member medical records when care is to be transitioned to a new provider, or if your Agreement terminates
- Participating in KP Quality Improvement and UM Programs. KP Quality Improvement and UM Programs are designed to identify opportunities for improving health care provided to Members. These programs may interact with various functions, including, but not limited to, the complaint or grievance process, disease management, preventive health, or clinical studies. KP will communicate information about the programs and extent of Provider participation through special mailings and updates to the Provider Manual. These programs are also described in various sections of this Provider Manual
- Securing authorization or referral from KP prior to providing any non-emergency services
- Verifying eligibility of Members prior to providing services
- Collecting applicable co-payments, deductibles, and co-insurance from Member as required by your Agreement and this Provider Manual
- Complying with this Provider Manual and the terms of your Agreement
- Cooperating with and participating in the Member complaint and grievance process, as necessary
• Encouraging all Providers and their staff to include patients as part of the patient safety team by requesting patients to speak up when they have questions or concerns about the safety of their care

• Discussing adverse outcomes related to errors with the patient and/or family

• Ensuring patients’ continuity of care including coordination with systems and personnel throughout the care delivery system

• Fostering an environment which encourages all Providers and their staff to report errors and near misses

• Pursuing improvements in patient safety including incorporating patient safety initiatives into daily activities

• Ensuring compliance with patient safety accreditation standards, legislation, and regulations

• Providing copies of this Provider Manual to all subcontractors and participating practitioners, and ensuring that downstream providers adhere to all applicable provisions of the Provider Manual and the Agreement

• Notifying Provider Relations in writing of any practice changes that may affect access for Members

• Reporting to the appropriate state agency any abuse, negligence or imminent threat to which the Member might be subject. You may request guidance and assistance from the local KP’s Social Services Department to help provide you with required information that must be imparted to these agencies

• Contacting your local county Public Health Department if you treat a patient for a reportable infectious disease

Providers also have the right to:

• Receive payment in accord with applicable laws and applicable provisions of your Agreement

• File a provider dispute

• Participate in the dispute resolution processes established by KP in accord with your Agreement and applicable law

• Rely on eligibility information provided by KP about any particular Member

8.2 Complaint and Patient Care Problems

KP will work with a Provider to resolve complaints regarding administrative or contractual issues, or problems encountered while providing health care to Members.
8.2.1 Administrative and Patient Related Issues

For assistance in resolving administrative and patient related issues, please contact a Referral Coordinator (or assigned Outside Services Case Manager), if applicable from the referring KP facility. Examples of administrative issues include clarification of the authorization or referral process, and billing and payment issues.

8.2.2 Claim Issues

Regarding claims for referred services or emergency services, you may contact KP by calling (800) 390-3510.

For questions and clarification on how payments were computed, you may contact the office that issued the payment identified on the remittance advice and EOP. The phone number will be listed on the remittance advice.

For assistance in filing a Provider Dispute, please refer to Section 6.2 of this Provider Manual.

8.3 Required Notices

8.3.1 Provider Changes That Must Be Reported

Providers may notify Provider Relations of the changes identified below by calling (844) 343-9370. Verbal notification must be followed by faxed documentation to (510) 987-4138. Please check your contract as it may contain provisions that limit your ability to add, delete or relocate practice sites, service locations or practitioners.

8.3.2 Provider Illness or Disability

If an illness or disability leads to a reduction in work hours or the need to close his/her practice or location, Providers must immediately notify Provider Relations.

8.3.2.1 Practice Relocations

Notify Provider Relations at least 90 days prior to relocation to allow for the transition of Members to other Providers, if necessary.

8.3.2.2 Adding/Deleting New Practice Site or Location

Notify Provider Relations at least 90 days prior to opening an additional practice site or closing an existing service location.
8.3.2.3  Adding/Deleting Practitioners to/from the Practice

Notify Provider Relations immediately when adding/deleting an employed or subcontracted practitioner to/from your practice. Before Members can be seen by the new practitioner, he or she must be credentialed according to applicable KP policy.

8.3.2.4  Changes in Telephone Numbers

Notify Provider Relations at least 30 days prior to the implementation of a change in telephone number. If the initial notification is given verbally, you must send written confirmation to the Notice address in your contract.

8.3.2.5  Federal Tax ID Number and Name Changes

If your Federal Tax ID Number or name should change, please notify us immediately so that appropriate corrections can be made to KP’s files.

8.3.2.6  Mergers and Other Changes in Legal Structure

Please notify us in advance and as early as possible of any planned changes to your legal structure, including pending merger or acquisition.

8.3.3  Contractor Initiated Termination (Voluntary)

Your Agreement requires that you give advance written notice if you plan on terminating your contractual relationship with KP. The written notice must be sent in accordance with the terms of your Agreement.

When you give notice of termination, you must immediately advise Provider Relations of any Members who will be in the course of treatment during the termination period.

Provider Relations may contact you to review the termination process, which may include transferring Members and their medical records to other providers designated by KP.

KP will make every effort to notify all affected Members of the change in providers at least 60 days prior to the termination, so that the Members can be given information related to their continuity of care rights, and to assure appropriate transition to ensure that they will have appropriate access to care. KP will implement a transition plan to move the Members to a provider designated by KP, respecting each Member’s legal continuity of care rights, and making every effort to minimize any disruption to medical treatment. You are expected to cooperate and facilitate the transition process. You will remain obligated to care for the affected Members in accordance with the written terms of the Agreement, state and federal law.
8.3.4 Other Required Notices

You are required to give KP notice of a variety of other events, including changes in your insurance, ownership, adverse actions involving your license(s), participation in Medicare or Medicare certification, and other occurrences that may affect the provision of services under your Agreement. Your Agreement describes the required notices and manner in which notice should be provided.

From time to time, KP will request Providers complete a Provider Profile Information Form (PPIF). When requested, you must provide updated information listing the name, location, and address of each physical site at which you and your practitioners and subcontractors provide services to Members under the Agreement. This information is needed to assure that our payment systems appropriately recognize your locations and practitioners. Additionally, it facilitates verification that Providers seeing Members are appropriately credentialed and is essential for KP to continue to meet its legal, business and regulatory requirements.

8.4 Call Coverage Providers

Your Agreement may require that you provide access to services 24 hours per day, 7 days per week. If you arrange for coverage by practitioners who are not part of your practice or contracted directly with KP, the practitioners must agree to all applicable terms of your Agreement with KP, including prohibition against balance billing Members, the KP accessibility standards, our Quality Assurance & Improvement and UM Programs and your fee schedule.

8.5 Health Information Technology

As Providers implement, acquire, or upgrade health information technology systems, your office or organization should use reasonable efforts to utilize, where available, certified health information technology systems and products that meet interoperability standards recognized by the Secretary of Health and Human Services (“Interoperability Standards”), have already been pilot tested in a variety of live settings, and demonstrate meaningful use of health information technology in accordance with the HITECH Act. Providers should also encourage their subcontracted providers to comply with applicable Interoperability Standards.
9. Quality Assurance and Improvement (QA & I)

9.1 Northern California Quality Program and Patient Safety Program

The KP Quality Program includes many aspects of clinical and service quality, patient safety, behavioral health, accreditation and licensing and other elements. The KP quality improvement program assures that quality improvement is an ongoing, priority activity of the organization. Information about our quality program is available to you in the “Quality Program at KP” document, including:

- Awards and recognition for our quality program presented by outside organizations
- Programs and systems within KP that promote quality improvement
- Our quality improvement structure
- Areas targeted by our quality goals

To obtain a copy of this document, call our Member Services Contact Center at 1-(800) 464-4000 or TTY: 711. Ask for a copy of the “Quality Program at KP”. Alternatively, you can view and print the document by visiting the KP website at http://www.kaiserpermanente.org. Click on “Locate our Services,” select “Forms and Publications,” then “Quality Report” and finally “Quality Program at Kaiser Permanente”.

Patient safety is a central component of KP’s care delivery model. We believe our distinctive structure as a fully integrated health care delivery system provides us unique opportunities to design and implement effective, comprehensive safety strategies to protect our Members. Providers play a key role in the implementation and oversight of patient safety efforts.

At KP, patient safety is every patient’s right and everyone’s responsibility. As a leader in patient safety, our five-year strategic plan outlines 6 focus areas. These themes include safe culture, safe care, safe staff, safe support systems, safe place, and safe patients.

If you would like independent information about KP’s health care quality and safety, the following external organizations offer information online:

The National Committee for Quality Assurance (NCQA) works with consumers, purchasers of health care benefits, state regulators, and health plans to develop standards that evaluate health plan quality. KP is responsible to manage, measure, and assess patient care in order to achieve NCQA accreditation which includes ensuring that all Members are entitled to the same high level of care regardless of the site or provider of care. The focus of NCQA is on care provided in the ambulatory setting.

KP is currently accredited by NCQA, and we periodically undergo re-accreditation. KP Northern California Region (KPNC) provides the appropriate information related to
quality and utilization upon request, so that KP may meet NCQA standards and requirements, and maintain successful NCQA accreditation. You can review the report card for KFHP, Northern California, at [http://www.ncqa.org](http://www.ncqa.org).

The Leapfrog Group is a group of Fortune 500 companies, including non-profit and other large private companies that encourages purchasers and consumers to use their health care buying power as leverage to create quality and safety standards in the U.S. The group gathers information about aspects of medical care and patient safety relevant to urban hospitals via an annual Leapfrog Survey. All KP hospitals in California participated in the most recent survey. To review survey results, visit [http://www.leapfroggroup.org/cp](http://www.leapfroggroup.org/cp).

The Office of the Patient Advocate (OPA) provides data to demonstrate the quality of care delivered at KPNC, as well as a comparison of our performance to other health plans in the state. To view the Clinical and Patient Experience Measures along with explanations of the scoring and rating methods used visit: [http://reportcard.opa.ca.gov/rc2013/medicalgroupcounty.aspx](http://reportcard.opa.ca.gov/rc2013/medicalgroupcounty.aspx).

The Joint Commission is a health care accreditation organization that is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards. To earn and maintain its accreditations, KP must undergo an onsite surveying by The Joint Commission survey team at least every 3 years. KP has adopted a set of The Joint Commission compliance expectations for contracted practitioners coming into our facilities. [http://www.jointcommission.org](http://www.jointcommission.org).

### 9.2 Quality Assurance and Improvement (QA & I) Program Overview

KP’s Quality Assurance and Improvement Program uses a multi-disciplinary and integrated approach, which focuses on opportunities for improving operational processes, health outcomes, and Member and Provider satisfaction.

The quality of care Members receive is monitored by KP’s oversight of Providers. You may be monitored for various indicators and required to participate in some KP processes. For example, we monitor and track the following:

- Patient access to care
- Patient complaint and satisfaction survey data of both administrative and quality of care issues
- Compliance with KP policies and procedures
- UM statistics
- Quality of care indicators and provision of performance data as necessary for KP to comply with requirements of NCQA, Medicare, The Joint Commission, and other regulatory and accreditation bodies.
• Performance standards in accordance with your Agreement
• Credentialing and recredentialing of Providers

In any of the above situations, when KP reasonably determines that the Provider’s performance may adversely affect the care provided to Members, KP may take corrective actions in accordance with your Agreement. As a Provider, you are expected to investigate and respond in a timely manner to all quality issues and work with KP to resolve any quality and accessibility issues related to services for Members. Each Provider is expected to remedy, as soon as reasonably possible, any condition related to patient care involving a Member that has been determined by KP or any governmental or accrediting agencies to be unsatisfactory.

9.3 Provider Credentialing And Recredentialing

As an important part of KP’s Quality Management Program, all credentialing and recredentialing activities are structured to assure applicable Providers are qualified to meet KP, NCQA, and other regulatory standards for the delivery of quality health care and service to Members.

The credentialing and recredentialing policies and procedures approved by KP are intended to meet or exceed the managed care organization standards outlined by the NCQA.

KP has developed and implemented credentialing and recredentialing policies and procedures for Providers. Practitioners include, but are not limited to, MDs, DOs, oral surgeons, podiatrists, chiropractors, advanced practice nurses, behavioral health practitioners, acupuncturists and optometrists. Organizational Providers (OPs) include, but are not limited to, hospitals, SNFs, home health agencies, hospice agencies, dialysis centers, congregate living facilities, behavioral health facilities, ambulatory surgical centers, clinical laboratories, comprehensive outpatient rehabilitation facilities, portable x-ray suppliers, federally qualified health centers and community based adult services centers. Services to Members may be provided only when the Provider meets KP’s applicable credentialing standards and has been approved by the appropriate Credentials and Privileges Committee.

Providers must also submit, upon renewal, ongoing evidence of current licensure, insurance, accreditation/certification, as applicable, and other credentialing documents subject to expiration.

9.3.1 Practitioners

KP requires that all practitioners within the scope of KP’s credentialing program be credentialed prior to treating Members and must maintain credentialing at all times. Recredentialing will occur at least every 24 months and may occur more frequently.
Requirements for initial and recredentialing for practitioners include, but are not limited to:

- Complete, current and accurate credentialing/recredentialing application
- Current healing arts licenses, certificates and/or permits as required by law
- Evidence of appropriate education, clinical training and current competence in practicing specialty
- No history of State or Federal sanctions/limitations/exclusions
- Evidence of current insurance, in amounts as required by KP
- Complete clinical work history
- Complete malpractice claim history
- Evidence practitioner is not currently opted out of Medicare
- No significant events as identified through KP performance data (at recredentialing only)

KP adheres to the NCQA standards for credentialing and recredentialing of hospitalists. Hospitalists who provide services exclusively in the inpatient setting and provide care for Members only as a result of Members being directed to the hospital setting are deemed appropriately credentialed and privileged in accordance with state, federal, regulatory and accreditation standards when credentialed and privileged by the hospital in which they treat Members.

A KP Credentials and Privileges Committee will communicate credentialing determinations in writing to practitioners. In the event the committee decides to deny initial credentialing, terminate existing credentialing or make any other adverse decision regarding the practitioner’s ability to treat Members, appeal rights will be granted in accordance with applicable legal requirements and KP policies and procedures. The practitioner will be notified of those rights when notified of the committee’s determination.

All information obtained by KP during the practitioner credentialing and recredentialing process is considered confidential as required by law. For additional information regarding credentialing and recredentialing requirements and policies, please contact Quality & Operations Support.

**9.3.2 Practitioner Office Site Quality**

KP adheres to the NCQA standards for Practitioner office site quality. Practitioner office site visits will be conducted when Member complaints exceed established thresholds for physical accessibility, physical appearance, adequacy of waiting room and examining room space, and adequacy of medical/treatment record keeping. Actions will be instituted to improve offices that do not meet established thresholds. Effectiveness of improvement actions will be evaluated at least every six months until all deficiencies are corrected.
KP will complete a site visit utilizing the Practitioner Office Site Review tool within 60 days of the threshold being met, or sooner if severity warrants. Threshold criteria may be waived altogether when issues of patient safety are at risk.

**KP OFFICE SITE REVIEW STANDARDS**

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| Physical Accessibility                | • Handicap parking is clearly designated  
• Facility is handicap accessible externally and internally  
• All exits are clearly labeled and free of obstruction |
| Appearance and Cleanliness            | • Interior surroundings are clean; carpets and tiles are secure  
• Public areas are free from food, beverages and food containers  
• Public areas are free from personnel belongings  
• Office hours are clearly posted |
| Adequacy of Waiting Area              | • Waiting room is well lit  
• Waiting room has adequate patient seating (i.e. seating accommodates 3-4 patients per practitioner per hour)  
• Furniture is clean, secure and free of rips and tears  
• Patient Registration area ensures confidentiality |
| Adequacy of Exam Room                 | • Exam room is well lit and has adequate space for patient scheduling (i.e., at least two available exam rooms for each provider; each exam room can accommodate 3-4 patients per hour)  
• Exam room ensures patient privacy and confidentiality  
• Trash containers have appropriate liners (red for regulated waste)  
• Sharp containers are present and not overfilled  
• Exam room, table and equipment are clean, secure and free of rips and tears |
| Adequacy of Medical/Treatment Record Keeping | • Medical/treatment records are orderly (paper based)  
• There is a secure/confidential filing system (electronic or paper based)  
• File markers are legible (paper based)  
• Medical/treatment records are easily located (electronic or paper based) |
9.3.3 Practitioner Rights

9.3.3.1 Practitioner Right to Correct Erroneous or Discrepant Information.

The credentials staff will notify the practitioner, orally or in writing of information received that varies substantially from the information provided during the credentialing process. The practitioner will have 30 calendar days in which to correct the erroneous or discrepant information. The notice will state to whom, and in what format, to submit corrections.

9.3.3.2 Practitioner Rights to Review Information

Upon written request, and to the extent allowed by law, a practitioner may review information submitted in support of their credentialing application and verifications obtained by KP that are a matter of public record. The credentials file must be reviewed in the presence of KP credentialing staff. Upon receipt of a written request, an appointment time will be established during which practitioners may review the file.

9.3.3.3 Practitioner Right To Be Informed of the Status of the Credentialing Application

The credentials staff will inform the practitioner of their credentialing or recredentialing application status upon request. Requests and responses may be written or oral. Information regarding status is limited to:

- Information specific to the practitioner's own credentials file
- Current credentialing status
- Estimated committee review date, if applicable and available
- Outstanding information needed to complete the credentials file

9.3.3.4 Practitioner Right to Credentialing and Privileging Policies

Upon written request, a practitioner may receive a complete and current copy of KFHP, Northern California Region Credentialing & Privileging Policies and Procedures. For those hospitals where the practitioner maintains active privileges, the practitioner may also request and receive complete and current copies of Professional Staff Bylaws and The Rules and Regulations of the Professional Staff of Kaiser Foundation Hospital.
9.3.4 Organizational Providers (OPs)

KP requires that all OPs within the scope of its credentialing program be credentialed prior to treating Members and maintain credentialing at all times. Recredentialing will occur at least every 36 months and may occur more frequently. Requirements for both initial and recredentialing for OPs include, but are not limited to:

- Completed credentialing/recredentialing application
- California License in good standing, as applicable
- Medicare and Medicaid certification, if applicable
- Accreditation by a KP-recognized accreditation body and/or site visit by KP
- Evidence of current professional and general liability insurance, in amounts as required by KP
- Other criteria specific to organizational specialty

9.3.4.1 Corrective Action Plan or Increased Monitoring Status for OPs

Credentialing and recredentialing determinations are made by the KP Regional Credentials and Privileges Committee (RCPC). At the time of initial credentialing, newly operational OPs may be required to undergo monitoring.

Newly operational OPs are typically monitored for at least 6 months. These providers may be required to furnish monthly reports of applicable quality and/or clinical indicators for a minimum of the first 3 months of the initial credentialing period. This monitoring may include onsite visits.

If deficiencies are identified through KP physicians, staff or Members, the OP may be placed on a Corrective Action Plan (CAP) or Performance Improvement Plan (PIP) related to those deficiencies.

The OP will be notified in writing if deficiencies are identified. The notice will include the reason(s) for which the CAP or PIP is required, the monitoring time frames and any other specific requirements that may apply regarding the monitoring process. Within 2 weeks of such notice, the OP must create, for KP review, a time-phased plan that addresses the reason for the deficiency and their proposed actions toward correcting the deficiency. KP will review the draft CAP or PIP and determine whether it adequately addresses identified issues. If the plan is not acceptable, KP representatives will work with the OP to make necessary revisions to the plan. OPs subject to a CAP or PIP will be monitored for 6 months or longer.

For additional information regarding credentialing and recredentialing requirements and policies, please contact Provider Relations.
9.4 Monitoring Quality

9.4.1 Compliance with Legal, Regulatory and Accrediting Body Standards

KP expects all applicable Providers to be in compliance with all legal, regulatory and accrediting requirements, to have and maintain accreditation as appropriate, to maintain a current certificate of insurance, and to maintain current licensure. If any entity takes any adverse action with regard to licensure or accreditation, this must be reported to KP’s Medical Services Contracting Department, along with a copy of the report, the action plan to resolve the identified issue or concern, within 90 days of the receipt of the report.

9.4.2 Member Complaints

Written complaints by Members about the quality of care provided by the Provider or Provider’s medical staff or KP representatives must be reported within 30 days. The above aggregate reporting is part of the quality management process and is independent of any other requirements contained in your Agreement concerning the procedure for addressing specific complaints made by Members (either written or oral).

9.4.3 Infection Control

KP requests the cooperation of Providers in monitoring their own practice for reporting of communicable diseases, preventing transmission of communicable diseases, and efforts aimed at prevention of hospital associated infection (HAI) including, but not limited to, multi-drug resistant organisms such as MRSA, VRE, and C.difficile (C.diff), postoperative surgical site infections, central line associated bloodstream infections, and catheter-associated urinary tract infection. When a potential infection is identified, notify the local Infection Preventionist to determine if it meets NHSN definition. Confirmed HAI should be tracked and rates determined and entered into NHSN for trending. When a trend is identified by the affiliated practitioner or Provider, this should be shared with local Infection Control Committee (ICC) and a collaborative approach should be undertaken in order to improve practices related to infection prevention and control. All HAI summary reports and analysis should be submitted for review on an ongoing basis to the KP ICC and Quality Management (QM) Departments. Results of this review should then be shared with the affiliated practitioner or Provider. The IP and QM Departments will request certain actions and interventions be taken to maximize patient safety, as appropriate.

9.4.4 Practitioner Quality Assurance and Improvement Programs

KP ensures that mechanisms are in place to continually assess and improve the quality of care provided to Members to promote their health and safety through a comprehensive and effective program for practitioner peer review and evaluation of practitioner performance. This policy supports a process to conduct a peer review investigation of a health care
practitioner’s performance or conduct that has affected or could affect adversely the health or welfare of a Member.

9.5 **Quality Oversight**

The peer review process is a mechanism to identify and evaluate potential quality of care concerns or trends to determine whether standards of care are met and to identify opportunities for improvement. The process is used to monitor and facilitate improvement at the individual practitioner and system levels to assure safe and effective care. Peer review provides a fair, impartial, and standardized method for review whereby appropriate actions can be implemented and evaluated. The peer review process includes the following:

- **Practitioner Performance Review and Oversight**—Practitioner profiling for individual re-credentialing as well as oversight and evaluation of the quality of care provided by practitioners in a department
- **Practitioner Peer and System Review**—Quality of care concern
- **Focused Practitioner Review and Practice Improvement Plan**—provides an objective evaluation of all or part of a practitioner’s practice when issues are identified around the performance of that practitioner

The primary use of the information generated from these activities is for peer review and quality assurance purposes. Such information is subject to protection from discovery under applicable state and federal law. All such information and documentation will be labeled “Confidential and Privileged,” and stored in a separate, secured, and appropriately marked manner. No copies of peer review documents will be disclosed to third parties unless consistent with applicable KP policy and/or upon the advice of legal counsel. Information, records, and documentation of completed peer review activity (along with other information on practitioner performance) shall be stored in the affected individual practitioner’s confidential quality file.

Individuals involved in the peer review process shall be subject to the policies, principles, and procedures governing the confidentiality of peer review and quality assurance information.

When a peer review investigation results in any adverse action reducing, restricting, suspending, revoking, or denying the current or requested authorization to provide health care services to Members based upon professional competence or professional conduct, such adverse actions will be reported by the designated leaders of the entities responsible to make the required report (e.g., the chief of staff or hospital administrator) to the National Practitioner Data Bank and/or regulatory agencies, as appropriate.

9.5.1 **Quality Review**

Criteria that trigger a referral for Quality Review are identified through multiple mechanisms. Some sources include, but are not limited to:
• Allegations of professional negligence (formal or informal)
• Member complaints / grievances related to quality of care
• Risk Management (sentinel and significant events, potentially compensable events)
• Medical legal referrals
• Inter- or intra-departmental or facility referrals
• Issues identified by another practitioner
• UM
• Member complaints to external organizations

Cases referred for quality review are screened for issues related to the professional competence of a practitioner, which may be subject to peer review. These may include, but are not limited to:

• Concerns regarding the possibility of any breach of professional judgment or conduct towards patients
• Concerns regarding the possibility of failure to appropriately diagnose or treat a Member/patient
• Adverse patterns of care identified through aggregate review of performance measures (e.g., automatic triggers)

To assist in review, the reviewer will use appropriate information from sources that include, but are not limited to:

• Nationally recognized practice standards, preferably evidence based
• Professional practice requirements
• KP and other CPG
• KP Policies and procedures, including policies related to patient safety
• Regulatory and accreditation requirements
• Community standard of care

9.5.2 OPs’ Quality Assurance & Improvement Programs (QA & I)

Each OP must maintain, at all times, a QA & I program, described in a written plan approved by its governing body that meets all applicable state and federal licensure, accreditation and certification requirements. When quality problems are identified, the OP must show evidence of corrective action, ongoing monitoring, revisions of policies and procedures, and changes in the provision of services. Each OP is expected to provide KP with its QA & I Plan and a copy of all updates and revisions.
9.5.3 Sentinel Events / Reportable Occurrences for OPs (Applicable to Acute Hospitals, Chronic Dialysis Centers, Ambulatory Surgery Centers, Psychiatric Hospitals, SNFs and Transitional Residential Recovery Services Providers)

All Providers must report sentinel events and reportable occurrences as defined below. OPs must report events and occurrences at its facility or facilities covered by its Agreement.

9.5.3.1 Definitions: Sentinel Events and Reportable Occurrences

A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof, to a Member. The phrase “the risk of” includes any process variation for which an occurrence (as in “close call” or “near miss”) or recurrence would carry a significant chance of a serious adverse outcome. Sentinel events are inclusive of all the Joint Commission’s sentinel events and National Quality Forum serious reportable events.

Reportable occurrences include, but are not limited to, all of the following:

- Patient falls resulting in serious injury, which require subsequent medical intervention
- A cluster of nosocomial infections (cohort of three or more)
- Outbreaks of infectious disease reportable to the County Health Department
- Official notice concerning revocation (requested or actual) of Medicare/Medi-Cal Certification or suspension of Medicare/Medi-Cal admissions

9.5.3.2 Notification Timeframes

Practitioners and OPs will report sentinel events and reportable occurrences within 24 hours of becoming aware of the event or occurrence. The report will be made to KP as follows:

<table>
<thead>
<tr>
<th>Provider</th>
<th>KP Contact</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practitioner</td>
<td>Referral Coordinator</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Acute Hospital</td>
<td>Care Coordinator</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Chronic Dialysis Center</td>
<td>Care Coordinator</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Ambulatory Surgery Center</td>
<td>Care Coordinator</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Psychiatric Hospital</td>
<td>Care Coordinator</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>SNF</td>
<td>Care Coordinator</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>TRRR</td>
<td>Care Coordinator</td>
<td>Within 24 hours</td>
</tr>
</tbody>
</table>
9.5.4 Sentinel Event/Reportable Occurrences—Home Health & Hospice Agency Providers

9.5.4.1 Report Within 24 Hours

Immediately upon discovery, verbally report to the referring KP Home Health Agency, Hospice Agency or facility any sentinel event (as defined above in Section 9.5.3.1) and the following significant events. The verbal report must be followed by a written notification sent within 24 hours or by the end of the next business day by certified mail, return receipt.

- The event is a significant adverse deviation from the usual process(es) for providing health care service or managing health care operations
- The event or related circumstances has the potential for significant adverse media (press) involvement
- Any process variation from which a reoccurrence would carry a significant chance of a serious adverse outcome
- Significant drug reactions
- Medication errors resulting in actual or potential harm to the patient
- Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities
- Member/patient is either a perpetrator or victim of a crime or reportable abuse while under home health or hospice care
- Loss of license, certification or accreditation status
- Release of any toxic or hazardous substance that requires reporting to a local, state or federal agency

9.5.4.2 Report Within 72 Hours

You must report to the referring KP Home Health Agency, Hospice Agency or facility during KP business hours the following events involving Members that may impact the quality of care and/or have the potential for a negative outcome. Such report should be made within 72 hours of the occurrence. These include but are not limited to the categories below.

- Reportable, communicable diseases, outbreaks of scabies or lice, and breaks in infection control practices
- Falls resulting in injury
- Re-admission to a hospital
- Medication errors (wrong patient, wrong drug, wrong dose, wrong route, wrong time, wrong day, or an extra dose, or an omission of an ordered drug)
Disciplinary action taken against a practitioner caring for a KP Member that requires a report to the applicable state board or the National Practitioner Data Bank

- Noncompliance with regulatory and/or accreditation standards requiring CAP
- Any unexpected Member death

### 9.5.5 DNBES / Reportable Occurrences for Providers

As part of its required participation in KP’s QI Program and in addition to the Claims submission requirements in Section 5.18.6 of this Provider Manual, and to the extent permitted by Law, the Provider must promptly notify KP and, upon request, provide information about any DNBES (as defined in Section 5.18.6) that occurs at its Location or Locations covered by its Agreement in connection with Services provided to a Member. Notices and information provided pursuant to this section shall not be deemed admissions of liability for acts or omissions, waiver of rights or remedies in litigation, or a waiver of evidentiary protections, privileges or objections in litigation or otherwise. Notices and information related to DNBES should be sent to:

Regional Medical Services Contracting Department  
Attn: Provider Relations  
P.O. Box 23380  
Oakland, CA 94623-2338  
Phone: (844) 343-9370  
Fax: (510) 987-4138

At a minimum, Providers should include the following elements in any DNBES notice sent to KP:

- KP Medical Record Number (MRN)
- Date(s) of service
- Place of service
- Referral number or emergency claim number
- General category description of DNBES(s) experienced by the Member

### 9.6 QA & I Reporting Requirements for Home Health & Hospice Providers

Quality monitoring activities will be conducted at each individual home health and hospice agency site and branch location.
9.6.1 Annual Reporting

On an annual basis, Providers of Home Health and Hospice services, and licensed/certified Providers who manage Members’ plan of care on referral, must submit to KP:

- Copies of current license and insurance
- Reports of any accreditation and/or regulatory site visits occurring within the last 12 calendar months
- Copy of current quality plan and indicators
- Results of most recent patient satisfaction survey
- Action plans for all active citations, conditions, deficiencies and/or recommendations

9.6.2 Site Visits and/or Chart Review

A site visit and/or chart review may be requested by KP at any time to monitor quality and compliance with regulations. When onsite reviews are requested by the referring KP Home Health Agency, Hospice Agency, or facility or regional representative, your agency will make the following available:

- Personnel records
- Quality plan and indicators
- Documentation for Member complaints and follow-up
- Member medical records
- Policy and procedure manuals
- Other relevant quality and compliance data

9.6.3 Personnel Records

Providers providing home health and hospice services shall cooperate with KP audits of staff personnel records. Audits are designed to assure personnel providing care to KP Members are qualified and competent. Information reviewed may include but not be limited to:

- Professional License
- Current CPR certification
- Tuberculin or PPD testing
- Evidence of competency for those services provided to KP Members
- Continuing education
- Annual evaluation
Section 9: Quality Assurance and Improvement

9.7 QA & I Reporting Requirements for SNFs

The KP QA & I plan includes quality indicators that are collected routinely. Some of these indicators KP will collect; others will be collected by the SNF Providers. These indicators will be objective, measurable, and based on current knowledge and clinical experience. They reflect structures, processes or outcomes of care. KP promotes an outcome-oriented quality assessment and improvement system and will coordinate with SNF Providers to develop reportable outcomes.

9.7.1 Quarterly Reporting

Quarterly, SNF Quality Assessment indicator trend reports will include, at a minimum, the following:

- Patient falls
- Pressure sores
- Medication errors
- Any CMS deficiency with a CAP or California Department of Public Health (CDPH) deficiency or citation with a CAP
- Reports to CDPH of unusual occurrences involving KP Members

9.7.2 Medical Record Documentation

KP procedures regarding medical record documentation for SNF Providers are detailed below. Any contradiction with a SNF Provider’s own policies and procedures should be declared by the SNF, so that steps can be taken to satisfy both the SNF Provider and KP.

All patient record entries shall be written (preferably printed), made in a timely manner, dated, signed, and authenticated with professional designations by individuals making record entries.

Medical record documentation shall include at least the following:

- Member information, including emergency contact and valid telephone number
- Diagnoses and clinical impressions
- Plan of care
- Applicable history and physical examination
- Immunization and screening status when relevant
- Allergic and adverse drug reactions when relevant
- Documentation of nursing care, treatments, frequency and duration of therapies for Member, procedures, tests and results
- Information/communication to and from other providers
- Referrals or transfers to other providers
- Recommendations and instructions to patients and family members
- For each visit: date, purpose and updated information
- Advance Directive

9.8 QA & I Reporting Requirements for Chronic Dialysis Providers

9.8.1 Reporting Requirements

Providers who deliver chronic dialysis services are expected to send, on a monthly basis via hard copy or electronic file, a Patient Activity Report form containing the following information for patients who are:
- dialyzing for the first time
- transferring into the contracted dialysis center from another dialysis center
- returning after transplant
- recovering renal function
- receiving a transplant
- transferring to another dialysis center
- deceased
- changing treatment modality

Providers must also submit the above information for patients who were on dialysis prior to joining KP.

9.8.2 Vascular Access Monitoring (VAM)

Pursuant to your Agreement, the chronic dialysis Provider is responsible for monitoring the blood flow in all grafts and fistulas of Members at the levels prescribed by the assigned nephrologist. Your Agreement will specify whether you are obligated to perform VAM services either using the Transonic Flow QC System® or the Fresenius K+ machine, or a combination of the 2 modalities.

Desirable levels for flow rates are >400 ml/min for fistulas and >600 ml/min for grafts. When blood flow rates fall below the desirable targets, notify the nephrologist and/or KP renal case manager so that an appropriate intervention to prevent the access from clotting can be planned.
9.8.2.1 Surveillance Procedure for an Established Access

1. Obtain an access monitoring order from the nephrologist.

2. The Provider performs monthly access flow measurements once prescribed blood flow and optimal needle size are achieved at the intervals described below:

**Grafts**

- **VAM services testing frequency**
  - Transonic Flow QC System®—Monthly*
  - Fresenius K+ machine—Monthly
  - As otherwise prescribed by a Nephrologist

- **Graft flow > 600 ml/min**—continue to test at monthly intervals and trend results

- **Graft flow rate 500 to 600 ml/min**—review test results and trend. If trending indicates that flows are decreasing, refer the patient for angiogram and evaluation

- **If trends remain constant and are not decreasing**, repeat the test at the scheduled time

- **Graft flow rate < 500 ml/min**—refer for angiogram and evaluation

**Fistula**

- **VAM services testing frequency**
  - Transonic Flow QC System®—Every other month*
  - Fresenius K+ machine—Monthly
  - As otherwise prescribed by a nephrologist

- **Fistula flow rate > 400 ml/min**—continue to test at monthly intervals and trend results.

- **Fistula flow rate 300 to 400 ml/min**—Review test results and trend. If trending indicates that flows are decreasing, refer the patient for angiogram and evaluation.

- **If trends remain constant**, use slower blood flows and perform a clinical evaluation to verify the adequacy of the treatments at a lower pump speed.

- **Fistula flow rate < 300 ml/min**—Refer for angiogram and evaluation

  *In the case of the Transonic Flow QC System®, recirculation should be zero percent (0%) when testing the vascular access.

3. The Provider performs access flow measurements at frequencies other than that outlined above under the following conditions:

- **After a surgical procedure to create a new vascular access**
Within a week following an access intervention, including but not limited to, a fistulogram, de-clotting, angioplasty or a surgical revision

As ordered by a nephrologist or KP renal case manager

9.8.3 Performance Target Goals/Clinical Indicators

9.8.3.1 Chronic Dialysis Patients

The following performance targets are the clinical indicators for hemodialysis and peritoneal dialysis KP Members and shall be reported by the Provider to KP within 15 calendar days from the end of the calendar quarter. The submission of the indicators shall be in a format acceptable to KP via an electronic file or other method designated by KP. Each contracted dialysis company must report the indicators on a quarterly basis for each of its participating dialysis centers in their Agreement:

<table>
<thead>
<tr>
<th>MODALITY</th>
<th>MEASUREMENT</th>
<th>DESCRIPTION</th>
<th>TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Center HD</td>
<td>Vascular Access</td>
<td>Percentage of patients in a given reporting period with a central venous catheter in place. If Fistula or Graft in use, but CVC in place, CVC will count.</td>
<td>Monitoring only with plan to develop target by January 2014</td>
</tr>
<tr>
<td></td>
<td>Adequacy of Dialysis</td>
<td>Percent of all patients at clinic whose last valid Kt/V of the month ≥ 1.2</td>
<td>≥ 95%</td>
</tr>
<tr>
<td></td>
<td>Positive Blood Cultures</td>
<td>Report all positive blood cultures according to NHSN guidelines</td>
<td>100% of known positive blood cultures are reported</td>
</tr>
<tr>
<td></td>
<td>Patients with Flu Vaccination</td>
<td>Includes vaccines administered at the unit and if patient reports that they received a vaccine elsewhere September through March. Patients who are contraindicated, refused or who are allergic are counted as &quot;No.&quot; Data not included on reports April through August.</td>
<td>N/A (Data provided if available)</td>
</tr>
<tr>
<td></td>
<td>Patients with Pneumo Vaccination</td>
<td>Includes patients who received one dose within the last five years or two doses, five years apart within a lifetime. Either administrated at the unit or reported by the patient. Patients who are contraindicated, refused or who are allergic are counted as &quot;No.&quot;</td>
<td>N/A (Data provided if available)</td>
</tr>
</tbody>
</table>
### REGIONAL RENAL ESRD QUALITY IMPROVEMENT PROGRAM

#### DIALYSIS FACILITY SPECIFIC TARGETS

<table>
<thead>
<tr>
<th>MODALITY</th>
<th>MEASUREMENT</th>
<th>DESCRIPTION</th>
<th>TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>PD</td>
<td>Adequacy of Dialysis</td>
<td>Percent of all patients at clinic whose last valid Kt/V of the month ≥ 1.7</td>
<td>≥ 85%</td>
</tr>
<tr>
<td></td>
<td>Peritonitis Rates</td>
<td>12-month rolling peritonitis rate</td>
<td>Peritonitis not more frequent than 1 infection in 36 patient months</td>
</tr>
<tr>
<td>PD</td>
<td>Patients with Flu Vaccination</td>
<td>Includes vaccines administered at the unit and if patient reports that they received a vaccine elsewhere September through March. Patients who are contraindicated, refused or who are allergic are counted as &quot;No.&quot; Data not included on reports April through August.</td>
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<td>N/A (Data provided if available)</td>
</tr>
</tbody>
</table>

### 9.9 Medical Record Review and Standards

KP recommends that all Providers maintain their medical records following standards applicable to their specialty to assure the consistency and completeness of patient medical records.

**NOTE:** A Provider may demonstrate compliance with these standards by preparing a sample medical record and discussing it with the reviewer or by redacting several medical records for existing patients.

#### KP MEDICAL RECORD STANDARDS

<table>
<thead>
<tr>
<th>Summary of Medical Record Standards</th>
<th>Information Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Identification*</td>
<td>All entries (entry, page, or screen) in a patient’s medical record must include the patient’s last name, first name, and the patient’s unique KP medical record number (MRN).</td>
</tr>
<tr>
<td>Summary of Medical Record Standards</td>
<td>Information Required</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>-----------------------</td>
</tr>
</tbody>
</table>
| Personal/Biographical Data*         | Patient demographic information which includes:  
- Birth date  
- Gender  
- Marital status  
- Home address and  
- Home/work telephone numbers  
**NOTE:** For pediatric medical records, this information should also address the child’s parent/guardian. |
| Medical Record Entries*              | All notes/entries  
- Include the name of the rendering provider and, if paper documentation, are authenticated by the provider  
- Are dated and in sequential order  
- Are legible to someone other than the writer  
- Are done in a timely manner |
| Problem List (PCP Only)*             | Medical records include a completed “problem list” which notes significant illnesses or medical conditions. |
| Allergies*                           | Allergies and adverse reactions to medications or immunizations are noted and prominently displayed inside or on the cover of a hard copy of a medical record, and in any computer based program.  
If the patient has no known allergies or history of adverse reactions, this must be also noted. |
| Medical History*                     | Medical history must include:  
- Date of birth  
- Documentation of past medical history for which includes serious illnesses, past surgeries, or significant procedures.  
- Pertinent family and social history  
For **Pediatric Patients**, the history should also include:  
- Birth history including location, child’s birth weight, and any special circumstances regarding the birth.  
- Growth chart with height, weight, and head circumference to (HC age 2)  
- Operations and childhood illnesses  
- Immunizations |
<p>| Substance Abuse/Tobacco Products     | For patients 14 years and older, medical records should document use/non-use of tobacco products, alcohol, or other substances. If the patient has been seen 3 or more times, he or she should be asked about substance abuse history. |</p>
<table>
<thead>
<tr>
<th>Summary of Medical Record Standards</th>
<th>Information Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pertinent History/Exams for Patient “Complaints”</td>
<td>Pertinent history, physical exam for presenting complaints is completed and noted. The patient's vital signs are also noted.</td>
</tr>
<tr>
<td>Laboratory/Radiology Tests</td>
<td>Lab and Radiology and other testing are ordered as appropriate and the ordering practitioner must make a notation in the record indicating abnormal results.</td>
</tr>
<tr>
<td>Working Diagnosis Consistent With Findings</td>
<td>Impression/working diagnosis clearly documented for each visit (except for preventive visits where no illness, complaint, etc. is identified.)</td>
</tr>
<tr>
<td>Treatment Plans</td>
<td>Treatment plans are consistent with diagnosis.</td>
</tr>
<tr>
<td>Follow-up Care/Visits</td>
<td>Date for return visit or other follow-up plan(s) for each encounter are noted when appropriate. The specific time of the follow-up visit is noted in weeks, months, or as needed.</td>
</tr>
<tr>
<td>Instruction in Self-Care</td>
<td>Date training/instruction on self-care provided to patient noted.</td>
</tr>
<tr>
<td>Unresolved Problems</td>
<td>Problems from previous visits are addressed in subsequent visits.</td>
</tr>
<tr>
<td>Use of Consultants</td>
<td>There is evidence of appropriate use of consultants.</td>
</tr>
<tr>
<td>Consultant Notes</td>
<td>There is evidence of continuity and coordination of care between primary and specialty providers. If consults are requested, copies of consultant notes are included in the medical record.</td>
</tr>
<tr>
<td>PCP Review of Consult/Lab Reports</td>
<td>Consultation summaries and lab &amp; imaging reports indicate provider review. There is evidence that follow-up plans are in place for significant abnormal findings.</td>
</tr>
<tr>
<td>Patient at Inappropriate Risk</td>
<td>There is no evidence that patient is placed at inappropriate risk by diagnostic or therapeutic intervention.</td>
</tr>
<tr>
<td>Immunizations*</td>
<td>An immunization record is present and up-to-date for all pediatric patients. Adult immunizations are noted as appropriate.</td>
</tr>
<tr>
<td>Advance Directive</td>
<td>Document in record, prominently placed, to denote whether or not an Advance Directive has been executed.</td>
</tr>
<tr>
<td>Preventive Services</td>
<td>There is evidence that preventive screening and services are offered according to nationally accepted standards and practice guidelines.</td>
</tr>
<tr>
<td>Medications</td>
<td>A medication list is included.</td>
</tr>
</tbody>
</table>

**NOTE:** Information and data recorded in the Medical Record and in other Member health & enrollment records must be accurate, complete, and truthful.

* Medical records must comply with these standards if only general medical recordkeeping practices are being reviewed.
9.10 **Access and Availability Guidelines**

Access to care is evaluated using Member satisfaction questions from the Consumer Assessment of Healthcare Providers and Systems (CAHPS), provider surveys, and Member complaints and grievances.

To assure all Members are able to access medical care in a safe and timely manner, KP utilizes access guidelines. These guidelines generally correspond with those accepted within the community. Safe, efficient, and accessible practice sites are essential components to delivering high quality care and services to Members. Compliance with access and facility guidelines is measured through office site reviews (for affected Providers), Member complaints and Member satisfaction surveys. Findings are used to support quality improvement activities, and are also considered during the recredentialing process for certain Providers, for example, those contracted to provide primary care. Adhering to the following guidelines increases access to care and overall Member satisfaction.

<table>
<thead>
<tr>
<th>Access Indicator</th>
<th>Maximum Appointment/Response Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care Practitioners</strong></td>
<td></td>
</tr>
<tr>
<td>New patient visit</td>
<td>30 Business Days</td>
</tr>
<tr>
<td>Preventive Gynecological Exam</td>
<td>7 Business Days</td>
</tr>
<tr>
<td>Non-urgent Care</td>
<td>7 Business Days</td>
</tr>
<tr>
<td>Routine/Preventive Care</td>
<td>7 Business Days</td>
</tr>
<tr>
<td><strong>Behavioral Health Providers</strong></td>
<td></td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Non-Urgent Care</td>
<td>Within 10 Business Days</td>
</tr>
<tr>
<td><strong>Specialists and Ancillary Services Practitioners</strong></td>
<td></td>
</tr>
<tr>
<td>Non-urgent symptomatic visit</td>
<td>14 Business Days. The time-frame begins on the day a referral is generated by the PCP and ends the day the patient is scheduled to see the specialist.</td>
</tr>
<tr>
<td>Routine Follow-Up</td>
<td>14 Business Days</td>
</tr>
<tr>
<td><strong>ALL Providers</strong></td>
<td></td>
</tr>
<tr>
<td>Urgent care (non-life threatening, if left untreated could lead to harmful outcome)</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Emergency care</td>
<td>Immediately</td>
</tr>
</tbody>
</table>
## Access Indicator

<table>
<thead>
<tr>
<th>Access Indicator</th>
<th>Maximum Appointment/Response Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wait times in physician’s office</td>
<td>Less than 30 minutes.</td>
</tr>
<tr>
<td></td>
<td>If an emergency occurs that will substantially lengthen a Member’s waiting time, the office staff should inform the patient of the delay as soon as possible, and offer to:</td>
</tr>
<tr>
<td></td>
<td>Reschedule appointments for Members if medically acceptable</td>
</tr>
<tr>
<td></td>
<td>Have Members see another provider in the office if one is available, and the option is acceptable to the Member</td>
</tr>
<tr>
<td>Access to after-hours care</td>
<td>Continuous coverage must be available</td>
</tr>
</tbody>
</table>

### Calls Placed to a Provider’s Office

<table>
<thead>
<tr>
<th>Time Frame</th>
<th>Response Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>During business hours</td>
<td>Returned same day the call is received</td>
</tr>
<tr>
<td>After business hours</td>
<td>Returned within 24 hours</td>
</tr>
</tbody>
</table>

When Members request same day or future appointments and their medical condition warrants, the appointment should be scheduled as close to the requested day and time as possible. If the Member does not request a specific day or time, an appointment within the time frames noted in the table above should be offered.

The applicable waiting time for a particular appointment may be extended if the KP referring or treating licensed health care provider, or the KP health professional providing triage or screening services to Members, as applicable, has determined that a longer waiting time will not have a detrimental impact on the health of the Member. If any Member declines an appointment offered within these guidelines, or if the Provider, in consultation with the KP referring or treating licensed health care provider, determines that a longer waiting time will not have a detrimental impact on the health of the Member, we strongly recommend that the declination or the professional determination and underlying clinical basis for a delayed appointment be documented in the Member’s medical record maintained by the contractor. For inquiries regarding these situations, Providers should contact the KP office which issued the referral as noted in the authorization communication.
10. Compliance

KP strives to demonstrate high ethical standards in our business practices. The Agreement details specific laws and contractual provisions with which you are expected to comply. This section of the Provider Manual details additional compliance obligations.

10.1 Compliance with Law

Providers are expected to conduct their business activities in full compliance with all applicable state and federal laws.

10.2 KP Principles of Responsibility and Compliance Hotline

The KP Principles of Responsibility (POR) is the code of conduct for KP physicians, employees and contractors working in KP facilities (KP Personnel) in their daily work environment. If you are working in a KP facility, you will be given a copy of the POR for your reference. You should report to KP any suspected wrongdoing or compliance violations by KP Personnel under the POR. The KP Compliance Hotline is a convenient and anonymous way to report a suspected wrongdoing without fear of retaliation. It is available 24 hours per day, 365 days per year. The toll free Compliance Hotline number is (888) 774-9100.

Additionally, Providers may review the KP POR and Provider Code of Conduct at: http://providers.kaiserpermanente.org/html/cpp_national/compliance.html and are encouraged to do so. The KP POR and Code of Conduct are applicable to interactions between you and KP and failure to comply with provisions of these standards may result in a breach of your Agreement with KP.

10.3 Gifts and Business Courtesies

Even if certain types of remuneration are permitted by law, KP discourages Providers from giving gifts, meals, entertainment or other business courtesies to KP Personnel, in particular the following strictly prohibited items:

- Gifts or entertainment of any kind or value
- Gifts, meals or entertainment that are provided on a regular basis
- Cash or cash-equivalents, such as checks, gift certificates/cards, stocks, or coupons
- Gifts from government representatives
- Gifts or entertainment that reasonably could be perceived as a bribe, payoff, deal or any other attempt to gain advantage
- Gifts or entertainment given to KP Personnel involved in KP purchasing and contracting decisions
- Gifts or entertainment that violate any laws or KP policy

10.4 Conflicts of Interest

Conflicts of interest between a Provider and KP Personnel or the appearance of it, should be avoided. There may be some circumstances in which members of the same family or household may work for KP and for a Provider. However, if this creates an actual or potential conflict of interest, you must disclose the conflict at the earliest opportunity, in writing, to a person in authority at KP (other than the person who has the relationship with the Provider). You may call the toll free Compliance Hotline number at (888) 774-9100 for further guidance on potential conflicts of interest.

10.5 Fraud, Waste and Abuse

Providers must be aware that funds received from KP are in whole or in part derived from federal funds. You are expected to comply with all applicable state and federal laws governing remuneration for health care services, including anti-kickback and physician self-referral laws. KP will investigate allegations of Provider fraud, waste or abuse, related to services provided to Members, and where appropriate, will take corrective action, including but not limited to civil or criminal action. The Federal False Claims Act and similar state laws are designed to reduce fraud, waste and abuse by allowing citizens to bring suit on behalf of the government to recover fraudulently obtained funds (i.e., “whistleblower” or “qui tam” actions). No individual may be threatened, harassed or in any manner discriminated against in retaliation for exercising their rights under the False Claims Act or similar state laws.

10.6 Providers Ineligible for Participation in Government Health Care Programs

KP requires the Provider to (a) disclose whether any of its officers, directors, employees, or subcontractors are or become sanctioned by, excluded from, debarred from, or ineligible to participate in any federal program or is convicted of a criminal offense related to the provision of health care and (b) assume full responsibility for taking all necessary steps to assure that Provider’s employees, subcontractors and agents directly or indirectly involved in KP business have not been and are not currently excluded from participation in any federal program and this shall include, but not be limited to, routinely screening all such names against all applicable lists of individuals or entities sanctioned by, excluded from, debarred from, or ineligible to participate in any federal program published by government agencies (including the U.S. Department of Health and Human Services, Office of Inspector General, List of Excluded Individuals and Entities at http://oig.hhs.gov/exclusions/exclusions_list.asp and U.S. General Services Administration, Excluded Parties List System at https://www.sam.gov) as and when those lists are updated from time to time, but no less often than upon initial hiring or contracting and annually thereafter. Providers are required to document their actions to
screen such lists, and upon request certify compliance with this requirement to KP. KP will not do business with a health care practitioner who is or becomes excluded by, debarred from, or ineligible to participate in any federal health care program or is convicted of a criminal offense related to the provision of health care.

10.7 Visitation Policy

When visiting KP facilities (if applicable), you are expected to comply with the applicable visitation policy, which is available at KP facilities upon request. “Visitor” badges provided by the visited KP facility must be worn at all times during the visit.

10.8 Compliance Training

KP requires certain providers, including those who provide services in a KP facility, to complete KP’s Compliance Training, as required by your Agreement, applicable law or regulatory action or as required by any government health care program contract to which KP is a party. Where applicable, you must ensure that your employees and agents involved in KP business complete, and provide evidence of completion of, the relevant KP Compliance Training. Please refer to your KP Contracts Manager for more guidance regarding these requirements.

10.9 Confidentiality and Security of Patient Information

Health care providers, including KP and you or your facility, are legally and ethically obligated to protect the privacy of patients and Members. KP requires that Providers keep Members’ medical information confidential and secure. These requirements are based on state and federal laws both applicable to Providers and KP, as well as policies and procedures created by KP.

Providers may not use or disclose the personal health information of a Member, except as needed to provide medical care to Members or patients, to bill for services or as necessary to regularly conduct business. Personal health information refers to medical information, as well as information that can identify a Member, for example, a Member’s address or telephone number.

Medical information may not be disclosed without the authorization of the Member, except when the release of information is either permitted or required by Law.

10.9.1 HIPAA and Privacy and Security Rules

As a Provider, you may have signed a document that creates a “Business Associate” relationship with KP, as such relationship is defined by federal regulations commonly known as HIPAA. If you are providing standard patient care services that do not require a
business associate agreement, you still must preserve the confidentiality, privacy and security of our common patients’ medical information.

If you did not sign a business associate agreement, you are likely a "Covered Entity" as that term is defined under HIPAA, and the Privacy and Security Rules issued by the Department of Health and Human Services. As a Covered Entity, you have specific responsibilities to limit the uses and disclosures and to ensure the security of protected health information (PHI), as that term is defined by the Privacy Rule (45 CFR Section 160.103).

Certain data which may be exchanged as a consequence of your relationship with KP is subject to the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-91) and its regulations or as updated and amended by Health Insurance Portability and Accountability Act of 1996 (Public Law 104-91) and the Health Information Technology and Economic and Clinical Health Act (HITECH), Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5), as each are codified in the United States Code, and all regulations issued under any of the foregoing statutes, as and when any of them may be amended from time to time (collectively “HIPAA”). To the full extent applicable under HIPAA, you must comply with HIPAA, including but not limited to the HIPAA standards for (i) privacy, (ii) code set, (iii) data transmission standards, and (iv) security regarding physical storage, maintenance, transmission of and access to individual health information.

Providers must use and disclose PHI only as permitted by HIPAA and the Privacy Rule, subject to any additional limitations, if any, on the use and disclosure of that information as imposed by your Agreement or any Business Associate Agreement you may have signed with KP. You must maintain and distribute your Notice of Privacy Practices (45 CFR Section 164.520) to and obtain acknowledgements from Members receiving services from you, in a manner consistent with your practices for other patients. You must give KP a copy of your Notice of Privacy Practices upon request and give KP a copy of each subsequent version of your Notice of Privacy Practices whenever a material change has been made to the original Notice.

Providers are required by HIPAA to provide a patient with access to his or her PHI, to allow that patient to amend his or her PHI, and to provide an accounting of those disclosures identified under the Privacy Rule as reportable disclosures. You must extend these same rights to Members who are patients.

10.9.2 Confidentiality of Alcohol and Drug Abuse Patient Records

In receiving, storing, processing or otherwise dealing with any patient records, Provider is fully bound by the federal substance abuse confidentiality rules set forth at 42 CFR Part 2 and if necessary, must resist in judicial proceedings any efforts to obtain access to patient records, except as permitted by these regulations.
10.10 **Provider Resources**

- KP’s National Compliance Office: (510) 271-4699
- KP’s Compliance Hotline: (888) 774-9100
- Regional Compliance Office: (510) 625-2400
- Medical Services Contracting Department: (844) 343-9370
11. Additional Information

11.1 Affiliated Payors

In accordance with the terms of your Agreement with KP, the mutually agreed upon rates in the Agreement may be extended to Affiliated Payors as identified below:

Kaiser Foundation Health Plan, Inc.
KP Cal, LLC
Kaiser Foundation Health Plan of Colorado
Kaiser Foundation Health Plan of Georgia, Inc.
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Kaiser Foundation Health Plan of the Northwest
Kaiser Foundation Hospitals
Kaiser Permanente Insurance Company
Group Health Cooperative (headquartered in Seattle, Washington)
The Permanente Medical Group, Inc.
Southern California Permanente Medical Group
Colorado Permanente Medical Group, P.C.
Hawaii Permanente Medical Group, Inc.
Mid-Atlantic Permanente Medical Group, P.C.
Northwest Permanente, P.C., Physicians and Surgeons
Permanente Dental Associates
The Southeast Permanente Medical Group, Inc.
Permanente Services of Hawaii

11.2 Subcontractors and Participating Practitioners

KP defines a “subcontractor” as an individual participating practitioner, participating practitioner group, or any other entity that provides or arranges for services to KP Members pursuant to a direct or indirect contract, agreement, or other arrangement with a Provider contracted with KP.

Subcontractor participating practitioners may be locum tenens, members of the Provider’s call group, and others who may provide temporary coverage excluding employees, owners and/or partners of the contracting entity. For assistance in determining whether or not a participating practitioner is a subcontractor, please contact Provider Relations.
All rights and responsibilities of the Provider are extended to the subcontractor, individual participating practitioner, participating practitioner group and facilities providing services to Members. The Provider is responsible to distribute this Provider Manual and subsequent updates to all its subcontractors and participating practitioners, assuring that its subcontractors and participating practitioners and facilities adhere to all applicable provisions of this Provider Manual.

11.2.1 Regulatory Compliance

CMS conducts surveys of KP in order to measure compliance. Regulatory requirements surrounding the use of subcontractors obligate KP to validate that subcontracts are in place where applicable, and that they meet contractual and necessary Medicare Advantage (“MA”) language requirements. The Provider is to provide KP a copy of its subcontract template along with executed signature pages for each subcontractor upon request. When a subcontract is amended or altered, the Provider should notify KP within 30 calendar days. The Provider is responsible to furnish copies of executed subcontracts, and other documents related to subcontractors upon the request of governmental or regulatory agency personnel and/or when KP is preparing for internal and/or regulatory agency audits.

Additionally, upon request, the Provider is responsible to furnish copies of its policies and procedures related to any economic profiling information that is used to evaluate participating practitioner or subcontractor performance. Further the Provider is responsible to provide a copy of the information, upon request, to the subcontractor or participating practitioner. Economic profiling is defined as an evaluation based in whole or in part on the economic costs or utilization of services associated with providing medical care.

11.2.2 Licensure, Certification and Credentialing

Subcontractors and participating practitioners are subject to the same credentialing and recredentialing requirements as the Provider. The Provider is responsible to ensure that all subcontractors and participating practitioners are properly licensed by the State of California or the state(s) in which services are provided, and that the licensure and/or certification is in good standing in accordance with all applicable local, state, and federal laws. Further, the Provider is responsible to ensure that its subcontractors and participating practitioners participate in KP’s credentialing and recredentialing processes and that any site where Members may be seen is properly licensed. For additional information on credentialing requirements, please refer to Section 9.3 of this Provider Manual.
11.2.3 Billing and Payment

Services provided for KP Members should be billed by the Provider to include services provided by any of its subcontractors. KP will not pay subcontractor bills directly but will return them to the subcontractor for submitting to the Provider.

11.2.4 Encounter Data

KP is required to certify the accuracy, completeness and truthfulness of data that CMS and other state and federal governmental agencies and accrediting organizations request. Such data includes encounter data, payment data, and any other information provided to KP by its contractors and subcontractors. As such, KP may request such certification from the Provider in order to meet regulatory and accreditation requirements.

11.2.5 Identification of Subcontractors

Each Provider at the time of initial contracting, and periodically thereafter, is required to complete and submit to KP a completed PPIF (incorporated by reference in your Agreement). This form identifies all participating facilities and practitioners, including those practitioners that are employed by the Provider, facilities that are operated by the Provider and those which are subcontractors.

11.3 KP's Health Education Programs

KP is dedicated to providing quality care for its Members. A key step towards this goal is to make available and encourage the use of health education programs and to provide preventive health services and screenings which are based on the latest scientific information presented in medical specialty journals, sub-specialty organization guidelines, and the US Preventive Services Task Force Guide.

KP’s health education programs support KP clinicians by providing expertise in evidence-based patient health communication, behavior change, and technology. Health Education supports physicians in motivating and informing patients at the point of care while enhancing KP’s reputation for excellence in prevention, health promotion, and care of chronic conditions.

The local health education departments oversee the development and implementation of educational services for KP Members. All Members and Providers have access to the KP health education departments for information and health education materials. Health education departments can also offer Providers assistance with the planning or delivery of health education programs.

For more information contact your local KP facility and ask to be connected to the health education department.
11.3.1 Health Education Program

KP health education programs generally include:

- Health Education Centers, located at KP Medical Centers, provide free educational materials and support including direct services to patients to supplement or provide alternatives to doctor office visits. Members can also get answers to health questions from knowledgeable staff, help with registering on the Member website (kp.org) and downloading mobile apps exclusively for use by Members, watch training and self-care videos, sign up for classes and programs or purchase health products.

- Health education provides patients and clinicians easy access to understandable and actionable health information they need, when they need it, and in a form they can use. These resources include print materials, patient instructions, and a rich variety of online tools and information, which may also be used in classes and office visits.

- Health education classes and programs that are available throughout Northern California and cover a wide variety of topics. Most classes are taught in groups but some facilities offer individualized instruction or counseling. Each KP facility maintains its own schedule of classes, some which require a fee for enrollment. For more information, contact your local KP Health Education Center.

- Members can also find health information, preventive care recommendations, and access to interactive online tools on their physician’s home page at http://www.kp.org/mydoctor.

- Partners in Health newsletter, which provides Members with timely medical news, preventive health care information, and updates about local KP facilities. Partners in Health is emailed each month (12 times per year) to Members registered on kp.org and mailed to those not registered on kp.org 2 times per year.

- The Appointment and Advice Call Center (Call Center) available to all Members, 24 hours a day, 7 days a week. The Call Center is staffed by registered nurses who have special training to help answer questions about certain health problems or concerns and to advise on an appropriate response to symptoms. The advice nurses are not an impediment to physician, but serve as a complement to any appropriate physician or practitioner care.

11.3.2 Focused Health Education Efforts

As part of the Quality Management Program, KP conducts focused health education efforts to address clinical or preventive health quality improvement activities. Many of these programs are developed regionally and are intended to address the specific health care issues of Members and the general community. Practitioners are generally made aware of these programs in order to obtain their support or participation.
11.3.3 Preventive Health and Clinical Practice Guidelines (CPGs)

KPNC supports the development and use of evidence-based CPGs and Practice Resources to aid clinicians and Members in the selection of the best preventive health care and screening options. The best options are those that have a strong basis in evidence regarding contribution to improved clinical outcomes, quality of care, cost effectiveness, and satisfaction with care and service. The Northern California guidelines portfolio includes CPGs for key preventive care services. These guidelines recommend the preferred course of action while recognizing the role of clinical judgment and informed decision making.

11.3.4 Telephonic Wellness Coaching Service

Wellness Coaching over the telephone from a KP Wellness Coach is available at no charge for KP Members who want to get more active, manage weight, quit tobacco, eat healthier, or handle stress. Our Wellness Coaches hold a Master’s degree in Clinical Health Education, trained in motivational interviewing and brief negotiation. They employ a collaborative approach designed to help Members overcome obstacles and tap into their intrinsic motivation for achieving behavior change. Coaches can also help match Members’ needs, preferences, and readiness with the appropriate support resources.

Phone coaching typically takes place over several months through a series of 4 to 6 coaching sessions. Members can find out more about Wellness Coaching and book an appointment at: http://www.kp.org/mydoctor/wellnesscoaching. Members can also call toll free, 1-866-251-4514, to schedule an appointment with a KP Wellness Coach.

11.4 KP's Language Assistance Program

All Providers need to cooperate and comply with KP’s Language Assistance Program by assisting any limited English proficient (LEP) Member with access to KP’s Language Assistance Program services.

Providers must ensure that Members receive effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs, practices, and preferred language. Providers should offer language assistance to Members who appear to need it even if they do not ask for it or if their language preference was not indicated on the referral form. Should a LEP Member refuse to access KP’s language interpreter services, the Provider must document that refusal in the Member's medical record.

If a companion/caregiver involved in care decisions for a Member requires language assistance to communicate with the Member or Provider regarding those care decisions, then all such encounters warrant the offer of free language assistance services to the companion/caregiver. The use of interpreter services in such encounters must be documented in the patient's chart. In addition, a note should be included that language assistance services were provided to the Member's companion or caregiver.
Questions regarding the following information on language assistance can be discussed with KP’s Language Assistance Program by calling (510) 987-3422, or by emailing NCAL-Language-Assistance-Program@kp.org.

11.4.1 Using Qualified Bilingual Staff

Our expectation is that you will provide interpreter services in-person using your own qualified bilingual staff if you have them.

Your qualified bilingual staff should meet the regulatory standards set out in KP’s minimum quality standards for interpreters:

- Documented and demonstrated proficiency in both English and the other language
- Fundamental knowledge in both languages of health care terminology and concepts
- Education and training in interpreting ethics, conduct and confidentiality

11.4.2 When Qualified Bilingual Staff Is Not Available

In the event that you do not have qualified bilingual staff at the time services are needed, KP has made the following arrangements available to Providers when providing services to Members. KP will directly reimburse the companies below for interpreter services provided to Members. Neither Members nor Providers will be billed by these companies for interpreter services.

11.4.2.1 Telephonic Interpretation

Language Line is a company with the capability to provide telephonic interpreter services in over 240 different languages. Phone interpreter services are available 24 hours per day, 7 days per week through the Language Line by calling: (888) 898-1301. This phone number is dedicated to the interpreter needs of Members. While no lead time is needed to engage an interpreter through this service, Providers must have the following data elements available before placing the call:

- The KP Client ID number. This number will be provided to you, in writing, together with your authorization
- KP referral or authorization number
- Member’s MRN

If you require access to language assistance for a KP Member but were not provided a KP Client ID number with your authorization, please contact the referrals staff which issued the authorization for a KP Client ID number. Language Line customer service can be reached at (800) 752-6096 Option #2 (6:00AM–6:00 PM PST M–F). After hours and weekends, access Option #1 and request a Supervisor. In addition, Language Line offers an online support tool called "Voice of the Customer" (VOC) to enter an issue.
You will receive an instant receipt acknowledgement and a follow-up response within 48 hours.

11.4.2.2 In-Person Interpreter: American Sign Language Support

Kaiser Permanente contracts with multiple companies to provide in-person interpreter services for Members requiring American Sign Language (ASL). In-person interpreter services require a minimum of 24 hours lead time for scheduling and are available 24 hours per day, 7 days a week. In-person interpreters are available according to the following schedule: Mon-Fri, 8:00am-5:00pm.

The Kaiser Permanente contracted American Sign Language companies are:

<table>
<thead>
<tr>
<th>Company</th>
<th>Customer Service/Scheduling</th>
<th>Cancellation Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpreting and Consulting Services, Inc.</td>
<td>1-888-617-0016 1-707-747-8200</td>
<td>Cancellations must be made 24 hours in advance of appointment</td>
</tr>
<tr>
<td>Partners in Communication LLC</td>
<td>1-800-975-8150</td>
<td>Cancellations must be made 24 hours in advance of appointment</td>
</tr>
<tr>
<td>Bay Area Communication Access</td>
<td>1-415-356-0405</td>
<td>Cancellations must be made 24 hours in advance of appointment</td>
</tr>
</tbody>
</table>

Providers may arrange in-person interpreter services for multiple dates of service with one call, but must have the following data elements available before placing the call to schedule:

- KP referral or authorization number
- Member’s KP referring facility
- Member’s KP referring provider or MD
- Member’s MRN
- Date(s) of Member’s appointment(s)
- Time and duration of each appointment
- Specific address and location of appointment(s)
- Any access or security measures the interpreter will need to know and plan for to gain entry to the place of service

11.4.3 Documentation

Providers need to note the following in the Member’s Medical Record:

- that language assistance was offered to an LEP Member and/or their companion/caregiver
• if the language assistance was refused by the Member
• what type of service was utilized (telephonic, in-person interpreter services or bilingual staff), for those Members who accept language assistance

Providers must capture information necessary for KP to assess compliance, and cooperate with KP by providing access to that information upon request.

11.4.4 Family Members as Interpreters

The KP Language Assistance Program does not prohibit adult family members from serving as interpreters for Members; however, using family members to interpret is discouraged. Members must first be offered language assistance and informed of the benefits of using professional language assistance. If after that offer, the Member refuses and prefers to use a family member, that refusal must be documented in the Member's medical record.

• Family members and friends typically may not understand the subtle nuances of language and culture that may influence the interaction and may not question the use of medical terminology that they and the patient do not understand.

• Minor children should not to be used as interpreters, except in extraordinary situations such as medical emergencies where any delay could result in harm to a patient, and only until a qualified interpreter is available.

11.4.5 How to Offer Free Language Assistance

Asking Members if they would like to use an interpreter may be uncomfortable for both Providers and Members. Members may feel that their language skills are being questioned, or they may fear that use of an interpreter will delay care or incur extra cost. The following is scripting that may be used by your office staff to offer free language assistance:

• “We want to make sure you have the best possible communication with your Provider so that you receive the highest quality of care. I am going to arrange for <insert language assistance of choice> to help us. Don’t worry, language assistance services are free of charge.”

• “In case you’d like to use an interpreter, I’d be happy to call one. Don’t worry, language assistance services are free of charge.”

• “I can understand why you’d feel more comfortable with your husband interpreting for you today, however, interpreters are trained in medical terminology and can provide you and your Provider with quality interpretation and confidentiality. May I call an interpreter to help us? Don’t worry, language assistance services are free of charge.”
11.4.6 How to Work Effectively with an Interpreter

Knowing how to effectively work with an interpreter contributes to effective communication, which promotes a better health outcome and increases Member satisfaction. The following recommendations will contribute to a successful discussion:

- Ask one question at a time
- Keep statements short, pausing to allow for interpretation
- Don’t say anything you don’t want the Member to hear
- Speak in a normal voice, clearly, and neither too fast nor too slow
- Avoid slang and technical terms that may not be understood by the Member
- Be prepared to repeat yourself and rephrase statements if your message is not understood
- Observe the Member’s body language for signs of misunderstanding
- Check to see if the message is understood by having the Member repeat important instructions/directions
- Avoid asking the interpreter for opinions or comments. The interpreter’s job is to convey the meaning of the source of language
- Members and providers that speak directly to each other during the medical encounter will strengthen the Member-provider relationship. To do this:
  - Position yourself to look directly at the Member and not the interpreter
  - Address yourself to the Member, not to the person providing language assistance
  - Do not say “tell him” or “tell her”
12. Additional Service Specific Information

12.1 General Assistance for SNFs

SNFs can contact their local KP Skilled Nursing Department for general assistance and requesting Authorizations for ancillary services to Members. The following table indicates which KP Skilled Nursing Department to call based on your location:

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antioch, Martinez, Walnut Creek</td>
<td>(925) 229-7765</td>
</tr>
<tr>
<td>Fremont, San Leandro, Hayward, Union City, Richmond, Oakland</td>
<td>(510) 675-5571 or (510) 675-5542</td>
</tr>
<tr>
<td>Fresno</td>
<td>(559) 448-4606</td>
</tr>
<tr>
<td>Manteca, Modesto, Stockton</td>
<td>(209) 735-7333</td>
</tr>
<tr>
<td>Redwood City</td>
<td>(650) 299-2708</td>
</tr>
<tr>
<td>Roseville, Sacramento, South Sacramento</td>
<td>(916) 648-6839</td>
</tr>
<tr>
<td>San Francisco, South San Francisco</td>
<td>(415) 833-4909</td>
</tr>
<tr>
<td>San Jose, Santa Clara</td>
<td>(408) 366-4080</td>
</tr>
<tr>
<td>Marin – San Rafael</td>
<td>(415) 893-4046</td>
</tr>
<tr>
<td>Sonoma – Santa Rosa</td>
<td>(707) 571-3869</td>
</tr>
<tr>
<td>Vacaville, Vallejo</td>
<td>(707) 651-2085</td>
</tr>
</tbody>
</table>

12.1.1 Requesting Ancillary Services for SNFs

Members residing in SNFs may require ancillary services during their stay. These services may include, but are not limited to, therapies, physician specialty consultation, vision, hearing, podiatry, imaging, and lab services.

Once a Provider has written an order for an ancillary service, an Authorization should be requested by contacting your local KP Skilled Nursing Department as indicated in the table in Section 12.1 above. KP will work with you to determine the most appropriate provider and venue for providing the requested ancillary service to the Member.

12.1.2 Laboratory Services Ordering for SNFs

Below is information that will assist contracted SNFs, KP SNF managers, and KP’s contracted laboratory vendors in addressing claims for laboratory services provided to Members at SNFs as efficiently as possible.
The main status categories of Members most likely to receive services in your SNF are “Skilled” or “Custodial.” Identifying the Member’s status category is essential to processing the claim correctly. Lab services are paid in the following manner depending on the Member’s status category and whether the service has been authorized by a Plan Physician:

<table>
<thead>
<tr>
<th>Status Category</th>
<th>Payment Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled</td>
<td>Lab services are SNF responsibility</td>
</tr>
<tr>
<td>Custodial, if authorized by Plan Physician</td>
<td>KP responsibility</td>
</tr>
<tr>
<td>Custodial, not authorized by Plan Physician</td>
<td>CMS if patient has Medicare Part B coverage, or patient, or other responsible party</td>
</tr>
</tbody>
</table>

When a Member receives lab services at the SNF, the Member’s status category as described above, should be noted on the lab requisition form. This status is usually found in the patient’s chart or in the SNF census reports.

### 12.2 Psychiatric Care Settings

KP authorizes psychiatric services for Members at different levels of care, depending on the Member’s clinical conditions. Authorizations must be obtained as set forth in Section 4.4 of this Provider Manual.

The primary types of settings in which KP authorizes Members’ care are:

**Inpatient Hospitalization.** This represents the highest level of control (involuntary) and treatment. Hospitalization is intended for interventions requiring very high frequency or intense treatment.

**Psychiatric Health Facility.** This is an inpatient-like setting, but not in an acute care hospital. This type of licensed facility provides a restrictive setting (involuntary) for high frequency or intense treatment.

**23 Hour Observation.** This level of care provides a restrictive setting for voluntary or involuntary patients, and provides a high degree of safety and security for patients who may be dangerous to themselves or others. This level of care allows for an extended diagnostic assessment to permit a more targeted referral to the appropriate level of care, and provides active crisis intervention and triage.

**Partial Hospitalization.** This level of care provides structured treatment and treatment comparable to that of an inpatient unit, however patients live and sleep at home. This level of care provides daily supervision of high risk patients, medication monitoring, milieu therapy, and other interventions.

**Hospital Alternative Program.** This is a hospital diversion program in a residential setting for voluntary patients. This level of care is less restrictive than inpatient and 23-hour holding.
units, but allows for relatively intensive or frequent interventions, and provides 24 hour monitoring and supervision by behavioral health clinicians with physician case supervision and consultation.

**Intensive Outpatient Program.** This level of care provides a short-term comprehensive program designed as an alternative to psychiatric hospitalization, and is generally appropriate for persons at risk for hospitalization or recently discharged from an inpatient hospital and at risk for re-hospitalization.

### 12.3 KP Chemical Dependency Services Program

Chemical Dependency Services (CDS) are offered at all KP Medical Centers. At 8 KP Medical Centers, a full comprehensive program called KP’s Chemical Dependency Recovery Programs (CDRP) is offered. Transitional Residential Recovery Services (TRRS) are authorized through CDRP. CDRP is designed to enable chemical dependency clinicians to determine the appropriate level of chemical dependency care.

The 6 levels of chemical dependency care available through KP’s Chemical Dependency Recovery Programs are listed below. It is important that you contact the CDRP for your sub-region to obtain authorization prior to provision of services.

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemical Dependency Residential Services (CDRS)</td>
<td>Residential/ “inpatient” detoxification, 3-5 days in a medical facility with nursing-level care overseen by a physician</td>
</tr>
<tr>
<td>Residential Treatment Program (RTP)</td>
<td>Provides a 24 hour/day residential treatment program with intensive therapy and educational services, lasting up to 30 days</td>
</tr>
<tr>
<td>Transitional Residential Recovery Services (TRRS)</td>
<td>Provides 24 hour/day non-medical residential programming, with counseling and educational services.</td>
</tr>
<tr>
<td>Day Treatment</td>
<td>14-21 day outpatient program providing therapy and educational services 6-8 hours each day</td>
</tr>
<tr>
<td>Chemical Dependency Intensive Recovery Program (CD IRP)</td>
<td>An 8 week program of outpatient therapy and educational services provided at least 4 days/week for 2-3 hours each day</td>
</tr>
<tr>
<td>Chemical Dependency Services (CDS)</td>
<td>A program of outpatient therapy and educational services provided at least 1-3 days/week for 1-2 hours each day</td>
</tr>
</tbody>
</table>

**Levels of Care and Description of Chemical Dependency Services Provided by KP**

All service durations listed below are approximations. Clinical services are provided at a length that is appropriate to the patient and his or her condition and progress in and through treatment.
**Day Treatment.** Consists of a minimum of 2 weeks intensive program which the patient attends 7 days per week, up to 8 hours each day. In Day Treatment the patient participates in ongoing, comprehensive educational and process groups, homework exercises, and individual counseling, and is expected to become involved with community self-help groups.

**Intensive Outpatient Program.** This is an 8 week, intensive program of educational and process groups, which the patient attends at least 4 days per week for 2 ½ hours each day. The program may vary slightly by sub-region.

**Outpatient Treatment.** This is a 3 month program of ongoing education and support groups, at least 6 hours per week, designed to help patients with issues that arise during the initial period of sobriety.

**Continuing Treatment.** This is an ongoing program for patients who have completed early recovery treatment. The patient attends at least one regular process group per week for up to 1½ years, attends sessions as scheduled with his/her individual Case Manager, and maintains a clean and sober lifestyle.

**Early Intervention Program.** This is a 6 week program for individuals who are unsure whether they have a serious problem with chemicals, even though there is some evidence suggesting that they do. This program consists of at least one process group per week, and is designed to help patients evaluate their relationship with addictive chemicals. If a patient decides at any time that the problem is indeed serious, he or she may transfer immediately to the appropriate level of treatment. The program may vary slightly by sub-region.

**Family and Codependency Programs.** These are a series of programs ranging from brief education for family members to intensive treatment for serious codependency issues. These programs are available to Members whether or not the chemically dependent person is in treatment.

**Adolescent Treatment Program.** This is a multilevel program designed to help adolescents and their parents evaluate the extent of their problems with psychoactive chemicals, to decide what steps they are willing to take to address these problems, and to provide more intensive treatment. The program includes adolescent groups, parent groups, multifamily groups, and individual and family sessions with a Case Manager.

### 12.4 Special Needs Plan (SNP)

KFHP offers a Medicare Advantage special needs plan (SNP) enrolling beneficiaries who are eligible for Medicare and full benefits under Medi-Cal. As a special needs plan, KFHP is required to provide a model of care (MOC) that addresses the special needs of these Members. All SNP MOCs must include the following elements:

- Description of Overall SNP Population
- Description of Subpopulation – Most Vulnerable Beneficiaries
SNPs must collect data on quality indices as required and in concert with the KP program plan. SNPs must also provide a chronic care improvement program (CCIP) which has methods to identify beneficiaries with multiple or severe chronic conditions who would benefit from the CCIP and a mechanism to monitor beneficiaries in CCIPs.

Please contact your local SNP clinical lead or team members if you have additional questions about the program or your SNP patients.

### 12.5 Autism Spectrum Disorder (ASD) Services

Providers must provide Behavioral Health Treatment (including, but not limited to, Applied Behavior Analysis Services) as defined by California Health and Safety Code Section 1374.73(c)(1), Speech Therapy, Physical Therapy and Occupational Therapy in accordance with the requirements set forth in California Health and Safety Code Section 1374.73, including providing Services through Qualified Autism Service Providers who supervise and employ Qualified Autism Service Professionals or Qualified Autism Service Paraprofessionals who provide and administer Behavioral Health Treatment (as those terms are defined by California Health and Safety Code Section 1374.73(c)(3)-(5)). Providers must ensure (and provide documentary evidence to KP upon request) that all such Qualified Autism Service Providers, Qualified Autism Service Professionals and Qualified Autism Service Paraprofessionals meet the licensure, certification, experience, competence, approval, training and other requirements set forth in California Health and Safety Code Section 1374.73 in order to provide Behavioral Health Treatment and, if necessary, Provider shall, at its cost, provide necessary training and experience to such individuals.