Kaiser Permanente Colorado

PPO Provider Manual

- **Billing and Payment**

KAISER PERMANENTE®

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.

KAISER PERMANENTE®

Table of Contents

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 Fee Schedule within 45 days after the File Publish Date or 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 1-866-213-3062
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

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 has been 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 U.S. 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 on how to submit EDI claims to KP, send an email to EDISupport@kp.org

5.2.3 Supporting Documentation for EDI Claims

Kaiser Permanente Colorado permits providers to submit electronic claim appeals/disputes, upload 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: kp.org/providers/co

5.2.4 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).

Contact your clearinghouse for assistance sending COB claims electronically.

5.2.5 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: EDISupport@kp.org

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

Payer ID	Payer Phone
SSI 837– **999990273**	1-800-880-3032
Change HealthCare/Emdeon 837– 91617	1-800-845-6592
KPIC Self-Funded - 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

To Initiate ERA/EFT

Electronic Payment and Remittance Advice Online Enrollment

Kaiser Permanente collaborated with Citi Payment Exchange to provide a portal for enrolling in Electronic Fund Transfer (EFT) and Electronic Remittance Advice (ERA) through Citi Payment Exchange. Kaiser Permanente requests that all vendors pursuing EFT/ERA enrollment utilize the Payment Exchange portal for enrollment and changes to existing EFT/ERA. The portal is open 24 hours a day and 7 days a week for new enrollments or changes.

Reduce turn-around-time for receipt of payments and remove overhead costs associated with handling paper correspondence by signing up for EFT/ERA today.

It's easy to get started now!
Each Kaiser Permanente region requires a separate enrollment.

If you wish to create a new enrollment for EFT/ERA in the Colorado region,
Click here to enter a secure portal.
Activation code YJRWT6 is required at login.

Frequently Asked Questions

Q: What if I already have EFT/ERA set up with Kaiser Permanente? Will I need to re-enroll through Citi Payment Exchange?
A: No, vendors with EFT/ERA already in place at Kaiser Permanente will have their account set up on their behalf. You will receive an invitation from Citi Payment Exchange to sign in and make changes or additions to your existing account. If you do nothing, your current EFT/ERA arrangements will remain as they are today.

Q: If I've submitted a change or an enrollment request, what will be the turnaround time to complete the request?
A: Continue to check Citi Payment Exchange for status updates. Once approved in the portal, Kaiser Permanente will require 7-10 business days to update the system. If you continue to receive paper checks, contact EDIsupport@kp.org.

Q: Can I remove a bank account from my profile in Citi Payment Exchange?
A: Yes, you can also stop sharing a bank account with a region/payer under Settings.
The provider may have more than one bank account set up per region (sub designations are made by adding an NPI) and UNSHARE is the appropriate action if you want to keep one account in play but remove another one.

Q: Can I change my demographic information through Citi Payment Exchange?
A: No, any demographic information changes need to be handled through Kaiser Permanente. Contact EDIsupport@kp.org for more information.

Q: If I sign up for EFT in Colorado, will my California claim payments be automatically included?
A: No, you'll need to request each region if not autoloaded in the initial set up of Payment Exchange.
Go to NEW region URL – sign in with activation code - using the specific activation code notifies the specific region of a new request. If the activation code is not used, the region isn't notified of a new enrollment.

When Citi automation sees the provider information already exists, a message will pop up and direct the billing provider to log into their existing account. Once logged in and the established password is entered, the request for the new region will pop up in the "established accounts" list and the provider will be asked to link it to the existing account.

There is no limit to the number of regions a provider can be registered to bill. Providers who have multiple regions registered will all show in the "established accounts". If you do not see your preferred region on this list, please contact EDIsupport@kp.org.

Q: Can I cancel my EFT/ERA setup?
A: Yes, you can revoke the link between your account and the EFT/ERA vendor.
Within the Payment Exchange portal, provider will select Payers > click the Payer > then select Revoke.
That will cancel the enrollment altogether with that payer (region).

Important Note: If you are a provider retrieving ERAs from a clearinghouse, you must reMember to complete the ERA setup with your clearinghouse as well as with Kaiser Permanente via the Citi Payment Exchange portal.

5.2.6 Paper Claims 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 according to National Uniform Billing Committee (NUBC) directions and contain all mandatory entries, 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.

5.2.7 Record Authorization Number

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

5.2.8 One Member/Provider per Claim Form

One Member per Claim Form/One Provider per claim:

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

5.2.9 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.

5.2.10 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.

5.2.11 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".

5.2.12 Entering Dates

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

<table>
<tr><th>TOPIC</th><th>INSTRUCTIONS</th></tr>
<tr><td>ENTERING DATES</td><td>
• 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.

Example:

Correct Way to Bill →
<table>
<tr><th>CPT/HCPCS</th><th>DATE OF SERVICE</th><th>UNITS</th></tr>
<tr><td>97110</td><td>01/05/2004-01/07/2004</td><td>3</td></tr>
<tr><td>97110</td><td>01/09/2004-01/13/2004</td><td>5</td></tr>
</table>
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.

Incorrect Way to Bill →
<table>
<tr><th>CPT/HCPCS</th><th>DATE OF SERVICE</th><th>UNITS</th></tr>
<tr><td>97110</td><td>01/05/2004-01/13/2004</td><td>5</td></tr>
</table>
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.
</td></tr>
</table>

5.2.13 Multiple Dates of Services and Place of Services

Do not bill multiple 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 services at different locations.
- Same date of service different locations must be filed on a separate claim form.

5.2.14 Surgical Dates of Services and Places of Services

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.

5.2.15 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.

5.2.16 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.

5.2.17 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 (Diagnosis Related Group) 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.

5.2.18 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 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.*

5.2.19 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 possible. (See section 5.3.2 for EDI Payor IDs).

Kaiser Permanente of Colorado
Claims Administration
PO Box 373150
Denver, CO 80237

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 version 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 the required field 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 Commercial Members and 365 calendar days from the date of service for 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) business 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).

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 business 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) business 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 amounts due to Kaiser Permanente against future 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, the amount due will be offset against future claims. Remit notices for claims against which amounts 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: kp.org/providers/co

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 a 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 receivea 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.*

4. 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-Fully Insured/Choice Products)	Kaiser Permanente Insurance Co PO Box 740951 Los Angeles, CA 90074-0951

KPIC Self-Funded/Level 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 amounts owed against future payments.

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

Providers 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.

1. NPI's ***MUST*** be in the correct position on the claim.
2. Individual Rendering Provider NPI in Box 24J and Billing Entity Organizational NPI in Box 33a or electronic equivalent.
3. If the contractual arrangements are made with an Organization and not a 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.

5.3.11 Telehealth

Telehealth is the mode of delivering health care services via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care. All laws regarding the confidentiality of health care information and a patient's rights to the patient's medical information shall apply to telehealth interactions.

Kaiser Permanente follows federal and state guidelines related to the specific services which may be eligible for telehealth.

Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions, and asynchronous store-and-forward transfers.

Telehealth may be conducted using audio and video or audio only.

Reimbursements for telehealth continue to evolve so it is important to reference resources on billing and reimbursement for Medicare, Medicaid, and private insurers. Kaiser Permanente will process claims for payment with the appropriate CPT-4 or HCPCS codes when coding for services delivered by telehealth, for both synchronous and asynchronous interactions. Providers must annotate the claim using the correct Place of Service, 02, and modifier, 95.

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 usuallyNOT 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.

1. Consultant reports
2. Discharge Summaries
3. Emergency Department reports
4. Diagnostic reports
5. Progress reports

6. CDIMD 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.

5.7. First and Third Party Definitions

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.

Third Party Liability refers to situations in which a third party's auto or other policy covers healthcare costs related to injuries or illness caused by or alleged to be caused by the third party.

Both definitions of alternate liability here shall be considered Third Part Liability (TPL) for the purposes of this Section.

5.8. First- and Third-Party Liability Guidelines

Providers are required to assist and cooperate with Kaiser Permanente'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)

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

5.9. 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 Kaiser Permanente 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 Kaiser Permanente 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 NOCO/SOCO areas should be mailed to:

Carelon Behavioral Health Inc as of 3/1/2023
(Formerly 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 how Kaiser Permanente processed a particular claim, please contact Claims Customer Service at 303-338-3800 for Fully Insured Members and 866-213-3062 for KPIC Self-Funded Members.

For Fully Insured Member claims, you can submit a claim inquiry online using KP Online Affiliate. Please visit the Community Provider Portal at https://kp.org/providers/co to sign up for access to Online Affiliate.

Many questions and issues regarding claim payments, coding, and submission policies can be resolved via phone or online.

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 provides tools for 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 https://kp.org/providers/co to sign up for access to Online Affiliate.

If you have additional questions, please reach out to your regional representative at (866) 866-3951.

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. *In addition, providers are responsible for seeking authorization from another payor (if authorization is required) and/or responding to requests for information submitted by the other payor to make an authorization determination.* 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 and the Member's benefit plan. Examples are as follows but not limited to:

Dependent vs. Non-Dependent

Adults
The plan that covers the person other than as a dependent, for example as an employee, Member, subscriber, policyholder, or retiree, is the primary plan and the plan that covers the person as a dependent is the secondary plan. If the person is a Medicare beneficiary, then Centers for Medicare & Medicaid Services (CMS) Guidelines must apply.

Children
For a dependent child whose parents are married or are living together and is covered by both parents, 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:

1. Natural parent with custody pays first;
2. Stepparent with custody pays next;
3. Natural parent without custody pays next;
4. Stepparent 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
The commercial benefit plan is primary for Medicare beneficiaries who are covered by a Large Employer Group Health Plan (EGHP) as a result their own or a family Members' current employment status when the CMS Working Aged or Disabled Beneficiaries provisions apply.

Medicare is primary for Medicare beneficiaries who are covered by an Employer Group Health Plan (EGHP) whose subscriber is a retiree of the employer when the CMS Working Aged or Disabled Beneficiaries provisions apply.

Medicare is the primary payer to GHPs for individuals eligible for or entitled to Medicare benefits based on End-Stage Renal Disease (ESRD) after the duration of coordination period as stipulated under the Medicare Secondary Payer Provisions for ESRD Beneficiaries.

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 health benefit plans or carriers to be considered cumulatively so the Member receives the maximum benefit from their primary and secondary health benefit plans together.

When Kaiser Permanente is secondary to another payor, Kaiser Permanente will coordinate benefits and determine the amount payable to the Provider, where the standard payment determination methodology is to pay the difference between what the primary paid and their allowable, in an amount not to exceed the Kaiser Permanente benefit allowable.

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 when submitting the claim via EDI and if needed will be requested.

Kaiser recognizes submission of an 837 electronic claim transaction to a sequential payer populated with data from the previous payer's 835 electronic remittance advice. Based on the information provided, 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).

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, 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 policy and/or group number of the insured individual named in **Field 9**. If you do not 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 name of the insurance plan or program, 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 another health benefit plan. (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.

5.13.7 Fully Insured Explanation of Payment (EOP)

KAISER PERMANENTE®

COLORADO CLAIMS ADMINISTRATION
COLORADO
KAISER FOUNDATION HEALTHPLAN,INC
PO Box 373150
Denver, CO 80237-3150

Questions? Sign up for Online Affiliate or enroll in ERA/EFT at providers.kp.org/cod for easy access to all of your claims information. For answers to claims questions that are not available online, call Customer Service at (800) 382-4661, weekdays Mon - Fri 8:00 AM - 6 PM MT .

Check / EFT #: XXXXXXXXXXXXXXXX
Remittance Number: XXXXXXXXXXXX
Payment Date: 07/31/2023
Total Payment Amt: 100.28
Vendor Tax ID No:
Vendor ID No:
Vendor NPI No:

Vendor Name
Address
City, State ZIP

*****ACCOUNT SUMMARY*****

	EOP Totals
Claims	
Claims Payment	$100.28
Interest	$0.00
Penalty	$0.00
Reversal of Previously Applied Recoupments	$0.00
Total Claims Paid/Liability/Included in RA	**$100.28**
Funding	
Check/EFT Amount	$100.28
Current Check Applied Recoupments**	$0.00
Applied to Prepayments	$0.00
Total Funding Distributed	**$100.28**
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**

KAISER PERMANENTE®

Payment Date: 07/31/2023

Explanation of Payment

#	Service Dates	Billed SC / Payable SC	Service Mod	Billed Amount / Allowed Amount	Disallowed Amount/Discount / Payer Initiated Reduction	Not Cov'd Amount	Applied to Deductible	CoPay / Coins	Other Ins	Plan Pays	Remark Code(s)
Patient Name: .XXXXXXXX **Patient ID / MRN:** XXXXX				**Provider:** XXXXXXXX **Provider NPI:** ' XXXXX		**POS:** **TOB:** 111 **LOB:** HMO - HMO COMMERCIAL		**Patient Acct No (Provider):** XXXXXXXX **Vendor TIN:** XXXXX		**Claim #:** XXXXX **Auth #:**	**Clm Type:** ORIGINAL
1	06/28/2023 06/28/2023	99213		150.00 120.28	29.72 0			20.00		100.28	3, 45
	Total			**150.00** **120.28**	**29.72**	**0.00**	**0.00**	**20.00** **0.00**	**0.00**	**100.28**	
	Claim Payment Total									**100.28**	

Remark Codes

3	Co-payment Amount
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability).

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).

Ad Hoc Adjustment - Any other necessary adjustment not described elsewhere.

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 Service Code - 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).

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

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

Current Check Applied Recoupments - Previously identified overpayments used to pay down current claims on this EOP.

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).

NDC Please submit a corrected claim with an accurate NDC code if CED14 is applied.

Newly Created Vendor Balance Owed - Previously paid claims that have been determined to have been overpaid.

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

OHC Codes - The appearance of OHC codes (e.g., OHC01, OHC02) in the Remarks column of a denied claim indicates that other coverages were found during processing. The details of all payers and plans related to those codes are in the Remarks at the end of the EOP (the coverages are not listed in order of primacy).

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

Payable Service Code - This is the Payable CPT Code (down coded)

Payer Initiated Reduction - This is the payer-initiated reduction amount

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.

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

Subtotal Reversals, Recoupments & Refunds - Includes reversal, claims,refunds received, recoupments applied, prepayments, write-ons and write-offs.

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
COLORADO REGION
COLORADO
KAISER PERMANENTE INSURANCE COMPANY
PO Box 373150
Denver, CO 80237-3150

Questions? Call Customer Service at (855) 364-3184
Weekdays Mon - Fri 8:00 AM - 6 PM MT

Check / EFT #: XXXXXXXXXXXXXXXX
Remittance Number: XXXXXXXXXXXX
Payment Date: 07/31/2023
Total Payment Amt: 362.00
Vendor Tax ID No: XXXXXXXXXXXXXXXX
Vendor ID No: XXXXXXXXXXX
Vendor NPI No: XXXXXXXXXXX

Vendor Name
Address
City, State ZIP

*****ACCOUNT SUMMARY*****

	EOP Totals
Claims	
Claims Payment	$362.00
Interest	$0.00
Penalty	$0.00
Reversal of Previously Applied Recoupments	$0.00
Total Claims Paid/Liability/Included in RA	**$362.00**
Funding	
Check/EFT Amount	$362.00
Current Check Applied Recoupments**	$0.00
Applied to Prepayments	$0.00
Total Funding Distributed	**$362.00**
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**

KAISER PERMANENTE®
Kaiser Permanente Insurance Company

Payment Date: 07/31/2023

Explanation of Payment

#	Service Dates	Service Code	Service Mod	Billed Amount / Allowed Amount	Discount/ Disallowed	Not Cov'd Amount	Applied to Deductible	CoPay / Coins	Other Ins	Plan Pays	Remark Code(s)
Patient Name: XXXXXXXX **Patient ID / MRN:** XXXXX				**Provider:** XXXXXXXX **Provider NPI:** XXXXX		**POS:** **TOB:** 201 **LOB:** PPO-2 AND 3 TIER-KPIC		**Patient Acct No (Provider):** Add text here **Vendor TIN:** XXXXX		**Claim #:** XXXXX **Auth #:**	**Clm Type:** ORIGINAL
1	07/17/2023 07/17/2023	93000		91.00 72.80	18.20			0.00		72.80	45
2	07/17/2023 07/17/2023	99204		424.00 339.20	84.80			50.00		289.20	3, 45
	Total			**515.00** **412.00**	**103.00**	**0.00**	**0.00**	**50.00** **0.00**	**0.00**	**362.00**	
	Claim Payment Total									**362.00**	

Paid according to First Health network agreement.

Remark Codes

3	Co-payment Amount
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability).

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.

Ad Hoc Adjustment - Any other necessary adjustment not described elsewhere.

Allowed Amount - This amount reflects the amount of the provider's bill available to apply plan benefits. If an In-Network Provider was used, the Allowed Amount is the "Billed Amount" less the "In-Network Provider Discount". If an out-of-network provider was used, this amount will reflect the Maximum Allowable charge as outlined in the insured' s Certificate of Insurance.

Applied to Deductible - The portion of the charges applied to plan deductible. See Annual Year Deductible information in your Certificate of Insurance for additional information.

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

Billed Amount - The total amount billed by the provider.

Copay/Coinsurance" plus " Interest Paid" equals " Paid to Provider".

Claim Number - This is the unique number assigned to this claim. Please have it ready if you contact our office.

Co-Pay/Coinsurance - The amount of the charge that is the insured's responsibility per the benefit plan.

Current Check Applied Recoupments - Previously identified overpayments used to pay down current claims on this EOP.

Discount/Disallowed - If a participating provider was used, the billed amount less the allowed amount is the discount. The insured is not responsible for the Discount.

If a non-participating provider was used, the billed amount less the allowed amounts is the disallowed amount. The insured may be responsible for the Disallowed.

Insured - This is the name of the subscriber covered by this benefit plan.

Insured ID - This is the unique identification number assigned to this subscriber. Please have it ready if you contact our office.

In-Network Provider Discount - This amount reflects the amount saved as a result of care being received from a Preferred Provider.

Newly Created Vendor Balance Owed - Previously paid claims that have been determined to have been overpaid.

Not Covered Amount - This amount represents the portion of " Billed Amount" that exceeds the allowable charges as outlined in the insured' s Certificate of Insurance, or charges not covered by the plan. Insured may be responsible for these charges.

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 Worker's Compensation.

Patient Control Number - tracking number listed on provider billing

Patient ID - This is the unique identification number assigned to this patient. Please have it ready if you contact our office.

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

Patient Name - This is the name of the patient to whom 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 Insurance Company on non-primary claims

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 - This is the amount payable by Kaiser Permanente Insurance Company.

Provider Name - This is the name of the provider of services associated with this claim.

Remarks Code - Codes describing how the claim was processed. See Remarks Description section.

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

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

Service Dates - To and from service dates, taken from the provider bill.

Service Description - The description of the medical procedure(s) related to the billed amount..

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.

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

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