



Kaiser Permanente Colorado Provider Manual

▪ Billing and Payment



Billing and Payment

Kaiser Permanente's billing and payment policies and procedures aim to ensure that you receive timely payment for the care you provide. This section of the Manual provides a quick and easy resource with contact phone numbers, detailed processes, and site lists for services.

If you have a question or concern about the information in this section, please call 1-888-681-7878 or 303-338-3600.

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Section 5: Billing and Payment

It is your responsibility to submit itemized claims for services provided to in accordance with your Agreement, this Manual and applicable law. The Member's Payor is responsible for payment of claims in accordance with your Agreement. Please note that this manual does not address submission of claims under tier 2 and 3 of POS product. ***The provisions of this Section 5 apply unless your Agreement provides otherwise.***

Health Plan agrees to implement any new or revised CMS Fee Schedule within 45 calendar days after the CMS File Publish Date or CMS Implementation Date, whichever is later.

5.1. Contacts for Questions

Central Referral Center 303-636-3131 or 1-877-895-2705, FAX 1-866-529-0934

Provides authorization prior to rendering services. Specialists are limited to procedures and services defined on the Referral Authorization Form. Members must return to Kaiser Permanente for services that have not been pre-authorized.

Fully Insured Claims and Member Service Department 303-338-3600, 1-800-632-9700 (Member Services)

All claim inquiries or requests for information related to claims payment will need to be submitted via KP Online Affiliate in accordance with Section 5.3.6 (Inquiry about Claims Payments). Claims should be submitted on a CMS 1500 or CMS 1450 form. Clean claims will be paid or denied within the timeframes required by applicable Federal or state law. Kaiser Permanente Claims and Referral Department PO Box 373150 Denver, CO 80237-6970.

KPIC Self-Funded Claims Department 866-213-3062

Provides information related to KPIC Self-Funded claims payment for services provided. All claims should be sent electronically, if possible. Otherwise, please mail paper claims to the address listed below. Paper Claims should be submitted on a CMS 1500 or CMS 1450 form. Clean claims will be paid or denied within the timeframes required by applicable Federal or state law. Kaiser Permanente Insurance Company PO Box 30547 Salt Lake City, UT 84130-0547.

Note: KPIC manages Self-Funded plans for members in all states except Washington, which has its own Self-Funded plans. The guidelines in this book pertain specifically to the KPIC Self-Funded plans. For Washington Self-Funded plans, please follow the normal instructions for Visiting Members in Section 5.4.

Member Service Department - Benefit Information 303-338-3800 (Denver/Boulder members) or 1-800-632-9700

Expansion Service Areas:

- Mountain Colorado 844-837-6884
- Northern Colorado 844-201-5824
- Southern Colorado 888-681-7878

The Member Service Department provides benefits or eligibility information to Kaiser Permanente members. Providers can also find benefit information on Kaiser Permanente ID cards. All member cost share should be collected at the time services are provided. This department also documents, reports and facilitates the response to member complaints.

Provider Credentialing Requirements:

Individual Practitioner Credentialing requirements:

Phone: 303-283-2968

Fax: 855-419-9180

Provider Data Updates or Inquiries: KPCO-PDM@KP.org

Facility Credentialing requirements:

303-344-7293

Facility Updates or Inquiries: Kaiser-Provider-Notification@kp.org

Our Credentialing Committee prior to rendering services must approve all consultants contracting with Kaiser Permanente. If you add new providers to your practice, you must contact your contract manager to have them properly credentialed. **If providers bill prior to being credentialed and or added to the roster, claims will be denied with the denial reason of “CLD94 Provider not credentialed at time of services”. *This is a provider liability not a member’s liability.***

5.2. Methods of Claims Filing

5.2.1 Electronic Data Interchange (EDI)

Electronic Claim Submissions: Kaiser Permanente encourages electronic submission of claims.

EDI is an electronic exchange of information in a standardized format that adheres to all Health Insurance Portability and Accountability Act (HIPAA) requirements. EDI transactions replace the submission of paper claims. Required data elements (for example, claims data elements) are entered into the computer only ONCE - typically at the Provider’s office, or at another location where services were rendered.

Benefits of EDI Submission

- **Reduced Overhead Expenses:** Administrative overhead expenses are reduced, because the need for handling paper claims is eliminated.
- **Improved Data Accuracy:** Because the claims data submitted by the Provider is sent electronically to Kaiser Permanente via the Clearinghouse, data accuracy is improved, as there is no need for re-keying or re-entry of data.
- **Low Error Rate:** Additionally, “up-front” edits applied to the claims data while information is being entered at the Provider’s office, and additional payer-specific

edits applied to the data by the Clearinghouse before the data is transmitted to the appropriate payer for processing, increase the percentage of clean claim submissions.

- Bypass US Mail Delivery: The usage of envelopes and stamps is eliminated. Providers save time by bypassing the U.S. mail delivery system.
- Standardized Transaction Formats: Industry-accepted standardized medical claim formats may reduce the number of “exceptions” currently required by multiple payers.

NOTICE TO ALL PROVIDERS:

Subscriber Information: Submit claims using only the patient’s information (e.g. name, date of birth, Kaiser Permanente medical record number); do not use the subscriber’s information. Since each Kaiser Permanente member is assigned a unique medical record number, they are considered their own subscriber for electronic transmissions, i.e., patient relationship should be equal to **SELF (18)**.

5.2.2 Electronic Claims Forms / Submission

Kaiser Permanente of Colorado accepts all claims submitted by mail or electronically.

Professional and facility claims can be submitted electronically via the current version of:

- 837P must be used for all professional services and suppliers.
- 837I must be used by all facilities (e.g., hospitals).

Standardized Transaction Formats

Industry-accepted standardized medical claim formats may reduce the number of “exceptions” currently required by multiple payers.

For information or questions how to submit EDI claims to KP, send an email to EDIEngagementTeam@kp.org

5.2.3 Supporting Documentation for EDI Claims

Kaiser Permanente Colorado is permitting providers to submit electronic claim appeals/disputes, upload of claim supporting documents, and respond to request for information (RFI) via Online Affiliate. If additional information is needed for claim processing, you will receive a request for information from Kaiser Permanente Colorado that can be responded to via Online Affiliate.

If supporting documentation is required to process an EDI claim, KP will request the supporting documentation by sending a request for information (RFI) letter via USPS.

You may also use Online Affiliate to view KP requests for information (RFI). Online Affiliate now has a RFI tab that displays which claims we are requesting more information. You can submit the RFI documentation online with a few clicks of the mouse.

Navigate to the following link to access KP Online Affiliate and start using this feature today:
providers.kp.org/cod

Coordination of Benefits

Specific 837 data elements work together to coordinate benefits between Kaiser and other carriers. Following the Provider-to-Payer-to-Provider model;

The provider sends the 837 to the primary payer. The primary payer adjudicates the claim and sends an 835 Payment Advice to the provider.

The 835 includes the claim adjustment reason code and/or remark code for the claim.

Upon receipt of the 835, the provider sends a second 837 with COB information populated in Loops2320, 2330A-G, and/or 2430 to the secondary payer. The secondary payer adjudicates the claim and sends an 835 Payment Advice to the provider.

Kaiser recognizes submission of an 837 transaction to a sequential payer populated with data from the previous payer's 835. Based on the information provided and the level of policy, the claim will be adjudicated without the paper copy of the Explanation of Benefits from Medicare or the primary carrier.

When more than one payer is involved on a claim, data elements for all prior payers must be present (i.e., if a tertiary payer is involved, then all the data elements from the primary and secondary payers must also be present).

If data elements from previous payer(s) are omitted, Kaiser will fail the claim

Contact your clearinghouse for assistance sending COB claims electronically.

5.2.4 To Initiate Electronic Claims Submissions

Trading Partners or Trading Parties interested in implementing EDI transactions with Kaiser Permanente should contact Regional EDI Business Operations for information via email:
EDIEngagementTeam@kp.org

Providers with existing electronic connectivity, please use the Payer ID list below:

- **SSI 837– 999990273**
1-800-880-3032
- **Change HealthCare/Emdeon 837– 91617—KPIC Self-Funded use 94320**
1-800-845-6592
- **OptumInsight/Ingenix 837– COKSR**
719-277-7545
- **Relay Health 837 - RH003**
1-800-545-2488

- **Office Ally – 91617**
306-975-7000 Option 1
<https://cms.officeally.com/>
info@officeally.com

5.2.5 Paper Claim Forms

Institutional charges must be submitted using a preprinted OCR red lined UB-04 claim form (or successor form) with appropriate coding. Entries must be completed in accordance with National Uniform Billing Committee (NUBC) directions and contain all mandatory entries, and as required by applicable statutes and regulations. Reference material can be found at WWW.NUBC.ORG.

Professional charges must be submitted on a preprinted OCR red lined CMS-1500 v 0212 form (or successor form) with current ICD-10 diagnostic and CPT-4 procedure coding (or successor coding accepted commonly in the industry). Entries must be completed in accordance with National Uniform Claim Committee (NUCC) directions and contain all mandatory entries, and as required by applicable statutes and regulations. Reference material can be found at WWW.NUCC.ORG.

5.2.6 Record Authorization Number

All services that require prior authorization must have an authorization number reflected on the claim form.

5.2.7 One Member/ Provider per Claim Form

One Member per Claim Form/One Provider per claim:

- Do not bill for different Members on the same claim form.
- Do not bill for different Providers on the same claim form.
- Separate claim forms must be completed for each Member and for each Provider.

5.2.8 Motor Vehicle Accident/ Workers' Compensation/Other Accident

Be sure to indicate on the CMS-1500 (HCFA-1500) Claim Form in the "Is Patient's Condition Related To" fields (Fields 10a -10c), whenever Motor Vehicle Accident, Workers' Compensation, or Other Accident situations apply.

5.2.9 Record the Name of the Provider You Are Covering For

When "covering" for another Provider, submit a CMS-1500 (HCFA-1500) claim form for these services and enter the name of the physician you are covering for in Field 19 (Reserved for Local Use).

NOTE: If a non-contracting Provider will be covering for you in your absence, please notify that individual of this requirement.

5.2.10 Submission of Multiple Page Claim

If due to space constraints a multipage claim form is needed, please write “continuation” at the top of the second form and attach all pages of the multipage claim with a paper clip. Each page of the multipage claim form’s charge lines (block 24 a-f) must be filled except for the final page. The claim will be rejected if the charge line is not continuous. There is a maximum of 50 charge lines per multipage claim. Multipage claims that contain more than 50 charge lines will be rejected. The TOTAL CHARGE (Field 28) on the final page of the claim submission will need to be the sum of charge lines for all pages of the multipage claim. The TOTAL CHARGE field on the first and intermediate pages is to either be blank or contain the work “continued”.

5.2.11 Entering Dates

Below is an example of how to enter dates on the CMS-1500 (HCFA-1500) Claim Form:

TOPIC	INSTRUCTIONS															
ENTERING DATES	<ul style="list-style-type: none"> All dates (dates of birth, dates of service, etc.) must be reported in the following format: month, day, and FOUR DIGITS for the year (MM/DD/YYYY). Example: 01/05/2003 CONSECUTIVE DATES OF SERVICE Consecutive dates of service can be billed on one claim line as long as the units entered in Field 24g equal the total number of days billed. <p>Example:</p> <p>Correct Way to Bill →</p> <table border="1" style="margin-left: 20px;"> <thead> <tr> <th>CPT/HCPCS</th> <th>DATE OF SERVICE</th> <th>UNITS</th> </tr> </thead> <tbody> <tr> <td>97110</td> <td>01/05/2004-01/07/2004</td> <td>3</td> </tr> <tr> <td>97110</td> <td>01/08/2004-01/13/2004</td> <td>5</td> </tr> </tbody> </table> <p style="margin-left: 20px;">This is the correct way to bill for consecutive dates of service. The Units field should equal the total number of days billed on each claim line.</p> <p>Incorrect Way to Bill →</p> <table border="1" style="margin-left: 20px;"> <thead> <tr> <th>CPT/HCPCS</th> <th>DATE OF SERVICE</th> <th>UNITS</th> </tr> </thead> <tbody> <tr> <td>97110</td> <td>01/05/2004-01/13/2004</td> <td>5</td> </tr> </tbody> </table> <p style="margin-left: 20px;">Practitioners/Providers should not enter a date span on the claim line if the services are not performed on consecutive dates. Claims will be denied for the exact dates of service.</p>	CPT/HCPCS	DATE OF SERVICE	UNITS	97110	01/05/2004-01/07/2004	3	97110	01/08/2004-01/13/2004	5	CPT/HCPCS	DATE OF SERVICE	UNITS	97110	01/05/2004-01/13/2004	5
CPT/HCPCS	DATE OF SERVICE	UNITS														
97110	01/05/2004-01/07/2004	3														
97110	01/08/2004-01/13/2004	5														
CPT/HCPCS	DATE OF SERVICE	UNITS														
97110	01/05/2004-01/13/2004	5														

5.2.12 Multiple Dates of Services and Place of Services

- Do not bill for different Members on the same claim form.
- Multiple dates of services at the same location can be filed on the same claim form but must be entered on a separate line. Dates of service at different locations must be filed on a separate claim form.
- Same date of service at different locations must be filed on a separate claim form.

5.2.13 Surgical and/or Obstetrical Procedures

When submitting UB-04 claims, use ICD-10 PCS codes in Field 74a-e (Principal Procedure Code and Date). The claim will be rejected for invalid code submission if CPT/HCPCS codes are used in Field 74a-e.

5.2.14 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 two claims for these services. Bill all services for this inpatient stay on one claim form (if possible), reflecting the correct date of admission and the correct date of discharge. Kaiser Permanente will apply the appropriate/applicable payment methodologies when processing these claims.

5.2.15 Rates for an Episode of Care

Contracts that include multiple services under a single rate, such as infertility care or radiation oncology services, should bill only once for the entire episode of care. Do not submit separate bills for care that is encompassed in the package rate.

5.2.16 Interim Inpatient Bills

For inpatient services only, we will accept separately billable claims for services in an inpatient facility on a bi-weekly basis. Interim hospital billings should be submitted under the same Member account number as the initial bill submission.

DRG/Case Rate/Other Reimbursement Contracts

Facilities contracted with Kaiser Permanente under a DRG or a case-rate payment methodology CANNOT submit interim inpatient bills; bills can only be submitted upon patient discharge.

Per Diem

Skilled nursing facilities contracted with Kaiser Permanente under a “per diem” methodology may submit interim inpatient bills on a monthly basis for prolonged patient hospitalization. Be sure to indicate via appropriate codes in Field 22 (Discharge Status Code) and Field 4 (Type of Bill) that this is an “interim” inpatient bill.

5.2.17 Supporting Documentation for Paper Claims

Supporting documentation is only required when requested upon the denial or pending of a claim. You will receive written notice if you need to provide written documentation in order to reprocess your claim. See section 5.2.3 for information on how to respond to a KP request for information via KP Online Affiliate.

When billing with an unlisted CPT code, to expedite claims processing and *adjudication*, *providers should submit supporting written documentation.*

5.2.18 Where to Mail Paper Claims

Paper claims are not accepted via fax or email due to HIPAA regulations. All providers should submit claims via EDI if at all possible. (See section 5.2.1 for Payor IDs).

5.3. Claim Filing Requirements

5.3.1 Clean Claims

Kaiser Permanente follows all state and Federal clean claim requirements. Kaiser Permanente considers a claim 'clean' when the following requirements are met:

Correct Form

Kaiser Permanente requires all professional claims to be submitted using the Original preprinted CMS Form 1500 ver 02/12, and all facility claims (or appropriate ancillary services) to be submitted using the Original Preprinted Form CMS 1450 (UB04) based on CMS guidelines. Original claim forms are those printed in Flint OCR Red J6983 (or exact match) ink per NUCC guidelines.

Standard Coding

All fields should be completed using industry standard coding.

Applicable Attachments

Attachments should be included in your submission when circumstances require additional information.

Completed Field Elements for CMS Form 1500 or CMS 1450 (UB-04 based on CMS guidelines)

All applicable data elements of CMS forms should be completed.

A claim is not considered to be "Clean" or payable if one or more of the following are missing or are in dispute:

- 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 physician is missing.
- The vendor 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.

- The Original Claim number for any Corrected or Voided claim submission (see Correcting a Previously Submitted Claim)

NOTE: Failure to include all information will result in the claim being rejected for missing information. A claim missing any of the required information will not be considered a clean claim.

5.3.2 Claims Submission Timeframes

Timeframes for Filing a Claim:

New Claims

The standard is ninety (90) calendar days from the date of service, for both Commercial and Medicare members.

COB Claims

COB information must be received within 12 months of the request for Commercial members and 24 months for Medicare/Medicaid Members. (If within the last three months of the year, Medicare/Medicaid Members have 27 months.) Processing of your claim may be delayed for receipt of COB information.

Claim Corrections

When a claim is received within the contractual timely filing period but is received with missing information, the provider will be required to submit a corrected claim to Kaiser Permanente within ninety (90) calendar days for contracted from the date of the original Remittance Advice.

Correcting a Previously Submitted Claim

If your claim requires correction, you will receive a notice accompanying your denied claim detailing the error. If corrections can be made, you should submit a corrected claim.

The timeframe for submitting a corrected claim is either detailed in the notice you receive requesting corrections or will default to the timely filing limit if not specified.

Contracted providers can submit a claim correction if he/she has the following justifications:

- Original claim submitted with incorrect diagnosis.
- Original claim submitted with incorrect procedure(s).
- Original claim submitted with incorrect member.
- Original claim submitted with incorrect date of service.
- Original claim submitted with incorrect rates applied.
- Authorization has been obtained.
- Any other information that has been added/corrected on the original claim.

Corrected claims should be submitted via EDI, using the appropriate frequency code (7 or 8), and providing the original KP Claim number that you want corrected.

Electronic Replacement/Corrected Claim Submissions

The KP claims system recognizes claim submission types on electronic claims by the frequency code submitted. The ANSI X12 837 claim format allows providers to submit changes to claims which were not included on the original claim adjudication. Claims submitted without the valid original claim number will be rejected. The DCN/original claim number can be obtained from the 835 Electronic Remittance Advice (ERA or the providers EOP. The DCN/original claim number can be obtained from the 835 Electronic Remittance Advice (ERA or the providers EOP.

Claim Frequency Codes

The 837 Implementation Guides refer to the National Uniform Billing Data Element Specifications Loop 2300 CLM05-3 for explanation and usage. In the 837 formats, the codes are called “claim frequency codes.” Using the appropriate code, you can indicate that the claim is an adjustment of a previously submitted, finalized claim

If submitting a paper claim correction to Kaiser Permanente for processing:

- Identification of the corrected claim is based on codes entered in specific fields on the form, no additional notifications are required. For example: do not write “Corrected claim” on the form or the inclusion of a cover page indicating that a corrected claim is being submitted.
- On the CMS 1500 0212 box (resubmission code) would contain a “7” and under the Original Ref. No. the Kaiser (Tapestry) claim number is to be provided. Claims submitted without the valid original claim number will be rejected. The DCN/Original claim number can be obtained from the 835 Electronic Remittance Advice (ERA or the providers EOP.
- On the UB04 claim, a correct claim is indicated by the last digit of the type of bill field (Block 4) being a “7” (example 117,137) the original claim number is placed in block 64 (Document Control Number) it needs to be in the same row as the payor in block 50. For example: if this is a corrected claim and Kaiser has been identified in row “A” in block 50, the Tapestry claim number needs to be in block 64 row “A” when submitting a paper claim.
- If Tapestry claim number is not provided, the claim will be rejected for missing original claim number.

For Fully Insured members, submit the corrected claim(s) electronically to:

Payer ID #999990273 (SSI)
Payer ID #91617 (Change Healthcare)
Payer ID #COKSR (OptumInsight)
Payer ID #RH003 (RelayHealth)

or mail to:

**Kaiser Permanente of Colorado
Claims Administration**

P.O. Box 373150
Denver, CO 80237

- For KPIC Self-Funded members, mail the corrected claim(s) to:

Kaiser Permanente Insurance Company
P.O. Box 30547
Salt Lake City, UT 84130-0547

Or submit electronically to Payer ID #94320

5.3.3 Claims Processing Turn-Around Time

Clean claims will be processed pursuant to the timeframe specified by applicable law for Commercial lines of business and 30 calendar days from receipt for Senior Advantage/Medicare lines of business.

5.3.4 Claim Reconsideration

Claims submitted for reconsideration must be submitted within the forty-five (45) calendar days of the Remittance Advice with proof of timely filing.

Examples of reconsiderations are timely filing denials, provider contract payment disputes, and incorrect eligibility denials. Refer to Section 6.6 of this Manual for further information on reconsiderations.

Proof of **timely filing** may include the following documentation and/or situations:

- EDI Transmission reports (Kaiser Permanente acknowledgement of EDI transaction)
- Remit notices
- Denial notices

NOTE: *Hand-written or typed documentation is not acceptable proof of timely filing.*

KPIC Self-Funded Reconsideration Requests

KPIC Self-Funded reconsideration requests do not go to the standard claims address.

For KPIC Self-Funded reconsiderations, please submit to:

KPIC Reconsiderations
3701 Boardman-Canfield Road, Building B
Canfield, OH 44406

Please note that Self-Funded claim status will not be available via the Online Affiliate. For Self-Funded claim status information, you can sign up for the Self-Funded Provider Portal at <http://kpclaimservices.com>.

5.3.5 Claims Adjustments / Corrections

Claim Adjustments

We reserve the right to audit claims for adjustments and corrections to ensure services rendered are medically necessary, coding requirements are met as stated in this Manual, and payment is according to your Agreement.

Necessary adjustments may be made by offsetting against future claims to any and all claims prior to or after payment.

Periodically, Kaiser Permanente will perform audits on claims to determine if payments have been made appropriately. If our audit determines that an overpayment was made, you will be notified in writing of the amount of the overpayment and given instructions on the process and time frame for reimbursing Kaiser Permanente for the amount overpaid.

If you do not send a check for the amount of the overpayment within the timeframe specified in your notice, future claims will be offset. Remit notices for claims that have been offset will reflect the amount deducted from the expected payment. Multiple claims may be affected until the entire balance of the overpayment is recovered.

5.3.6 Inquiry about Claims Payments

For Claim Payment Inquires

Claim Status information must be obtained online via the KP Online Affiliate. By registering for Online Affiliate, you gain access to a robust set of features that can help simplify the process of obtaining KP member information and performing claim reconciliation. With Online Affiliate, you can download Explanation of Payment (EOP), file disputes/appeals, submit an online claim or payment inquiry and even respond to KP request for information (RFI).

Navigate to the following link to access these tools and start using today: providers.kp.org/cod

Please Note: *No claims adjustments will be made after 12 months from the date of the initial Remittance Advice.*

If Kaiser Permanente agrees that there has been an error, appropriate corrections will be made by Kaiser Permanente and the underpayment amount owed will be added to/reflected in your next Kaiser Permanente reimbursement check.

For an Overpayment Error

You have responsibility to identify and notify us of any overpayments. If you have identified an overpayment or KP has notified you of an overpayment, the following options are available to you.

- You may respond to a notice of overpayment electronically via Kaiser Permanente’s Online Affiliate tool. You may log in and search for the claim for which there was an overpayment. From that claim record, you may take an action of an Overpayment Inquiry and select the Responding to an Overpayment Notice option. Complete the questionnaire and provide any supporting documents as appropriate. This questionnaire will allow you to authorize recoupment or let us know you are sending in payment, or you can indicate if you disagree with the amount or with the overpayment finding itself, and initiate a dispute regarding the overpayment. You will receive a response from Kaiser Permanente in your provider portal in-basket.

In addition to responding to a notice of overpayment, you may now also self-report an overpayment if you feel we have overpaid a claim. Follow the same steps to submit your overpayment inquiry and select the self-reporting an overpayment option. Complete the questionnaire and submit any supporting documents as appropriate. We will complete an audit and respond back to you with any findings.

- Write a refund check to Kaiser Permanente for the excess amount paid to you by Kaiser Permanente. Attach a copy of Kaiser Permanente’s Remittance Advice to your refund check, as well the Kaiser Permanente claim number and a brief note explaining the error.

NOTE: *If Kaiser Permanente’s Remittance Advice is not available, please record the Member’s Medical Record Number, date of service, and claim number on the payment check you are returning.*

- Mail your refund check (and brief note) to:

Colorado Region (Health Plan)	Kaiser Foundation Health Plan of Colorado PO Box 740812 Los Angeles, CA 90074-0812
Colorado Region (KPIC-FI)	Kaiser Permanente Insurance Co PO Box 740951 Los Angeles, CA 90074-0951
KPIC Self-Funded	Kaiser Permanente Insurance Co PO Box 741025 Los Angeles, CA 90074-1025

- Send the appropriate refund to Kaiser Permanente within thirty (30) days from when you confirm that you are not entitled to the payment.

- Write or call Claims Customer Service and explain the error. Appropriate corrections will be made, and the overpayment amount will be automatically deducted from your next Kaiser Permanente reimbursement check.

If you discover an overpayment and you do not choose one of the above options, Kaiser Permanente reserves the right to offset future payments for the amount owed.

5.3.7 Rejected Claims Due to EDI Claims Error

The submitting provider is responsible for monitoring the acceptance and reject reports provided by the clearinghouse and to resolve transmission and format issues with the clearinghouse. Issues between the clearinghouse and Kaiser Permanente will be addressed by Kaiser Permanente.

5.3.8 Required Identification Information

5.3.8.1 Federal Tax ID Number

The Federal Tax ID Number as reported on any and all claim form(s) must match the information filed with the Internal Revenue Service (IRS).

When completing IRS Form W-9, please note the following:

- Name: This should be the equivalent of your “entity name”, which you use to file your tax forms with the IRS.
- Sole Provider/ Proprietor: List your name, as registered with the IRS.
- Group Practice/Facility: List your “group” or “facility” name, as registered with the IRS.
- Business Name: Leave this field blank, unless you have registered with the IRS as a “Doing Business As” (DBA) entity. If you are doing business under a different name, enter that name on the IRS Form W-9.
- Address/City, State, Zip Code: Enter the address where Kaiser Permanente should mail your IRS Form 1099. Enter Zip + 4.
- Taxpayer Identification Number (TIN): The number reported in this field (either the social security number or the employer identification number) **MUST** be used on all claims submitted to Kaiser Permanente.
- Sole Provider/Proprietor: Enter your taxpayer identification number, which will usually be your social security number (SSN), unless you have been assigned a unique employer identification number (because you are “doing business as” an entity under a different name).
- Group Practice/Facility: Enter your taxpayer identification number, which will usually be your unique employer identification number (EIN).

If you have any questions regarding the proper completion of IRS Form W-9, or the correct reporting of your Federal Taxpayer ID Number on your claim forms, please contact the IRS help line in your area or refer to the following website: <http://www.irs.gov/Forms-&Pubs>

IMPORTANT: If your Federal Tax ID Number should change, please notify us immediately, so that appropriate corrections can be made to Kaiser Permanente's files to ensure timely payments.

5.3.8.2 Changes in Federal Tax ID Number

If your office/facility changes any pertinent information (i.e., tax identification number, phone or fax number, billing address, practice address, etc.) please mail or fax written notice, including the effective date of the change, as soon as possible, or if at all possible, with 90 days advance notice. For changes in Federal Tax-ID numbers, please include a W-9 form with the correct information and send it to the following:

- Providers contracted with CPMG, please email: KPCO-PDM@kp.org or fax 866-380-9188
- Provider contracted with KFHP or KFH, please email: Kaiser-Provider-Notification@kp.org or fax 303-338-3088

5.3.8.3 National Provider Identification (NPI)

Kaiser Permanente will not be able to process electronic claims unless they contain the NPI. ***NPI's must be in the correct position on the claim. Individual Rendering Provider NPI in Box 24J and Billing Entity Organizational NPI in Box 33a or electronic equivalent. If the contractual arrangements are made with an Organization and not an Sole Proprietor, Box 33 Name and NPI must be the Organization's Name and Organization's NPI.***

Individual (Type 1) and Organization/Group (Type 2) NPI applications and instructions can be accessed at: <https://nppes.cms.hhs.gov>.

5.3.9 Member Cost Share

Depending on the benefit plan, Kaiser Permanente Members may be responsible to share some cost of the services provided. Copayment, co-insurance and deductible (collectively, "Member Cost Share") are the fees a Member is responsible to pay a Provider for certain covered services. This information varies by plan and all Providers are responsible for collecting Member Cost Share in accordance with Kaiser Permanente Member's benefits.

Please verify applicable Member Cost Share at the time of service. Member Cost Share information can be obtained from:

- Member ID Card: Copayments, co-insurance and deductible information are listed on the front of the Member ID card when applicable.

Note: As required by Medicare regulations and as outlined in your contract with Kaiser Permanente, providers are prohibited from collecting cost-sharing for Medicare covered services from members dually enrolled in the Medicare and Medicaid programs. This requirement also applies to individuals enrolled in the Qualified Medicare Beneficiary (QMB)

Program, a program that pays for Medicare premiums and cost-sharing for certain low-income Medicare beneficiaries. Accordingly, it is imperative that you take steps to avoid inappropriate billing/collection of cost-sharing from dual eligible beneficiaries, including QMB enrollees. Kaiser Permanente's contract with the Medicare program requires that we actively educate contracted providers about this requirement and promptly address any complaints from dual-eligible beneficiaries/members alleging that cost-sharing was inappropriately requested or collected.

5.3.10 Member Claims Inquires

Members seeking information regarding Fully Insured claims should contact Kaiser Permanente Customer Service at **303-338-3600**.

Members seeking information regarding KPIC Self-Funded claims should contact Kaiser Permanente KPIC Self-Funded Customer Service at 866-213-3062.

5.4. Visiting Members

Kaiser Permanente members who access routine and specialty health services while they are temporarily visiting another Kaiser Permanente region are referred to as **visiting members**. Kaiser Permanente health benefit plans allow members to receive non-urgent and non-emergent care* while traveling in other Kaiser Permanente regions (excludes HSA qualified, Medicaid only and PPO plans). We refer to their visiting region as the "HOST" region and where the member lives as their "HOME" region.

Your first step when a visiting Kaiser Permanente member requests services from you.

- Review the member identification card and confirm their "HOME" region Medical Record Number (MRN).
- Verify "HOME" region benefits, eligibility and cost share by calling the Member Services Call Center (MSCC) number on the member's identification card.
- As a reminder, services are covered according to the member's contract benefits, subject to general visiting member exclusions. *
- Follow standard referral procedures.

Does the visiting member need a referral to see a network provider?

- Follow standard referral procedures.

What do I need to know if an authorization is required?

- Do not bill for different Members on the same claim form.
- Visiting members require a "HOST" MRN for ALL authorizations. **

- The member or network provider should call the Chart Accuracy Group at 303-404-4800 between 8 a.m. and 4 p.m. to get the “HOST” MRN before submitting the referral request for an authorization. After 4PM, press 0 within the recording and the call be transferred to a representative who will assign the “HOST MRN.
- Included the “HOST” MRN on the referral request submission.
- Authorization forms can be found at the Community Provider Portal (CPP). http://www.providers.kaiserpermanente.org/html/cpp_cod/index.html
- Should additional services be required, refer to the Colorado authorization guidelines. http://www.providers.kaiserpermanente.org/html/cpp_cod/index.html
- As a reminder, services are covered according to the member’s contract benefits, subject to the general visiting member exclusions. *

What do you need to know when submitting claims?

- Do not bill for different Members on the same claim form.
- Claims must be submitted to the member’s “HOME” region with the members “HOME” region medical record number (MRN) included on the claim. For KPIC Self-Funded members, all claims go to the same address for all Regions (Refer to section 5.2.18).
- **Always** use the “HOME” MRN. **Never** add the “HOST” MRN on the claim form.
- If the member does not have an identification card or the “HOME” region’s claim submission address is not on the identification card, please call the corresponding “HOME” region’s MSCC number below to obtain the claims address.
- If you have a claim status inquiry, refer to the “HOME” region’s MSCC numbers below.
- If an authorization has been obtained, be sure to add the authorization number on the claim.

Where do I send reconsiderations or appeal forms?

For reconsiderations or **appeals**, call the home region’s MSCC.

* Refer to Visiting Member brochure located on the Community Provider Portal.

** **EXCEPTION:** for DME authorizations, contact the HOME region MSCC.

5.5. Coding for Claims

Contracted providers are responsible to ensure that billing codes used on claims forms are current and accurate. Individual physician evaluation and management coding statistics are routinely trended and compared with national statistics. Aberrant coding statistics may result in contract termination and investigation by Federal regulators.

5.5.1 Coding Standards

Coding: All fields should be completed using industry standard coding as outlined below.

ICD-10

To code diagnoses and hospital procedures on inpatient claims, use the International Classification of Diseases- 10th Revision-Clinical Modification (ICD-10-CM) developed by the Commission on Professional and Hospital Activities.

The U.S. Department of Health and Human Services (HHS) has set the compliance date of October 1, 2015 for the implementation of the International Classification of Diseases, 10th Edition (ICD-10), which is used in administrative health care transactions. This compliance date will apply to both diagnosis and procedure (ICD-10-CM and ICD-10-PCS) codes.

CPT-4 and Modifiers

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

A service or procedure can be further described by using 2-digit modifiers. The Modifier Reference Guide lists Level I (CPT-4), Level II (non-CPT-4 alpha numeric), and Level III (local) modifiers. Level I and II modifier definitions are contained in the Healthcare Common Procedure Coding System (HCPCS).

If you would like to request a new code or suggest deleting or revising an existing code, obtain and complete a form from the AMA's Web site at

www.ama-assn.org/ama/pub/category/3112.html or submit your request and supporting documentation to:

CPT Editorial Research and Development
American Medical Association
515 North State Street
Chicago IL 60610

HCPCS

The Healthcare 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

Approved by the Health Services Cost Review Commission for a hospital located in the State of Maryland, or of the national or state uniform billing data elements specifications for a hospital not located in that State.

NDC (National Drug Codes)

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

5.5.2 Claims Editing Software Program

Services must be reported in accordance with the reporting guidelines and instructions contained in the American Medical Association (“AMA”) CPT Manual, “CPT® Assistant,” and HCPCS publications” and CMS guidelines. Providers are responsible for accurately reporting the medical, surgical, diagnostic, and therapeutic services rendered to a member with the correct CPT and/or HCPCS codes, and for appending the applicable modifiers, when appropriate. Provider documentation must support services billed.

Claims are processed utilizing claims editing software product from Change Healthcare ClaimsXten. ClaimsXten is used to evaluate the accuracy of medical claims and their adherence to accepted CPT/HCPCS coding practices and it allows us to monitor the increasingly complex developments in medical technology and correct procedure coding used to process claims. American Medical Association Complete Procedural Terminology (CPT®), CPT Assistant, coding guidelines developed from national specialty societies, CMS, National Correct Coding Initiative (“NCCI” or “CCI”), Healthcare Common Procedure Coding System (HCPCS®), American Society of Anesthesiology (“ASA”), and other standard-setting organizations for claims billing procedures are considered in developing Kaiser Permanente’s coding and reimbursement edits and policies. ClaimsXten will be updated at a minimum quarterly.

Fraudulent coding will be investigated by Kaiser Permanente. In addition, individual physician evaluation and management coding statistics are routinely trended and compared with national statistics. Aberrant coding statistics may result in contract termination and investigation by Federal regulators.

5.5.3 Coding Edit Rules

Major Categories of Claim Coding Errors/Inconsistencies:

Procedure Unbundling

Occurs when two (2) or more procedures are used to describe a service when a single, more comprehensive procedure exists that more accurately describes the complete service performed by a provider. In this instance, the two (2) codes may be replaced with the more appropriate code by our bundling system.

Example 1: Laboratory

Laboratory unbundling edits are applied when certain laboratory tests are billed separately when a pre-defined panel exists that contains all the individual tests billed. These tests should **not** be billed separately but should be billed using **one (1)** panel coding.

Example 2: Electrocardiograms

A claim billed with the following two (2) codes together would be considered as unbundled:
Claim Detail Line 1 - **93005** Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report.

Claim Detail Line 2 - **93010** Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only.

Example 3: Explanation

When CPT codes 93005 and 93010 are performed on the same day, the appropriate comprehensive procedure code would be 93000 - Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report.

Incidental Procedures

An incidental procedure is typically performed at the same time as a more complex primary procedure. However, the incidental procedure requires little additional physician resources, and/or is clinically integral to the performance of the primary procedure. Therefore, incidental procedures are NOT reimbursed separately.

Separate Procedures

Procedures designated as a “separate procedure” in the CPT code book are commonly performed as an integral part of a total, larger procedure, and normally does NOT warrant separate identification. Therefore, these services are typically included as part of the “global” charges submitted for the related, larger procedure.

However, when the procedure is performed as a separate, independent service not in conjunction with any normally related procedure it may be billed as a “separate procedure.” If the procedure is performed alone for a specific purpose, it may be eligible for separate reimbursement.

Mutually Exclusive Procedures

Mutually exclusive procedures are two or more procedures that are usually NOT performed at the same operative session on the same member on the same date of service. Mutually exclusive rules may also include different procedure code descriptions for the same type of procedure(s), for which the physician should be submitting only ONE of the procedure codes.

Age and Gender (Sex) Conflicts

An age conflict occurs when the contracted provider bills an age-specific procedure code for a member outside of the designated age range. Similarly, a gender conflict occurs when a gender-specific procedure is assigned to a member of the opposite gender.

Example 1: The contracted provider assigns the code for surgical opening of the stomach, for newborns (43831), to a 45-year-old member.

Example 2: Code 58150 Total abdominal hysterectomy is submitted for a male member.

Exception: Initial Newborn Care (99431, 99432, 99435) are payable under the mother's contract and are excluded from the age processing rules.

The following age categories are examined for conflicts:

- Newborn (age less than 1 year old)
- Pediatric (ages 1-17 years old)
- Maternity (ages 12-55 years old)
- Adult (ages over 14 years old)

Obsolete/Deleted Codes

If obsolete or deleted codes are submitted, the code will be denied. Obsolete or deleted codes are updated each calendar year and are not accepted past the end date specified by CMS. Medicare claims with outdated codes will be subject to denial as per CMS guidelines.

Multiple or Duplicate Component Billing

When procedures are billable for professional and technical components (i.e., with Modifiers 26 and TC), Kaiser Permanente monitors that the total amount paid for the service does not exceed what would have been paid if the procedure had been billed without the modifier(s). Kaiser Permanente reserves the right to adjust claims that are paid in excess of the total.

Frequency Edits

Occur when a procedure is billed more often than would be expected in comparison to the units of service or date of service.

Global Surgical Packaging

Identifies Evaluation & Management (E&M) codes and supplies billed on a claim within the global period of the surgical procedure. The time frames are set by both the Center of Medicare and Medicaid Services (CMS).

New Patient Visit

As defined by the AMA, A new patient is one who has not received any professional service from the physician or another physician of the same specialty who belongs to the same group practice within the past three (3) years.

History Editing

Occurs when a previously submitted historical claim that is related to current claim submission is identified. This identification/edit may result in adjustments to claims previously processed and adjustments to the current claim being reviewed.

- An example of such a historical auditing action would occur when an E/M visit is submitted on one (1) claim and then a surgery for the same service date is submitted on a different claim. If a determination that the E/M visit paid in history is included in the allowable for the surgery, an adjustment of the E/M claim will be necessary, this may result in an **overpayment** recovery
- History editing capability are not limited to; global surgery, multiple visits per day, pre/post-operative visits, new patient visits, frequency rules, incidental, mutually exclusive and rebundle edits and maternity services

Place of Service Edits

Identify the reporting of an inappropriate place of service for a particular procedure, either due to the descriptive verbiage of the code, or due to published CPT coding guidelines which indicate that a specific procedure is not intended to be reported in a certain setting.

Modifier 50 - Bilateral Procedure is used to indicate a bilateral procedure and using CMS guidelines when processing bilateral surgeries/procedures. When a procedure **is not** identified by its terminology as a bilateral procedure it is billed on **one line** with the surgical procedure code, one unit of service and modifier 50. Bilateral surgeries/procedures are considered one surgery. We will be using CMS guidelines to determine appropriateness.

If the code is reported as a bilateral procedure and is reported with other procedure codes on the same day, then the bilateral adjustment will be applied before applying any multiple procedure rules.

Multiple modifiers: All modifiers are used to make payment determination; the claim will be held for manual adjudication and review.

5.5.4 Clinical Review

Claims may be reviewed by a physician or other appropriate clinician to ensure that providers comply with commonly accepted standards of coding and billing, that services rendered are appropriate and medically necessary, and that payment is made in accordance with applicable requirements set forth in your Agreement and/or this Provider Manual. Kaiser Permanente does not reimburse for items or services that are considered inclusive of, or an integral part of, another procedure or service.

Sources of commonly accepted standards include CMS, the National Uniform Billing Committee (NUBC), the National Correct Coding Initiative, and professional and academic journals and publications. If you would like more information about commonly accepted standards applied by Kaiser Permanente, please contact Kaiser Permanente Claims Services at **(800) 632-9700**.

You are required to code and bill in accordance with applicable laws and regulations, your provider contract, and industry standard practices, some of which are described above. You are also required to follow our Payment Determination Policy, which contain further detail on how Kaiser Permanente applies industry standard practices. These policies may be amended from time to time and are available upon request.

If we do not have enough information to adjudicate a claim, we will mail you a request for specific additional medical records. We may also request itemized bills.

Whenever services include transplant services, we always require submission of itemized bills and medical records.

When we request medical records, we will ask you for one or more of the following:

- History and Physical reports
- Consultant reports
- Discharge Summaries
- Emergency Department reports
- Diagnostic reports
- Progress reports CDI MD Coding Queries:
 - ***If additional documents are obtained after discharge, please attach as a scan in CareEverywhere.***

5.6. Third Party Liability (TPL)

In the state of Colorado, Kaiser Permanente may seek reimbursement from a member's settlement or judgement due to injuries or illnesses caused by a third party. These activities are managed by Equian:

P.O. BOX 36380
Louisville, KY 40233
TEL: 1-800-327-4016
Fax: (502) 454-1137
Hours of Operations
8:30 a.m. to 5:00 p.m. Monday-Friday (Eastern Time)

5.7. First Party Liability

First Party Liability is when the member's other insurance coverage (such as an automobile policy) covers costs related to injuries or illnesses due to an accident, regardless of fault. In the event that you receive a partial payment from an auto carrier that falls under the category of First Party Liability (such as Med Pay, Personal Injury Protection, etc), please submit your claim and indicate the auto carrier name and amount paid along with the Explanation of Benefits (EOB). Any amount paid by the auto carrier will first be applied to the member's cost share before it is applied to the KP allowable amount.

5.8. First- and Third-Party Guidelines

Providers are required to assist and cooperate with KP's efforts to identify these situations by entering the following information on the billing form, if applicable:

- Automobile carrier information in appropriate fields, along with payment information
- ICD-10 diagnosis data in appropriate fields
- Accident related claim codes (e.g. occurrence codes, condition codes, etc)

5.9. 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. You must include a copy of the denial letter or Explanation of Payment from the Workers Compensation carrier.

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.

5.10. Ground Ambulance, Dental and Behavioral Health Claims.

Ground Ambulance is paid **through KP's** TPA for all lines of business. All Ground Ambulance claims should be mailed to the below address:

Relation Insurance Services of Florida, Inc.
PO Box 853915
Richardson, TX 75085-3915

Claims for Dental Services should be mailed to:

Delta Dental of Colorado
P.O. Box 173803
Denver, CO 80217-3803

Claims for Behavioral Health Services in Denver/Boulder areas should be mailed to:

Beacon Health Options
P.O. Box 1854
Hicksville, NY 11802-1850

5.11. Provider Claim Payment Appeals Process

If your office/facility has questions or concerns about the way a particular claim was processed by Kaiser Permanente, please contact Claims Customer Service at 303-338-3800 for Fully Insured members and 866-213-3062 for KPIC Self-Funded members. Many questions and issues regarding claim payments, coding, and submission policies can be resolved quickly over the phone.

If your issue cannot be resolved through this initial contact, you have the right to appeal. See Section 6 of this Manual for a full explanation of this process.

You may submit an appeal or dispute online via Online Affiliate.

Kaiser Permanente Colorado is permitting providers to submit electronic claim appeals/disputes, upload of claim supporting documents, and respond to request for information (RFI) via Online Affiliate. Please visit the Community Provider Portal at providers.kaiserpermanente.org/cod to sign up for access to Online Affiliate.

If you have additional questions, please reach out to your regional representative at KP-CO-OnlineAffiliate@kp.org

5.11.1 Claim Form Examples and Instructions

- Correct Form: Kaiser Permanente requires all professional claims to be submitted using the Original Red Industry Standard CMS Form 1500 ver 02/12, and all facility claims (or appropriate ancillary services) to be submitted using the CMS Form 1450 (UB04) based on CMS guidelines.
- Standard Coding: All fields should be completed using industry standard coding.
- Applicable Attachments: Attachments should be included in your submission when circumstances require additional information.
- Completed Field Elements for CMS Form 1500 (02/12 based on CMS guidelines) Or CMS 1450 (UB-04 based on CMS guidelines): All applicable data elements of CMS forms should be completed.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 0212

PICA <input type="checkbox"/>												
1. MEDICARE <input type="checkbox"/> (Medicare)	2. MEDICAID <input type="checkbox"/> (Medicaid)		3. TRICARE <input type="checkbox"/> (TRICARE)		4. CHAMPVA <input type="checkbox"/> (Member ID#)		5. GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		6. FECA <input type="checkbox"/> (ID#)		7. OTHER <input type="checkbox"/> (ID#)	
14. INSURED'S I.D. NUMBER (For Program in Item 1)												
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)						3. PATIENT'S BIRTH DATE MM DD YY			4. INSURED'S NAME (Last Name, First Name, Middle Initial)			
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO:			11. INSURED'S POLICY GROUP OR FECA NUMBER			
a. OTHER INSURED'S POLICY OR GROUP NUMBER						a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>			
b. RESERVED FOR NUCC USE						b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO			b. OTHER CLAIM ID (Designated by NUCC)			
c. RESERVED FOR NUCC USE						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME			
d. INSURANCE PLAN NAME OR PROGRAM NAME						10c. CLAIM CODES (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.			
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.						
SIGNED _____ DATE _____						SIGNED _____						
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (IMP) MM DD YY				15. OTHER DATE MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY				
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. OJAL				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				
17b. NPI				17c. NPI				19. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO				
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (4HE) ICD Ind.												
A. _____			B. _____			C. _____			D. _____			
E. _____			F. _____			G. _____			H. _____			
I. _____			J. _____			K. _____			L. _____			
24. A. DATES OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE		C. PROCEDURE, SERVICE, OR SUPPLY (Explain Unusual Circumstances)		D. OPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER		F. \$ CHARGES		
25. FEDERAL TAX I.D. NUMBER		SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$		29. AMOUNT PAID \$		
30. Revid for NUCC Use		31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof))		32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH# ()						
SIGNED _____ DATE _____		a. _____ b. _____		a. _____ b. _____		a. _____ b. _____						

NUCC Instruction Manual available at: www.nucc.org
OMB APPROVAL PENDING

PLEASE PRINT OR TYPE

OMB APPROVAL PENDING

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

CMS-1450 (UB-04) Field Descriptions

The fields identified in the table below as "Required" must be completed when submitting a

- FOR REFERENCE ONLY

1	2	3a PAI CNTRL #	4 TYPE OF BILL
5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	7 THROUGH	
8 PATIENT NAME	9 PATIENT ADDRESS		
10 BIRTH DATE	11 SEX	12 DATE	13 HR
14 TYPE	15 SFC	16 DI-R	17 STAT
18	19	20	21
22	23	24	25
26	27	28	29 ACCT STATE
30	31	32	33
34	35	36	37
38	39	40	41
42 REV. CD	43 DESCRIPTION	44 HCPCS / RATE / HPPS CODE	45 SERV. DATE
46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
PAGE	OF	CREATION DATE	TOTALS
50 PAYER NAME	51 HEALTH PLAN ID	52 DEL INFO	53 ASS. BEN.
54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	57 OTHER PRV ID
58 INSURED'S NAME	59 P-REL	60 INSURED'S UNIQUE ID	61 GROUP NAME
62 INSURANCE GROUP NO.	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
66 DX	67	68	69
70 PATIENT REASON DX	71 PPS CODE	72 ECI	73
74 PRINCIPAL PROCEDURE CODE	75	76 ATTENDING NPI	77 OPERATING NPI
78 OTHER NPI	79 OTHER NPI	80 REMARKS	81

- FOR REFERENCE ONLY

5.12. Billing Requirements and Instruction for Specific Services

5.12.1 Capitation Payments

Contracted providers with a capitated contract will still need to bill for services. Kaiser Permanente requires the monthly submission of encounter data and utilization information. This information is used to determine the volume and the types of services your office provides, and will be used to determine future contract rates.

NOTICE TO ALL PROVIDERS: Even though you may be reimbursed under a Periodic Interim Payments (PIP), or other reimbursement methodology, you are still required to submit Member Encounter Data to Kaiser Permanente electronically (preferred) or via standard claim forms (CMS-1500/HCFA-1500 or CMS-1450/UB-04 as applicable), and to follow all claims completion instructions set forth in this Manual. Please Review Sections 5.2 and 5.3 for Methods of Claim Filing and Claim Filing Requirements.

5.13. 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 plan. It is intended to prevent duplication of benefits when an individual is covered by multiple plans providing benefits or services for medical or other care and treatment.

Kaiser Permanente Providers are responsible for determining the primary payer and for billing the appropriate party. If Kaiser Permanente is not the primary carrier, an EOB is required with the claim submission.

5.13.1 How to Determine the Primary Payor

Primary coverage is determined using the guidelines established under applicable law. Examples are as follows but not limited to:

Dependent vs. Non-Dependent

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

Children

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

When determining the primary payer for a child of separated or divorced parents, inquire about the court agreement or decree. In the absence of a divorce decree/court order stipulating parental healthcare responsibilities for a dependent child, insurance benefits for that child are applied according to the following order:

Insurance carried by the:

- Natural parent with custody pays first;
- Step-parent with custody pays next;
- Natural parent without custody pays next;
- Step-parent without custody pays last.

If the parents have joint custody of the dependent child, then benefits are applied according to the birthday rule referenced above.

Medicare Members

Kaiser Permanente 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, or disability entitled regardless of age, or for employee group health plan (EGHP) Members with End Stage Renal Disease (ESRD) after the first 30 months of dialysis treatment. This does not apply to direct pay Members.

Workers' Compensation

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

5.13.2 Description of COB Payment Methodologies

Kaiser Permanente Coordination of Benefits allows benefits from multiple carriers to be added together so that the Member receives the full benefits from their primary carrier and the secondary carrier pays their entire benefit up to 100 percent of allowed charges. When Kaiser Permanente has been determined as the secondary payor, Kaiser Permanente pays the member’s responsibility based on what the primary carrier paid. Kaiser Permanente will never pay more as a secondary carrier than the amount that would have been paid if Kaiser Permanente were the primary carrier.

Benefit carve-out calculations are based on whether the contracted provider accepts Medicare assignment for the provider contract corresponding to the claim. Medicare assignment means the provider has agreed to accept the Medicare allowed amount as payment.

5.13.3 COB Claims Submission Requirements and Procedures

Whenever Kaiser Permanente is the secondary payor, claims should be submitted via EDI (preferred) or on one of the standard claim formats. Secondary claims can be provided via EDI by providing the primary payor information on the EDI Claim. In most cases a copy of the primary payor Explanation of Benefit (EOB) or Explanation of Medicare Benefits (EOMB) is not necessary and if needed will be requested. On paper claim submissions, complete the following fields:

- CMS-1500 claim form: Field 29 (Amount Paid)
- CMS-1450 claim form: Field 54 (Prior Payments)

5.13.4 Members Enrolled in Two Kaiser Permanente Plans

Some members may be enrolled under two separate plans offered through Kaiser Permanente (dual coverage). If the member is enrolled in two Fully Insured plans or two KPIC Self-Funded plans, contracted providers need only submit ONE claim under the primary plan to Kaiser Permanente for processing. If the member is enrolled in one Fully Insured plan and one KPIC Self-Funded plan, however, please submit separate claim submissions, including a copy of the primary EOB for the secondary claim.

5.13.5 COB Claims Submission Timeframes

If Kaiser Permanente is the secondary payor, any Coordination of Benefits (COB) claims must be submitted for processing within 45 days of the date of the Explanation of Benefits or statement of remittance.

5.13.6 COB Fields on the CMS-1500 and UB-04 Claim Form

The following fields should be completed on the CMS-1500 (HCFA-1500) claim form, to ensure timely and efficient claims processing. Incomplete, missing, or erroneous COB information in these fields may cause claims to be denied or pended and reimbursements delayed.

Claims submitted electronically must meet the same data requirements as paper claims. For electronic claim submissions, refer to a HIPAA website for additional information on electronic loops and segments.

837P LOOP #	CMS 1500 FIELD NUMBER	FIELD NAME	INSTRUCTIONS/EXAMPLES
2330A NM	9	OTHER INSURED'S NAME	When additional insurance coverage exists (through a spouse, parent, etc.) enter the LAST NAME, FIRST NAME, and MIDDLE INITIAL of the insured. NOTE: This field must be completed when there is an entry in Field 11d (Is There Another Health Benefit Plan?).
2330A NM	9a	OTHER INSURED'S POLICY OR GROUP NUMBER	Enter the <u>policy and/or group number</u> of the insured individual named in Field 9 . If you do <u>not</u> know the policy number, enter the Social Security number of the insured individual. NOTE: Field 9a must be completed when there is an entry in Field 11d (Is There Another Health Benefit Plan?). NOTE: For each entry in this field, there must be a corresponding Entry in 9d (Insurance Plan Name or Program Name).
2330B NM	9d	INSURANCE PLAN NAME or PROGRAM NAME	Enter the <u>name of the insurance plan or program</u> , of the insured individual named in Field 9 . NOTE: This field must be completed when there is an entry in Field 11d (Is There Another Health Benefit Plan?).
N/A	11d	IS THERE ANOTHER HEALTH BENEFIT PLAN?	Check "yes" or "no" to indicate if there is <u>another health benefit plan</u> . (For example, the patient may be covered under insurance held by a spouse, parent, or some other person). NOTE: If "yes," then Field Items 9 and 9a-d must be completed.
2320 AMT	29	AMOUNT PAID	Enter the amount paid by the primary insurance carrier in Field 29.

The following fields should be completed on the CMS-1450 (UB-04) claim form, to ensure timely and efficient claims processing. Incomplete, missing, or erroneous COB information in these fields may cause claims to be denied or pended and reimbursements delayed.

Claims submitted electronically must meet the same data requirements as paper claims. For electronic claim submissions, refer to a HIPAA website for additional information on electronic loops and segments.

837I LOOP #	UB FIELD NUMBER	FIELD NAME	INSTRUCTIONS/EXAMPLES
2320 SBR	50	Payer Identification	Enter the name of the Payer through which the insurance is being provided to the insured individual. Record entries in the following order : A = primary payer B = secondary payer C = tertiary payer
2320 SBR	51	Health Plan ID	Enter the Health Plan ID assigned by the carrier or administrator to identify the individual. List entries in the following order : A = primary payer B = secondary payer C = tertiary payer
2320 AMT	54	Prior Payments	Enter the Amount Paid by the Other Insurance Record entries in the following order : A = primary payer B = secondary payer C = tertiary payer

5.13.7 Fully Insured Explanation of Payment (EOP)



Questions? Call Customer Service at (800) 382-4661
Weekdays Mon - Fri 9:00AM - 4:00PM MT

Check / EFT #: [REDACTED]
Remittance Number: [REDACTED]
Payment Date: 07/29/2021
Total Payment Amt: 187.31
Vendor Tax ID No: [REDACTED]
Vendor ID No: [REDACTED]
Vendor NPI No: [REDACTED]



ACCOUNT SUMMARY		EOP Totals
Claims		
Claims Payment		\$187.31
Interest		\$0.00
Penalty		\$0.00
Reversal of Previously Applied Recoupments		\$0.00
Total Claims Paid/Liability/Included in RA		\$187.31
Funding		
Check/EFT Amount		\$187.31
Current Check Applied Recoupments**		\$0.00
Applied to Prepayments		\$0.00
Total Funding Distributed		\$187.31
Informational*		
Refunds Applied		\$0.00
Newly Created Vendor Balance Owed		\$0.00
Ad Hoc Adjustment		\$0.00
Total Informational		\$0.00
*Informational section does not impact check/EFT amount on this EOP		
**Amount paid via recoupment		

Explanation of Payment

#	Service Dates	Service Code	Service Mod	Billed Amount	Disallowed Amount/Discount	Not Cov'd Amount	Applied to Deductible	CoPay	Other Ins	Plan Pays	Remark Code(s)
				Allowed Amount				Coins			
Patient Name:		Provider:		POS:	TOB: 111	Patient Acct No (Provider):		Claim #:	Cim Type: ORIGINAL		
Patient ID / MRN:		Provider NPI:		LOB: SRA - SENIOR ADVANTAGE		Vendor TIN:		Auth #:			
1	07/07/2021 07/07/2021	92250		104.00 40.81	63.19			0.00		40.81	45
2	07/07/2021 07/07/2021	99204		337.00 171.50	165.50			25.00		146.50	3,45
Total				441.00	228.69	0.00	0.00	25.00	0.00	187.31	
Claim Payment Total				212.31				0.00		187.31	

Remark Codes

- 3 Co-payment Amount
- 45 Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement



UNDERSTANDING YOUR EXPLANATION OF PAYMENT (EOP) STATEMENT

*** Please retain for your records ***

[Line Number] - The line number that coincides with the line number on the submitted claim.

of claims [Number of Claims] - The total number of claims covered by this Explanation of Payment (EOP).

Allowed Amount - The total allowable amount as determined by contract, other provider agreement, or reasonable and customary payment guidelines.

Applied to Deductible - The amount of member's deductible applied to the claim.

Auth # [Authorization Number] - An assigned number that identifies the authorization for approved services identified on the claim.

Billed Amount - The amount billed by the provider for a specific service or set of services.

Check/EFT Amount [Check/Electronic Funds Transfer Amount] - The net amount of the check/EFT payment.

Check/EFT No [Check/Electronic Funds Transfer Number] - The payment instrument number issued on a check/EFT paid to the vendor or member/subscriber.

Claim # [Claim Number] - A number assigned by Kaiser Permanente to an individual claim.

Claim Payment Amount - The sum of the individual claims Total amounts covered by this Explanation of Payment (EOP).

Claim Payment Total - The total amount of the claim, interest, and penalty paid by the Health Plan.

Coins [Coinsurance] - A percentage of the payment amount the insured pays against a claim.

CoPay - A fixed amount the insured pays against a claim.

Disallowed Amount/ Discount - Reflects contractual allowances, usual and customary (U&C) charges, provider responsibility/not covered, and discounts.

Interest Amount - The interest penalty amount required under governing rules for the specific Line of Business.

LOB [Line of Business] - The relevant rules under which the patient is enrolled as Kaiser Foundation Health Plan member.

Method of Payment - Describes the method of payment for the Claim Payment Total or Total Payment Amount (e.g. check/EFT, recoupment, prepayment, etc., as applicable).

Not Cov'd Amount [Not Covered Amount] - Services not included under the terms of the insured's health care coverage.

Other Claim Related Transactions - Includes reversal claims, refunds received, recoupments applied, prepayments, write-ons and write-offs.

Other Ins [Other Insurance] - The amount paid by another financially responsible insurance carrier as primary on the claim, under Coordination of Benefits, Third Party Liability or Workers' Compensation.

Patient Acct No (Provider) [Patient Account Number (Provider)] - Your account number for the patient.

Patient ID/MRN [Patient Identification Number/Medical Record Number] - The Kaiser Permanente identification number or medical record number for the patient.

Patient Name - The name of the patient to whom the services were provided on this claim.

Patient Out of Pocket - Remaining cost share from the amount determined by primary coverage that the patient owes after additional payment by Kaiser Permanente on non-primary claims

Payment Date - The date that the claims represented on this Explanation of Payment (EOP) were paid.

Penalty Amount - A payment amount other than interest that may be required to pay the provider under governing rules for the specific Line of Business.

Plan Pays - The total amount paid by Kaiser Permanente for all payable services on the individual claim or total of all claims.

POS [Place of Service] - The location where the service was provided.

Prepayments - Funds paid to provider in advance of services used to satisfy liability of submitted claims consistent with the terms of the provider's contractual agreement.

Provider - The provider of services associated with the claim.

Provider NPI [Provider National Provider Identification Number] - A CMS number assigned to the vendor for billing and identification purposes.

Recoupments - Funds used from previous overpayments that are applied to offset payment of claims.

Refunds Received - Funds received from the vendor for identified overpaid claims.

Remark Code - Codes describing how the claim was processed.

Remittance Number - A unique number identifying this Explanation of Payment (EOP).

Reversal Claims - Used to account for adjusted claims.

Service Code - A code used to describe the medical services and procedures provided.

Service Dates - The dates on which the services were provided.

Service Mod [Service Modifier] - An alpha and/or numeric code appended to a CPT/HCPCS procedure code to clarify the services or procedures being billed.

Total Payment Amount - The sum of the individual claims Total amounts covered by this Explanation of Payment (EOP). Total Payment Amount = Claims Payment Amount + Interest Amount + Penalty Amount.

TOB [Type of Bill] - A three digit code located on a claim form that describes the type of bill a provider is submitting.

Vendor ID No [The Vendor Identification Number] - The internal account number that Kaiser Permanente assigns each vendor.

Vendor NPI No [Vendor National Provider Identification Number] - A CMS number assigned to the vendor for billing and identification purposes.

Vendor Tax ID No [Vendor Tax Identification Number/Vendor TIN] - Federally issued tax identification number.

Withheld Amount - Payments made to 3rd parties/ lien holders on behalf of the vendor.

Write Offs - Vendor balance forgiven by Kaiser Permanente

Write Ons - Used to account for existing overpayment balances.

5.13.8 KPIC Self-Funded Explanation of Payment (EOP)

 KAISER PERMANENTE. Kaiser Permanente Insurance Company PO BOX 30547 Salt Lake City UT, 84130-0547	Client ID: Customer Service Number: 1-866-213-3062	See Last Page for Explanation of Code	Provider #: Tax #: Date: Check#: EDI Payer ID: 94320
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Patient Name Account #	Member ID # Claim #	Dates of Service	Code	Submitted Charges	Negotiated Discount	EXPL code	Non COVID Charges	Allowed Amount	Copay	Deductible	Co-ins	Total Benefit
		03/15/2019	250	\$5.05	\$0.50	WRP	\$0.00	\$4.55	\$4.55	\$0.00	\$0.00	\$0.00
		03/15/2019	306	\$49.00	\$4.90	P9 WRP	\$0.00	\$44.10	\$44.10	\$0.00	\$0.00	\$0.00
		03/15/2019	306	\$31.00	\$3.10	P9 WRP	\$0.00	\$27.90	\$27.90	\$0.00	\$0.00	\$0.00
		03/15/2019	306	\$16.00	\$1.60	P9 WRP	\$0.00	\$14.40	\$14.40	\$0.00	\$0.00	\$0.00
		03/15/2019	450	\$1,775.00	\$177.50	P9 WRP	\$0.00	\$1,597.50	\$159.05	\$0.00	\$0.00	\$1,438.45
		03/15/2019	450	\$847.00	\$84.70	P9 WRP	\$0.00	\$762.30	\$0.00	\$0.00	\$0.00	\$762.30
		Claim Totals		\$2,723.05	\$272.30		\$0.00	\$2,450.75	\$250.00	\$0.00	\$0.00	\$2,200.75
		Previous Claim Amount		\$0.00				Other Insurance	\$0.00	Payment to Provider		\$2,200.75
							Patient Responsibility	\$250.00		Payment to Member		\$0.00
										Total Paid	\$2,200.75	

Code Descriptions

- P9** Plan payment reduced by Patient's applicable copay amount
- WRP** Charges billed by provider exceed contracted rate with Zelis. Patient not responsible for charges above contracted rate.
PAID ACCORDING TO NPPN-Direct (888)266-3053

Depending on your plan, providers may have up to 365 days from date of service to submit a claim. Providers also have 365 days from claim process date to submit a written and complete Provider Dispute/Reconsideration form to challenge a claim determination. If multiple services are included in the provider's request for dispute/reconsideration, the latest date of action on the Claim/Explanation of Payment(s) (EOPs) will be used to start the clock. If additional information is needed, the clock is stopped and the provider will have 45 days from the date of request to provide the information before the clock is restarted.

If an audit shows a Provider owes reimbursement to the Plan Sponsor(s), the identified overpayment(s) will be offset against any money payments owed to the Provider, to the maximum extent permitted by Law.