MEDI-CAL MANAGED CARE TRAINING
PROVIDER TRAINING OBJECTIVES

By the end of today’s presentation participants will:

• Have a comprehensive understanding of the unique benefits or processes related to serving Kaiser Permanente’s (KP) Medi-Cal Members
• Understand the administrative process related to claim submissions and payment
• Identify resources/contacts for specific Medi-Cal services

This training covers specific Medi-Cal regulations. This presentation is a supplement to the HMO Provider Manual for institutional providers serving Kaiser Permanente’s Medi-Cal members.

• Please refer to the Appendix beginning on slide 61 to locate a specific topic
ABOUT KAISER PERMANENTE

Kaiser Permanente is committed to help shape the future of health care. We are recognized as one of America’s leading health care providers and not-for-profit health plans.

Founded in 1945, Kaiser Permanente has a mission to provide high-quality, affordable health care services, and to improve the health of our members and the communities we serve. We currently provide services to more than 12.2 million members in eight regions - CA, CO, GA HI, OR, WA, Mid-Atlantic, and the District of Columbia.
KAISER PERMANENTE MISSION

Kaiser Permanente exists to provide affordable, high-quality health care services to improve the health of our members and the communities we serve.

KAISER PERMANENTE PROMISE

Is our commitment to our members and patients to provide high-quality, convenient, and affordable care with a personal touch.
LONG-TERM SERVICES AND SUPPORT (LTSS)
MEMBER PLACEMENTS BY PLACEMENT TYPE

- Short term placements and authorization are managed by the local Medical Center Long Term Care Department. The nursing facility does not have to request authorization.
- If and when a member transitions to Long Term Care (LTC) in a Coordinated Care Initiative County (CCI), the nursing facility may need to request authorization from Kaiser Permanente’s Regional LTSS Department, if there is not already an authorization.

<table>
<thead>
<tr>
<th>Placement Scenarios</th>
<th>Authorization Request</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled short-term placements</td>
<td>KP case manager manages referral</td>
</tr>
<tr>
<td>Skilled placement from KP hospital which extends to long-term care</td>
<td>KP case manager transitions auth request to KP LTSS</td>
</tr>
<tr>
<td>Member admits from home</td>
<td>SNF contacts Medical Center Long Term Care Department to facilitate placement authorization. They will advise if any additional steps are needed.</td>
</tr>
<tr>
<td>Member initially admitted under Medicare benefit and transitioned to long-term care under KP Medi-Cal</td>
<td>SNF faxes request to KP LTSS</td>
</tr>
<tr>
<td>Member was placed under another Medi-Cal health plan and transitioned to KP for Medi-Cal or Medicare</td>
<td></td>
</tr>
<tr>
<td>Member was previously Medi-Cal Fee-For-Service (FFS) covered under Treatment Authorization Request (TAR) and is now KP Medi-Cal Managed Care</td>
<td></td>
</tr>
</tbody>
</table>

KP LTSS Questions?
Call: (626) 405-5218
Fax: (866) 473-0344
KAISER PERMANENTE FOR LONG-TERM CARE (LTC) SKILLED NURSING FACILITY (SNF) MEMBER PLACEMENTS

The majority of KP member placements to Skilled Nursing facilities for Long Term Care KP Medi-Cal member are either through a KP hospital or by a KP physician through the Medical Center Long Term Care Department

- Authorizations are initiated by KP LTC care managers for short-term placement.
- If your facility is not contracted, a letter of agreement (LOA) for the member stay is created.

The KP LTC case manager will transfer the referral to Regional LTSS Department if member transitions to LTC

- Your facility should confirm with the KP case manager that the handoff occurred.
- If a facility is non-contracted for LTC, a new LOA is required.

Contact the Medical Center Long Term Care Department if you receive any admission which wasn’t directly ordered by a KP physician. This includes members admitted from a non-KP hospital/ED, home or board and care/assisted living facility.

If your facility accepted a KP Medi-Cal member and didn’t follow this process, contact your Medical Center Long Term Care Department
MEMBER TRANSITIONS AND SUPPORTING DOCUMENTS

Nursing facilities are to notify KP Regional Long Term Support Services (LTSS) of member changes as soon as known/possible. This applies to discharges, hospital admissions, change to hospice, SNF to SNF transfers, or death notifications.

What to do:
1. Always fax the KP Admission and Discharge Notice to the Regional LTSS Department. Please include the change date and reason for change so we can update authorizations accurately.

2. Add the following documentation depending on the situation:
   - **Initial Authorization** (when initiated by nursing facility): Nursing Face Sheet, Current Minimal Data Sheets (MDS), and Pre-Admission Screening (PAS)/Pre-Admission Screening Resident Review (PASARR)
   - **Renewal Authorization**: Nursing Face Sheet and Current MDS
   - **Bed Hold**: Nursing Face Sheet and SNF Transfer Order
   - **Discharge** (to home, other SNF): SNF Transfer or Discharge Order
   - **Health Plan Transition**: Nursing Face Sheet Current MDS, and PAS/PASAAR

*This does not replace the facility’s responsibility to submit the MC 171 with the state.*

Fax each individual request and all supporting documents to the regional KP LTC Secure FAX at (866) 473-0344. Please send one fax with all documentation for one member. Do not send multiple members in one fax.
LONG TERM CARE ADMISSION & DISCHARGE

Nursing facility must send the LTC form to Regional LTSS department for:

• Initial LTC authorizations for: transition from short-term to LTC if no KP staff on site, SNF to SNF transfer, transition from another health plan, and any retroactive request not managed by the Medical Center Long Term Care department.

• Reauthorization requests. Submit one week prior to the expiration of the current authorization.

• Any discharge for bed hold/leave of absence requests, admit/discharge from hospice and for death notices.

• Similar to the MC 171 form – but does not replace that obligation with the State.

• Helps Regional LTSS track members

Fax to (866) 473-0344 – LTSS Department
Authorization process is typically 5 to 10 business days. Timeframe may be longer if documentation is incomplete.
BED HOLDS AND THERAPEUTIC LEAVES OF ABSENCE

• KP LTSS honors payment requests for Bed Holds and Therapeutic Leaves of Absence.
• Facilities will need to make an authorization request to KP LTSS.
• Notify KP LTSS by completing the Admission and Discharge Notification form with either the SNF Transfer Order for Hospitalizations for bed hold or the SNF physician order for Therapeutic Leaves of Absence.
• As soon as you know the dates for bed hold or therapeutic leave, submit the start and end dates and fax to (866) 473-0344. Submit only once. Do not submit until you know the end date is final. It is OK to request once the member returns, but do submit prior to billing.
• KP LTSS will prepare authorization and transmit to the corresponding medical center Outside Referral Department (ORD) for processing. ORD will generate a hard copy referral which is sent to the facility.
• Bed hold days are granted for a maximum of seven days per admission.

For bed holds:
• As long as the member returns within the seven day time frame under an existing referral, the existing referral prevails.
• If the hospital stay is longer than seven days, a new authorization will be needed.
LONG-TERM CARE REAUTHORIZATIONS

• Applies to facility residents with a KP Medi-Cal authorization with an upcoming expiration date
• LTC Authorizations are 180 days.
• Facilities should submit renewal request no sooner than one week before the expiration date.
• Notify Regional LTSS by completing the Admission and Discharge Notification form and submit the Nursing Face Sheet and most recent MDS.
• Fax to (866) 473-0344.
• KP LTC will prepare authorization and transmit to the corresponding medical center Outside Referral Desk (ORD) for processing. ORD will generate hard copy referral, which is sent to the contracted LTSS facility.
• Reauthorizations are not processed until eligibility is updated on the Medi-Cal website on the first of each month.

Example: July renewals will not be processed until after July 1.
AUTHORIZATION NOTIFICATION

• Hard copy authorizations are mailed or faxed to the nursing facility by the Outside Referral Department (ORD).

• If you are having issues with receiving the authorizations, validate your facility’s profile with ORD to ensure that your fax number and/or mailing addresses are correct and confirm your facility’s preferred delivery method (fax or mail).

• The Skilled Nursing Facility is to confirm the patients Share of Cost (SOC) with the County Medi-Cal as the amount or eligibility status is subject to change.
### KP MEDICAL CENTER LONG-TERM CARE DEPARTMENTS

<table>
<thead>
<tr>
<th>Medical Center</th>
<th>Telephone</th>
<th>Medical Center</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antelope Valley</td>
<td>(661) 428-1306</td>
<td>Orange County</td>
<td>(714) 734-5500</td>
</tr>
<tr>
<td>Baldwin Park</td>
<td>(626) 851-7037</td>
<td>Panorama City</td>
<td>(818) 832-7292</td>
</tr>
<tr>
<td>Downey</td>
<td>(562) 622-3823</td>
<td>Riverside</td>
<td>(951) 602-4230</td>
</tr>
<tr>
<td>Fontana</td>
<td>(909) 609-3500</td>
<td>San Diego</td>
<td>(619) 528-1245</td>
</tr>
<tr>
<td>Kern County</td>
<td>(661) 337-7235</td>
<td>South Bay</td>
<td>(424) 251-7875</td>
</tr>
<tr>
<td>Los Angeles</td>
<td>(213) 351-4534</td>
<td>West Los Angeles</td>
<td>(323) 857-3606</td>
</tr>
<tr>
<td>Ontario</td>
<td>(909) 609-3500</td>
<td>Woodland Hills</td>
<td>(818) 592-2400</td>
</tr>
</tbody>
</table>

- If you have any questions, please contact KP’s Regional LTSS Department at (626) 405-5218, Monday through Friday, from 9 a.m. to 5 p.m.
- Email address: LTSS-SNF@kp.org
SNF ANCILLARY SERVICES AUTHORIZATIONS

For therapy, diagnostic and other specialty requests:

- Obtain a physician order for the requested service.
- Contact your local medical center Long Term Care Department to request the authorization:

<table>
<thead>
<tr>
<th>Medical Center</th>
<th>Telephone</th>
<th>Medical Center</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antelope Valley</td>
<td>(661) 428-1306</td>
<td>Orange County</td>
<td>(714) 734-5500</td>
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<tr>
<td>Baldwin Park</td>
<td>(626) 851-7037</td>
<td>Panorama City</td>
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<td>Riverside</td>
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<td>South Bay</td>
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<td>Los Angeles</td>
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<td>West Los Angeles</td>
<td>(323) 857-3606</td>
</tr>
<tr>
<td>Ontario</td>
<td>(909) 609-3500</td>
<td>Woodland Hills</td>
<td>(818) 592-2400</td>
</tr>
</tbody>
</table>
KP OUTSIDE REFERRAL DEPARTMENT (ORD)

<table>
<thead>
<tr>
<th>Facility</th>
<th>Telephone</th>
<th>Facility</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antelope Valley</td>
<td>(661) 729-7108</td>
<td>Baldwin Park</td>
<td>(562) 622-3880</td>
</tr>
<tr>
<td>Downey</td>
<td>(562) 622-3880</td>
<td>Fontana</td>
<td>(909) 609-3262</td>
</tr>
<tr>
<td>Los Angeles</td>
<td>(213) 351 4530</td>
<td>Panorama City</td>
<td>(818) 375-2806</td>
</tr>
<tr>
<td>Riverside</td>
<td>(951) 602-4294</td>
<td>San Diego</td>
<td>(619) 589-3360</td>
</tr>
<tr>
<td>South Bay</td>
<td>(310) 816 5324</td>
<td>Orange County</td>
<td>(714) 564-4150</td>
</tr>
<tr>
<td>Woodland Hills and Ventura</td>
<td>(844) 424-1869</td>
<td>West Los Angeles</td>
<td>(213) 351 4530</td>
</tr>
<tr>
<td>Coachella Valley/Yucca Valley</td>
<td>(951) 602-4294</td>
<td>Kern County/Bakersfield</td>
<td>(661) 852-3482</td>
</tr>
</tbody>
</table>

- If it's been 15 business days since authorization was requested, provide follow-up with details to ORD and confirm your fax or mailing address.
- If there is a trend of ongoing issues, then call provider support because ORD phone number may have changed or other changes may have occurred.
Recommended Billing and Coding
BILLING GUIDELINES

• Provider shall bill the normal, usual, and customary charges for **authorized** services.

• Provider should inform our Medi-Cal members, in writing, that Kaiser Permanente may not cover, or continue to cover, the cost of a specific service or services, that may not be covered under their benefits.

• Members **should not be billed** for services that are **pending** payment from Kaiser Permanente.
CLAIMS

LTC BILLING REQUIREMENTS
There are certain data elements that are required when submitting claims for processing.

01 ALWAYS POPULATE FIELDS
Providers should always make sure these fields are populated to ensure prompt payment of claims.

02 BE SURE TO INCLUDE IMPORTANT FIELDS
Share of cost amount, accommodation codes, and covered days need to be included in box 39-40 of the UB.

03 KP AUTHORIZATION NUMBER IS REQUIRED
The KP authorization number is required in box 63 of the claim. This is the referral number given by the Utilization Management department.

REQUIRED VALUE CODES
- 23 - Recurring Monthly Income – members share of cost amounts.
- 24 - Medicaid Rate Code Medicaid - eligibility requirements to be determined at state level.
- 80(a) - Covered Days - the number of days covered.
REVENUE CODES BY TYPE OF SERVICE

When billing, please ensure Revenue Code is the **same** as what is authorized for the dates of services and what is noted in your contract.

<table>
<thead>
<tr>
<th>Billing Codes Bill Type</th>
<th>Revenue Code</th>
<th>Type(s) of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>021x</td>
<td>160</td>
<td>Long Term SNF Services - Daily Rate (NF – A)</td>
</tr>
<tr>
<td>021x</td>
<td>169</td>
<td>Long Term SNF Services – Bed Hold or Leave of Absence (NF-A)</td>
</tr>
<tr>
<td>021x</td>
<td>120</td>
<td>Long Term SNF Services - Daily Rate (NF – B)</td>
</tr>
<tr>
<td>021x</td>
<td>130</td>
<td>Long Term SNF Services – Bed Hold or Leave of Absence (NF-B)</td>
</tr>
<tr>
<td>021x</td>
<td>110</td>
<td>Subacute – Daily Rate, Non- Ventilator Dependent</td>
</tr>
<tr>
<td>021x</td>
<td>119</td>
<td>Subacute – Bed Hold or Leave of Absence, Non-Ventilator Dependent</td>
</tr>
<tr>
<td>021x</td>
<td>129</td>
<td>Subacute – Daily Rate, Ventilator Dependent</td>
</tr>
<tr>
<td>021x</td>
<td>139</td>
<td>Subacute – Bed Hold or Leave of Absence, Ventilator Dependent</td>
</tr>
</tbody>
</table>
MEMBER SHARE OF COST

• Please remember to designate the Member Share of Cost on your 837/UB 04, in Field Locator 39, **Value Code =23= Medicaid spend down amount.**

• Please note the Value code has been changed from “Field locator 39 – Value Code = 66 = Medicaid spend down amount” to “Field Locator 39, Value Code =23= Medicaid spend down amount.”
CLAIM SUBMISSION AND INQUIRIES
PROCESS FOR SUBMITTING CLAIMS AND ELECTRONIC TRANSMISSION

• Timeliness – claims must be submitted with reasonably relevant supporting information required within 90 calendar days after the date of service, or as noted in your contract or Letter of Agreement (LOA).

• Submit paper claims to Kaiser Permanente for payment to:

  Kaiser Permanente Claims Administration Department  
  P.O. Box 7004  
  Downey, CA 90242-7004

  For questions please call: 800.390.3510
Submit Claims Electronically and reap the benefits!

- **Reduce Costs:** Eliminate expenses associated with paper claim submission: Paper Claim Forms, Ink, Envelopes & Postage.
- **Save Time:** Submit claims and check claims status online anytime 24/7; Provide verification of Claim Receipt within 48 hours of submission.

Get connected and sign up today by contacting your clearinghouse. Provide the appropriate payer ID from the table to your right:

**Providers may send EDI through one of Kaiser’s direct clearinghouses (see table on right); or any clearinghouse that can reroute through a Kaiser direct clearinghouse.**

<table>
<thead>
<tr>
<th>Clearinghouse</th>
<th>Southern CA Payer ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>ChangeHealthcare</td>
<td>94134</td>
</tr>
<tr>
<td>Office Ally</td>
<td>94134</td>
</tr>
<tr>
<td>Relay Health</td>
<td>94134</td>
</tr>
<tr>
<td>SSI</td>
<td>SKAISERCA</td>
</tr>
</tbody>
</table>
Electronic Fund Transfers (EFT) & Electronic Remittance Advice (ERA)

Electronic remittance advice (ERA) is offered when you submit electronically, allowing you to post payments automatically!

Providers seeking to register or manage account changes for EFT and ERA will need to use the Council for Affordable Quality Healthcare (CAQH) Enrollment tool.

This secure electronic tool will eliminate the need for paper registration and reduce time, costs, and allow you to register with multiple payers at one time!

For more information, please contact the Provider Self Service Strategy Team:

e-mail: EDISupport@kp.org

Or visit your Community Provider Portal (CPP) website for additional information: Providers.kp.org
**CLAIM INQUIRIES AND DISPUTES**

<table>
<thead>
<tr>
<th>CONTRACTING PARTNER</th>
<th>DISPUTES/CLAIMS ADJUSTMENTS/REQUEST MANAGEMENT</th>
<th>CALLS AND ONLINE PORTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of Inquiries</strong></td>
<td><strong>Type of Inquiries</strong></td>
<td><strong>Type of Inquiries</strong></td>
</tr>
<tr>
<td>• Contract term</td>
<td>• Payment disputes</td>
<td>• Claim status – an online claim status tool is being implemented</td>
</tr>
<tr>
<td>• Application</td>
<td>• Denials (partial/full)</td>
<td>• Claim payments</td>
</tr>
<tr>
<td>• Payment trends (e.g. pre-dispute)</td>
<td>• Overpayments</td>
<td>• Member benefits (SCAL only)</td>
</tr>
<tr>
<td>• Process (e.g. disputes upheld)</td>
<td>• COB</td>
<td><strong>Rules</strong></td>
</tr>
<tr>
<td>• Retro-contract</td>
<td>• System issues</td>
<td>• Required to provide: provider TIN, provider name and address, member name, Medical Record Number (MRN) and date of birth</td>
</tr>
</tbody>
</table>

**Provider Disputes Resolution (PDR) Expectation**

- Acknowledge - 15 working days
- Resolve - 45 working days

**Rules**

- If call regarding a dispute – call will be re-directed
CLAIM INQUIRIES

• Inquiries on claims submitted to KP Claims Administration should be directed to Claims Customer Service at: 1-800-390-3510(toll free).

• Information on claim status can also be found using the KP Online Affiliate portal described on the next slide.
As a Kaiser Permanente contracted provider, you’re eligible to access Online Affiliate to view your patients’…

- Claim details and status
- Benefits
- Referrals**
- Medical records**

**for clinical users

Clinicians holding a valid license to practice should apply for clinical access, while non-clinical staff such as the billing department should apply for administrative access.

If you’re in the process of becoming contracted, you can still view claim status online!

Simply go to the Community Provider Portal (CPP) site and click the “view claim status as a guest user” link on the right hand quick links menu.

For Questions or additional information, please contact the Provider Self-Service Strategy Team:

Email: KP-SCAL-OnlineAffiliate@kp.org

Register today by following the steps outlined on the Southern California (SCAL) CPP site:

providers.kp.org/scal

(click the Registration link under Online Affiliate on the left-hand menu bar).

Quick links
- ICD-10 Information
- KP ClaimsConnect Information
- Provider contact information
- Institutional provider manuals
- Institutional provider required training
- View claim status as a guest user

Community Provider Portal
- Southern California
- Home
- Eligibility
- Authorizations
- Claims
- Member Information
- Provider Information
- Pharmacy
- Emergency services

Online Affiliate
- Registration
- Sign On
REFUNDS BY NURSING FACILITY TO KP

If you have identified an overpayment (including Share of Cost), please forward your refund to:

Kaiser Permanente
Attn: Regional Claims Recovery
File 50187
Los Angeles, California 90074-0187

Please include the following information with your refund:

- Provider Name
- Provider Tax Identification Number
- Member Name
- KP Medical Record Number
- Kaiser Claim Number
- Dates of Service
- Refund Reason, e.g., Member Share of Cost
PROVIDER DISPUTES
PROVIDER DISPUTES

TYPES OF DISPUTES

• **Claims disputes**: challenging, appealing, or requesting reconsideration of a claim (or bundled group of claims) that has been denied, adjusted incorrectly, or contested.

• **Responding to requests for overpayment reimbursement**: disputing a request by Kaiser Permanente of reimbursement by provider of overpayment of a claim.

• **Billing determinations disputes**: seeking resolution of a billing determination (or bundled group of billing determinations) by Kaiser Permanente.

• **Other contract disputes**: seeking resolution of a contract dispute.

In the event that you need to file a provider dispute, please contact or submit the dispute to:
Kaiser Permanente
Claims Administration Department
P.O. Box 7006
Downey, CA 90242-7006
1-800-390-3510 (toll free)
Time Period for Submitting Disputes
We must receive your Provider Dispute Notice within 365 days after (i) our action which led to your dispute (e.g. a denial of a claim) or (ii) in the case of our inaction, 365 calendar days plus 45 additional working days after the date of our receipt of your claim, or such longer timeframe as may be specifically applicable to you (the provider).

PROVIDER PAYMENT DISPUTE RESOLUTION REQUEST

• Requestor’s name, provider identification number, and requestor’s contact information.
• Claim number, date of service, and clear explanation of the basis of the dispute.
• Patient’s name and Medical Record Number.
Compensation – Payment for covered services shall be made within 45 working days of the date of receipt by Kaiser Permanente of all necessary documents.
TIMELY FILING DENIALS

In the event that a LTSS nursing facility receives a denial for untimely submission, the nursing facility must:

1) Submit Provider Dispute Request.
2) Attach the appropriate proof as outlined below.

<table>
<thead>
<tr>
<th>Proof of timely filing:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) A copy of the billing system with proof of when claim was mailed and Kaiser Permanente is listed as the payor with a date prior to timely filing cutoff.</td>
</tr>
<tr>
<td>2) Clearinghouse report of acceptance from Kaiser Permanente with a date prior to the timely filing cutoff (EDI submissions).</td>
</tr>
<tr>
<td>3) Date request for additional information letter from Kaiser Permanente with a date prior to timely filing cutoff.</td>
</tr>
<tr>
<td>4) Dated claim denial letter, EOB or EOMB from Kaiser Permanente with date prior to timely filing cutoff.</td>
</tr>
<tr>
<td>5) Denial letter from other insurance carrier dated and printed on letterhead with date prior to timely filing cutoff.</td>
</tr>
<tr>
<td>6) Dated EOB from another insurance company matching claim in dispute with a date prior to the timely filing cutoff.</td>
</tr>
<tr>
<td>7) Proof of mailing including: certified mail receipt, Fed express receipt, Express mail receipt, or other mail service receipt that shows both the date mailed and the address of the receipt with a date prior to the timely filing cutoff. Reference contents on original receipt, and include copies of documents submitted within packet.</td>
</tr>
<tr>
<td>8) Proof of hand delivery with the date delivered.</td>
</tr>
</tbody>
</table>
KEEP US INFORMED OF ANY CHANGES

• Federal Tax Identification Number (TIN)

• Include copy of W-9 form/Copy of Letterhead Effective date of change

• National Provider Number (NPI)

• Information that may affect billing and payment

Notify:

Kaiser Permanente
Network Development and Administration
393 E. Walnut Street – 7th Floor (S/W)
Pasadena, CA 91188-8116
Tel: 1-626-405-3240
Fax: 1-626-405-6774
SUMMARY OF IMPORTANT TELEPHONE NUMBERS

Automated Telephone System (eligibility/benefits)
  1-888-576-6789 (toll free)
Claims Inquiry / Provider Disputes (claim status)
  1-800-390-3510 (toll free)
Member Services
  1-800-464-4000 (toll free)
Provider Relations – Network Development and Administration (Contracting) Department
  626-405-3240
Regional LTSS Department
  626-405-5218
ADDITIONAL INFORMATION

- Kaiser Permanente Medi-Cal Plan
- Eligibility and Benefits
- Language Assistance Program
- Long Term Care Pharmacy
- Community-Base Adult Services
- Hospice
- Medi-Cal Non-Medical Transportation
KAISER PERMANENTE MEDI-CAL PLAN
### KAISER PERMANENTE MEDI-CAL LONG TERM CARE RESPONSIBILITY BY COUNTY

KP manages and is responsible for paying LTC in four Coordinated Care Initiative (CCI) Counties – Los Angeles, San Diego, Riverside, and San Bernardino. In Kern, members are disenrolled to FFS. In Ventura and Orange Counties the plan partner is responsible.

<table>
<thead>
<tr>
<th>SCAL County</th>
<th>Service Area</th>
<th>Local Plan Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Los Angeles – KP Manages LTC*</td>
<td>Antelope Valley, Baldwin Park, Downey, Los Angeles, Panorama City, South Bay, West Los Angeles, Woodland Hills</td>
<td>LA Care</td>
</tr>
<tr>
<td>San Diego – KP Manages LTC*</td>
<td>San Diego</td>
<td>*Geographic Managed Care (GMC)</td>
</tr>
<tr>
<td>Riverside &amp; San Bernardino – KP Manages LTC*</td>
<td>Riverside &amp; Fontana</td>
<td>Inland Empire Health Plan (IEHP)</td>
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<tr>
<td>Orange (COHS) – Cal Optima Manages LTC</td>
<td>Orange</td>
<td>Cal Optima</td>
</tr>
<tr>
<td>West Ventura (COHS) – Gold Coast Manages LTC</td>
<td>Woodland Hills</td>
<td>Gold Coast Health Plan</td>
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</table>

**Notes:**

- KP holds a direct contract for Medi-Cal in San Diego. In all other counties, we are a delegated plan partner.
- Intermediate Care Facilities for the Developmentally Disabled (ICF-DD) - KP pays for month of admission plus one month, member disenrolled to FFS, all counties.
- *Members 21YO+ are managed by KP, members <21 are disenrolled to FFS.
- KP is NOT a part of Cal MediConnect.

*Kern is not a CCI County. Members disenroll from Managed Medi-CAL to Medi-CAL FFS*

*COHS=County Organized Health System*
MEDI-CAL ASSIGNED TO KAISER PERMANENTE

KP LTSS will perform primary source verification on Medi-Cal coverage for all MLTSS authorization requests. **Facilities do not have to submit screenshots of their verifications.**

KP is represented in different ways on the Medi-Cal website because of our contract relationship

- Medi-Cal assignment will show as the HCP (for Los Angeles, Ventura and Orange Counties) or as the PHP in San Diego. **For Riverside and San Bernardino counties, consult the IEHP website**
- “Carrier” will refer to other insurances, primarily Medicare medical or prescription coverage.

![Image of KP Managed MediCAL card]

KP Managed MediCAL will show up in the HCP line for LA, OC and Ventura counties. In SD, KP shows up in the PHP.

Medicare through KPSA
MEDI-CAL ELIGIBILITY AND BENEFITS
MEDI-CAL ELIGIBILITY AND BENEFITS

• We encourage you to verify and confirm member eligibility and benefits prior to services being rendered.
• Also verify at the beginning of the month, if continuing care from the previous month.

AUTOMATED TELEPHONE SYSTEM

Member Services Call Center - Provider Call Flow - 1-888-576-6789 (toll free)
You will be prompted to enter either the MRN or the last four digits of the Social Security Number (SSN) the member’s zip code and/or the complete date of birth (month/day/year)
• For eligibility, press 1.
• For benefit, co-payment and deductible status, press 2.
• For claims, press 3.
• For all other concerns, press 4.
## PROVIDER CONTACT INFORMATION

<table>
<thead>
<tr>
<th>Contact Information</th>
<th>Type of Help or Information from this Department</th>
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<tr>
<td>Member Service Call Center</td>
<td>• Member Eligibility</td>
</tr>
<tr>
<td>Information is available:</td>
<td>• Copayments/Deductibles</td>
</tr>
<tr>
<td>24 hours a day, 7 days a week</td>
<td></td>
</tr>
<tr>
<td>Tel: (888) 576-6789</td>
<td></td>
</tr>
<tr>
<td>Claims Call Center</td>
<td>• Billing/Claims</td>
</tr>
<tr>
<td>Available 8:00am to 6:00pm (PST)</td>
<td>• Claims Status</td>
</tr>
<tr>
<td>(800) 390-3510</td>
<td></td>
</tr>
</tbody>
</table>
### LANGUAGE ASSISTANCE – CALIFORNIA LAW

**Knox Keene Act:**

| §1300.67.04. | Effective January 1, 2009, Kaiser Foundation Health Plan, Inc. (or “Kaiser Permanente” or “KP”) and its contracted providers are required to comply with the Language Assistance Program (“LAP”) regulations for health plan enrollees who are Limited English Proficient (“LEP”), including enrollees needing sign language services. |
| “Language Assistance Programs” | (formerly, SB-853) |

- Our expectation is that you will provide interpreter services in-person using your own qualified bilingual staff if you have them. If you do not have qualified bilingual staff when needed, utilize KP Language Assistance.
- Contracted 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
  - Enrollee’s KP Medical Record Number (MRN)
LANGUAGE ASSISTANCE – PHONE and SIGN

PHONE

- We have contracted with United Language Group, with the capability to provide telephonic interpreter services in 200 different languages.
- Phone interpreter services are available 24 hours a day, 7 days a week. United Language Group: 1-855-701-8100. This phone number is dedicated to the interpreter needs of KFHP enrollees.

SIGN LANGUAGE

- KP has contracted the services of Interpreters Unlimited, with the capability to provide in-person interpreter services for enrollees requiring Sign Language (SL)
- Two week’s advance notification of need for an SL interpreter is recommended to help ensure an interpreter is available.
- Interpreters Unlimited: 1-844-855-0249, 24 hours a day, 7 days a week.
LONG-TERM CARE PHARMACY
LONG TERM CARE (LTC) PHARMACY BACKGROUND

• In 2014, DHCS implemented the Care Coordination Initiative (CCI) which means many members in LTC are no longer disenrolled from Medi-Cal Managed Care into Fee For Service. They continue to be assigned to KP for their Medi-Cal benefit which includes medications.

  • CCI shifted the responsibility for LTC from Medi-Cal Fee for Service to Medi-Cal managed care plans and eliminated the need for disenrollment of those 21 years old and over in LTC in the SCAL CCI counties [Los Angeles, Riverside, San Bernardino, and San Diego].

  • Requires mandatory assignment of Medi-Cal to managed care for those dually eligible for Medicare and Medi-Cal.

• KP Medi-Cal only and partial dual managed care members in LTC may have their medications provided through the nursing facility pharmacy in their nursing facility. Includes select over the counter (OTC) medications when ordered by prescription.

• What does not change: KP Medi-Cal managed care members in LTC who are also eligible for Medicare Part D have access to their Medicare covered medications in their nursing facility through their Part D LTC pharmacy benefit.
KP MEDI-CAL ONLY MEMBERS CAN OBTAIN MEDICATIONS THROUGH THE NURSING FACILITY PHARMACY

In the Los Angeles, Orange, Riverside San Bernardino and San Diego counties the Nursing Facility Pharmacy can obtain new or refill medication for members with Medi-Cal only or Partial Duals without Medicare Part D.

The PBM now receives member information on eligibility file and allows nursing facility’s pharmacy to fill the prescription.

In collaboration with KP Pharmacy and MedImpact a process has been developed using MedImpact:

• **Members may obtain medications from their LTC facility’s pharmacy**
• A network of pharmacies attached to LTC facilities can be associated to KP Medi-Cal members
• Medi-Cal members are identified using enrollment units (EU) from KP’s membership system
• KP sends an automated file to MedImpact each month to allow the identified members to access the identified pharmacies
### SNF MEMBER PHARMACY NEEDS

How to obtain member prescriptions by type of coverage

<table>
<thead>
<tr>
<th>Member Coverage</th>
<th>LTC with KP (LA, OC, Riv, SB, SD, Vta)</th>
<th>LTC in FFS (member disenrolled – Kern, Member &lt;21 YO in LA, Riv, SB, SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>KP Full Dual (KP Medicare) Eligible and any Medi-Cal</td>
<td>Medications are covered by Medicare Part D – Catamaran</td>
<td></td>
</tr>
<tr>
<td>PARTIAL Dual Eligible with KP Part D and any Medi-Cal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>KP Medi-Cal Only and Partial Dual Eligible without Part D</td>
<td>MedImpact: LTC Pharmacy processes order or refill and submit claim to MedImpact. MedImpact approves and provides to the Member via Pharmacy in facility</td>
<td>Meds covered by Medi-Cal FFS</td>
</tr>
<tr>
<td>KP Medi-Cal only</td>
<td></td>
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</tr>
</tbody>
</table>

To set up with MedImpact: (800) 788-2949
COMMUNITY-BASED ADULT SERVICES (CBAS)
NEW REQUEST FOR CBAS SERVICES

1. CBAS provider completes Benefit Inquiry Form and submits to KP Complex Case Management (CCM) via fax at (877) 515-6591

2. CCM reviews inquiry and applies pre-screen eligibility and criteria:
   - Medi-Cal eligible and assigned to KP
   - 18 years or older

3. If not eligible, CCM sends to the member and requestor notification of ineligible status

4. If eligible, KP sends acknowledgment letter to outside requester within 5 business days from receipt of inquiry

5. KP schedules the Face-to-Face assessment within 5 business days from receipt of inquiry, using the DHCS-approved CBAS eligibility determination tool (CEDT)

6. Two additional attempts are made via the telephone to schedule Face-to-face assessment between 5 and 8 business days of receipt of request

7. KP mails letter to member to inform that she/he has until the 14th day from receipt of inquiry to schedule the Face-to-Face assessment

8. If KP member does not schedule the Face-to-Face within the 14 days of receipt of inquiry, KP sends a letter to both the member and the requestor stating that if services are still needed a new inquiry needs to be submitted to start the process again
NEW REQUEST FOR CBAS SERVICES (cont.)

9. The face to face must be completed using CEDT tool within 30 days from initial inquiry
10. Approval or denial of eligibility for CBAS to conduct 3-day Comprehensive Multidisciplinary Evaluation will be faxed to the CBAS provider within 1 business day of decision; the authorization is valid for 3 months
   • HCPCS Code for 3-day assessment: H2000
11. CBAS provider must conduct the 3-day evaluation within 3 months of receipt of the approved authorization to develop the Individual Plan of Care (IPC); once completed, the CBAS provider sends in a prior authorization request, including the IPC with level of service recommendations and duration of services
   • HCPCS Code for CBAS Services: S5102
12. KP will authorize, modify, or deny prior authorization within 5 business days. If approved this authorization is valid for 6 month
13. KP will notify the CBAS provider within 24 hours, and the member within 48 hours, via phone call, of the decision
14. The written notification of the authorization, modification, or denial will go to the member, the CBAS provider and the requesting provider
15. If unable to make a decision within 5 business days, a 14-day delay letter will be sent to the member and CBAS provider
16. CBAS provider must reassess member and re-submit the new IPC before the expiration of the current authorization
17. When a member is discharged from services, the CBAS provider should fax a discharge summary to KP Permanente CCM at (877) 515-6591
18. Member has the right to choose a CBAS center
KAISER PERMANENTE CBAS FORMS

Benefit Inquiry Form

Authorization Request Form
CBAS FORMS: Additional Information

- CBAS providers may download the following forms directly from the California Department of Aging website:
  https://www.aging.ca.gov/ProgramsProviders/ADHC-CBAS/Forms/Eligibility_and_Service_Authorization/
  
  - CBAS Eligibility Determination Tool (CEBT)
  - Individual Plan of Care (IPC)

- To request a copy of the authorization, please contact the ORD department in your area (refer to slide 16)
- For additional questions, please contact Kaiser Permanente’s CCM department at (866) 551-9619 or Complex-Case-Management@kp.org
KAISER PERMANENTE MANAGED CARE HOSPICE
LONG TERM CARE MEDI-CAL MEMBERS IN HOSPICE

Hospice room and board in a SNF is a covered Medi-Cal benefit under hospice. The hospice agency pays the SNF directly for Room and Board and is reimbursed from Medi-Cal or the Medi-Cal payor.

Members maintain the choice to select their preferred hospice. We are encouraged by the response of our SNFs in aiding our members to seek this service.

Whenever a Long Term Care member, residing in a SNF, transitions to hospice, the nursing home needs to:

- Obtain a physician order for hospice Service or have the KP MD place the order.
- FAX the physician order to the KP hospice intake.
- Contact the hospice agency to coordinate care and obtain bed payment.
## KAISER PERMANENTE HOSPICE AGENCIES

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<th>Telephone/Fax</th>
<th>Facility</th>
<th>Telephone</th>
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<tbody>
<tr>
<td>Antelope Valley</td>
<td>P: (661) 729-7250</td>
<td>Orange County</td>
<td>P: (714) 734-5464</td>
</tr>
<tr>
<td></td>
<td>F: (661) 729-7254</td>
<td></td>
<td>F: (714) 734-7590</td>
</tr>
<tr>
<td>Baldwin Park</td>
<td>P: (626) 480-5176</td>
<td>Panorama City</td>
<td>P: (818) 832-7422</td>
</tr>
<tr>
<td></td>
<td>F: (626) 480-5112</td>
<td></td>
<td>F: (818) 832-7253</td>
</tr>
<tr>
<td>Downey</td>
<td>P: (562) 622-4300</td>
<td>Riverside</td>
<td>P: (951) 358-2655</td>
</tr>
<tr>
<td></td>
<td>F: (562) 622-3841</td>
<td></td>
<td>F: (951) 358-2659</td>
</tr>
<tr>
<td>Fontana</td>
<td>P: (909) 609-3838</td>
<td>San Diego</td>
<td>P: (619) 641-4100</td>
</tr>
<tr>
<td></td>
<td>F: (909) 609-3865</td>
<td></td>
<td>F: (619) 641-4111</td>
</tr>
<tr>
<td>Kern County</td>
<td>P: (661) 664-6734</td>
<td>South Bay</td>
<td>P: (877) 486-4024</td>
</tr>
<tr>
<td></td>
<td>F: (661) 664-3793</td>
<td></td>
<td>F: (424) 251-7719</td>
</tr>
<tr>
<td>Los Angeles / West Los Angeles</td>
<td>P: (213) 351-4522</td>
<td>Woodland Hills and West Ventura</td>
<td>P: (818) 832-7422</td>
</tr>
<tr>
<td></td>
<td>F: (213) 351-4515</td>
<td></td>
<td>F: (818) 832-7253</td>
</tr>
</tbody>
</table>
MEDI-CAL NON-MEDICAL TRANSPORTATION
MEDI-CAL TRANSPORTATION - Includes all the following benefits:

1. Emergency medical transportation via air or ground - no authorization required (i.e. 911)
2. Non-Emergency Ambulance - Member requires ambulance transportation, clinical authorization usually required
3. Non-Emergent Medical Transportation (NEMT) – wheelchair or gurney van
   - Member’s medical condition does not allow the member to travel by bus, car, taxi, public or private conveyance. Transportation is required for the purpose of obtaining needed medical care.
   - A physician must indicate medical necessity for up to 12 months.
   - Authorization follows the member, NOT just a trip.
   - KP provides for member to go to County Mental Health and Substance abuse services (carved out)
4. Non-Medical Transportation (NMT) – no special needs
   - Members access by calling Kaiser Permanente Transportation (MTM, Medical Transportation Management is our vendor): 1-844-299-6230
   - Member physically able to travel by car, taxi, bus, etc., and needs transportation
   - Unlimited number of trips
   - KP provides for member to go to any Medi-Cal covered (carved out) service (CCS, dental, County mental health, substance abuse, etc.)
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