

# PART II

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## **II.1 Section 1: Self-Funded Program Overview**

### **1.1 Kaiser Permanente Insurance Company (KPIC)**

Kaiser Permanente Insurance Company (KPIC), an affiliate of Kaiser Foundation Health Plan, Inc., will be administering Kaiser Permanente's Self-Funded Program. Each self-funded Plan (an "Other Payor" under your Provider Contract) through its Plan Sponsor will contract with KPIC to provide administrative services for the Self-Funded plan. KPIC has a dedicated administrative services team to coordinate administration with the Plans and Plan Sponsors. KPIC will provide network administration services and certain other administrative functions through an arrangement with Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS).

### **1.2 Third Party Administrator (TPA)**

KPIC has contracted with a Third Party Administrator (TPA), Harrington Health, to provide certain administrative services for Kaiser Permanente's Self-Funded Program, including claims processing, eligibility information, and benefits.

Harrington Health administers the Self-Funded Customer Service System, with automated functions as well as access to customer service representatives that allows you to check eligibility, benefit, and claims information for SF Members.

The automated system (interactive voice response or IVR) is available 24 hours a day, 7 days a week. Customer Service Representatives are available Monday - Friday from 7 A.M. to 9 P.M. Eastern Time Zone (ET).

### **1.3 Self-Funded Products**

Kaiser Permanente is offering Self-Funded products, administered by KPIC, including Self-Funded Exclusive Provider Organization, Self-Funded Point-of-Service, and Self-Funded Preferred Provider Organization. Individuals enrolled in these Self-Funded products will be referred to as SF Members in this guide.

\* Please refer to the Fully Funded guide for further details on Products Descriptions

#### **1.3.1 Exclusive Provider Organization (EPO)**

- Mirrors our HMO product, offered on a Self-Funded basis
- Self-Funded EPO members choose a Kaiser Permanente primary care Provider and receive care at Kaiser Permanente or plan medical facilities
- Self-Funded EPO members are covered for non-emergent care only at designated plan medical facilities and from designated plan practitioners (unless referred by a participating primary care Provider)

#### **1.3.2 Point of Service (POS) - Two-Tier**

- Tier 1 is the EPO Provider network
- Tier 2 is comprised of all other providers
- SF Members incur greater out-of-pocket expenses in the form of higher copayments, coinsurance and/or deductibles when they use Tier 2 benefits

### **1.3.3 Point of Service (POS) - Three Tier**

- Tier 1 is the EPO Provider network
- Tier 2 is comprised of KPIC's contracted PPO network Providers.
- Tier 3 includes non-contracted providers
- SF Members incur greater out-of-pocket expenses in the form of higher copayments, coinsurance and/or deductibles when they self-refer to a contracted PPO network Provider (Tier 2)
- Generally, the out-of-pocket costs will be highest for self-referred services received from non-contracted Providers (Tier 3)

### **1.3.4 Preferred Provider Organization (PPO)**

The Self-Funded PPO is offered to SF Members. They receive care from our contracted provider network.

Self-Funded PPO members may choose to receive care from a non-network provider; however, their out-of-pocket costs may be higher.

There are no requirements for PCP selection.

## **1.4 Self-Funded Identification Cards**

Each SF Member will be issued a Self-Funded Identification Card (Self-Funded ID card). SF Members should bring their Self-Funded ID card and a photo ID when they seek medical care.

Each SF Member is assigned a unique Health/Medical Record Number, which is used to locate membership and medical information. Every SF Member receives a Self-Funded ID card that shows his or her unique number. If a replacement card is needed, the SF Member can order a Self-Funded ID card online.

The Self-Funded ID card is for identification only and does not give a SF Member rights to services or other benefits unless he or she is eligible under his/her Plan. Anyone who is not a SF Member at the time services are rendered will be billed for any services provided.

Examples of Self-Funded ID cards for various regions are on the following pages.

Please note the actual membership card may vary slightly from the images shown below.

## SAMPLE SF MEMBER CARD



All ID cards will have the Kaiser Permanente logo prominently displayed on the front side of the card, ID Cards for a Self-Funded Plans administered by Kaiser Permanente Insurance Company will look somewhat different from ID cards for KPMAS HMO plans. Furthermore, Self-Funded ID cards may vary slightly by employer group.

## II.2 Section 2: Key Contacts and Tools

### 2.1 Key Contacts

Below are key contacts for SF Member inquiries.

Department	Contact information	Type of Help or Information from this Department
Self-Funded Customer Service	<p>Customer Service Representatives are available Monday through Friday 7 a.m. to 9 p.m. Eastern Time Zone</p> <p>1-877-740-4117</p> <p><i>Check this HH telephone number</i></p> <p>Self-Service IVR System available: 24 hours / 7 days a week</p> <p>Website available: 24 hours / 7 days a week <a href="http://provider.kphealthservices.com">http://provider.kphealthservices.com</a></p> <p>1-877-740-4117 toll free</p>	<ul style="list-style-type: none"> <li>• General enrollment questions</li> <li>• Eligibility and benefit verification</li> <li>• Claims management</li> <li>• Billing and payment inquiries</li> <li>• EDI questions</li> <li>• Appeal and claims dispute questions</li> <li>• Co-pay, deductible and coinsurance information</li> <li>• Members terminated greater than 90 days</li> <li>• Members presenting with no Kaiser Permanente identification number</li> <li>• Verifying Member's PCP assignment</li> </ul>
Provider Contracting & Provider Relations	<p>KPMAS Provider Relations Department may be contacted Monday through Friday , 9am to 5pm Eastern Time Zone at :</p> <p>Toll Free: 1-877-806-7470 Fax: 301-388-1700 Email: <a href="mailto:provider.relations@kp.org">provider.relations@kp.org</a></p> <p>Provider Relations 2101 East Jefferson Street, 2East Rockville, MD 20849</p> <p>Websiteavailable: 24 hours/ 7 days a week <a href="http://www.providers.kp.org">www.providers.kp.org</a></p>	<ul style="list-style-type: none"> <li>• Send Provider demographic updates such as Tax ID changes, address changes here</li> <li>• Send information regarding practitioner additions or terminations from your office here</li> <li>• Provider education and training</li> <li>• Contract questions</li> <li>• Contracted rate payment questions</li> <li>• Form requests</li> <li>• Issues and problem solving</li> </ul>

Department	Contact information	Type of Help or Information from this Department
Provider Service Center (PSC) (For EPO utilization inquiries)	KPMAS Provider Service Center Monday through Friday, 8am to 5pm Eastern Time Zone For emergent hospital admission, 24-hour access at :  Phone: 1-800-810-4766 Fax: 1-800-660-2019  Provider Service Center 11921-B Bournefield Way Silver Spring, MD 20904	Obtain preauthorization for services and admissions (if online services are unavailable) <ul style="list-style-type: none"> <li>• DME and Home Health referrals</li> <li>• Emergency Department notifications</li> <li>• All inpatient admissions</li> <li>• Transfers to Skilled Nursing Facilities (SNF)</li> <li>• Ambulance Transports</li> <li>• Discharge planning, case management</li> </ul>
SHPS (For POS Tier 2 re-certification)	SHIPS 1 (800) 448-9776	Obtain precertification for services in Tier 2 of Two- or Three-Tier POS Plans
Behavioral Health <i>(all products)</i>	<u>Psychiatric Hospitalization:</u> 1 (800) 810-4766  <u>Intensive Outpatient Treatment:</u> 1 (866) 530-8778  <u>Info &amp; Assistance:</u> 1 (866) 311-0531  <u>Non-routine or additional outpatient services:</u> (301) 897-2434 Fax: 1 (866) 311-0052	Arrange for services

## 2.2 Self-Funded Customer Service IVR System

Self-Funded Customer Service interactive voice response system (IVR) can assist you with a variety of questions. Call 1-877-740-4117 to use this service. Please have the following information available when you call into the system to provide authentication:

- Provider Tax ID or National Provider Index (NPI)
- SF Member’s medical record number (MRN)
- SF Member’s date of birth
- For Claims—Providers will also need to know the date of service

The IVR can assist you to verify eligibility, benefits, authorizations and referrals; check an SF Member's accumulator (amount applied to deductible or benefits); inquire about claims and payments; or speak to a customer service representative. Follow the prompts to access these services.

## 2.3 Website

Harrington Health, the TPA, will maintain a web site that allows you and your staff to check eligibility, benefit, and claims information for SF Members.

A formal user guide will be published and provided to you.

*NOTE: This web site is restricted to information for individuals enrolled in Self-Funded plans administered by KPIC only. Information regarding members enrolled in Kaiser Permanente's fully funded plans (e.g., HMO), cannot be accessed from the Harrington Health site.*

The Harrington Health website, once available, can be directly accessed at <http://provider.kphealthservices.com>. You will also be able to link over to the Harrington Health website from Kaiser Permanente's Community Provider website, [www.providers.kp.org](http://www.providers.kp.org).

The KP AffiliateLink system is a software program that integrates with Tapestry UM and KP HealthConnect. It allows Providers select access to the electronic health records of Kaiser Permanente members.

With AffiliateLink, Providers can:

- review patient demographics
- verify eligibility
- view benefit information
- view a patient's clinical information
- review and create patient referrals
- communicate with Kaiser Permanente clinicians and other administrative departments

Please contact Provider Relations Department by calling 1-877-806-7470 to obtain a copy of the AffiliateLink manual.

## II.3 Section 3: Eligibility and Benefits Determination

### 3.1 Eligibility and Benefit Verification

You are responsible for verifying SF Members' eligibility and benefits. Each time an SF Member presents at your office for services, you should:

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

Do not assume that eligibility is in effect because a person has a Kaiser Permanente Self-Funded ID card. Please check a form of photo identification to verify the identity of the SF Member. The effective date of eligibility varies according to the terms of the contract between the Plan Sponsor and KPIC. Therefore, each time you must verify that the SF Member is eligible and he/she is eligible for the benefit for the service prior to providing such service to a patient.

Certain services require prior authorization. The Utilization Management section of this Manual (Section 4) provides further details on which services require authorization and the process for obtaining referrals and authorizations.

Contact Self-Funded Customer Service at 1-877-740-4117, or through one of the methods detailed below to verify the validity of the Self-Funded ID card/number and benefits. Otherwise, you provide services at your own financial risk.

Option	Description
#1	<p style="text-align: center;"><b>Affiliate Link</b> <u><a href="http://providers.kp.org">http://providers.kp.org</a></u></p> <p>If you have electronic access to our systems. You can make referrals, get authorizations, and look up eligibility for SF Members anytime, 24 hours a day, seven days a week.</p> <p>To request electronic access to our systems, please contact your Provider Relations Representative at 1-877-806-7470, or email your request to <a href="mailto:provider.relations@kp.org">provider.relations@kp.org</a>. The SF Member information is in a secured site, for which you need a user ID number and a password. You will be given a packet detailing the requirements for obtaining a user ID and password. Once your password is obtained, we will forward you a user guide with instructions.</p> <p>Due to HIPAA regulations, you must keep your office's user information current. User ID and passwords are unique. New staff members are</p>

Option	Description
	required to obtain their own unique user ID's and passwords.
#2	<p style="text-align: center;">Harrington Health Website  <a href="http://provider.kphealthservices.com">http://provider.kphealthservices.com</a></p> <p style="text-align: center;">24 hours / 7 days a week</p> <p>To verify eligibility, benefit, and claims information for SF Members.</p>
#3	<p style="text-align: center;">Self-Funded Customer Service Department Telephone            1-877-740-4117</p> <p style="text-align: center;">Monday - Friday from 7 A.M. to 9 P.M. Eastern Time Zone (ET).</p> <p>To verify SF Member eligibility, benefits or PCP assignment, you may speak with a customer service representative by calling the Self-Funded Customer Service Line at 1-877-740-4117. Please provide the SF Member's name and Self-Funded ID card number, which is located on the Kaiser Permanente Self-Funded ID card.</p>

### 3.2 Benefit Exclusions and Limitations

Self-Funded benefit plans may have different benefits and may be subject to limitations and exclusions different than those for our fully-insured HMO and POS products. It is important to verify the availability of benefits for services before rendering the service so the SF Member can be informed of any potential payment responsibility and/or any limitations or exclusions.

Contact Self-Funded Customer Service to verify and obtain information on SF Member benefits at 1-877-740-4117

If you provide services to a SF Member and the service is not a benefit or the benefit has been exhausted, denied or not authorized, the Plan and the Plan Sponsor will not be obligated to pay for those services.

### 3.3 Drug Benefits

The drug benefits, drug formulary and the procedures for formulary exception may vary based on the benefit plan.

To verify a SF Member's drug benefit, to obtain our drug formulary, or for general questions, please contact the Self-Funded Customer Service at

1-877-740-4117

### 3.4 Retroactive Eligibility Changes

If you have received payment on a claim(s) that is(are) impacted by a retroactive eligibility change, a claims adjustment will be made. The reason for the claims adjustment will be reflected on the remittance advice.

If you provide services to an SF Member and the service is not a benefit, or the benefit has been exhausted, denied or not authorized, you do so at your own financial risk.

## II.4 Section 4: Utilization Management

### 4.1 Overview of UM Program

The KPMAS Utilization Management program addresses quality management and resource stewardship across the care continuum. The ultimate goal is to determine what resources are necessary and appropriate for an individual SF Member, and to provide those services in an appropriate setting and in a timely manner. Kaiser Permanente utilization management consists of five major categories: Concurrent Review, Transition Care Management, Case Management, Referral Management/Pre-authorization, and Post Service Review.

The UM Department is organized around (3) three Service Areas and the Provider Service Center (PSC): (1) Baltimore, (2) DC/SM - District of Columbia/ Suburban Maryland (DC/SM), and (3) NOVA - Northern Virginia. The UM activities within each service area include inpatient and ambulatory case management (ACM), hospital utilization management and SNF utilization management. Collectively, these areas implement the UM Program for medical, surgical, and behavioral health care rendered to SF Members. Registered Nurses and Referral Management Assistants at the Provider Service Center process outpatient and durable medical equipment referrals, set up home care services, coordinate emergency department visits and admissions facilities that do not have KPMAS on-site reviewers admissions. Physical Therapy Resource Specialists (PTRS) review clinical appropriateness for SF Members with functional and mobility needs requiring durable medical equipment, physical, occupational, and speech therapies.

### Our Integrated and Collaborative Approach

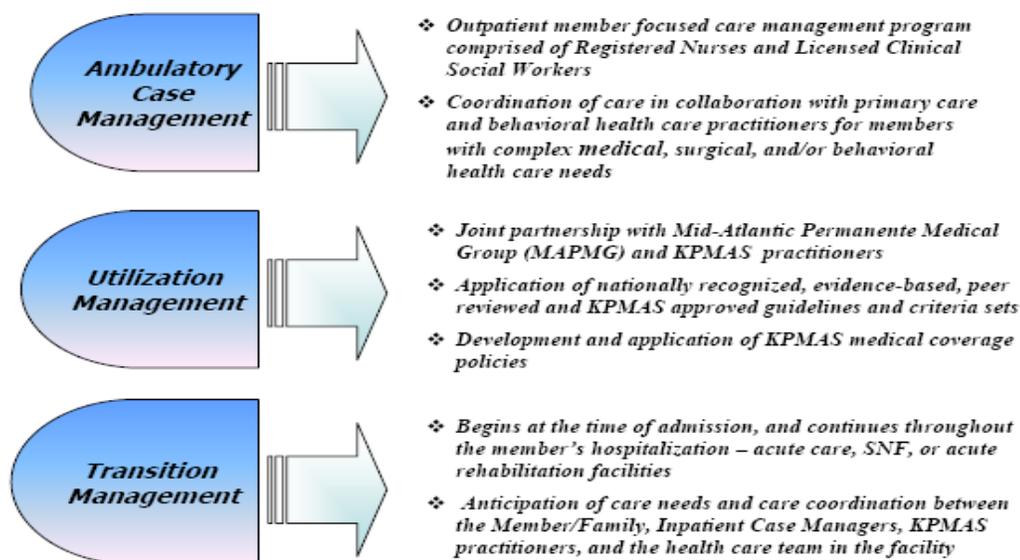


Figure 1 demonstrates our integrated approach to Utilization Management

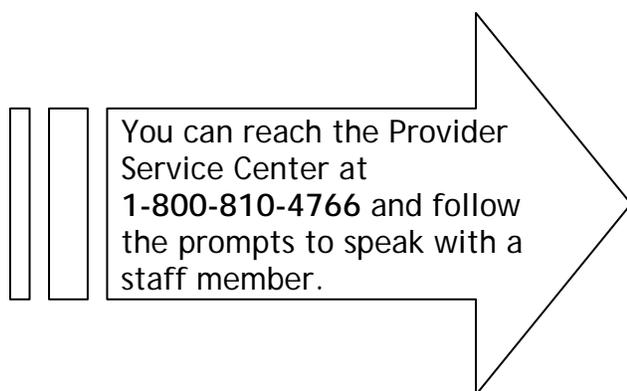
## Utilization Management Hours of Operation

Kaiser Permanente Utilization Management Department ensures that all members and providers have access to UM staff, physicians and managers 24 hours a day, seven days a week.

Table 1 describes our hours of operations.

UM Department Section	Hours of Operation	Core Responsibilities
Provider Service Center - Telephonic Admission and Concurrent Review Team (TACT)	Monday to Friday 8:30 A.M. to 5:00 P.M.	<ul style="list-style-type: none"> <li>Perform concurrent review for SF Members in facilities that do not have KPMAS on-site reviewers</li> <li>Support facilities that do not have KPMAS on-site reviewers with transition management care needs</li> </ul>
Provider Service Center - Emergency Care Management (ECM)	24 hours/day, 7 days/week, including holidays	<ul style="list-style-type: none"> <li>Process requests for Emergency Services for SF Members at facilities that do not have KPMAS on-site reviewers</li> <li>Process transfer requests for SF Members who need to be moved to a different level of care including emergency rooms, inpatient facilities, and Kaiser Permanente Medical Centers</li> <li>Enter Referrals for all in-patient admissions received from facilities</li> <li>Process transfer requests for SF Members needing behavior health admissions</li> <li>Support all cardiac transfers for level of care needed.</li> </ul> <p>Note: Patients receiving Emergency Services (ER) at the facilities with KPMAS on-site reviewers are managed by the Mid-Atlantic Permanente Medical Group (MAPMG) Hospitalists.</p>
Provider Service Center - Outpatient, Specialty Referrals and Clinical Trials	Regular business hours Monday through Friday 8:00 A.M. to 4:30 P.M. Excluding major holidays	<ul style="list-style-type: none"> <li>Conduct preservice review, concurrent review of outpatient services, and post-service review of non-Emergency Services</li> </ul>
Provider Service Center - Durable Medical Equipment (DME), Home Care	Regular business hours Monday through Friday 8:30 A.M. to 5:00 P.M. Saturday, Sunday and holidays 8:00 A.M. to 4:30 P.M.	<ul style="list-style-type: none"> <li>Conduct pre-service review, concurrent review of Home Care and DME</li> </ul>
Hospitals with KPMAS UM on-site reviewers- Non-Behavioral Health	Monday to Friday: 8:30 A.M. to 5:00 P.M. Weekends and Holidays: 8:00 A.M. to 4:30 P.M.	<ul style="list-style-type: none"> <li>Conduct concurrent review and transition care management</li> </ul>

UM Department Section	Hours of Operation	Core Responsibilities
Skilled Nursing Facility (SNF) and Rehabilitation Services	Regular business hours Monday through Friday 8:30 A.M. to 5:00 P.M. Excluding major holidays	<ul style="list-style-type: none"> <li>Conduct concurrent review and transition care management</li> </ul>
UM Hospital Services - Behavioral Health	Monday to Friday: 8:30 A.M. to 5:00 P.M. Excluding major holidays	<ul style="list-style-type: none"> <li>Conduct concurrent review and transition care management services of behavioral health service</li> </ul>
UM Outpatient Services - Behavioral Health	Monday to Friday: 8:30 A.M. to 5:00 P.M. Excluding major holidays	<ul style="list-style-type: none"> <li>Conduct Pre-service review as applicable and perform concurrent review of SF Members requiring outpatient services. (Refer to Section 4.15 for further information regarding access to KP Behavioral Health Services)</li> </ul>
Ambulatory Case Management (ACM) Program	Regular business hours Monday through Friday 8:30 A.M. to 5:00 P.M. Excluding major holidays	<ul style="list-style-type: none"> <li>Conduct outpatient medical case management and care coordination</li> </ul>



The PSC staff can assist you with:

- ★ Obtaining information regarding utilization management processes
- ★ Checking the status of a Referral
- ★ Providing copies of criteria/guidelines utilized for decision making
- ★ Answering questions regarding a benefit denial decision
- ★ Referring you to the UM Physician Reviewer for medical necessity questions or denials

## 4.2 Medical Appropriateness

Medically appropriate care is defined as care that is necessary for the diagnosis, treatment, and/or management of a medical, surgical, or behavioral health condition; within accepted standards of medical, surgical, or behavioral health care; and provided in the least intensive setting appropriate to the condition of the patient; and, not for the convenience of the patient, patient's family and/or provider. .

Utilization Management within KPMAS is a collaborative partnership between Mid-Atlantic Permanente Medical Group (MAPMG) practitioners and UM staff to ensure appropriate treatment plans and resources are utilized in the management of SF Members' health care needs throughout the care continuum. Medical necessity decisions are made by licensed KPMAS UM trained physicians.

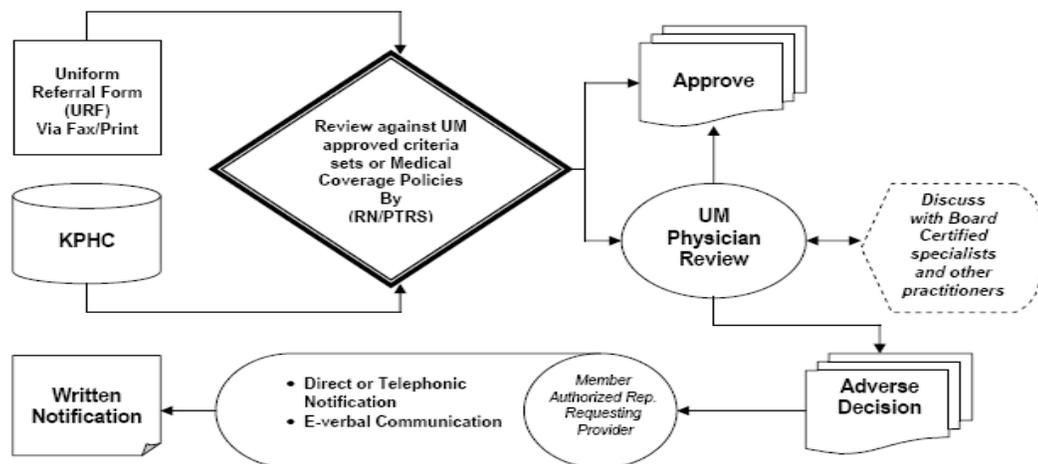


Figure 2 demonstrates the flow of decision making for medical necessity determinations. Medical appropriateness decisions can only be made by a UM Physician.

KPMAS ensures that patient safety is an integral part of all aspects of the UM Program. KPMAS believes that the following core elements are key principles associated with high quality Utilization Management practices:

1. An integrated/collaborative approach by KPMAS and MAPMG to utilization/resource management, inclusive of all practitioners, administrators and multidisciplinary staff, is essential to achieve desired clinical outcomes and stewardship. Recognition of the valuable contributions of practitioners, managers and staff achieves and sustains ongoing improvement efforts.
2. An admission process is in place for SF Members who are seen in the emergency departments.
3. Case Management rounds are conducted 5 days/week in the facilities that have KPMAS on-site reviewers to evaluate and plan for safe and proactive identification of transition management needs. SF Members are screened on admission for potential transition management needs. Any member meeting the screening criteria is interviewed by the Inpatient Case Manager who assesses their current condition and potential needs for post-acute care. This information is shared with physicians during Case Management Rounds.

## Application of UM Criteria, Development and Implementation of Medical Coverage Policies

### Selection and Application of UM Criteria, Emerging Technology and Medical Coverage Policies

KPMAS UM utilizes and adopts nationally developed medical policies, commercially recognized criteria sets, regionally developed medical coverage policies, and locally produced specialty medical coverage policies. Additionally, the opinions of subject matter experts, certified in the specific field of medical practice, are sought in the guideline development process.

All criteria sets are reviewed and revised annually. The Regional Utilization Management Committee (RUMC) reviews and approves these guidelines, and then the Regional Quality Improvement Committee (RQIC) makes the final approval. UM criteria are not designed to be the final determinate of the need for care, but are based upon local practice patterns and are applied based upon the needs and stability of the individual patient. In the absence of applicable criteria or Medical Coverage Policies (MCP) [ the UM staff refers the case for review to a licensed, board-certified practitioner in the same specialty as the requested service. The reviewing practitioners base their determinations on their training, experience, the current standards of practice in the community, published peer-reviewed literature, on the needs of individual patients (age, co-morbidities, complications, progress of treatment, psychosocial situation, and home environment when applicable), and characteristics of the local delivery system.

#### Development of Emerging Technology and Medical Coverage Policies (MCP)

Medical coverage policies are developed in collaboration with the primary and/or specialty care service chiefs or other board-certified physicians and practitioners within MAPMG. MCPs are based on current scientific literature, expert medical opinion based on training and clinical experience, adapted from nationally developed criteria or from other Kaiser Permanente regions. The development process includes a compilation of current evidence, expert opinion, national association guidelines and policy statements, state and/or federal mandates regarding coverage, and/or departmental consensus.

#### Technology Assessment

The Interregional New Technologies Committee (INTC) performs the formal assessment of emerging technologies. The membership of this national committee includes board certified physicians, ethicists, and medical-legal experts. INTC members base their assessment of a new technology on evidence published in peer reviewed medical journals, recommendations from federal health and regulatory agencies, and, clinical experts both internal and external to the Permanente Medical Groups. The Region's Technology Review Implementation Committee (TRIC) evaluates and implements the decisions of the INTC. The membership of this committee includes board certified physicians, nurses and administrative staff knowledgeable about benefits and contract administration. Implementation of KPMAS adopted new technology is a collaborative approach led by the Director of Medical Policies and Referrals in partnership with an ad hoc group of functional disciplines who play a vital role in the administration and implementation of new technology. Informing practitioners and health plan benefits administrators of the medically appropriate use of a new medical technology is the primary mission of the Region's Technology Review Implementation Committee.

In addition to the formal technology assessments performed by the national committee, Kaiser Permanente supports its practitioners and their patients with a Technology Assessment Inquiry Line. Practitioners contact this service with questions about individual technologies, which may or may not receive formal assessment by the national committee. Individual physicians receive summaries of published data on their requested topics, which they can use to discuss the treatment option with their patients.

Table 2. List of UM approved Criteria Sets used by KPMAS UM in utilization review

Service Type	UM Approved Criteria Sets
Inpatient Services	<input checked="" type="checkbox"/> Milliman Care Guide™
Outpatient Services:	<input checked="" type="checkbox"/> KPMAS Medical Coverage Policies <input checked="" type="checkbox"/> Milliman Care Guide™
Durable Medicare Equipment	<input checked="" type="checkbox"/> Medicare National/Local Coverage Determination Policies
Home Health Services	<input checked="" type="checkbox"/> Milliman Care Guide
PT/OT/Speech	<input checked="" type="checkbox"/> Milliman Care Guide <input checked="" type="checkbox"/> Guide to Physical Therapist Practice, Second Edition
Neonatal Care	<input checked="" type="checkbox"/> Paradigm Neonatal Clinical Guidelines Fifth Edition
Transplant Services <ul style="list-style-type: none"> <li>• Solid organs</li> <li>• Bone marrow</li> <li>• Stem cell</li> </ul>	<input checked="" type="checkbox"/> National Transplant Network Services Patient Selection Criteria <input checked="" type="checkbox"/> Interqual/ISP Criteria - Transplant and Hematology/Oncology

### Implementation and Communication Strategies

There are several ways to access the UM criteria sets, national guidelines and medical coverage policies:

- UM approved criteria sets and medical coverage policies can be accessed by any KPMAS staff and physicians through KP HealthConnect, Clinical Library and Mid-Atlantic States Knowledge Base (MASK)
- The Provider Service Center can be reached during business hours to request copies of UM criteria or MCPs, or to reach a Utilization Management Physician regarding UM medical coverage policies and medical necessity decisions
- Milliman Care Guide is an interactive application tool used by UM staff and physicians for review of inpatient and skilled nursing facility admissions and continued stays, ambulatory/ outpatient, and home health services. The application is interlinked with the KP HealthConnect system so decisions are documented in “real time”
- Medicare National Coverage Determination (NCD) and Local Determination Policies (LCD) applicable for DME are accessible through the Centers for Medicare and Medicaid Services (CMS) website: <http://www.cms.hhs.gov/mcd/search.asp?from2=search1.asp&> , in the Medicare national database for national and local determinations.
- Providers have access to the Kaiser Permanente medical coverage policies through the MAPMG website portal: <http://providers.kp.org/mas/utilizationguidelines.html>
- The Referral Management Newsletter is a quarterly publication available in electronic and print formats developed and distributed by the Referral and Medical Policy team. The intent of the newsletter is to improve understanding and enhance transparency of the referral management processes, publicize new and updated Medical Coverage Policies, and highlight problematic referral topics. Distribution of this newsletter includes internal physicians and staff as well as community and network providers.
- Kaiser Permanente e-Clinical Library is the main portal for all Kaiser Permanente

information within the organization, accessible by all KP employees nationally.



To discuss a medical necessity decision with the UM Physician Reviewer or if you need a copy of any medical coverage policy, rule, guideline, protocol or criteria used in decision-making of a referral

- Call the Provider Service Center Monday to Friday from 8:30 AM to 5:00 PM at 1-800-810-4766 and select the appropriate prompt #.
- To reach the UM Physician Reviewer, call the Kaiser Permanente Page Operator at (703) 359-7460 or 1-888-989-1144.

### 4.3 “Referral” vs “Authorization”

A Referral is a written recommendation by a Physician that a SF Members seek care from a specialist. This can be submitted electronically via the Referral Management System, Health Connect or via a Uniform Referral Form (URF).

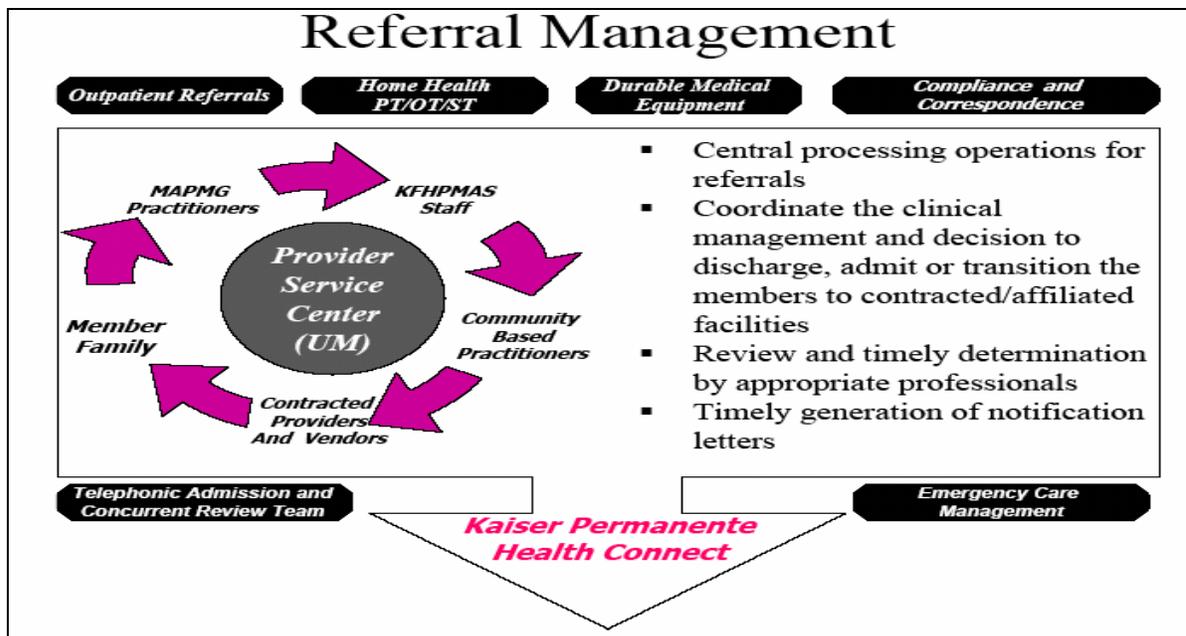
An Authorization is a referral that has been approved through Utilization Management process which includes validation of coverage and benefits eligibility, and determining medical necessity for the procedure/service(s) requested.

### 4.4 Referral Policy and Procedure

#### Managing Referrals through the Provider Service Center (PSC)

Registered Nurses at the PSC work collaboratively with licensed, board-certified UM Physician Managers and the practitioners in managing the patient's medical, surgical, or behavioral health care through electronic or telephonic utilization review of requested services and equipment, and by coordinating care across the continuum.

Figure 3 describes the collaboration with internal and external entities and the interaction processes involved in referral management.



### 4.5 Referral Policy and Procedure

Referrals are processed in accordance with the SF Member’s Plan as described in the Summary Plan Description (SPD) and the medical appropriateness of the requested service.

Medical necessity determinations are made using KPMAS approved and nationally recognized and locally developed criteria sets outlined in Table 3. Referrals are processed based on the urgency of the referral request and according to designated time frames as described in the following Table 3 below.

Decision Type	Timeframe for UM Decision	Timeframe for Electronic or Written Notification
Non- Urgent Pre- Service	Within 15 calendar days of receipt of the request	Within 15 calendar days of the request  Preservice decision is any case or service that KPMAS must approve, in whole or in part, in advance of the SF Member obtaining medical care or services. Preauthorization and precertification are preservice decisions.
Urgent Preservice	Within 72 hours of receipt of the request	Within 72 hours of the request  Urgent care is any request for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations: (1) could seriously jeopardize the life or health of the SF Member or the SF Member's ability to regain maximum function, based on a prudent layperson's judgment, <i>or</i> (2) in the opinion of a practitioner with knowledge of the SF Member's medical condition, would subject the SF Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.
Urgent Concurrent	Within 24 hours of receipt of the request	Within 24 hours of the request if the request is made at least 24 hours prior to the expiration of the current treatment  Concurrent review decision is any review for an extension of a previously approved ongoing course of treatment over a period of time or number of treatments. Concurrent reviews are typically associated with inpatient care or ongoing ambulatory care.  Urgent Concurrent. This is a request made while the AF Member is in the process of receiving care as an <u>urgent concurrent request</u> if medical care requested meets the definition of "urgent." (See Urgent Preservice, above)
Post Service Decisions	Within 30 calendar days of receipt of the request	Within 30 calendar days of the request  Post-service decisions include any requests for coverage of care or service that a SF Member has already received. A request for coverage of care that was provided for which the required prior authorization was not obtained is a post service decision

#### 4.5.1 Admission Notification Procedures

##### Non-Emergency & Elective Admissions



All non-emergent and elective admissions require preauthorization. The Participating PCP should initiate the referral form for authorization, or contact the Provider Service Center at ☎ 1 (800) 810-4766. An authorization number will

be generated for all approved admissions.

### Pre-Admission Notification Requirements

The participating hospital and/or facility are responsible for initiating all calls and requests for authorization for an admission. Kaiser Permanente must receive all calls and requests at least five (5) business days prior to the admission for all elective admissions. The hospital is also responsible to notify Kaiser Permanente at the time the SF Member is admitted. An exception to this policy is applied when it is not medically feasible to delay treatment due to the SF Member's medical condition. Failure to notify KPMAS within this time frame may result in the denial of authorization and payment for services. The participating hospital and/or facility cannot hold the SF Member financially liable for the denial of services when it fails to follow the authorization procedure.

Table 4 lists the services which require Kaiser Permanente Review by Utilization Management.

#### LIST OF SERVICES WHICH REQUIRE KAISER PERMANENTE REVIEW

*Please note that this is periodically updated and may not be an all inclusive list. To obtain the most up-to-date list of services which require Kaiser Permanente review, contact the Provider Service Center at ☎ 1 (800) 810-4766.*

#### A. Acute Inpatient Services

1	Inpatient Admissions (elective and emergent)	6	Inpatient Hospice Admissions
2	Short Stay Admissions	7	Inpatient Behavioral Health Admissions
3	Observation Services	8	Outpatient Behavioral Health Admissions (Partial Hospitalization)
4	Acute Rehabilitation		
5	Skilled Nursing Facility (SNF)/Sub-acute Rehabilitation services		

#### B. Elective Services

1.	Abortions, Elective/Therapeutic	23.	Nasal Surgery (Rhinoplasty or Septoplasty)
2.	Acupuncture	24.	Referrals to Non-Participating Providers
3.	Anesthesia for Oral Surgery/Dental	25.	Obstructive Sleep Apnea Treatment including Sleep Studies
4.	Any Services Outside Washington Baltimore Metro Areas	26.	Oral Surgery
5.	Assistive Technologies	27.	Orthognatic Surgery
6.	Behavioral Health Services	28.	Outpatient Surgery -All Hospital Settings/Ambulatory Surgery Centers
7.	Biofeedback	29.	Pain Management Services
8.	Blepharoplasty	30.	Penile Implants
9.	Breast Surgery for any reason	31.	Positron Emission Tomography (PET) Scan
10.	Chiropractic Care	32.	Podiatry Services
11.	Clinical Trials	33.	Post Traumatic (Accidental) Dental Services
12.	Cosmetic and Reconstructive or Plastic Surgery		
13.	Dental Services Covered Under Medical Benefit		

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li>14. Durable Medical Equipment (DME)</li> <li>15. Gastric Bypass Surgery, Gastroplasty</li> <li>16. Home Health Care Services (Including Hospice)</li> <li>17. Infertility Assessment and Treatment</li> <li>18. Infusion Therapy and Injectables (Home IV, Excluding Allergy Injections)</li> <li>19. Intensity Modulated Radiation Therapy (IMRT)</li> <li>20. Investigational/ Experimental Services</li> <li>21. Magnetic Resonance Imaging (MRI)</li> <li>22. Narrow Beam Radiation Therapy Modalities           <ul style="list-style-type: none"> <li>22.1. Cyberknife</li> <li>22.2. Gamma Knife</li> <li>22.3. Stereotactic Radiosurgery</li> </ul> </li> </ul> | <ul style="list-style-type: none"> <li>34. Prosthetics/Braces/Orthotics/Appliances</li> <li>35. Rehabilitation Therapies           <ul style="list-style-type: none"> <li>35.1. Cardiac Rehabilitation</li> <li>35.2. Occupational Therapy</li> <li>35.3. Physical Therapy</li> <li>35.4. Pulmonary Rehabilitation Therapy</li> <li>35.5. Speech Therapy</li> <li>35.6. Vestibular Rehabilitation</li> </ul> </li> <li>36. Scar Revision</li> <li>37. Sclerotherapy and Vein Stripping Procedures</li> <li>38. Uvulopalatopharyngoplasty (UPPP)</li> <li>39. Social Work Services</li> <li>40. Temporo Mandibular Joint Evaluation and Treatment</li> <li>41. Transplant Services - Solid Organs (including bone marrow and stem cell transplants) and Renal Transplant Services</li> </ul> |
|--|---|

#### 4.5.2 Documentation Requirements

All referral requests must be initiated by the participating Primary Care Physician or Specialist. Providing a succinct clinical history with an appropriate amount of detail allows the referral management staff to process and provide the appropriate coverage and medical decision timely. Delays in processing referrals often create serious member and internal/external provider dissatisfaction.

#### Referral Documentation Do's and Don'ts

- Do: Follow the *5 Finger Documentation Rules***



1. WHAT service/procedure are you requesting, explain briefly (initial or follow- up consult, 2nd opinion, etc.)
  2. WHEN will the service take place
  3. WHERE will the service take place (home, hospital, inpatient, outpatient),
  4. WHO are you referring to (identify the provider: first and last name and phone #)
  5. WHY - indicate the diagnosis, or indication for the service) and any pertinent clinical information to facilitate the decision for the requested service/procedure
- Do:** Use the correct note type when entering referrals - Use Provider Comments for electronic requests in AffiliateLink
  - Do:** Use the appropriate template when entering referrals Ex: wheelchairs, oxygen, breast reduction surgery
  - Do:** Keep documentation simple and direct to the point.

- ☑ **Do:** Use “Please Manually Review” reason for referral if you want the UM Referral team to review a referral for a particular reason and supercede auto-adjudication rules (for electronic requests)
- ⊖ **Don’t:** Forget to include your signature when entering referrals
- ⊖ **Don’t:** Include criticisms, personal comments and other “unprofessional remarks” in your documentation

Table 5 outlines the procedures and services requiring specific information documented for the referral request.

Procedure	KPMAS Medical Coverage Policies	Documentation Requirements
Acupuncture	☑	PCP progress notes for initial Referrals including descriptions of other types of treatments attempted; acupuncturist records may be requested for Referrals requesting continuation of acupuncture treatment.
Biofeedback	☑	PCP progress notes, including descriptions of other types of treatments attempted. Biofeedback records may be requested for Referrals requesting continuation of biofeedback treatment.
Blepharoplasty	☑	Visual field testing with and without the upper eyelids taped to relieve visual obstruction.
Breast Reconstruction	☑	History of breast cancer and any previous surgery, actual expected date of surgery, facility where surgery will be performed.
Breast Surgery, not related to cancer	☑	PCP notes, consultant notes, all pertinent clinical information.
Breast Mastectomy for Benign Conditions	☑	Pathology reports, age at onset (for gynecomastia) and results of hormonal evaluation, actual or expected date of surgery, facility where surgery will be performed.
Breast, Reduction Mammoplasty	☑	Patient age, height, weight, and frame size, description of any medical problems related to size of breasts, documentation of treatment of medical symptoms related to macromastia including prescription drugs such as NSAIDs, physical therapy and/or chiropractic care, history of any previous breast surgery, estimate of grams of tissue to be removed from each breast (plastic surgeons only), actual or expected date of surgery, facility where surgery will be performed.
Chiropractic services	☑	X-Ray/MRI reports, PCP’s notes documenting conservative medical treatment attempted, PT, medications.
Cosmetic/Plastic Surgery	☑	Photographs of area to be operated, description of any functional impairment, history of injury or previous surgery, expected date/facility of surgery.
Gastric Bypass Surgery, Gastroplasty	☑	SF Member height and weight, duration of BMI in excess of 35, complicating medical conditions secondary to morbid obesity, history of weight loss methods that have been tried in the past three years, completion of six months of individual and group nutrition counseling specifically designed for modalities of surgical weight loss w/ documented loss of 3% body weight during the six months of

Procedure	KPMAS Medical Coverage Policies	Documentation Requirements
		counseling and education, behavioral health clearance for weight reduction surgery, actual expected date of surgery, facility where surgery will be performed.
Infertility	<input checked="" type="checkbox"/>	Female: Primary gynecology notes, ultrasound results, lab results (AM Day 3 FSH, Estradiol if female over age 35, TSH, AM fasting prolactin, LH if oligo or amenorrhea), Clomid Challenge Test for females over age 40 or elevated Day FSH, Hysterosalpingogram w/i the past two years. Male: Semen analysis within past year and urology consultation if abnormal.
MRI Substitutes for Angiography (any body part)		PCP notes, specialist progress notes, x-ray and laboratory reports.
MRI (Magnetic Resonance Imaging) (any body part)	MRI, Breast guideline available	PCP notes, specialist progress notes, x-ray and laboratory reports. (Medical coverage policies are available for Breast MRI for Screening, Breast MRI for Diagnosis, Staging and Treatment Response, and for Genetic Testing for Breast Cancer Susceptibility.)
Nasal Surgery, Rhinoplasty		Date and type of nasal injury or trauma, history of breathing difficulties or problems, documentation of medical necessity, previous conservative medical treatment including medications and duration treated, actual or expected date of surgery, facility where surgery will be performed.
Nasal Surgery, Septoplasty		History of difficulty breathing through nose with types and dates of treatment, physician findings with estimate of airway obstruction for each side, history of ear, sinus or throat infections with types and dates of treatment, reports of any sinus x-ray or CT scans, expected date of treatment and facility where surgery will be performed.
Oral Surgery, TMJ Surgery		PCP notes, Specialist progress notes, x-rays and laboratory reports, arthrograms, CT scan reports.
Orthognathic Surgery		Narrative of SF Member's impairment of speech and/or nutritional function, photographs, cephalometric x-rays, posterior-anterior view if asymmetry is identified, computer analysis may substitute for models, photos and x-rays (analysis must allow measurement of the SNA and SNB angles), actual or expected date of surgery, facility where surgery will be performed
Out of Area Service		PCP notes, Specialist notes, ER notes, x-ray and laboratory reports and Advice Call documentation.
Pain Clinic	<input checked="" type="checkbox"/>	Physician and Specialist progress notes including documentation of medication and therapeutic interventions, PT and OT record, x-rays and laboratory reports.
Penile Implants		History of disease process causing impotence, history or past and present alcohol or substance abuse, history of past or present psychiatric conditions and treatments, date and type of inquiry causing impotence, length of time SF Member has been impotent, serum testosterone level, results of penile tumescence studies or rigiscan, documentation of failed medical treatment or contraindication to medical treatment, actual or expected date of surgery
Prosthetics, Braces, Orthotics,		PCP notes, consultant progress notes, x-ray and laboratory reports.

Procedure	KPMAS Medical Coverage Policies	Documentation Requirements
Appliances		
Rehabilitation Services	<input checked="" type="checkbox"/>	Note: Use applicable guideline for pediatric rehabilitation, habilitation, early intervention, cardiac or pulmonary rehabilitation (Physical Therapy, Occupational Therapy, Speech Therapy, Cardiac, Pulmonary, Vestibular) PCP or Specialist notes to include history of medical condition which caused deficit, anticipated duration and frequency of treatment. Evaluation by licensed speech therapist (for speech therapy).
Scar Revision	<input checked="" type="checkbox"/>	Photographs of the scar and any impairment to be corrected, history relating to cause of scar and date of injury, complicating medical conditions and attempted treatment, actual or expected date of surgery, facility where surgery will be performed, description of any functional impairment caused by the scar.
Varicose Veins	<input checked="" type="checkbox"/>	Treatments - PCP and Specialist progress notes, x-rays and laboratory reports, doppler ultrasound study.
Sleep Studies and Surgical Treatment of Obstructive Sleep Apnea		Clinical history and physical exams (including SF Member's height, weight, pharyngeal exam, and treatment for obesity, if present), x-ray and laboratory reports, description of any surgical procedure proposed (UPPP, Laser UPPP, or any other airway modifying intervention), CPT code(s), sleep lab report (including measurements), history of alcohol use, results of trial of abstinence from alcohol, facility and expected date of surgery, SF Member response to trial of CPAP or BiPAP

### 4.5.3 Admission to Skilled Nursing Facility (SNF)

SF Members needing SNF placement may originate from acute care facilities, emergency departments, Kaiser Permanente medical centers, other health care facilities or his/her home. Eligibility of the SF Member for SNF is based on benefits as outlined in the SPD, the number of benefited skilled days allowed, and medical necessity based on Milliman Care Guidelines®, Recovery Facility Care General Recovery Guidelines<sup>1</sup>. Placement is prioritized based on urgency of need. SF Member must have the following information prior to transition:

- a) discharge summary, any relevant and pertinent clinical information
- b) physician order and documentation of SF Member skilled needs
- c) most current chest x ray within the last 30 days
- d) laboratory results: CBC and electrolyte studies within the last 30 days

### 4.5.4 Home Health/Hospice Services

#### Home Care

Home Health care is part-time intermittent skilled nursing and home health aide services, physical, occupational and speech therapy, and medical social services provided in the patient's home. Home health care provides skilled care to assess the patient or patient's environment and to treat, or teach the patient or caregiver in a familiar setting. It enables the home health provider to continue communication with caregivers to achieve positive health outcomes for the patient. Home health care can also serve as a transitional service for recovering patients following discharge from an acute or recovery facility. Specific home care services and limitations depend on the SF Member's SPD.

In order to receive home care the SF Member must:

- Be confined to the home, i.e., SF Member should be unable to leave home and, consequently, leaving home would require a considerable and taxing physical effort.
- Be in need of home care on an intermittent basis, i.e., care that is either provided or needed less than 7 days per week, less than 8 hours a day.

When ordering home care, please provide a brief medical history, the skilled care needed by the patient, whether the patient is home bound, and where the care is to be provided.

Milliman Care Guidelines are used to determine medical necessity for the home care services requested. Home Care agencies are chosen according to contract, availability, and the SF Member's specific needs.

#### Hospice Care

**Hospice Services** are an interdisciplinary approach to patient care and management for terminal illness. The emphasis of care is supportive and comfort services rather than

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<sup>1</sup> Recovery Facility Care General Recovery Guidelines is a product of Milliman Care Guidelines®.

curative treatment. Hospice care consists primarily of home hospice but may include inpatient hospice when necessary. All SF Members who meet criteria for Hospice care will receive hospice care as outlined in their SPD.

SF Members may receive hospice services if the following criteria are met:

1. Hospice coverage is included in the SF Member's SPD
2. The SF Member has a life expectancy of six (6) months or less, if the disease runs its normal course.
3. The patient chooses to receive supportive care and comfort services, rather than curative treatments for the terminal illness.

It is not required that an SF Member have a "Do not Resuscitate" (DNR) order.

The SF Member's hospice benefit must meet the criteria for each Hospice Level of care as outlined table 6 below. Additionally, the admitting diagnosis must be directly related to the terminal illness. The patient's primary care physician must concur with the hospice plan of care developed by the hospice interdisciplinary team.

Table 6. Hospice levels of care

<p><b>Routine Home Care</b> defined as less than 8 hours of nursing care in 24 hours and is:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Provided for the SF Member at home or at other places of residence such as a nursing home or residential care facility</li> <li><input type="checkbox"/> Paid each day the SF Member is under the care of hospice and not receiving one of the other levels of care.</li> <li><input type="checkbox"/> Paid when the SF Member is receiving hospital care for a condition unrelated to the terminal condition.</li> </ul> <p><b>Continuous Home Care</b> defined as a minimum of 8 hours of care during a 24 hour period:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Only furnished during brief periods of crisis which are defined as periods in which the individual requires continuous care to achieve palliation or management of acute medical symptoms.</li> <li><input type="checkbox"/> Provided by an RN or LPN for 50% or greater of the period of care; aide or homemaker services may be used to supplement the RN/LPN hours.</li> <li><input type="checkbox"/> Hospice is paid at a predetermined hourly rate for the number of continuous care hours.</li> </ul> <p><b>General Inpatient Care</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Must be provided in an inpatient hospice unit, a participating Medicare or Medicaid acute facility or skilled nursing facility.</li> <li><input type="checkbox"/> The admission must be related to the terminal illness.</li> <li><input type="checkbox"/> The admission is for pain control, acute or chronic symptoms which cannot be managed in other settings or for respite purposes (see below).</li> <li><input type="checkbox"/> Hospice is paid at the inpatient rate for every day except the day of discharge.</li> </ul> <p><b>Inpatient Respite Care</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Admission for the purpose of relieving the family members or others caring for the SF Member.</li> </ul>
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Check the SF Member's SPD for benefit limits on the number of days available respite care.

### DME for Hospice SF Members

Durable medical equipment (DME) deemed medically necessary for the hospice plan of care and/or required to maintain the patient's quality of life, is generally included in the per diem paid to hospice and will be ordered by the hospice vendor at no additional charge.

DME may include but is not limited to:

- |                     |                      |                    |
|---------------------|----------------------|--------------------|
| 1. Hospital bed     | 4. Walker            | 7. Suction machine |
| 2. Portable commode | 5. Cane              | 8. Crutches        |
| 3. Oxygen           | 6. Over-head trapeze | 9. Wheelchair      |

Medically necessary equipment ordered but not covered by the hospice contract will be reviewed by the Kaiser UM nurse using the UM DME guidelines. Basic supplies associated with the care of the patient related to the terminal illness, including but not limited to, dressings, ostomy products, incontinence measures, etc., will be provided by the hospice vendor at no additional charge. Selected prescription drugs related to the terminal illness, including IV pain management drugs, will be provided when ordered as part of the hospice plan of care according to the SF Member's SPD.

Note: TPN, hematopoietic agents (epogen, neupogen etc), and chemotherapeutic agents both IV and oral, have been excluded from the hospice per diem . Coverage for these medications depends on the SF Member's SPD and if ordered by the Kaiser physician for palliative treatment. IV infusions which are ordered as part of the hospice plan of care are covered only in accordance with the SF Member's SPD. Medically necessary ambulance transfers from one level of hospice care to another level of hospice care is the responsibility of the hospice provider. Residence in a long term care or assisted living facility is not a barrier to hospice care. Primary care physicians or specialists continue to be the SF Member's attending physician providing professional medical services unless other arrangements are made.

#### 4.5.5 Durable Medical Equipment (DME)

Authorization for Durable Medical Equipment is based upon the SF Member's benefits and eligibility. Medical necessity is determined using KPMAS approved guidelines and criteria sets, or expert opinion of a Kaiser Permanente board certified physician when no guideline or criteria set is applicable.

To process your DME request, please include the following in your documentation:

- Type of DME requested
- Brief medical history/current problem/reason for DME request
- Physician order
- Height
- Weight

#### 4.5.6 Non-Emergent Member Transfers

Non-Emergent transfers for SF Members are coordinated through the Provider Service Center. Please refer to Section 1.10.

#### **4.6 Standing Referral Requirements**

Standing Referral is a referral to a specialty practitioner to provide consultative, diagnostic and therapeutic services to the SF Member without additional referral from the PCP. Standing Referrals may not exceed the life of the referral (designated by requesting practitioner), the extent of the SF Member's contract year, or deviate from the treatment plan developed in collaboration with the SF Member, his/her Primary Care Physician (PCP), and his/her specialist.

##### **Handling Requests for Standing Referrals**

1. A Standing Referral request is generated if it is determined the SF Member has a life threatening, degenerative, chronic, disabling condition, or pregnancy that requires continuing care from the Specialist or Non-Physician Specialist
2. A PCP or Specialist or Non-Physician Specialist should discuss options for care with the SF Member or his/her authorized representative
3. A Standing Referral can be requested by a PCP, Specialist, or Non-Physician Specialist for the SF Member's specific condition through the following methods:
  - 3.1. A MAPMG PCP or Specialist may generate an electronic referral and selects referral type "Standing Referral".
  - 3.2. A Network PCP may request a Standing Referral by:
    - Completing the Uniform Consultation Request (UCR) form indicating "Standing Referral" in the service section of the form, or
    - Generating an electronic referral and selecting a referral type of "Standing Referral".
  - 3.3. The referral will be pended to the PSC for review.
4. The referral must have a documented treatment plan/plan of care from the Specialist, Non-Physician Specialist, or PCP. Treatment plans are not required for pregnant SF Members receiving care from the obstetrician.
5. The PSC staff will review the referral and generate an approval notification, if appropriate, for consultation and plan of care.
  - An approved referral will be faxed to the consultant.
  - Denied referral requests are processed according to applicable requirements.
6. Additional authorization(s) will be processed according to the recommended plan of care with the PCP as the authorizing practitioner.
7. If the Specialist must refer to another practitioner or provider they must fax a UCR form to the PSC which will generate a referral with the PCP as co-authorizing provider.

#### **4.7 Request for Out-of-Network Referrals**

##### **Authorization to a Non-Participating Specialist**

A SF Member, primary care practitioner, or specialist may request a Referral to a specialist who is not part of the Health Plan's provider panel (Non-Participating Specialist).

Referrals to a non-participating specialist must be provided if the SF Member is diagnosed with a condition or disease that requires specialized medical care; and

- KPMAS does not have in its panel a specialist with the professional training and expertise to treat the condition or disease; or
- KPMAS cannot provide reasonable access to a specialist with the professional training and expertise to treat the condition or disease without unreasonable delay or travel

All referrals to non-participating providers must be authorized and approved by the KPMAS Utilization Management department staff/physicians in order for these services to be covered.

## 4.8 Specialty Care Referrals

### Specialty Care Physician Responsibilities

Specialists receive Referrals from participating providers. Every SF Member receiving services from a Specialist must have an approved Referral for that visit. Referral forms authorizing services will be faxed to the requesting provider, and the specialist (unless otherwise requested by the requesting provider) prior to the SF Member's scheduled appointment. The SF Member may request a copy of the approved referral from the requesting provider. It is the responsibility of the specialist's office to ensure that KPMAS has the correct information to contact the specialist's office on file to ensure accurate and timely communication of referral information.



Basic diagnostic testing, including most routine radiology studies do not require a referral form or Authorization. Routine laboratory services and routine radiology may be rendered and billed directly to Kaiser Permanente Insurance Co. (KPIC) Self-Funded Claims Administrator P.O. Box 30547 Salt Lake City, UT 84130-0547.

Each Referral has a unique Referral number. This Referral number must be reflected on the claim/bill for appropriate processing and payment.

During the initial office visit, a specialist may perform whatever services are medically indicated (even if they are not specified on the Referral form) provided the services:

1. Are performed in your office and not in another facility or location
2. Are performed on the same day as the initial office visit
3. Are in accordance with the SF Member's SPD
4. Do not appear on the list of services that require separate Pre-authorization.

Only one (1) visit is approved per Referral, unless otherwise indicated on the Referral form. We encourage our referred by providers to use their clinical judgment and discretion in anticipating a reasonable number of visits that might be required for a particular consultation.

Each approved Referral is valid only until the identified expiration date as noted on the Kaiser Permanente Referral Summary Report.

It is the responsibility of the referred by provider's office and the referred to Specialist's office to ensure that KPMAS has accurate fax numbers on file to ensure timely and efficient communication of Referral information.

Referred to Specialists must send a written report of their findings to the referring provider, and should call the referring provider, if their findings are *urgent*.

All consulting Specialists' reports must be reviewed, initialed, and dated by the referred by provider and maintained in the SF Member's chart.

### Requesting for additional visits, care or consultations

Following the initial authorized consultation, should the SF Member require additional visits, care and/or consultation with you or another provider, the Specialist may initiate an extension to the initial Referral and/or submit a new Referral/Authorization request. The request should include all required clinical documentation such as clinical notes and treatment plans.

To obtain additional visits directly use one of the following options:

**Option 1:** Call the Provider Service Center (PSC) at 1-800-810-4766 (follow the prompts) to request additional visits and/or an extension to an existing Referral.

**Option 2:** Specialists with secure internet access to our AffiliateLink service may enter a Referral message directly to the Provider Service Center (PSC) to request *additional* visits on an existing Referral or simply create a *new* Referral request directly via the web: [www.providers.kp.org/mas](http://www.providers.kp.org/mas)

Following the initial approved consultation, should the patient require a Referral to another provider, facility and/or a service requiring Pre-authorization, the Specialist may initiate a Referral/Authorization request directly by using one of the following options:

**Option 1:** Complete a Uniform Referral Form (URF) and fax it to the Provider Service Center (PSC) at Fax 1-800-660-2019.

**Option 2:** A Participating Specialist with secure access to AffiliateLink may enter a Referral or Authorization request directly via the web: [www.providers.kp.org/mas](http://www.providers.kp.org/mas).

In all instances, after a Specialist has received an approved Referral and has determined that additional services are required, it is not necessary to contact the referred by PCP for approval. Rather, the request should always be directed to the Provider Service Center (PSC) as noted above by phone, fax or internet communication.



If a SF Member visits your office for care, but does not have a Referral, please, call the Provider Service Center at ☎ 1 (800) 810-4766 to determine if the care is

authorized and if so, obtain a Referral number, which should be noted on the claim/bill for these services.

**To request a Referral for Specialist Care (No Authorization required), please follow these steps.**

Step 1:	VERIFY that the referred to specialist is participating in the Self Funding program through the Provider Directory at <a href="http://www.providers.kp.org">www.providers.kp.org</a> .
Step 2:	VERIFY that the requested procedure DOES NOT REQUIRE AUTHORIZATION (see section 1.5.1, List of Services which require KPMAS review)
Step 3:  Choose any of the Options listed here	Fax a copy of the Uniform Referral Form or the KPMAS Referral request to the Provider Service Center Fax ☎ 1 (800) 660-2019
	Mail a copy of the Uniform Referral Form or the KPMAS Referral request to: Provider Service Center 11921-B Bournefield Way Suite B Silver Spring, Maryland 20904
	A Primary Care Physician or Specialist with secure access to AffiliateLink may enter a Referral directly via the web <a href="http://www.providers.kp.org/mas">www.providers.kp.org/mas</a>
	A Primary Care Physician or Specialists with secure internet access to our AffiliateLink service may enter a Referral message directly to the Provider Service Center (PSC) to request <i>additional</i> visits on an existing Referral
Step 4:	Give a copy of the Uniform Referral Form or electronic Referral to the SF Member to take to his appointment with the Specialist

**To request a Referral for Specialist Care (Authorization required), please follow these steps.**

Step 1:	Verify that the procedure/service requires Authorization (see section 1.5.1, List of Services which require Kaiser Permanente review)
Step 2:	Determine if the Specialist is contracted.
Step 3:  Choose any of the Options listed here	Fax a copy of the Uniform Referral Form or the KPMAS Referral request to the Provider Service Center Fax ☎ 1 (800) 660-2019
	Mail a copy of the Uniform Referral Form or the KPMAS Referral request to: Provider Service Center 11921-B Bournefield Way Suite B Silver Spring, Maryland 20904
	A Primary Care Physician or Specialist with secure access to AffiliateLink may enter a Referral directly via the web. ( <a href="http://www.providers.kp.org/mas">www.providers.kp.org/mas</a> ).
	A Primary Care Physician or Specialists with secure internet access to our AffiliateLink service may enter a Referral message directly to the Provider Service Center (PSC) to request <i>additional</i> visits on an existing Referral

Step 4:	Ensure that all required clinical documentation accompanies the Referral request
Step 5:	Attach appropriate lab, x-ray results, or medical records. Incomplete Referrals will be faxed back to the Participating PCP or Participating Specialist office with request to include required information. Be sure to include fax numbers on the request.

## 4.9 Concurrent Review Process

All inpatient admissions (acute and sub-acute) are reviewed by Utilization Management Registered Nurses, Inpatient Case Managers (ICM). Ambulatory service concurrent review is performed by the Home Health and Durable Medical Equipment (DME) Coordinators located at the PSC. These nurses review medical, surgical, and behavioral health care. Concurrent review involves a combination of reviewing medical records against approved criteria; gathering information from practitioners, providers, and patients; and consulting with UM physician and nurse managers as needed.

Concurrent review is performed on care delivered in acute, SNF, and ambulatory settings:

- Observation (short stay) and chest pain units
- Acute inpatient hospitals
- Skilled nursing facilities
- Inpatient hospice facilities and home-based hospice care
- Inpatient rehabilitation facilities
- Partial Hospitalization and Intensive outpatient behavioral health services
- Home care
- Outpatient rehabilitation facilities
- Durable medical equipment

### **Managing our members in Participating Hospitals/Facilities that don't have KPMAS on-site reviewers**

The KPMAS Utilization Management Department performs concurrent review for all hospital and/or facility admissions.

- The participating hospital and/or facility's Utilization Review department is responsible for providing clinical information to Kaiser Permanente Utilization Management nurses by telephone. Failure to provide the clinical information within the required timeframe may result in a denial due to lack of information.
- The Utilization Management nurse applies Kaiser Permanente approved criteria to determine Medical Necessity for acute hospital care.
  - If the clinical information meets Kaiser Permanente's Medical Necessity criteria, the days/service will be approved.
  - If the clinical information does not meet Medical Necessity criteria, the days/service will be denied.

The participating hospital is responsible for securing authorization and cannot hold the SF Member financially liable for the denial of services when it fails to obtain authorization. KPMAS may enforce contractual obligations of the hospital to cooperate with KPMAS and to follow the procedures set forth in this Guide. This happens when:

***Lack of information denial:*** the provider/facility fails to provide KPMAS with clinical information regarding an inpatient admission or continued stay within 24 hours following KPMAS's request for such information.

***Lack of notification denial/Late notification denial:*** the provider/facility, SF Member or his/her authorized representative fails to notify Kaiser Permanente of the admission of an SF Member within (a) 24 hours or (b) the timeframes required by contract, communicated to

the provider/facility, or set forth on the SF Member's coverage documents, whichever is longer.

**Delay in service denial:** a service ordered in a facility was delayed; the delay was avoidable (i.e. not the result of a change in the SF Member's condition or for other clinical reasons); and the delay resulted in a longer length of stay than expected if the delay did not occur (avoidable day or days) or a provider fails to follow an approved course of treatment.

Table 7 outlines some of the most common delay in service/procedure by hospital, SNF or physician category. This table lists hospital and SNF services that hospitals and SNFs, respectively, are expected to be able to deliver seven days a week, provided that such services are within the scope of the provider/facility's services. For further questions, you may contact the utilization management contact assigned to your hospital.

## I. Hospital Delays

### Diagnostic Testing/Procedures

- MRI CT scans (test performed/read/results available)
- Other Radiology delays (test performed/read/results available)
- Laboratory tests (test performed/read/results available)
- Cardiac catheterization delays (including weekends and holidays)
- PICC Line placement
- Echocardiograms
- GI Diagnostic procedures (EGD, Colonoscopy, ERCP, etc.)
- Stress tests
- Technical delays (i.e. machine broken or machine is not appropriate for patient, causing delay)
- Dialysis
- Transfusions
- AFBs
- Pathology

### Operating Room

- CABG delays
- No OR time
- Physician delay (i.e. lack of availability)

### Ancillary Service

- PT/OT/Speech evaluation
- Social Work/Discharge Planning

### Nursing

- Delay in carrying out or omission of physician orders
- Medications not administered
- NPO order not acknowledged
- KPMAS Utilization Management not notified that the patient refuses to leave when discharged

## II. SNF Delays

### Diagnostic Testing/Procedures

- Laboratory tests (test performed/read/results available)
- PICC line placement
- Radiology delays(test performed/read/results available)

### Nursing

- Appointment delays due to transportation issues
- Delay in initiation of nursing services

### Ancillary Service

- Social Work/ Discharge Planning
- Delay in initiation of therapy services (PT/OT/Speech)
- Lack of weekend therapy services
- Delay in initiation of respiratory services
- Delay in Pharmacy services

## III. Physician Delays

### Hospital

- Delays in Specialty consults (non-KP physician)
- Discharge paperwork for alternative placement
- Patient not seen by attending or not seen in a timely manner.

### SNF

- Physician delays in facilities that do not have KPMAS on-site reviewers

## 4.10 Emergency Admissions and Services; Hospital Repatriation Policy

Emergency Services are health care services that are provided by a participating or non-participating Provider after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

- a) Placing the patient's health in serious jeopardy;
- b) Serious impairment to bodily functions;
- c) Serious dysfunction of any bodily organ or part; or
- d) In the case of a pregnant woman, serious jeopardy to the health of the mother and/or fetus.

Participating PCPs are responsible for providing evaluation, triage, and telephone services 24 hours a day, 7 days a week. If the Participating PCP is unavailable, that Participating PCP's on-call back up will direct the SF Member's care based upon medical necessity.



If a Participating PCP or coverage/on-call physician is unavailable, SF Members may call Kaiser Permanente's Medical Advice Nurse by calling ☎ 1 (703) 359-7878 or ☎ 1 (800) 777-7904.

If, due to the nature of the problem, the SF Member must be directed to a Hospital Emergency Department (ED), the Participating PCP should instruct the SF Member to go to the Emergency Department of the nearest hospital. The Participating PCP should notify the ED physician that the SF Member has been referred.

**Notification or referrals regarding an ED visit are not required.** However, if a patient requires inpatient admission after an ED visit, please be sure to notify PSC of the admission within 24 hours or next business day of the admission. *Failure to notify Kaiser Permanente within this time frame may result in the denial of authorization and payment of services. The provider cannot hold the SF Member financially responsible for services in the event that the provider has failed to obtain, or is late in obtaining authorization.*

### Hospital & Facility Admission Notification Requirements



All urgent and emergent admissions require notification within 24 hours or next business day of the admission to the Provider Service Center by the Participating PCP, his/her agent, or the participating hospital/facility at ☎ 1 (800) 810-4766.

*Failure to notify KPMAS will result in a denial. The provider cannot hold the SF Member financially responsible for lack of authorization or late notification.* If the admitting physician is not the Participating PCP, it is the admitting physician's responsibility to contact the Participating PCP in order to obtain authorization of the admission and discuss plans for care.

### Emergency Admission Procedures

In order to expedite reimbursement and facilitate concurrent review, please follow these steps:

- Step 1: Direct the SF Member to a participating facility where you have privileges, or to the nearest emergency room.
- Step 2: Contact the Provider Services Center at ☎ 1 (800) 810-4766 and select the appropriate prompt, to immediately report the admission, 24-hours a day, and 7-days a week via voice mail, fax or Affiliate Link.
- Step 3: Provide the following information in your call or fax:
  - SF Member Name
  - Member Record Number
  - Name of the Referring Physician
  - Admitting Hospital or Facility
  - Admitting Diagnosis
  - Proposed Treatment and Length Of Service
  - Date of Admission

The participating hospital and/or facility are responsible for notifying KPMAS for all inpatient emergency admissions. Calls, voice mails or faxes must be received within 24 hours next business day of the admission. *Failure to notify Kaiser Permanente within this time frame will result in the denial of payment for services. The provider cannot hold the SF Member financially responsible for lack of authorization or late notification.*

## Ambulance Transport



If the SF Member is in your office at the time of the emergency, and you would like the Provider Service Center to arrange ambulance transportation other than 911, please call our Provider Service Center at ☎ 1 (800) 810-4766 and listen for the appropriate prompt selection.

Please provide the following information to the PSC representative:

- Your name and phone name
- SF Member's name and Medical Record Number
- SF Member's specific location
- SF Member's diagnosis
- Type of ambulance requested: Basic Life Support, Advanced Life Support
- Medical necessity of ambulance transport. Please refer to the KPMAS medical Coverage Policy on Ambulance Transportation guideline accessible through the KP Provider website: <http://providers.kp.org/mas/utilizationguidelines.html> or through the KPMAS Clinical Library for KPMAS physicians and staff
- Specific patient needs for transport purposes, example: medications requiring monitoring, equipment (oxygen etc.), and
- Specify patient's weight

### 4.11 Case Management

The vision of the Ambulatory Case Management (ACM) program is to ensure that identified members have access to the right care, in the right setting and at the right time.

Beginning with defining and establishing the ACM program criteria, the UM department has renewed the focus (with management and staff) on helping our most vulnerable members. The criteria help identify those members who fit into high-risk categories or have complex health problems that require additional assistance in navigating the KPMAS system. The use of the established criteria by all practitioners throughout the region will help to ensure that these members receive the care that they need. By targeting these populations and managing them efficiently, inpatient readmission may be avoided.

The Ambulatory Case Management Program was strengthened with a focus on the following factors: (1) to be a resource for the health care team that problem solves to provide episodic, tactical recommendations for cases that are atypical; (2) to coordinate care when internal and external care providers are involved and there are communication gaps; and, (3) to provide follow-up on medically complex patients.

SF Members are referred to the program through a variety of sources that include: their Primary Care Provider, a Specialist treating them for an episode of care, a clinical RN, or by the SF Member. SF Members who would benefit from case management are those who have documented patterns of poor clinical responses, inappropriate resource utilization, at risk for hospitalization with multiple medical problems, or who meet the specific criteria for automatic admission for the specialty programs as outlined in Table 8. The Ambulatory Case

Management Referring and Screening Criteria are utilized as guidelines to identify SF Members for case management. SF Members may also self-refer to the program. SF Members are enrolled in the program only with their consent and may disenroll at any time.

**Table 8. Members in the following categories could be considered as possible candidates for the Ambulatory Case Management Program:**

SF Members who have recurrent episodes of care:	<ol style="list-style-type: none"> <li>1. Three or more urgent/unscheduled hospitalizations in a rolling six-month period</li> <li>2. Three or more Urgent Care/ER visits in a rolling six-month period</li> </ol>
SF Members who might need assistance in coordination of care	<ol style="list-style-type: none"> <li>1. Collaboration with the Hospital/SNF Case Managers and complex transition planning required</li> <li>2. Approaching and/or reaching the exhaustion of benefits</li> <li>3. Need to be connected to community resources for adherence to plan of care/overall health status</li> <li>4. Need for identification and management of psychosocial barriers that impact adherence to the plan of care</li> </ol>
SF Members with complex medical conditions	<ol style="list-style-type: none"> <li>1. Non-adherence to plan of care</li> <li>2. Visits to multiple specialists</li> <li>3. At-risk for future hospitalizations</li> <li>4. Need for complex referral/complicated service request</li> </ol>
Special needs populations	<ol style="list-style-type: none"> <li>1. High-risk infants - e.g., birth weight less than 2500 grams, hospitalized more than 30 days, babies with equipment needs and specialty appointment coordination.</li> <li>2. High-risk children - e.g., hospitalized for pediatric asthma, two or more refills of beta agonist meds per month; and complex medical conditions.</li> <li>3. Frail Elderly Patients whose age or medical condition is compromising their ability to be independent or adhere to the plan of care</li> </ol>

### Getting in-touch with the KPMAS Ambulatory Case Managers

The Ambulatory Case Management Department consists of Registered Nurses and Social Workers who cover each and every KPMAS medical center in Baltimore, DCSM, and Northern Virginia. Our Case Managers maintain offices, on site, in 20 Centers and cover the remainder by remotely and/or in- person as needed. The Case Managers are readily available to our physicians by phone-just call the medical center and ask for the Ambulatory Case Manager- or, in person-just stop by the office- or request a meeting, through staff messaging in Health Connect, or via an online referral through Health Connect.

If you are a Provider and do not have Affiliate Link or on-site access to an Ambulatory Case Manager, you may refer to us by either calling the medical center closest to the SF Member's home and speak directly with the Case Manager, or you may complete and send a Uniform Referral Form, which can be found on the KP.org website

Our Case Managers can assist and provide SF Members with the following services:

- Coordination of care due to complex medical conditions.

- Education and ongoing assessment related to a newly diagnosed medical problem.
- Advice and referrals for socio-economic issues impacting their health care.
- Close monitoring of SF Members who've experienced a recent increase in hospitalizations or urgent care visits.



***Self Referral Phone Line to request for a Case Manager***

Please advise the SF Member to contact:

301-321-51CM ( local phone line)

1-866-223-2347 (Toll-free)

## 4.12 Disease Management

### Population-based Care Management

Population-based Care Management (PCM) is one of the foundations of the KPMAS clinical care strategy that provides evidence-based, systematic support to the care teams physicians who care for the members. The PCM strategy is used to support care delivery to populations of members with chronic diseases and conditions and to populations of healthy members.

The PCM strategy is based on several key concepts, including:

- Evidence-based care
- Customized Information Technology to support the program with tracking and feedback
- Health care team-based care that supports the physician-patient relationship
- Involvement of the patient in their own care
- Performance metrics for program, area, center, team, and physician feedback.

The tools and interventions that arise from these key concepts are targeted across the region at areas of need and potential impact. For each program, the same interventions may not be used on all members of a specific population; instead, interventions are determined by the specific health status and/or risk of the individual member.

Although the programs develop and foster innovative relationships between various team members and patients, these relationships are explicitly designed to augment and support the key relationship between the primary care physician and the patient. This is a key value of all aspects of the PCM Program.

There are separate components of the KPMAS PCM Program, each targeted to differing types of populations:

- Population Care Management, which includes disease management programs, targeted towards large populations with chronic illness(es); case management of patients with chronic kidney disease and end stage renal disease; and primary screening and support for self care and healthy lifestyle choice.
- Senior Services that target members age 65 and over from preventive through end-of-life care.

- Department-based care management programs that target small volume populations of very high-risk patients such as patients with organ transplants, anticoagulation use, or high-risk pregnancy.

### Linkage of Population Care Management to Clinical Operations

Several Population Care Management Group programs have Workgroups and Committees composed of stakeholders in Specialty and Primary Care as well as content experts in the area. These include:

1. Depression
2. Diabetes
3. Chronic Pain
4. Allergy and Asthma Department
5. Weight Management
6. Healthy Living



To learn more about these programs, please call the Population Care Management Department at (301) 816-7122.

### **Renal Disease Management (RDM)**

The RDM program is an outcome-based, continuous quality improvement model that requires physician collaboration and inter-agency cooperation in order to utilize disease management tools, including multidisciplinary pathways and guidelines, patient outcome data, population-based interventions, and individual case management. Clinical practice guidelines published by the National Kidney Foundation, Kidney Disease Outcomes Quality Initiative (KDOQI) provide the evidence-based framework for KPMAS renal disease management protocols. The goals of the program are: (1) to improve quality and continuity of care; (2) maximize member self-care and health-preserving behaviors, and (3) decrease costs associated with avoidable patient morbidities and system inefficiencies.

The program is staffed by Renal Care Specialists who work closely with nephrologists and contracted outpatient dialysis centers. Members are identified through physician referrals, requests to initiate dialysis services, and laboratory values that indicate a member has entered stage four (Glomerular Filtration Rate/GFR < 30ml/min) of chronic kidney disease. The goal of Chronic Kidney Disease care management is to postpone the development of kidney failure and to prepare members for renal replacement therapy when it becomes imminent. The program is a coordinated team approach. UM nurses (ICMs, ACMs, and the PSC nurses) and Renal Care Specialists work together to coordinate the care delivery needs of our members with renal conditions.



To learn more about the Renal Disease Management Program, please call (301) 816-5955 or 1-800 368 5784 Extension 5955.

### **Tender Loving Care (TLC) High Risk Obstetrics Case Management Program**

The KPMAS Perinatal Case Management program focuses on the improvement of health for high-risk mothers and their newborns. The program's purpose is to develop, implement, and reinforce methods to collaboratively foster the health of these mothers and their newborns. The criteria used to identify program participants is based upon evidence-based medicine to determine the clinical condition or maternal medical history, which may impact maternal or

neonatal outcome. Mothers who have no significant medical history but develop complications during the pregnancy, are also identified and enrolled in the program.

#### Program Methodology:

- Identify at-risk mothers by utilizing standardized list of high risk conditions and obstetric problems for all women at their first prenatal visit.
- Educate the total obstetrical patient population on self-help methods to prevent preterm delivery by recognizing early signs and symptoms of preterm labor. Educational materials in New OB packet, orientation class, and educational material mid-pregnancy accomplish this.
- Manage women at risk for preterm delivery, or with current Pregnancy Induced Hypertension (PIH), with positive Human Immunodeficiency Virus, or other major risk factors through physician referral and provision of educational materials including internal and external resources.
- Collaborate closely with obstetrical providers on specific management of care for high-risk mothers by working directly with OB Providers to evaluate and propose a plan of care for at-risk mother.
- Educate/Orient obstetrical providers and clinical staff on Perinatal Case Management Program procedures, referrals, and program modifications.
- Evaluate the Perinatal Case Management Program on member satisfaction, clinical outcomes, and quality standards.

Perinatal Case Management links with other internal case management programs in the following situations:

- Members currently being case managed by Ambulatory Case Management (ACM) are referred to Perinatal Case Management for risks specifically associated with the current episode of pregnancy. These members are referred back to ACM after discharge from Perinatal Case Management.
- Prenatal members, who are discharged from KPMAS hospitals with KPMAS on-site reviewers, meet Perinatal Case Management criteria, and who have been followed by Inpatient Case Managers are referred to Perinatal Case Management if discharged undelivered.
- Members are discharged from Perinatal Case Management, according to program guidelines. Members at risk for preterm delivery are discharged at 37 weeks gestational age. Members with Pregnancy Induced Hypertension who are stable within two weeks postpartum are discharged from Perinatal Case Management. Members who remain unstable more than two weeks postpartum are referred to ACM for evaluation for ACM.



To learn more about the Tender Loving Care (TLC) High Risk Obstetrics Case Management Program, please call (703) 922-1525.

## Transplant Services

The Kaiser Permanente National Transplant Network (NTN) provides members with access to the network of transplant programs located at premier medical centers (Centers of Excellence) chosen for their expertise and experience. The NTN services of Case Management and Quality Management are provided and coordinated through Kaiser Permanente NTN hub

operations, and has a dotted line responsibility to the KPMAS Utilization Management department. KPMAS is part of the Central East Hub. Transplant services include heart, liver, heart/lung, lung, kidney, simultaneous Kidney-Pancreas, bone marrow, and stem cell transplants. A KPMAS SF Member determined to be a potential transplant candidate is referred by a KP specialist or primary care practitioner for Transplant Case Management. The physician and transplant coordinator work together to ensure the SF Member meets the patient selection criteria and coordinate the care of the SF Member throughout the transplant process, from referral through the lift of the transplanted graft.

Patient selection criteria for each organ type are developed by a national NTN Clinical Management subcommittee that is comprised of Permanente physicians with expertise in the field of transplant. The criteria are reviewed annually and updated based on the current clinical evidence. KPMAS adopted the use of the Kaiser Permanente National Transplant Network (NTN) Transplant Network guidelines.

#### Transplant Complex Case Management Program

In solid organ transplants, graft function and early acute rejection are the primary predictors of long term graft, and therefore, prolongs patient survival. In Bone Marrow/Peripheral Stem Cell Transplant (BMT/PBSCT), the first 12 months post transplant are the most resource intensive and have the highest non-relapse related mortality rates. For these reasons, the intensive case management, or Complex Case Management (CCM) program was designed to apply resources, skills and knowledge to the period from the transplant surgical discharge until 12 months post transplant. The goal for this period is to help the SF Member obtain optimum health or improved functional capacity and quality of life with his/her new transplant graft. Within 7 days of the SF Members discharge from the transplant admission, CCM reassesses the SF Member's status including clinical needs, educational needs, benefit limitations and psychosocial barriers to achieving the goals of the self management program. The Case Manager uses assessment, planning, goal setting, empowerment, facilitation advocacy, and evaluation to promote quality care and cost-effective outcomes as the SF Member adapts to living with a transplant graft.

The goals of Transplant Complex Case Management Program are to:

1. Promote self-care management, resulting in prolonged graft life
2. Ensure quality case management outcomes through the use of evidence-based clinical guidelines and algorithms
3. Promote efficiency and effectiveness of member care coordination work processes
4. Optimize health care services at the appropriate level of care
5. Measure effectiveness of complex case management
6. Manage resource utilization



Please call the KPMAS Transplant Services Department at (301) 625-6201 to refer a patient for an evaluation for a transplant service or to receive additional information about the National Transplant Network.

## 4.13 Drug Formulary

Kaiser Permanente's drug formulary is developed, updated and maintained by a group of Kaiser Permanente physicians, pharmacists, and nurses who meet regularly to evaluate medications that are most effective, safe, and useful in caring for our members. Using formulary medications helps Kaiser Permanente maintain a high quality of care for our members while helping to keep the cost of prescription medications affordable. KPMAS reviews and updates the formulary regularly throughout the year.

To obtain a copy of our drug formulary, please review the community provider web site <http://www.providers.kp.org/mas/utilizationguidelines.html>.



For paper copies of the formulary you may contact Member Services: Washington Metro Area at 301 468 6000. TDD 301 879 6380 Outside Washington Metro Area 800 777-7902 TDD 301 879 6380.

Kaiser Permanente uses a closed formulary, which means that only those medications included in the formulary are offered under the SF Member's prescription drug benefit. Non-formulary or designated criteria restricted medications may be offered but require prior authorization or documentation if medically necessary. See Section 4.13.1 below for the procedure for requesting benefits for non-formulary or criteria-restricted drugs.

### **4.13.1 Requesting Coverage for Non-formulary or Criteria Restricted Medications**

#### ***Non-Formulary Documentation Process***

To request coverage for a non formulary drug, please document the reason that a preferred formulary product is not appropriate for use. The reasons for the use of a non-preferred product will be documented in the pharmacy information system.

The reasons for the use of a non-preferred drug are categorized as:

1. Allergy or Adverse Drug Reaction
2. Treatment Failure
3. Meets Criteria
4. Patient Request
5. Other (i.e., a new SF Member currently on a non-preferred product)

The Clinical Pharmacy Service and Regional Pharmacy & Therapeutics Committee periodically evaluates the frequency of use of non-preferred drugs and considers those with significant use for addition to the formulary of preferred products.

Please remember that SF Members may have different benefits, exclusions, limitations and cost shares for their prescription drug coverage. In addition, SF Members may not have this coverage; or, they may have a different administrator for their prescription drug coverage. If you have any questions regarding a SF Member’s prescription drug coverage, please call the Self-funded Customer Service Department at 1-877-740-4117.

#### 4.14 Complaints and Appeals

If a SF Member raises a complaint or a question regarding his right to appeal adverse benefit determinations with your office, please refer the SF Member to the Self-Funded Customer Service Department at 1-877-740-4117. The phone number is also located on the back of the SF Member’s identification card. Self-Funded Customer Service can also provide information to the SF Member on his/her right to file a complaint regarding care at KPMAS facilities.

##### 4.14.1 Member Appeals

Adverse benefit determinations may be appealed only by a SF Member or his/her authorized representative (authorization must be in writing). SF Members are made aware of their right to appeal through their Summary Plan Description (SPD) provided by the Plan Sponsor, or by calling the Self-Funding Customer Service Department, which can provide information about the time frames for submitting appeals and for responses. In addition, KPIC and KPMAS are responsible for notifying SF Members of an adverse benefit determination and providing an explanation of their appeal rights. Time frames may vary for decisions regarding an appeal, depending on whether the adverse benefits determination relates to urgent care, or a pre-service or post-service claim.

##### 4.14.1.1 Non-Urgent SF Member Appeals

An appeal may be initiated by the SF Member or the SF Member’s authorized representative, who may be a Provider who is authorized in writing by the SF Member to act on behalf of the SF Member. A health care professional may also act as the SF Member’s authorized representative for an urgent care appeal.

Formal appeals should be submitted using one of the options provided below with the following information included:

- All related information (any additional information or evidence)
- Name and identification number of the SF Member involved
- Name of SF Member’s contracted PCP
- Service that was denied
- Name of initial Kaiser Permanente reviewing physician, if known

Option	Description
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Option	Description
#1	By mailing directly to:  Kaiser Permanente Insurance Company Member Appeals Unit 3701 Boardman - Canfield Rd. Canfield, Ohio 44406
#2	By faxing to the following number:  ATTN: Kaiser Permanente Insurance Company Member Appeals Unit 614-212-7110

A complete review of the claim will occur and the SF Member (and his/her authorized representative) will be notified of the decision in writing. If the initial denial is upheld following the review of the appeal, an explanation of the decision and any further appeal rights will be sent.

#### 4.14.1.2 Urgent SF Member Appeals

Urgent appeals are available in circumstances where the normal decision time could result in serious jeopardy to the SF Members' health, life or ability to regain full function.

Please call Self-Funded Customer Service at 1-888-349-2516 to initiate an urgent appeal if you are a health care professional.

For urgent appeals, the decision will be rendered as quickly as possible, contingent upon the promptness of the SF Member or his/her authorized representative (which may be his/her Provider) in providing necessary additional information requested.

### 4.15 Behavioral Health

SF Members with outpatient behavioral health benefits that will be administered by KPIC have direct access to outpatient Behavioral Health and Chemical Dependency Services. They do not need a referral from their primary care physician. Members can arrange for outpatient services independently by calling the Behavioral Health Access Unit where licensed clinicians (social workers and nurses) and intake schedulers assist members in arranging appropriate services with a practitioner at one of the Kaiser Permanente Medical Centers. Behavioral Health and Chemical Dependency Inpatient admissions, day treatment or partial hospital programs, and intensive outpatient programs require pre-authorization.

#### Contacting Behavioral Health



Members interested in scheduling an appointment in Behavioral Health call (866) 530-8778



Providers arranging services for Behavioral Health for members call the Behavioral Health Access unit (866) 530-8778 and press 6 for non urgent inquiries or 9 for Emergency Services.



Providers with administrative questions should call the Behavioral Health Network Provider Line at (703) 208-6282 or (866) 311-0531.

### Referrals for Behavioral Health Services

When it is determined that a Referral to a Provider is appropriate, the SF Member is given the names of participating providers to contact for an available appointment. The SF Member is also advised to call the Behavioral Health Referral Confirmation Mailbox at (703) 249-7905 after scheduling their first appointment and to leave the name of the provider selected as well as the date of their first appointment. Once the SF Member notifies Kaiser Permanente that they have scheduled an appointment with a Provider, Kaiser Permanente enters the Referral and faxes the Referral Authorization to the provider.

Each Referral contains the following information:

- Member's Name
- Referral ID Number
- Service being authorized (New Evaluation, Medication Management, Psychotherapy, Psychological Testing)
- Number of visits authorized
- Expiration Date

Treating providers must ensure that they receive an approved Referral prior to the patient's first visit. If a Referral has not been received prior to a member's first appointment, please call our Network Provider Line at (703) 208-6282 or (866) 311-0531 for assistance.

### Documentation of Treatment and Requests for Continuing Authorization

Prior to the last approved visit or the expiration date on the referral, the treating provider must complete a treatment plan. Kaiser Permanente uses The State of Maryland Uniform Treatment Plan Form.



Fax completed Uniform Treatment Plan to the attention of the Behavioral Health Utilization Review Nurse at (301) 388-1638 or (866) 311-0052.

Upon receipt of the treatment plan, the Behavioral Health Utilization Review Department will review the request for additional services and will either fax or mail a Continuing Treatment Authorization form or notify the provider and SF Member of an adverse benefit decision.

### Authorization Waiver for SELECT SF Members

An Authorization Waiver for SELECT SF Members initiating outpatient behavioral health care with participating providers (psychiatrist or psychotherapist) is in effect. Providers will not receive hard copy Authorizations when SELECT SF Members choose to initiate treatment on their own. Diagnostic codes covered by this 'Authorization Waiver' include: 290 - 314.9

with office identified as place of service. This Authorization Waiver applies to outpatient office visits and not to programs or inpatient hospitalizations. Providers will need to continue to collect any amounts due from SF Members at the time of each office visit. Providers will submit claims to the SF Claims Administrator but will not need a Referral number.

### **Documentation of Coordination of Care with Primary Care Physicians (PCPs)**

Kaiser Permanente continues to be a leader in promoting the integration of behavioral and medical health care. Many psychiatric problems present as medical conditions and many medical conditions present with psychiatric symptoms. Communication between all providers caring for a patient is essential to assure the best care. Patients benefit when their PCP is fully informed regarding all aspects of their health care. Communication between the behavioral health provider and the PCP is particularly important when a patient has:

- Initiated behavioral healthcare treatment
- Been prescribed psychotropic medication
- Had a recent inpatient stay related to their mental health or substance abuse
- A substance abuse problem that impacts their physical health and which may require the patient to seek additional medication from their PCP or other providers

Behavioral Health providers are asked to obtain the SF Member's consent and to communicate the following to the patient's PCP within seven (7) days of the beginning of treatment.

- Date of Initial Service
- Patient's Diagnosis and brief assessment of their findings
- Treatment Plan and Recommendations
- Medications Prescribed

If you are not sure how to contact the SF Member's PCP, you may mail or fax treatment information to the following address:

**Kaiser Permanente  
Regional HIMS  
6526 Belcrest Road, Suite 207  
Hyattsville, Maryland 20782  
FAX: (301) 209-6065**

A Kaiser Permanente Behavioral Health Case Manager or Behavioral Health Utilization Review Nurse may call to assist in coordinating care especially when there are multiple providers or when a SF Member is stepping down from a higher level of care.

### **Behavioral Health Emergency and Acute Care Services**

Participating Network Providers are expected to be available for their patients with appropriate after-hours or on-call coverage for their practice.

Emergency Services can be authorized 24 hours a day, 7 days a week.



**To arrange for Psychiatric Hospitalization:**

Call the Kaiser Permanente Provider Service Center at (800) 810-4766



**To arrange for Partial Hospitalization:**

Call the Behavioral Health Utilization Review Department at (301) 897-2409 or (301) 897-2406.



**To arrange for Intensive Outpatient Treatment:**

Call the Behavioral Health Access Unit at (866) 530-8778



**To make a Referral to a Kaiser Permanente Behavioral Health Case Manager:**

Call the Network Provider Line at (703) 208-6282 or (866) 311-0531



**To request non-routine or additional outpatient services including psychological testing, ECT and psychiatric consultation:**

Call the Behavioral Health Utilization Review Department at (301) 897-2406 or (301) 897-2409 .

**Behavioral Health Claims:** As a Participating Provider billing for behavioral health services, please follow the procedures and adhere to the requirements outlined in the Billing section of this manual.

## **II.5 Section 5: Billing and Payment**

For Self-Funded products, Kaiser Permanente Insurance Company (KPIC) utilizes a Third-Party Administrator (TPA), Harrington Health, to process claims.

The TPA's claim processing operation is supported by a set of policies and procedures which directs the appropriate handling and reimbursement of claims received.

It is your responsibility to submit itemized claims for services provided to SF Members in a complete and timely manner in accordance with your Agreement, this Manual and applicable law. The SF Member's Plan or Plan Sponsor is responsible for payment of claims in accordance with your Agreement. All claims for Plan benefits rendered to a SF Member should be submitted to the SF Claims Administrator even claims under tier 2 and 3 of the Self-Funded POS product.

### **5.1 Whom to Contact with Questions**

If you have any questions relating to the submission of claims for services to SF Members for processing, please contact Self-Funded Customer Service at 1-877-740-4117.

### **5.2 Methods of Claims Filing**

Claims may be submitted by mail or electronically.

### **5.3 Paper Claim Forms**

Effective October 2006, the center of Medicare & Medicaid Service (CMS) has revised the CMS -1500 form. The new CMS-1500 (08/05) version will accommodate the reporting of the National Provider Identifier (NPI).

The National Uniform Billing committee (NUBC) has approved the new UB-04 (CMS-1450) as the replacement for UB-92

- For Self-Funded paper claims submission, only the new CMS-1500 form (08/05 version), which accommodates the reporting of the National Provider Identifier (NPI), will be accepted for professional services billing.
- For Self-Funded paper claims submission, only the new UB-04 (CMS-1450) form will be accepted for facility services billing.

### **5.4 Record Authorization Number**

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

#### CMS 1500 Form

If applicable, enter the Authorization Number (Field 23) and the Name of the Referring Provider (Field 17) on the claim form, to ensure efficient claims processing and handling.

### **5.5 One Member/ Provider per Claim Form**

One Member per claim form/One Provider per claim form

- 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

### **5.6 Submission of Multiple Page Claim**

If due to space constraints you must use a second claim form, please write “continuation” at the top of the second form, and attach the second claim form to the first claim with a paper clip. Enter the TOTAL CHARGE (Field 28) on the last page of your claim submission.

### **5.7 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 may be necessary to submit two claims for these services. If the patient's coverage has not changed in the period, you may bill all services for this inpatient stay on one claim form. However, if the patient had a fully-funded Kaiser Permanente plan in December and became an SF Member on January 1st, two separate claims must be filed. For the December claim, you must follow the claims filing process for fully-funded products as noted under the appropriate section of this Provider Manual. Filing of the January claim must follow the process outlined for SF Members. The correct date of admission and the correct date of discharge must be noted on these claims.

### **5.8 Interim Inpatient Bills**

Interim hospital billings should be submitted under the same SF Member account number as the initial bill submission.

### **5.9 Supporting Documentation for Paper Claims**

Self-Funded claim submission requires supporting documentation for the following services:

- After Hour Medical Services

Supporting documentation is necessary in order to consider After Hours Medical Services and should include the following:

- Office notes
- Patient sign-in sheet
- Normal office hours
- Anesthesia  
Please bill with physical status codes whenever necessary for anesthesia services.

Additional specifications within Plan Sponsor contracts for Self-Funded products will supersede terms specified here. Additional documentation requirements will be communicated by the TPA via an Information Request Letter specifying the additional information needed.

### 5.10 Where to Mail/Fax Paper Claims

Paper claims are accepted; however EDI (electronic) submission is preferred. **No handwritten claims are accepted.** Paper claims are not accepted via fax due to HIPAA regulations.

Mail all paper claims to:  
KPIC Self-Funded Claims Administrator  
PO Box 30547  
Salt Lake City, UT 84130-0547

### 5.11 Where to Submit EDI (electronic) Claims

Submit all EDI (electronic) claims to:  
Kaiser Permanente Insurance Company Payor ID # 94320

### 5.12 Electronic Data Interchange (EDI)

KPIC encourages electronic submission of claims. Self-Funded claims will be administered by the TPA. Harrington Health has an exclusive arrangement with Emdeon for clearinghouse services. Providers can submit electronic claims directly through Emdeon or through another clearing house that has an established connection with Emdeon. Emdeon will aggregate electronic claims directly from Providers and other clearinghouses to route to Harrington Health for adjudication.

Electronic Data Interchange (EDI) is an electronic exchange of information in a standardized format that adheres to all Health Insurance Portability and Accountability Act (HIPAA) requirements. 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, 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 payor-specific edits applied to the data by the Clearinghouse before the data is transmitted to the appropriate payor 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 Plan Sponsors.

### 5.13 Supporting Documentation for Electronic Claims

Insubmitting claims electronically, the 837 transaction contains data fields to house supporting documentation through free-text format (exact system data field within your billing application varies). If supporting documentation is required, the TPA will request via Info Request Letters. Paper-based supporting documentation will need to be sent to the address below, where the documents will be scanned, imaged, and viewable by TPA claim processor. The TPA can not accept electronic attachments at this time.

Coordination of Benefits (COB) claims may be submitted electronically if you include primary payor payment information on the claim and specify in the notes that Explanation of Payment (EOP) is being sent via paper.

Mail all supporting documentation to:  
KPIC Self-Funded Claims Administrator  
PO Box 30547  
Salt Lake City, UT 84130-0547

### 5.14 To Initiate EDI Submissions

Providers initiate EDI submissions. Providers may enroll with Emdeon to submit EDI directly or ensure their clearinghouse of choice has an established connection with Emdeon. It is not necessary to notify KPIC or the TPA when you wish to submit electronically.

If there are issues or questions, please contact the TPA at:  
1-877-740-4117.

### 5.15 EDI Submission Process

Provider sends claims via EDI: Once a Provider has entered all of the required data elements (i.e., all of the required data for a particular claim) into a their claims processing system, the Provider then electronically “sends” all of this information to a clearinghouse (either Emdeon or another clearinghouse which has an established connection with Emdeon) for further data sorting and distribution.

Providers are responsible for working their reject reports from the clearinghouse.

**Exceptions to TPA submission:**

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

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

- When a Self-Funded Plan Sponsor is secondary to another coverage, Providers can send the secondary claim electronically by (a) ensuring that the primary payment data element within the 837 transaction is specified; and (b) submitting the primary payor payment info (Explanation of Payment (EOP)) via paper to the address below.

KPIC Self-Funded Claims Administrator  
PO Box 30547  
Salt Lake City, UT 84130-0547

Clearinghouse receives electronic claims and sends to Plan Sponsor: Providers should work with their EDI vendor to route their electronic claims within the Emdeon clearinghouse network. Emdeon will aggregate electronic claims directly from Providers and other clearinghouses for further data sorting and distribution.

The clearinghouse “batches” all of the information it has received, sorts the information, and then electronically “sends” the information to the correct Plan Sponsor for processing. Data content required by HIPAA Transaction Implementation Guides is the responsibility of the Provider and the clearinghouse. The clearinghouse should ensure HIPAA Transaction Set Format compliance with HIPAA rules.

In addition, clearinghouses:

- Frequently supply the required PC software to enable direct data entry in the Provider’s office.
- May edit the data which is electronically submitted to the clearinghouse by the Provider’s office, so that the data submission may be accepted by the appropriate Plan Sponsor for processing.
- Transmit the data to the correct payor in a format easily understood by the payor’s computer system.
- Transmit electronic claim status reports from Plan Sponsors to providers.

TPA receives electronic claims: The TPA receives EDI information after the Provider sends it to the clearinghouse for distribution. The data is loaded into the TPA's claims systems electronically and it is prepared for further processing. At the same time, the TPA prepares an electronic acknowledgement which is transmitted back to the clearinghouse. This acknowledgement includes information about any rejected claims.

### 5.16 Rejected Electronic Claims

Electronic Claim Acknowledgement: The TPA sends an electronic claim acknowledgement to the clearinghouse. This claims acknowledgement should be forwarded to you as confirmation of all claims received by the TPA.

**NOTE:** If you are not receiving an electronic claim receipt from the clearinghouse, Providers are responsible for contacting their clearinghouse to request these.

Detailed Error Report: The electronic claim acknowledgement reports include reject report, which identifies specific errors on non-accepted claims. Once the claims listed on the reject report are corrected, you may re-submit these claims electronically through the clearinghouse. In the event claims errors cannot be resolved, Providers should submit claims on paper to the TPA at the address listed below.

KPIC Self-Funded Claims Administrator  
PO Box 30547  
Salt Lake City, UT 84130-0547

*Until you receive an acknowledgement that the electronic claim was received by the TPA, the claim has not been submitted and the timeframes for timely submission of claims will continue to run.*

### 5.17 HIPAA Requirements

All electronic claim submissions must adhere to all HIPAA requirements. The following websites (listed in alphabetical order) include additional information on HIPAA and electronic loops and segments. If a Provider does not have internet access, HIPAA Implementation Guides can be ordered by calling Washington Publishing Company (WPC) at ☎ (301) 949-9740.

[www.dhhs.gov](http://www.dhhs.gov)  
[www.wedi.org](http://www.wedi.org)  
[www.wpc-edi.com](http://www.wpc-edi.com)

### 5.18 Clean Claim

Only clean claims -- those that are submitted on the appropriate CMS form (1500 or UB04), using current coding standards to complete form fields, and including all of the attachments that provide information necessary in the processing the claim will be processed.

A claim is considered “clean” when the following requirements are met:

- Correct Form: all professional claims should be submitted using the CMS Form 1500 and all facility claims (or appropriate ancillary services) should be submitted using the CMS Form CMS 1450 (UB04) based on CMS guidelines

*Note: Dentists should use a J512 Form and the most recent instructions provided by the American Dental Association.*

*Note: Pharmacies should use the Universal Prescription Drug Claim Form or its electronic equivalent.*

- 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): 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.

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

Additional specifications within Plan Sponsor contracts for Self-Funded products will supersede terms specified here.

### 5.19 Claims Submission Timeframes

Timely filing requirement for Self-Funded claim submission is based on Payor contract specifications and may vary from Payor to Payor (contract to contract). The standard timeframe for claim submission is 12 months from date of service, although the timeframe can vary with each Plan Sponsor.

Please contact Self-Funded Customer Service to obtain Payor-specific information.

### 5.20 Proof of Timely Claims Submission

Claims submitted for consideration or reconsideration of timely filing must be reviewed with information that indicates the claim was initially submitted within the appropriate time frames. The TPA will consider system generated documents that indicate the original date of claim submission and the Payor in which the claim was submitted to. Please note that hand-written or type documentation is not an acceptable form of proof of timely filing.

### 5.21 Claim Adjustments / Corrections

A claim correction can be submitted via the following procedures:

- Paper Claims - Write "CORRECTED CLAIM" in the top (blank) portion of the CMS-1500 (08/05 version) or UB-04 claim form. Attach a copy of the corresponding page of the KPIC Explanation of Payment (EOP) to each corrected claim. Mail the corrected claim(s) to KPIC using the standard claims mailing address
- Electronic Claims (CMS-1500) - Corrections to CMS-1500 claims which were already accepted (regardless whether these claims were submitted on paper or electronically) should be submitted on paper claim forms. Corrections submitted electronically may inadvertently be denied as a duplicate claim. If corrected claims for CMS-1500 are submitted electronically, Providers should contact Self-Funded Customer Service to identify the corrected claim electronic submission.
- Electronic Claims (UB-04) - Please include the appropriate Type of Bill code when electronically submitting a corrected UB-04 claim for processing. **IMPORTANT:** Claims submitted without the appropriate 3rd digit (xxX) in the "Type of Bill" code will be denied.

Additional specifications within Plan Sponsor contracts for Self-Funded products will supersede terms specified here.

## 5.22 Incorrect Claims Payments

Please follow the following procedures when an incorrect payment is identified on the Explanation of Payment (EOP):

- Underpayment Error - Write or call Self-Funded Customer Service and explain the error. Upon verification of the error, appropriate corrections will be made by the TPA and the underpayment amount owed will be added to/reflected in the next payment.
- Overpayment Error - There are two options to notify the TPA of overpayment errors:
  - A. Write or call Self-Funded Customer Service, and explain the error. Appropriate corrections will be made and the overpayment amount will be automatically deducted from the next payment.
  - B. Write a refund check to Kaiser Permanente Insurance Company (KPIC) for the exact excess amount paid within the timeframe specified by the Provider Contract. Attach a copy of the KPIC Explanation of Payment (EOP) to your refund check, as well as a brief note explaining the error. Mail the refund check to:  
Kaiser Permanente Insurance Co. (KPIC)  
P O Box 894197  
Los Angeles, CA 90189-4197

If for some reason an overpayment refund is not received by Kaiser Permanente within the terms and timeframe specified by the Provider Contract, the TPA on behalf of KPIC may deduct the refund amount from future payments.

Additional specifications with other Plan Sponsors for Self-Funded products will supersede terms specified here.

*[Note: KPIC will transfer money to appropriate Plan Sponsor once the adjustment has been processed by Harrington Health in the claims system. The KPIC P.O. Box is a lockbox account for overpayments.]*

## 5.23 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).

1. 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.
2. 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.

3. Address/City, State, Zip Code: Enter the address where Kaiser Permanente should mail your IRS Form 1099.
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/formspubs/>

Completed IRS Form W-9 should be mailed to the following address:

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.  
Provider Relations Department  
2101 East Jefferson Street, 2 East  
Rockville, MD 20852

**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.

#### **5.24 Changes in Federal Tax ID Number**

Changes in Federal Tax ID Number must be communicated as described in in Section 6.4 Required Notices. *Is it necessary to say this 3 times - above, in this section and in section 6.4? I would delete this section.*

#### **5.25 National Provider Identification (NPI)**

NPI numbers, both Type I and Type II should be submitted with any and all claims.

NPI numbers should be sent to Kaiser Permanente Provider Relations at (fax) 301-388-1700.

#### **5.26 SF Member Cost Share**

Please verify applicable SF Member cost share at the time of service.

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

Cost Share information can be obtained from:

Option	Description
#1	<p style="text-align: center;">Self-Funded Customer Service Department Telephone 1-877-740-4117 Monday - Friday from 7 A.M. to 9 P.M. Eastern Time Zone (ET). Self-Service IVR System is available 24 hours / 7 days a week</p>
#2	<p style="text-align: center;">Harrington Health Website <a href="http://provider.kphealthservices.com">http://provider.kphealthservices.com</a> 24 hours / 7 days a week</p>
#3	<p style="text-align: center;">Affiliate Link <a href="http://providers.kp.org">http://providers.kp.org</a> 24 hours / 7 days a week</p>
#4	<p style="text-align: center;">Self-Funded ID card. Certain copayments, co-insurance and deductible information are listed on the front of the Self-Funded ID card when applicable.</p>

### 5.27 SF Member Claims Inquiries

1-877-740-4117

### 5.28 Billing for Services Provided to Visiting SF Members

For visiting SF Members, the claim submission process is the same as for other Members. Reimbursement for visiting SF Members will reflect the visiting SF Member’s benefits. NOTE: At least the MRN displayed on the SF Member’s ID card must be identified on the submitted claim.

### 5.29 Coding for Claims

It is the Provider’s responsibility to ensure that billing codes used on claims forms are current and accurate, that codes reflect the services provided and that they are in compliant with KPIC’s coding standards. Incorrect and invalid coding may result in delays in payment or denial of payment. All coding must follow standards specified in 5.30 Coding Standards.

### 5.30 Coding Standards

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

#### ICD-9

To code diagnoses and hospital procedures on inpatient claims, use the International Classification of Diseases- 9th Revision-Clinical Modification (ICD-9-CM) developed by the Commission on Professional and Hospital Activities. ICD-9-CM Volumes 1 & 2 codes appear as three-, four- or five-digit codes, depending on the specific disease or injury being described. Volume 3 hospital inpatient procedure codes appear as two-digit codes and require a third and/or fourth digit for coding specificity.

#### CPT-4

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

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](http://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 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

### 5.31 Modifiers in CPT and HCPCS

Modifiers submitted with an appropriate procedure code further define and/or explain a service provided. Valid modifiers and their descriptions can be found in the most current CPT or HCPCS coding book. Note CMS-1500 Submitters: The TPA will process up to 4 modifiers per claim line.

When submitting claims, use modifiers to:

- Identify distinct or independent services performed on the same day
- Reflect services provided and documented in a patient's medical record

#### **5.31.1 Modifiers for Professional and Technical Services**

Modifier 26, Professional Component - Certain procedures consist of a physician component and a technical component. When the physician component is reported separately, adding the Modifier 26 to the CPT procedure code identifies the service.

Modifier TC, Technical Component - The modifier TC is submitted with a CPT procedure code to bill for equipment and facility charges, to indicate the technical component.

Use with diagnostic tests; e.g. radiation therapy, radiology, and pulmonary function tests.

Indicates the Provider performed only the technical component portion of the service.]

#### Modifiers Billed with Evaluation and Management (E/M) Services

Modifier 24 is used to report an unrelated evaluation and management service performed by the same physician who performed the surgery during a postoperative period.

Modifier 25 is used to report a significant, separately identifiable evaluation and management service performed by the same physician on the same date of service as a procedure or service. Modifier 25 can be used for significant, identifiable visits to be considered for reimbursement when substantiated in the medical records, which should be available upon request.

Modifier 57 is used when the decision to perform a major surgery happens the day before or day of the major surgery.

#### Modifiers Billed with Surgical Procedures

Modifier 50 is used in the service line of a unilateral 5-digit CPT procedure code to indicate that a bilateral procedure was performed. Modifier 50 may be used to bill surgical

procedures at the same operative session, or to bill diagnostic and therapeutic procedures that were performed bilaterally on the same day.

Modifier 51 is used to indicate multiple procedures were performed. *Should information similar to that for Modifier 50 be added?*

### 5.32 Modifier Review

The TPA will adjudicate modifier usage based on Current Procedural Terminology (CPT) guidelines. Providers are required to use modifiers according to standards and codes set forth in CPT4 manuals.

KPIC reserves the right to review use of modifiers to ensure accuracy and appropriateness. Improper use of modifiers may cause claims to pend and/or the return of claims for correction.

### 5.33 Coding & Billing Validation

For Self-Funded products, KPIC utilizes a Third-Party Administrator (TPA), Harrington Health, to process claims.

ClaimCheck release 8.5.39 by McKesson is a commercial code editor application utilized by our TPA for the Self-Funded product to evaluate and ensure accuracy of outpatient claims data including HCPCS and CPT codes as well as associated modifiers. ClaimCheck provides a set of rules with complex coding situations and specifies when certain combinations of codes that have been billed by a Provider are inappropriate. This process is intended to result in accurate coding and consistent claims payment procedures.

### 5.34 Coding Edit Rules

Edit Category	Description	Self Funded Edit
Rebundling	Use a single comprehensive CPT code when 2 or more codes are billed	Apply
Incidental	Procedure performed at the same time as a more complex primary procedure Procedure is clinically integral component of a global service. Procedure is needed to accomplish the primary procedure	Deny if procedure deemed to be incidental
Mutually Exclusive	Procedures that differ in technique or approach but lead to the same outcome.	Deny procedure that is deemed to be mutually exclusive
Medical Visits Pre- & Post-Op Visits	Based on Surgical Package guidelines; Audits across dates.	Deny E&M services within Pre- and Post-op Timeframe
Duplicate Procedures	Category I--Bilateral: Shown twice on submitted claim;	Allow one procedure per date of service; second procedure

	<p>Category II- Unilateral/Bilateral shown twice on submitted claim;</p> <p>Category III- Unilateral/single CPT shown twice</p> <p>Category IV- Limited by date of service, lifetime or place of service</p>	<p>denied.  <b>Allow only one procedure per date of service; second procedure denied.</b>  <b>Replace with corresponding Bilateral or multiple code</b>  <b>Allow/deny based on Plan's Allowable Limits</b></p>
	Category V--Not addressed by Category I-IV	<b>Pend for Review</b>
<b>Medical Visits/Pre- &amp; Post-Op Visits</b>	Based on Surgical Package guidelines; Audits across dates.	<b>Deny E&amp;M services within Pre- and Post-op Timeframe</b>
<b>Cosmetic</b>	Identifies procedures requiring review to determine if they were performed fo cosmetic reasons only	<b>Review for medical necessity</b>
<b>Experimental</b>	Codes defined by CMS and AMA in CPT and HCPCS manuals to be experimental	<b>Pend for Review</b>
<b>Obsolete</b>	Procedures no longer performed under prevailing medical standards.	<b>Review for medical necessity</b>

### 5.35 Workers' Compensation

Worker's compensation claims should not be submitted to the TPA for SF Members. Providers should follow their normal process in submitting WC claims to the appropriate state or federal worker's compensation payor.

### 5.36 CMS-1500 (08/05) Field Descriptions

The fields identified in the table below as "Required" must be completed when submitting a CMS-1500 (08/05) claim form to Kaiser Permanente Insurance Company for processing:

Note: The new CMS-1500 (08/05) form is revised to accommodate National Provider Identifiers (NPI).

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
1	MEDICARE/ MEDICAID/ TRICARE CHAMPUS/ CHAMPVA/ GROUP HEALTH PLAN/FECA BLK LUNG/OTHER	Not Required	Check the type of health insurance coverage applicable to this claim by checking the appropriate box.
1a	INSURED'S I.D. NUMBER	Required	Enter the subscriber's plan identification number.
2	PATIENT'S NAME	Required	Enter the patient's name. When submitting newborn claims, enter the newborn's first and last name.
3	PATIENT'S BIRTH DATE AND SEX	Required	Enter the patient's date of birth and gender. The date of birth must include the month, day and FOUR DIGITS for the year (MM/DD/YYYY).

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
			<u>Example:</u> 01/05/2006
4	INSURED'S NAME	Required	Enter the name of the insured (Last Name, First Name, and Middle Initial), unless the insured and the patient are the <u>same</u> —then the word "SAME" may be entered.
5	PATIENT'S ADDRESS	Required	Enter the patient's mailing address and telephone number. On the first line, enter the STREET ADDRESS; the second line is for the CITY and STATE; the third line is for the ZIP CODE and PHONE NUMBER.
6	PATIENT'S RELATIONSHIP TO INSURED	Required if Applicable	Check the appropriate box for the patient's relationship to the insured.
7	INSURED'S ADDRESS	Required if Applicable	Enter the insured's address (STREET ADDRESS, CITY, STATE, and ZIP CODE) and telephone number. When the address is the <u>same</u> as the patient's—the word "SAME" may be entered.
8	PATIENT STATUS	Required if Applicable	Check the appropriate box for the patient's MARITAL STATUS, and check whether the patient is EMPLOYED or is a STUDENT.
9	OTHER INSURED'S NAME	Required if Applicable	When additional insurance coverage exists, enter the last name, first name and middle initial of the insured.
9a	OTHER INSURED'S POLICY OR GROUP NUMBER	Required if Applicable	Enter the policy and/or group number of the insured individual named in Field 9 (Other Insured's Name) above. <b>NOTE:</b> <i>For each entry in Field 9A, there must be a corresponding entry in Field 9d.</i>
9b	OTHER INSURED'S DATE OF BIRTH/SEX	Required if Applicable	Enter the "other" insured's date of birth and sex. The date of birth must include the month, day, and FOUR DIGITS for year (MM/DD/YYYY). <u>Example:</u> 01/05/2006
9c	EMPLOYER'S NAME OR SCHOOL NAME	Required if Applicable	Enter the name of the "other" insured's EMPLOYER or SCHOOL NAME (if a student).
9d	INSURANCE PLAN NAME OR PROGRAM NAME	Required if Applicable	Enter the name of the "other" insured's INSURANCE PLAN or program.
10a-c	IS PATIENT CONDITION RELATED TO	Required	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. <b>NOTE:</b> <i>If "yes" there must be a corresponding entry in Field 14 (Date of Current Illness/Injury).</i>

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
			Place (State) - enter the State postal code.
10d	RESERVED FOR LOCAL USE	Not Required	Leave blank.
11	INSURED'S POLICY NUMBER OR FECA NUMBER	Required if Applicable	If there is insurance primary to Medicare, enter the insured's policy or group number.
11a	INSURED'S DATE OF BIRTH	Required if Applicable	Enter the insured's date of birth and sex, if different from Field 3. The date of birth must include the month, day, and FOUR digits for the year (MM/DD/YYYY). <u>Example:</u> 01/05/2006
11b	EMPLOYER'S NAME OR SCHOOL NAME	Not Required	Enter the name of the employer or school (if a student), if applicable.
11c	INSURANCE PLAN OR PROGRAM NAME	Required if Applicable	Enter the insurance plan or program name.
11d	IS THERE ANOTHER HEALTH BENEFIT PLAN?	Required	Check "yes" or "no" to indicate if there is another health benefit plan. For example, the patient may be covered under insurance held by a spouse, parent, or some other person.  If "yes" then fields 9 and 9a-d must be completed.
12	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Not Required	Have the patient or an authorized representative SIGN and DATE this block, unless the signature is on file. If the patient's representative signs, then the relationship to the patient must be indicated.
13	INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Not Required	Have the patient or an authorized representative SIGN this block, unless the signature is on file.
14	DATE OF CURRENT ILLNESS, INJURY, PREGNANCY	Required if Applicable	Enter the date of the current illness or injury. If pregnancy, enter the date of the patient's last menstrual period. The date must include the month, day, and FOUR DIGITS for the year (MM/DD/YYYY). <u>Example:</u> 01/05/2006
15	IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS	Not Required	Enter the previous date the patient had a similar illness, if applicable. The date must include the month, day, and FOUR DIGITS for the year (MM/DD/YYYY). <u>Example:</u> 01/05/2006
16	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not Required	Enter the "from" and "to" dates that the patient is unable to work. The dates must include the month, day, and FOUR DIGITS for the year (MM/DD/YYYY).

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
			Example: 01/05/2003
17	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	Required if Applicable	Enter the FIRST and LAST NAME of the referring or ordering physician.
17a	OTHER ID #	Not Required	In the shaded area, enter the non-NPI ID number of the physician whose name is listed in Field 17. Enter the qualifier identifying the number in the field to the right of 17a. The NUCC defines the following qualifiers: 0B - State License Number 1B - Blue Shield Provider Number 1C - Medicare Provider Number 1D - Medicaid Provider Number 1G - Provider UPIN Number 1H - CHAMPUS Identification Number EI - Employer's Identification Number G2 - Provider Commercial Number LU - Location Number N5 - Provider Plan Network Identification Number SY - Social Security Number X5 - State Industrial Accident Provider Number ZZ - Provider Taxonomy
17b	NPI NUMBER	Required	In the non-shaded area enter the NPI number of the referring Provider
18	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	Not Required	Complete this block when a medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	RESERVED FOR LOCAL USE	Required if Applicable	If you are "covering" for another physician, enter the name of the physician (for whom you are covering) in this field.  If a non-contracted provider will be covering for you in your absence, please notify that individual of this requirement.
20	OUTSIDE LAB CHARGES	Not Required	
21	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Required	Enter the diagnosis/condition of the patient, indicated by an ICD-9-CM code number. Enter up to 4 diagnostic codes, in PRIORITY order (primary, secondary condition).
22	MEDICAID RESUBMISSION	Not Required	
23	PRIOR AUTHORIZATION NUMBER	Required if Applicable	Enter the prior authorization number for those procedures requiring prior approval.
24a-g	SUPPLEMENTAL INFORMATION	Required	Supplemental information can only be entered

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
	SUPPLEMENTAL INFORMATION, con't.		<p>with a corresponding, completed service line.</p> <p>The top area of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 lines of service.</p> <p>When reporting additional anesthesia services information (e.g., begin and end times), narrative description of an unspecified code, NDC, VP - HIBCC codes, OZ - GTIN codes or contract rate, enter the applicable qualifier and number/code/information starting with the first space in the shaded line of this field. Do not enter a space, hyphen, or other separator between the qualifier and the number/code/information.</p> <p>The following qualifiers are to be used when reporting these services.</p> <p>7 - Anesthesia information  ZZ - Narrative description of unspecified code  N4 - National Drug Codes (NDC)  VP - Vendor Product Number Health Industry Business Communications Council (HIBCC) Labeling Standard  OZ - Product Number Health Care Uniform Code Council - Global Trade Item Number (GTIN)  CTR - Contract rate</p>
24a	DATE(S) OF SERVICE	Required	<p>Enter the month, day, and year (MM/DD/YY) for each procedure, service, or supply. Services must be entered chronologically (starting with the oldest date first).</p> <p>For each service date listed/billed, the following fields must also be entered: <i>Units, Charges/Amount/Fee, Place of Service, Procedure Code, and corresponding Diagnosis Code.</i></p> <p><b>IMPORTANT:</b> Do not submit a claim with a future date of service. Claims can only be submitted once the service has been rendered (for example: durable medical equipment).</p>
24b	PLACE OF SERVICE	Required	Enter the place of service code for each item used or service performed.

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
24c	EMG	Required if Applicable	Enter Y for "YES" or leave blank if "NO" to indicate an EMERGENCY as defined in the electronic 837 Professional 4010A1 implementation guide.
24d	PROCEDURES, SERVICES, OR SUPPLIES: CPT/HCPCS, MODIFIER	Required	Enter the CPT/HCPCS codes and MODIFIERS (if applicable) reflecting the procedures performed, services rendered, or supplies used.  <u>IMPORTANT:</u> Enter the anesthesia time, reported as the "beginning" and "end" times of anesthesia in military time above the appropriate procedure code.
24e	DIAGNOSIS POINTER	Required	Enter the diagnosis code <u>reference</u> number (pointer) as it relates the date of service and the procedures shown in Field 21. When multiple services are performed, the primary reference number for each service should be listed first, and other applicable services should follow. The reference number(s) should be a 1, or a 2, or a 3, or a 4; or multiple numbers as explained.  <u>IMPORTANT:</u> (ICD-9-CM diagnosis codes must be entered in Item Number 21 only. Do not enter them in 24E.)
24f	\$ CHARGES	Required	Enter the FULL CHARGE for each listed service. Any necessary payment reductions will be made during claims adjudication (for example, multiple surgery reductions, maximum allowable limitations, co-pays etc).  Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number.
24g	DAYS OR UNITS	Required	Enter the number of days or units in this block. (For example: units of supplies, etc.)  When entering the NDC units in addition to the HCPCS units, enter the applicable NDC 'units' qualifier and related units in the shaded line. The following qualifiers are to be used: F2 - International Unit ML - Milliliter GR - Gram UN Unit

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
24h	EPSDT FAMILY PLAN	Not Required	
24i	ID. QUAL	Required	<p>Enter in the shaded area of 24I the qualifier identifying if the number is a non-NPI. The Other ID# of the rendering Provider is reported in 24J in the shaded area. The NUCC defines the following qualifiers:</p> <p>0B - State License Number            1B - Blue Shield Provider Number            1C - Medicare Provider Number            1D - Medicaid Provider Number            1G - Provider UPIN Number            1H - CHAMPUS Identification Number            EI - Employer's Identification Number            G2 - Provider Commercial Number            LU - Location Number            N5 - Provider Plan Network Identification Number            SY - Social Security Number (The social security number may not be used for Medicare.)            X5 - State Industrial Accident Provider Number            ZZ - Provider Taxonomy</p>
24j	RENDERING PROVIDER ID #	Required	<p>Enter the non-NPI ID number in the shaded area of the field. Enter the NPI number in the non-shaded area of the field.</p> <p>Report the Identification Number in Items 24I and 24J only when different from data recorded in items 33a and 33b.</p>
25	FEDERAL TAX ID NUMBER	Required	<p>Enter the physician/supplier federal tax I.D. number or Social Security number. Enter an X in the appropriate box to indicate which number is being reported. Only one box can be marked.</p> <p><u>IMPORTANT:</u> The Federal Tax ID Number in this field <u>must match the information on file with the IRS.</u></p>
26	PATIENT'S ACCOUNT NO.	Required	<p>Enter the SF Members account number assigned by the Provider's/Provider's accounting system.</p> <p><u>IMPORTANT:</u> This field aids in patient identification by the Provider/Provider.</p>
27	ACCEPT ASSIGNMENT	Not Required	
28	TOTAL CHARGE	Required	Enter the total charges for the services rendered

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
			(total of all the charges listed in Field 24f).
29	AMOUNT PAID	Required if Applicable	Enter the amount paid (i.e., Patient copayments or other insurance payments) to date in this field for the services billed.
30	BALANCE DUE	Not Required	Enter the balance due (total charges less amount paid).
31	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	Required	<p>Enter the signature of the physician/supplier or his/her representative, and the date the form was signed.</p> <p>For claims submitted electronically, include a computer printed name as the signature of the health care Provider or person entitled to reimbursement.</p>
32	SERVICE FACILITY LOCATION INFORMATION	Required if Applicable	<p>The name and address of the facility where services were rendered (if other than patient's home or physician's office).</p> <p>Enter the name and address information in the following format:            1st Line - Name            2nd Line - Address            3rd Line - City, State and Zip Code</p> <p>Do not use commas, periods, or other punctuation in the address (e.g., "123 N Main Street 101" instead of "123 N. Main Street, #101"). Enter a space between town name and state code; do not include a comma. When entering a 9 digit zip code, include the hyphen.</p>
32a	NPI #	Required	Enter the NPI number of the service facility.
32b	OTHER ID #	Required	Enter the two digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number.
33	BILLING PROVIDER INFO & PH #	Required	Enter the name, address and phone number of the billing entity.
33a	NPI #	Required	Enter the NPI number of the service facility location in 32a.
33b	OTHER ID #	Required	Enter the two digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number.

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
			If available, please enter your Provider or unique vendor number.

**1500**
**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 06/05

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>	
1. MEDICARE <input type="checkbox"/> (Medicare #)	MEDICAID <input type="checkbox"/> (Medicaid #)	TRICARE <input type="checkbox"/> (Sponsor's SSN)	CHAMPVA <input type="checkbox"/> (Member ID)	GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID)	FECA <input type="checkbox"/> (SSN)	OTHER <input type="checkbox"/> (ID)	1a. 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		SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)						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			8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY		STATE	
ZIP CODE		TELEPHONE (Include Area Code) ( )				Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/>		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) YES <input type="checkbox"/> NO <input type="checkbox"/>		a. INSURED'S DATE OF BIRTH MM DD YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY						b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		b. EMPLOYER'S NAME OR SCHOOL NAME			
c. EMPLOYER'S NAME OR SCHOOL NAME						c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		c. INSURANCE PLAN NAME OR PROGRAM NAME			
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, return to and complete item 9 a-d.			
<b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b>						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.					
SIGNED _____						DATE _____					
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY						15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST 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. _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
						17b. NPI _____		20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)						19. RESERVED FOR LOCAL USE		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.			
1. _____						3. _____		23. PRIOR AUTHORIZATION NUMBER			
2. _____						4. _____					
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. FREQ Family Per	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	
25. FEDERAL TAX I.D. NUMBER		SSN EIN	26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$	29. AMOUNT PAID \$	30. BALANCE DUE \$		
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 _____						a. NPI _____		b. _____		a. NPI _____	
DATE _____						b. _____		b. _____			

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

 CARRIER  
 PATIENT AND INSURED INFORMATION  
 PHYSICIAN OR SUPPLIER INFORMATION

### 5.37 CMS-1450 (UB-04) FIELD DESCRIPTIONS

The fields identified in the table below as “Required” must be completed when submitting a CMS-1450 (UB-04) claim form to Kaiser Permanente Insurance Company for processing:

*\*Note: For Self-Funded paper claims submission, Kaiser Permanente will only accept the new UB-04 form for facility services billing.*

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
1	PROVIDER NAME and ADDRESS	Required	Enter the name and address of the hospital or person who rendered the services being billed.
2	PAY-TO NAME, ADDRESS, CITY/STATE, ID #	Required	Enter the name and address of the hospital or person to receive the reimbursement.
3a	PATIENT CONTROL NUMBER	Required	Enter the patient’s control number.  <b>IMPORTANT:</b> This field aids in patient identification by the Provider/Provider.
3b	MEDICAL RECORD NUMBER	Required if Applicable	Enter the number assigned to the patient’s medical/health record by the Provider.
4	TYPE OF BILL	Required	Enter the appropriate code to identify the specific type of bill being submitted. This code is required for the correct identification of inpatient vs. outpatient claims, voids, etc.
5	FEDERAL TAX NUMBER	Required	Enter the federal tax ID of the hospital or person entitled to reimbursement.
6	STATEMENT COVERS PERIOD	Required	Enter the beginning and ending date of service included in the claim.
7	BLANK	Not Required	Leave blank.
8	PATIENT NAME	Required	Enter the patient’s name.
9	PATIENT ADDRESS	Required	Enter the patient’s address.
10	PATIENT BIRTH DATE	Required	Enter the patient’s birth date.
11	PATIENT SEX	Required	Enter the patient’s gender.
12	ADMISSION DATE	Required	For inpatient claims only, enter the date of admission.
13	ADMISSION HOUR	Required	For either inpatient <u>OR</u> outpatient care, enter the 2-digit code for the hour during which the patient was admitted or seen.
14	ADMISSION TYPE	Required	Indicate the type of admission (e.g. emergency, urgent, elective, and newborn).
15	ADMISSION SOURCE	Required	Enter the source of the admission type code.

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
16	DISCHARGE HOUR (DHR)	Required if Applicable	Enter the two-digit code for the hour during which the patient was discharged.
17	PATIENT STATUS	Required	Enter the discharge status code.
18-28	CONDITION CODES	Required if Applicable	Enter any applicable codes which identify conditions relating to the claim that may affect claims processing.
29	ACCIDENT (ACDT) STATE	Not Required	Enter the two-character code indicating the state in which the accident occurred which necessitated medical treatment.
30	BLANK	Not Required	Leave blank.
31-34	OCCURRENCE CODES AND DATES	Required if Applicable	Enter the code and the associated date defining a significant event relating to this bill that may affect claims processing.
35-36	OCCURRENCE SPAN CODES AND DATES	Required if Applicable	Enter the occurrence span code and associated dates defining a significant event relating to this bill that may affect claims processing.
37	BLANK	Not Required	Leave blank.
38	RESPONSIBLE PARTY	Not Required	Enter the responsible party name and address.
39-41	VALUE CODES and AMOUNT	Required if Applicable	Enter the code and related amount/value which is necessary to process the claim.
42	REVENUE CODE	Required	Identify the specific accommodation, ancillary service, or billing calculation, by assigning an appropriate revenue code.
43	REVENUE DESCRIPTION	Required if Applicable	Enter the revenue description.
44	PROCEDURE CODE AND MODIFIER	Required	For ALL outpatient claims, enter <b>BOTH</b> a revenue code in Field 42 ( <i>Rev. CD.</i> ), and the corresponding CPT/HCPCS procedure code in <i>this</i> field.
45	SERVICE DATE	Required	<p><u>Outpatient Series Bills:</u></p> <p>A service date must be entered for all outpatient series bills whenever the "from" and "through" dates in Field 6 (<i>Statement Covers Period: From/Through</i>) are not the same. Submissions that are received without the required service date(s) will be rejected with a request for itemization.</p> <p><u>Multiple/Different Dates of Service:</u></p> <p>Multiple/different dates of service can be listed on ONE claim form. List each date on a separate line on the form, along with the corresponding revenue code (<i>Field 42</i>), procedure code (<i>Field 44</i>), and total charges (<i>Field 47</i>).</p>

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
46	UNITS OF SERVICE	Required	The units of service.
47	TOTAL CHARGES	Required	Indicate the total charges pertaining to the related revenue code for the current billing period, as listed in Field 6.
49	BLANK	Not Required	Leave blank.
48	NON COVERED CHARGES	Required if Applicable	Enter any non-covered charges.
50	PAYER NAME	Required	Enter (in appropriate ORDER on lines A, B, and C) the NAME and NUMBER of each payer organization from whom you are expecting payment towards the claim.
51	HEALTH PLAN ID	Required	Enter the Provider number.
52	RELEASE OF INFORMATION (RLS INFO)	Required if Applicable	Enter the release of information certification number
53	ASSIGNMENT OF BENEFITS (ASG BEN)	Required if Applicable	Enter the assignment of benefits certification number.
54a-c	PRIOR PAYMENTS	Required if Applicable	If payment has already been received toward the claim by one of the payers listed in Field 50 ( <i>Payer</i> ) prior to the billing date, enter the amounts here.
55	ESTIMATED AMOUNT DUE	Required if Applicable	Enter the estimated amount due.
56	NATIONAL PROVIDER IDENTIFIER (NPI)	Required	Enter the service Provider's National Provider Identifier (NPI).
57	OTHER PROVIDER ID	Required	Enter the service Provider's Kaiser-assigned Provider ID.
58	INSURED'S NAME	Required	Enter the subscriber's name.
59	PATIENT'S RELATION TO INSURED	Required if Applicable	Enter the patient's relationship to the subscriber.
60	INSURED'S UNIQUE ID	Required	Enter the insured person's unique individual patient identification number (medical/health record number), as assigned by Kaiser.
61	INSURED'S GROUP NAME	Required if Applicable	Enter the insured's group name.
62	INSURED'S GROUP NUMBER	Required if Applicable	Enter the insured's group number as shown on the identification card. For Prepaid Services claims enter "PPS".
63	TREATMENT AUTHORIZATION CODE	Required if Applicable	For ALL inpatient and outpatient claims, enter the referral number.

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
64	DOCUMENT CONTROL NUMBER	Not Required	Enter the document control number related to the patient or the claim.
65	EMPLOYER NAME	Required if Applicable	Enter the employer's name.
66	DX VERSION QUALIFIER	Not Required	Indicate the type of diagnosis codes being reported.  Note: At the time of printing, Kaiser only accepts ICD-9-CM diagnosis codes on the UB-04.
67	PRINCIPAL DIAGNOSIS CODE	Required	Enter the principal diagnosis code, on all inpatient and outpatient claims.
67 A-Q	OTHER DIAGNOSES CODES	Required if Applicable	Enter other diagnoses codes corresponding to additional conditions. Diagnosis codes must be carried to their highest degree of detail.
68	BLANK	Not Required	Leave blank.
69	ADMITTING DIAGNOSIS	Required	Enter the admitting diagnosis code on all inpatient claims.
70 (a-c)	REASON FOR VISIT (PATIENT REASON DX)	Required if Applicable	Enter the diagnosis codes indicating the patient's reason for outpatient visit at the time of registration.
71	PPS CODE	Required if Applicable	Enter the DRG number which the procedures group, even if you are being reimbursed under a different payment methodology.
72	EXTERNAL CAUSE OF INJURY CODE (ECI)	Required if Applicable	Enter an ICD-9-CM "E-code" in this field ( <i>if applicable</i> ).
73	BLANK	Not required	Leave blank.
74	PRINCIPAL PROCEDURE CODE AND DATE	Required if Applicable	Enter the ICD-9-CM procedure CODE and DATE on all inpatient AND outpatient claims for the principal surgical and/or obstetrical procedure which was performed ( <i>if applicable</i> ).
74 (a-e)	OTHER PROCEDURE CODES AND DATES	Required if Applicable	Enter other ICD-9-CM procedure CODE(S) and DATE(S) on all inpatient AND outpatient claims ( <i>in fields "A" through "E"</i> ) for any additional surgical and/or obstetrical procedures which were performed ( <i>if applicable</i> ).
75	BLANK	Not required	Leave blank.

FIELD NUMBER	FIELD NAME	REQUIRED FIELDS FOR CLAIM SUBMISSIONS	INSTRUCTIONS/EXAMPLES
76	ATTENDING PHYSICIAN / NPI / QUAL / ID	Required	<p>Enter the National Provider Identifier (NPI) and the name of the attending physician for inpatient bills or the physician that requested the outpatient services.</p> <p><u>Inpatient Claims—Attending Physician</u> Enter the full name (<i>first and last name</i>) of the physician who is responsible for the care of the patient.</p> <p><u>Outpatient Claims—Referring Physician</u> For ALL outpatient claims, enter the full name (<i>first and last name</i>) of the physician who referred the Patient for the outpatient services billed on the claim.</p>
77	OPERATING PHYSICIAN / NPI/ QUAL/ ID	Required If Applicable	Enter the National Provider Identifier (NPI) and the name of the lead surgeon who performed the surgical procedure.
78-79	OTHER PHYSICIAN/ NPI/ QUAL/ ID	Required if Applicable	Enter the National Provider Identifier (NPI) and name of any other physicians.
80	REMARKS	Required if Applicable	Special annotations may be entered in this field.
81	CODE-CODE	Required if Applicable	Enter the code qualifier and additional code, such as marital status, taxonomy, or ethnicity codes, as may be appropriate.



### 5.38 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 Patient 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.

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

#### 5.38.1 How to Determine the Primary Payor

- 1 The benefits of a plan that covers an individual as an employee, patient or subscriber other than as a dependent are determined before those of a plan that covers the individual as a dependent.
- 2 When both parents cover a child, the "birthday rule" applies - the payor for the parent whose birthday falls earlier in the calendar year (month and day) is the primary payor.

When determining the primary payor 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 Step-parent with custody pays next
- 3 Natural parent without custody pays next
- 4 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. If this does not apply, call the SF Customer Service at 1-877-740-4117

- 1 The Self-Funded plan is generally primary for working Medicare-eligible SF Members when the CMS Working Aged regulation applies.
- 2 Medicare is generally primary for retired Medicare members over age 65. Medicare is also primary for SF Members with End Stage Renal Disease (ESRD) beginning after the first thirty (30) months of dialysis treatment.

- 3 In cases of work-related injuries, Workers Compensation is primary unless coverage for the injury has been denied.
- 4 In cases of services for injuries sustained in vehicle accidents or other types of accidents, primary payor status is determined on a jurisdictional basis. Submit the claim as if the Self-Funded plan is the primary payor. The TPA will follow its standard “pay and chase” procedures.

### **5.38.2 Description of COB Payment Methodologies**

Coordination of Benefits allows benefits from multiple carriers to be added on top of each other so that the SF Member receives the full benefits from their primary carrier and the secondary carrier pays their entire benefit up to 100% of allowed charges.

When a Self-Funded plan has been determined as the secondary payor, the Plan pays the difference between the payment by the primary payor and the amount which would be have been paid if the Self-Funded plan was primary, less any amount for which the SF Member has financial responsibility. Please note that the primary payor payment must be specified on the claim, and an EOP (explanation of payment) needs to be submitted as an attachment to the claim.

### **5.38.3 COB Claims Submission Requirements and Procedures**

Whenever the Self-Funded plan is the SECONDARY payor, claims can be submitted EITHER electronically or on one of the standard paper claim forms:

#### Electronic Claims:

If the Self-Funded plan is the secondary payor, send the completed electronic claim with the payment fields from the primary insurance carrier entered as follows:

- 837P claim transaction Enter Amount Paid
- 837I claim transaction Enter Prior Payments

#### Paper Claims

If the Self-Funded plan is the secondary payor, send the completed claim form with a copy of the corresponding Explanation of Payment (EOP) or Explanation of Medicare Benefits (EOMB)/Medicare Summary Notice (MSN) from the primary insurance carrier attached to the paper claim to ensure efficient claims processing/adjudication. The TPA (Self-Funded) cannot process a claim without an EOP or EOMB/MSN from the primary insurance carrier.

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

### **5.38.4 SF Members Enrolled in Two Kaiser Permanente Plans**

Some SF Members may be enrolled under two separate plans offered through Kaiser Permanente (dual coverage). In these situations, Providers need only submit ONE claim under the primary plan and send to either Harrington Health (for Self-Funded plan) or Kaiser Permanente (for fully insured plan) depending on which plan is primary.

### 5.38.5 COB Claims Submission Timeframes

If a Self-Funded plan is the secondary payor, any Coordination of Benefits (COB) claims must be submitted for processing within the timely filing period as specified according to the standard claims submission timeframe.

### 5.38.6 COB FIELDS ON THE UB-04 CLAIM FORM

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. For additional information, refer to the current UB-04 National Uniform Billing Data Element Specifications Manual.

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 #	FIELD NUMBER	FIELD NAME	INSTRUCTIONS/EXAMPLES
2300 H1	32-35 (UB-92)  31-36 (UB-04)	OCCURRENCE CODE/DATE	Enter the appropriate occurrence code and date defining the specific event(s) relating to the claim billing period.  <b>NOTE:</b> If the injuries are a result of an accident, please complete Field 77 (E-Code)
2330B NM	50	PAYER <i>(Payer Identification)</i>	Enter the name and number <i>(if known)</i> for each payer organization from whom the Provider expects (or has received) payment towards the bill. List payers in the following order on the claim form:  A = primary payer B = secondary payer C = tertiary payer
2320 AMT	54	PRIOR PAYMENTS <i>(Payers and Patient)</i>	Enter the amount(s), if any, that the Provider has received toward payment of the bill <b>PRIOR</b> to the

837I LOOP #	FIELD NUMBER	FIELD NAME	INSTRUCTIONS/EXAMPLES
			billing date, by the indicated payer(s). List prior payments in the following order on the claim form:  A = primary payer B = secondary payer C = tertiary payer
2330A NM	58	INSURED'S NAME	Enter the name ( <i>Last Name, First Name</i> ) of the individual in whose name insurance is being carried. List entries in the following order on the claim form:  A = primary payer B = secondary payer C = tertiary payer <b>NOTE:</b> For each entry in <i>Field 58</i> , there MUST be corresponding entries in <i>Fields 59 through 62</i> (UB-92 and UB-04) AND <i>64 through 65</i> ( <i>Field 65 only on the UB-04</i> ).
2320 SBR	59	Patient's Relationship To Insured	Enter the code indicating the relationship of the patient to the insured individual(s) listed in <b>Field 58</b> ( <i>Insured's Name</i> ). List entries in the following order:  A = primary payer B = secondary payer C = tertiary payer
2330A NM	60	CERT. - SSN - HIC - ID NO. ( <i>Certificate/Social Security Number/Health Insurance Claim/Identification Number</i> )	Enter the insured person's ( <i>listed in Field 58</i> ) unique <b>individual member identification number</b> (medical/health record number), as assigned by the payer organization. List entries in the following order:  A = primary payer B = secondary payer C = tertiary payer
2320 SBR	61	GROUP NAME ( <i>Insured Group Name</i> )	Enter the name of the <b>group or plan</b> through which the insurance is being provided to the insured individual ( <i>listed in Field 58</i> ). Record entries in the following order:

837I LOOP #	FIELD NUMBER	FIELD NAME	INSTRUCTIONS/EXAMPLES
			A = primary payer B = secondary payer C = tertiary payer
2320 SBR	62	INSURANCE GROUP NO.	Enter the <b>identification number, control number, or code</b> assigned by the carrier or administrator to identify the <b>GROUP</b> under which the individual ( <i>listed in Field 58</i> ) is covered. List entries in the following order:  A = primary payer B = secondary payer C = tertiary payer
2320 SBR	64	ESC <i>(Employment Status Code of the Insured)</i>  <i>Note: This field has been deleted from the UB-04.</i>	Enter the code used to define the <b>employment status</b> of the insured individual ( <i>listed in Field 58</i> ). Record entries in the following order:  A = primary payer B = secondary payer C = tertiary payer
2320 SBR	65	EMPLOYER NAME <i>(Employer Name of the Insured)</i>	Enter the name of the employer who provides health care coverage for the insured individual ( <i>listed in Field 58</i> ). Record entries in the following order:  A = primary payer B = secondary payer C = tertiary payer
2300 H1	67-76 (UB-92) 67 A-Q (UB-04)	DIAGNOSIS CODE	The <b>primary diagnosis code</b> should be reported in <b>Field 67</b> . Additional diagnosis code can be entered in <b>Field 68-76</b> .
2300H1	77(UB-92) 72 (UB-04)	EXTERNAL CAUSE OF INJURY CODE (E-CODE)	If applicable, enter an ICD-9-CM "E-code" in this field.

### 5.38.7 COB FIELDS ON THE CMS-1500 (08/05) CLAIM FORM

The following fields should be completed on the CMS-1500 (08/05) 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 #	FIELD NUMBER	FIELD NAME	INSTRUCTIONS/EXAMPLES
2330A NM	9	OTHER INSURED'S NAME	When <b>additional</b> insurance coverage exists (through a spouse, parent, etc.) enter the LAST NAME, FIRST NAME, and MIDDLE INITIAL of the insured.  <b>NOTE:</b> 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.  <b>NOTE:</b> Field 9a must be completed when there is an entry in Field 11d (Is There Another Health Benefit Plan?).  <b>NOTE:</b> For each entry in this field, there must be a corresponding Entry in 9d (Insurance Plan Name or Program Name).
2320 DMG	9b	OTHER INSURED'S DATE OF BIRTH/SEX	Enter <u>date of birth</u> and <u>sex</u> , of the insured named in Field 9. The date of birth must include the month, day, and FOUR DIGITS for the year (MM/DD/YYYY). Example: 01/05/1971  <b>NOTE:</b> This field must be completed when there is an entry in Field 11d (Is There Another Health Benefit Plan?).
N/A	9c	EMPLOYER'S NAME or SCHOOL NAME	Enter the name of the <u>employer</u> or <u>school name</u> (if a student), of the insured named in Field 9.  <b>NOTE:</b> This field must be completed when there is an entry in Field 11d (Is There Another Health Benefit Plan?).
2330B NM	9d	INSURANCE PLAN NAME or PROGRAM NAME	Enter the name of the <u>insurance plan or program</u> , of the insured individual named in Field 9.  <b>NOTE:</b> This field must be completed when there is an

837P LOOP #	FIELD NUMBER	FIELD NAME	INSTRUCTIONS/EXAMPLES
			entry in Field 11d (Is There Another Health Benefit Plan?).
2300 CLM	10	IS PATIENT'S CONDITION RELATED TO:  a. Employment? b. Auto Accident? c. Other Accident?  PLACE (State) →	Check "yes" or "no" to indicate whether <u>employment</u> , <u>auto liability</u> , or <u>other accident</u> involvement applies to one or more of the services described in Field 24.  <b>NOTE:</b> If yes, there must be a corresponding entry in Field 14 (Date of Current Illness/ Injury) and in Field 21 (Diagnosis).  PLACE (State) → Enter the state the Auto Accident occurred in.
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).  <b>NOTE:</b> If "yes," then Field Items 9 and 9a-d must be completed.
2300 DTP	14	DATE OF CURRENT --Illness (First symptom) --Injury (Accident) --Pregnancy (LMP)	Enter the date of the current illness or injury. The date must include the month, day, and FOUR DIGITS for the year (MM/DD/YYYY).  Example: 01/05/2004
2300 H1	21	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the diagnosis and if applicable, enter the Supplementary Classification of External Cause of Injury and Poisoning Code.  <b>NOTE:</b> This field must be completed when there is an entry in Field 10 (Is The Patient's Condition Related To).
2320 AMT	29	AMOUNT PAID	Enter the amount paid by the primary insurance carrier in Field 29.

### 5.39 Explanation of Payment (EOP)

1		2		3		4		5		6		7		8		9		10		11		12		13		14		15		16		17		18			
1		2		3		4		5		6		7		8		9		10		11		12		13		14		15		16		17		18			
PATIENT NAME	MEMBER ID #	DATES OF SERVICE	CODE	SUBMITTED CHARGES	NEGOTIATED DISCOUNT	EXPL CODE	NON COVD CHARGES	ALLOWED AMOUNT	COPAY	DEDUCTIBLE	CO-INS	TOTAL BENEFITS																									
<b>KAISER PERMANENTE</b> Kaiser Permanente Insurance Company PO BOX 30547 SALT LAKE CITY UT 84130				ATLANTA ORTHOPAEDIC FOOT 550 PEACHTREE ST NE STE 1165 ATLANTA GA 30308				SEE LAST PAGE FOR EXPLANATION OF CODE				PROV#: 581083740AAS FAX#: 581083740 DATE: 03/25/2008 Dred #: 00001481 EDI Payor ID: 95266				Client: 4K KAI		PLAN: TEST100		257.00		257.00		U24		.00		103.91		15.00		.00		.00		.00	
CAROL BRADY	123456789	03/03/08 - 03/03/08	POV	257.00	257.00	U24	.00	103.91	15.00	.00	.00	.00																									
	081440139-00	03/03/08 - 03/03/08	SUM	218.00	.00	P9	114.09	103.91	15.00	.00	.00	88.91																									
		03/03/08 - 03/03/08	PHM	16.00	.00	P9	14.56	1.44	1.44	.00	.00	.00																									
		03/03/08 - 03/03/08	PHM	10.00	10.00	U03	.00	.00	.00	.00	.00	.00																									
<b>CLAIM TOTAL</b>				<b>501.00</b>	<b>267.00</b>		<b>128.65</b>	<b>105.35</b>	<b>16.44</b>	<b>0.00</b>	<b>0.00</b>	<b>88.91</b>																									
								<b>OTHER INSURANCE 0.00</b>	<b>Payment to Provider 88.91</b>		<b>21</b>																										
								<b>Patient Responsibility 16.44</b>	<b>Payment to Member 0.00</b>		<b>22</b>																										
SARAH NELSON	4EAB10001	03/03/08 - 03/03/08	POV	257.00	.00	SO	257.00	.00	.00	.00	.00	.00																									
	081440079-00	03/03/08 - 03/03/08	SUM	218.00	.00	SO	218.00	.00	.00	.00	.00	.00																									
		03/03/08 - 03/03/08	PHM	16.00	.00	SO	16.00	.00	.00	.00	.00	.00																									
		03/03/08 - 03/03/08	PHM	10.00	.00	SO	10.00	.00	.00	.00	.00	.00																									
<b>CLAIM TOTAL</b>				<b>501.00</b>	<b>0.00</b>		<b>501.00</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>																									
								<b>OTHER INSURANCE 0.00</b>	<b>Payment to Provider 0.00</b>		<b>21</b>																										
								<b>Patient Responsibility 501.00</b>	<b>Payment to Member 0.00</b>		<b>22</b>																										
										<b>TOTAL PAID</b>		<b>88.91</b>																									

VOID

<b>KAISER PERMANENTE</b> Kaiser Permanente Insurance Company PO BOX 30547 SALT LAKE CITY UT 84130-0547	<b>ATLANTA ORTHOPAEDIC FOOT</b> 530 PEACHTREE ST NE STE 1165 ATLANTA GA 30308 Client: 4K KAI <b>WHITE STOCK</b>	SEE LAST PAGE FOR EXPLANATION OF CODE	PROV#: 581980740AA5 TAX#: 581980740 DATE: 05/25/2008 Draft #: 00001481 EDI Payer ID: 95266
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PATIENT NAME ACCOUNT #	MEMBER ID # CLAIM #	DATES OF SERVICE	CODE	SUBMITTED CHARGES	NEGOTIATED DISCOUNT	EXPL CODE	NON COVD CHARGES	ALLOWED AMOUNT	COPAY	DEDUCTIBLE	CO-INS	TOTAL BENEFITS
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**Code Descriptions**
**Service Code Descriptions**

PLEASE NOTE: THE ATTACHED DRAFT MAY INCLUDE BENEFIT PAYMENTS FOR MORE THAN ONE OF YOUR PATIENTS. PLEASE REFER TO THIS DETAIL OF REMITTANCE LISTING TO ENSURE EACH OF YOUR PATIENTS IS CREDITED WITH THE CORRECT PAYMENT AMOUNT.

- POV OFFICE/HOME/CLINIC VISIT
- SJM SURGERY
- PJM MISCELLANEOUS PHYS SERVICE

- 25** P9 ALLOWED AMOUNT REDUCED BY COPAYMENT AS SPECIFIED BY THE PLAN.
- SO SERVICE DATES AFTER TERMINATION OF COVERAGE.
- U03 CHARGES FOR THIS PROCEDURE HAVE BEEN CONSIDERED AS PART OF THE PRIMARY PROCEDURE.
- U24 THIS PROCEDURE IS NORMALLY INCLUDED IN THE COST OF THE PRIMARY PROCEDURE WHEN PERFORMED ON THE SAME DAY.

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Screen Print Number	Field Name	Explanation
1	Payer Name & Address	Name of the payer issuing the EOP, along with address where applicable claims resubmission, supporting documentation, or overpayment refund check can be sent
2	Provider Name & Address	Name and address of the servicing Provider
3	Provider Number & TIN	Provider number noted on claim and Provider tax ID
4	Payment # & Date	Check or electronic funding transfer (EFT) draft number and date of payment
5	EDI Payer ID	EDI ID for payer issuing the Explanation of Payment (EOP)
6	Patient Name	Name of the patient to whom the services were provided to on the claim
7	SF Member ID & Claim #	Medical record number (MRN) for the patient and the unique claim number assigned to this claim
8	Date of Service	Date(s) in which services billed were rendered
9	Code	Code for the services rendered

Screen Print Number	Field Name	Explanation
10	Submitted Charges	Amount billed by the Provider for a given service
11	Negotiated Discount	Write-off amount based on claims adjudication outcome
12	Explanation Code	Reason code describing how the claim was processed
13	Non-Covered Charges	Amount billed by the Provider for services that is not covered due to limitations or exclusions defined by the patient's plan benefits
14	Allowed Amount	Amount allowed by contract or plan specification for the given service
15	Copay	Specific dollar amount that is the responsibility of the patient for a given service
16	Deductible	Specific dollar amount that is the responsibility of the patient for a given service; must be met before benefits for a given service can be paid
17	Co-Insurance	Percentage of the Allowed Amount that is the responsibility of the patient for a given service
18	Total Benefits	Amount paid by the payer for a given service
19	Other Insurance	Amount paid by another insurance under coordination of benefits
20	Patient Responsibility	Dollar amount that is the responsibility of the patient for an episode of care; total amount of copay + deductible + co-insurance
21	Payment To Provider	Amount paid by the Plan Sponsor to the servicing Provider for a given claim
22	Payment To SF Member	Amount paid by the Plan Sponsor to the SF Member for a given claim
23	Claim Total	Total amount of a given claim; sum of all submitted charges for an episode of care for a given patient
24	Total Paid	Total amount paid by the payer for all claims submitted and identified on the EOP
25	Explanation Code Description	Description of the reason code
26	Service Code Descriptions	Description of the code denoted for the services rendered

#### 5.40 Provider Claims Payment Disputes

For disputes of claims payment, contact Self-Funded Customer Service. The TPA will review the claim, to verify if the claim(s) were adjudicated correctly, according to the SF Member's benefits. If the TPA determines the correct payment was made and the dispute remains, the call will be transferred to the KPMAS Provider Relations Department.

## II.6 Section 6: Provider Rights and Responsibilities

As a Provider, you are responsible for understanding and complying with the terms of your Agreement and this section. If you have any questions regarding your rights and responsibilities under the Agreement and as described in this section, we encourage you to call our Provider Relations Department at 1-877-806-7470 for clarification.

Please note that you are required to collect cost share amounts, including co-payments, deductibles and coinsurance from SF Members, so be sure to:

- verify eligibility of SF Members prior to providing benefits, and
- collect applicable SF Member cost share including co-payments, deductibles and coinsurance as required by your Agreement.

### 6.1 Primary Care Providers' (PCP) Responsibilities

Physicians who have entered into contracts with MAPMG to serve as PCPs have responsibilities to the SF Member. These responsibilities are detailed in the contract and include:

- Responsible for providing, evaluating, triaging, and arranging for a patient's care 24 hours a day, 7 days a week - this responsibility includes the evaluation of the need and consequent arrangement of appropriate specialty referral or consultation
- Office visits during regular visit hours for the evaluation/management of common medical conditions - patient education functions may be delegated to appropriately trained staff under the PCP's supervision
- Management of patient care in hospital, skilled nursing facility, home, hospice, or acute rehabilitation unit
- Preventive care services, including well child, adolescent and adult preventive medicine, nutrition, health counseling and immunization
- Well-woman exams including breast exams and routine gynecological care with Pap and pelvic exams when the PCP is chosen by the female SF Member to render such services
- On-call coverage, 24 hours a day, 7 days a week - SF Members are entitled to access their primary care physician, or his/her designee who must be a MAPMG contracted, credentialed provider, by telephone after regular office hours
- Therapeutic injections (includes cost of medication)

- Allergy injections (includes administration, excludes cost of serum)
- Standard testing and/or rhythm strip EKGs in adults
- Basic pulmonary function tests, including timed vital capacity and maximum capacity in adults, and peak flow studies in children
- Local treatment of first degree and uncomplicated second degree burns
- Minor surgical procedures (e.g. simple skin repair, incision and drainage, removal of foreign body, benign skin lesion removal or destruction, aspiration)
- Simple splinting and treatment of fractures
- Removal of foreign body or cerumen from external ear
- Rectal exams and use of anoscopy and sigmoidoscopy
- Standard screening vision and hearing exams
- PPD skin tests
- Lab worked performed in the PCP's network office that does not require CLIA certification (e.g. urinalysis by dipstick, blood sugar by fingerstick, hemoglobin and/or hematocrit, stool occults blood, etc.)

For additional information concerning PCP responsibilities, call the Provider Relations Department at ☎ 1 (877) 806-7470.

### 6.1.1 PCP Roster Report

The PCP Roster Report identifies the Members, including SF Members, who have selected the indicated primary care physician as their PCP. On a monthly basis, PCP will receive a PCP Roster Report. This roster is mailed each month and should arrive at your office on or about the 15th day of the month. If you have any questions or problems with your PCP Roster Report, please contact Provider Relations at ☎ 1 (877) 806-7470.

### 6.1.2 Changing Primary Care Providers

Members may change their PCP by selecting a new provider from the directory and *then* contacting Customer Services representative with the new designation (See Section 5.1 for Customer Services phone numbers). Changes received by the 20<sup>th</sup> of the month will be effective the first of the following month. Otherwise, the new selection will not be effective until the subsequent month. For example, a change

made on or before April 20<sup>th</sup> would become effective on May 1; but a change made after the April 20<sup>th</sup> would not be effective until June 1.

When a PCP relocates or is no longer a Participating Provider, Kaiser Permanente sends a letter to all affected members explaining the change, when it will take place, and asking the member to select a new PCP.

Providers with questions about this process may contact the Provider Relations Department at ☎ 1 (877) 806-7470.

## **6.2 Specialty Care Providers' Responsibilities**

Specialty care Providers' Responsibilities are detailed in Section 4.8

## **6.3 Hospitals' and Facilities' Responsibilities**

Hospital and Facilities responsibilities are detailed in Section 4.10

## **6.4 Required Notices**

### **6.4.1 Change of Information**

If your office/facility changes any pertinent information such as tax identification number, phone or fax number, billing address, practice address, etc., please complete a Provider Service Form available on the Provider website at [www.providers.kp.org](http://www.providers.kp.org) under the Forms tab, including the effective date of the change

Kaiser Permanente  
Provider Relations  
2101 East Jefferson Street, 2 East  
Rockville, MD 20852  
Fax: 301-388-1700

### **6.4.2 Provider Office Status Change**

If you intend to close your practice to new patients, you are required to provide Kaiser Permanente with written notice 90 days prior to the effective date. The written notice should be mailed to the following address:

Kaiser Permanente  
Provider Relations  
2101 East Jefferson Street, 2 East  
Rockville, MD 20852  
Fax: 301-388-1700

If you would like to verify whether or not Kaiser Permanente has your practice listed as open or closed to new patients, please contact Provider Relations 1-877-806-7470

### **6.4.3 Practitioner Retirement or Termination**

A Specialty Care Physician must give 90 days notice (or longer as specified in the contract) of termination to either the MAPMG Human Resources department (for a MAPMG physician) or to the Provider Relations Department (for a participating physician). Once notice is received, the Personal Physician Program department is responsible for the written notification communicating the termination to all affected members.

Kaiser Permanente  
Provider Relations  
2101 East Jefferson Street, 2 East  
Rockville, MD 20852  
Fax: 301-388-1700

### **6.4.4 Other Required Notices**

You are required to give Kaiser Permanente notice of a variety of other events, including changes in your insurance and ownership, adverse actions involving your Practitioners' licenses, participation in Medicare, and other occurrences that may affect the provision of services under your Agreement. Your Agreement describes the required notices and manner in which notice should be provided.

## **6.5 Adding a New Practitioner**

If your office/facility would like to add a Provider to the practice please complete a Provider Service Form available of the Provider website at [www.providers.kp.org](http://www.providers.kp.org) under the Forms tab, including the effective date of the add/change.

Please note that Practitioners may not see SF Members or bill for services until they have successfully completed the credentialing process.

Kaiser Permanente  
Provider Relations  
2101 East Jefferson Street, 2East  
Rockville, MD 20852  
Fax: 301-388-1700

## 7 Section 7: Quality Assurance and Improvement

### Quality & Health Management

The KPMAS Quality of Care and Service Program applies to the patient care delivery system. The program addresses all medical, behavioral health and service activities provided to internal and external customers, Participating Providers and enrollees. All KPMAS Participating Providers and staff are involved in this process, with key staff serving on Quality of Care and Service Program Committees. Members and Participating Providers may request information about the Quality Program including a report of our progress toward quality improvement goals by calling or writing the Member Services Department at:

Kaiser Permanente  
Member Services Unit  
2101 East Jefferson Street  
Rockville, MD 20852

Inside the Local Calling Area:	☎ (301) 468-6000
Toll free Outside the Local Calling Area:	☎ 1 (800) 777-7902
TDD for the hearing impaired:	☎ (301) 816-6344

The activities that are monitored and reviewed by the Quality of Care and Service Program include, but are not limited to, the following:

- Monitoring access and member satisfaction
- Development and measurement of compliance with clinical practice guidelines and standards of care
- Focused studies of preventive and chronic care
- Identification of individual adverse outcomes and risk events
- Peer Review
- Incorporation of recommendations from external review bodies including the National Committee for Quality Assurance (NCQA) and KPMAS' Medical Directors' Quality Committee.

In addition, the Quality of Care and Service Program establishes effective monitoring and evaluation of care and services to ensure the care and service that KPMAS offers its customers meets or exceeds accepted national standards. The Program accomplishes this by:

1. Developing mechanisms to identify, monitor, evaluate and improve important aspects of care and service, including high-volume, high-risk services, by:

- Ensuring that information from monitoring and evaluation activities is disseminated and used to improve quality of care and service in inpatient, ambulatory, and affiliated settings;
  - Supporting the development and use of evidence-based clinical practice guidelines and formulating implementation plans and outcomes monitoring;
  - Ensuring full qualifications and competence of health care professionals through adherence to KPMAS's credentialing and recredentialing standards;
  - Assuring compliance with accreditation and regulatory standards;
  - Monitoring access standards and evaluating the region's compliance with these standards;
  - Providing appropriate oversight of delegated functions and monitoring delegate's performance against pre-established standards.
2. Providing consistent and timely identification and analysis of opportunities for improvement and intervention to improve care, when appropriate, by:
- Evaluating the continuity and coordination of care provided to KPMAS members;
  - Promoting member satisfaction and improvements in the health status of members;
  - Viewing complaints about care or service as opportunities for improvement;
  - Providing periodic feedback to members and practitioners regarding measurement and outcomes of quality improvement activities.
3. Improving the health status of SF Members whenever possible by:
- Continually integrating public health goals and evidence-based clinical standards into quality programs and including these in the development of benchmarks;
  - Surveying SF Members periodically about their perceived health status;
  - Promoting effective health management and case management for SF Members identified with chronic diseases;
  - Encouraging all SF Members to utilize appropriate preventive health services in order to promote member wellness;
  - Identifying and reducing access barriers for any segment of the SF Member population.
4. Continuing to be a recognized leader in local, state and national efforts to promote quality healthcare for all populations, within and outside the health plan, by:
- Collaborating with public and private health agencies in quality improvement activities;
  - Demonstrating value to purchasers through outcome-oriented quality assurance and clinical quality improvement activities;
  - Aligning the Quality Program with well-recognized public health goals.

5. Continuing to develop and implement the people strategy by increasing KPMAS employee engagement and satisfaction, attracting diverse and highly talented physicians and staff, fostering a learning environment, and ensuring continuity of organizational knowledge and culture that supports the mission, vision and values of the region by:

- Creating meaningful practices that reward the organization, physicians, staff and our members.
- Demonstrating that we respect and value our work force by:
  - Developing their competencies and rewarding their accomplishments
  - Collaborating with each individual and team in order to develop clear, targeted, and measurable expectations
  - Ensuring that highly achieving, talented, committed physicians and staff remain with the organization.

## 7.1 Clinical Practice Guidelines

Clinical practice guidelines are systematically designed tools to assist Participating Provider and patient decisions regarding specific medical conditions and preventive care. Guidelines are informational and are not intended or designed as a substitute for the reasonable exercise of independent clinical judgment by Participating Providers in any particular set of circumstances for each patient.

With the leadership of the physicians of MAPMG, KPMAS has developed and implemented a variety of clinical practice guidelines addressing preventive, acute, and chronic care for patients of all ages. All Participating Providers who deliver care to KPMAS members are invited to give input into the development and periodic review of clinical guidelines.

Preventive care guidelines include “Pediatric Preventive Care: Health Care Visits and Anticipatory Guidance” for ages 0-17, “Adult Preventive Care” for ages 18-64 and “Elder Care Preventive Care” for ages 65 and older. The type and periodicity of screenings and immunizations are described by age, gender, and risk category. “Prenatal Care” describes preventive care for average pregnant risk women.

Separate evidence-based clinical practice guidelines address the primary care management of common diagnoses such as, adult asthma, pediatric asthma, diabetes mellitus, hypertension, attention deficit hyperactivity disorder, coronary artery disease, adult depression, and chronic pain.

Clinical practice guidelines are available to KPMAS-affiliated practitioners either from the [mapmgonline.com](http://mapmgonline.com) website or by contacting the Provider Relations Department at ☎ 1 (877) 806-7470.

## 7.2 Contracted Provider Participation

Participating Providers are required through their KPMAS contract to comply with the KPMAS Quality Improvement Program. Participating Providers are given regular updates on the status of health plan activities through the Permanente Journal, the Permanente Post, Network News, and other practitioner mailings.

KPMAS encourages Participating Providers to participate in the QI program through membership and participation in Quality Improvement Committees. Participating Providers are also encouraged to provide feedback to QM staff through response to newsletter topics and through practitioner satisfaction surveys.

KPMAS provides ongoing educational services to Participating Providers through new Provider orientation materials, guide updates, Provider meetings and Provider training by provider education staff.

## 7.3 Provider Responsibilities and Rights

Provider responsibilities in the credentialing process include:

- Submission of a completed application and all required documentation before a contract is signed
- Producing accurate and timely information to ensure proper evaluation of the credentialing application
- Provision of updates or changes to their application
- Provision of a current certificate of insurance when initiating a credentialing application. A certificate of insurance must also be submitted at annual renewal.
- Cooperation with pre-credentialing site and medical record-keeping review process

Provider rights in the credentialing process include:

- Reviewing the information contained in his or her credentials file
- Correcting erroneous information contained in his or her credentials file
- Being informed, upon request, of the status of their application
- Appealing decisions of the Credentialing Committee if he/she has been denied re-credentialing, has had his/her participating status changed, been placed under a performance improvement plan, or had any adverse action taken against him/her.

These rights may be exercised by contacting the Practitioner and Provider Quality Assurance Department (PPOA) at ☎ (301) 816-5853 or by fax at (301) 816-7133. Written correspondence may also be sent to:

Kaiser Permanente  
Practitioner and Provider Quality Assurance  
2101 East Jefferson Street  
Rockville, MD 20852

#### **7.4 Credentialing & Re-credentialing Process**

The credentialing process is designed to ensure that all licensed independent practitioners and allied health practitioners under contract with the Mid-Atlantic Permanente Medical Group (MAPMG) and Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS) (collectively KPMAS) are qualified, appropriately educated, trained, and competent. All participating practitioners must be able to deliver health care according to KPMAS standards of care and all appropriate state and federal regulatory agency guidelines to ensure high quality of care and patient safety. The credentialing process follows applicable accreditation agency guidelines, such as those set forth by the National Committee for Quality Assurance (NCQA) and KPMAS.

KPMAS Participating Providers must meet MAPMG credentialing requirements. KPMAS credentialing policies and procedures are intended to protect our members and ensure quality. The Mid-Atlantic States Credentialing and Privileging Committee (MASCAP), chaired by the Associate Medical Director, Quality and Health Management (MAPMG), oversees all credentialing and re-credentialing activities.

Initial credentialing and re-credentialing are part of the practitioner/provider contract process. No Participating Provider may see KPMAS members prior to being approved through the credentialing process. All physicians who cover for participating providers must be credentialed by MAPMG. Providers will be credentialed upon initial application to the network; re-credentialing occurs every three years thereafter except for those with KP ambulatory surgery and moderate sedation privileges for whom re-credentialing occurs every two years. All Participating Providers must satisfactorily complete the re-credentialing process to maintain active status. Practitioners will be notified in writing of the actions taken to approve or disapprove the applicant for participation with KPMAS.

##### **7.4.1 Credentialing Files**

- Credentialing files remain confidential according to KPMAS policies and procedures

- Credentialing files are acted upon according to KPMAS policies and procedures

#### 7.4.2 Credentialing Process

All applications will be processed and verified according to KPMAS credentialing policies and procedures. The elements of the initial credentialing process include, but are not limited to, the following:

- Application
- License in each jurisdiction where practitioner provides services
- Out-of-state License
- DEA Certificate in each jurisdiction where practitioner provides services
- CDS Certificate
- Board Certification and Maintenance of Board Certification
- Graduate Professional Training
- Current Post-Graduate Education
- Professional School Graduation
- Hospital Privileges
- References
- Professional Liability Coverage
- Claims History
- NPDB Query
- HIPDB Query
- Work History
- Medicare and Medicaid Status and Sanctions
- Office Visit Report
- Mid-Level Practitioner Practice Agreement

#### 7.4.3 Site Visits

KPMAS Participating Primary Care Physicians, OB/GYN, and high volume Behavioral Health offices will be subject to a pre-contracting site visit. This site visit includes a review of medical record-keeping practices. The Mid-Atlantic States Credentialing and Privileging Committee and Regional Quality Assurance/Quality Improvement Committee use the review results in the selection and ongoing quality monitoring of network sites. Additional site visits may be conducted as needed based on member complaints or to meet an action plan for a previously identified deficiency. Feedback is provided to each practice with the completed site review tools and request for action plan if indicated.

#### 7.4.4 Participating Hospital Privileges

It is the policy of KPMAS to contract with and credential only those practitioners who have privileges at a participating hospital. In the event that there is a change in participating hospitals, Participating Providers with privileges at a terminated hospital will be notified of the change in hospital status, and of the need to obtain privileges at an alternative participating hospital or terminate their participation with KPMAS.

#### **7.4.5 Board Certification Policy**

If not already board certified, all physicians are required to obtain ABMS-recognized board certification in their contracted specialty at their earliest opportunity upon joining or contracting with MAPMG. Physicians will be given three opportunities to sit for the board examination. Each time that the board examination is offered is considered an opportunity. Physicians must maintain specialty board certification throughout the life of their employment or contract with MAPMG. The following boards are accepted by KPMAS:

- American Board of Medical Specialties (ABMS)
- American Osteopathic Association (AOA) Directory of Osteopathic Physicians.
- American Board of Podiatric Surgery
- American Midwifery Certification Board
- ANCC Certification for Nurse Practitioners
- NCCPA Certification for Physician Assistants
- Pediatric Nursing Certification Board

##### **7.4.5.1 Board Certification Exception Policy**

Exceptions to the requirement for board certification of Participating Providers in the specialty for which they deliver care to KPMAS members may be made in individual circumstances in accordance with the principles outlined in the MAPMG Board Certification Policy.

#### **7.4.6 Re-credentialing Process**

After initial credentialing, KPMAS Participating Providers will be re-credentialed every three (3) years except for those with KP ambulatory surgery and moderate sedation privileges who shall be re-credentialed every two (2) years by following the applicable accreditation agency guidelines, such as those set forth by the National Committee for Quality Assurance (NCQA) and Kaiser Permanente.

- Application
- License in each jurisdiction where the practitioner provides services
- Out-of-state License in each jurisdiction where the practitioner provides services
- DEA Certificate in each jurisdiction where the practitioner provides services
- CDS Certificate
- Board Certification and Maintenance of Board Certification

- Current Post-Graduate Education
- Hospital Privileges
- References
- Professional Liability Coverage
- Claims History
- NPDB Query
- HIPDB Query
- Work History
- Medicare and Medicaid Status and Sanctions
- Mid-Level Practitioner Practice Agreement
- Practitioner Profile
- Performance Evaluation

## 7.5 Notification

It is incumbent upon Participating Providers to notify the Practitioner and Provider Quality Assurance Department at ☎ (301) 816-5853 regarding any updates or changes to their application or credentials. These updates and/or changes will be reviewed according to the credentialing procedures outlined by KPMAS and will be included in the Participating Provider Credentials file. These may include, but are not limited to, the following:

- Voluntary or involuntary medical license suspension, revocation, restriction, or report filed
- Voluntary or involuntary hospital privileges reduced, suspended, revoked, or denied
- Any disciplinary action taken by a Hospital, HMO, group practice, or any other health provider organization
- Medicare or Medicaid sanctions, or any investigation for a federal healthcare program
- Medical malpractice action

## 7.6 Medical Record-Keeping Practices

KPMAS Participating Providers are responsible for maintaining the full medical record of patients who elect to receive their health care through their office. The KPMAS Medical Care Program has developed specific criteria for maintaining the medical record. These standards are a part of the periodic site review done within each network office. The standards for medical record-keeping practices and the standard requirements for medical charts are as follows:

### 7.6.1 Standards for Medical Record-Keeping Practices

1. Medical records are maintained in a confidential manner, filed in a locked cabinet and out of public view
2. Each patient has an individual medical record. Individual medical records can be easily retrieved from files, filed alphabetically or numerically
3. Each page is identified with name of patient and birth date, or medical record number
4. All progress notes are dated (including year); provider can be identified; signatures include title
5. There are biographical/personal data
6. Notes are legible
7. There is a date for return visit or a follow-up; plan for each encounter
8. Consultants' summaries, lab and imaging study results reflect primary physician review
9. Allergies and adverse reactions to medications are prominently displayed
10. There is a note from a consultant in the record if a consultation is requested
11. Significant illnesses and medical conditions are indicated on the problem list
12. There is a completed immunization record

#### **7.6.2 Standards for Medical Records for Medical Charts:**

1. Clearly identifiable patient information on each page:
  - Name
  - Date of birth/age
  - Sex
  - Medical record number
  - Physician name
  - Physician identification number
2. All progress notes will:
  - Be dated (including the year)
  - Clearly identify the provider
  - Include appropriate signatures and titles
3. Patient biographical/personal data are present

4. Notes are legible
5. Working diagnoses are consistent with findings
6. There is clear documentation of the medical treatment received by the patient
7. Plans of action and treatment are consistent with diagnosis(es)
8. There is a date for a return visit or other follow-up plan for each encounter
9. Unresolved problems from previous visit are addressed
10. There is evidence of appropriate use of consultants
11. There is evidence of continuity and coordination of care between primary and specialty physicians
12. Consultant summaries, lab, and imaging study results reflect ordering physician review as evidenced by:
  - Initials of the referring PCP following review
  - Recorded date of review
  - Comments recorded in progress note regarding interpretation and findings
  - Indication of treatment notice to patient
13. Allergies and adverse reactions to medications are prominently displayed. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record
14. There is documentation of past medical history as regards diagnoses of permanent or serious significance, and past surgeries or significant procedures. Pediatric patients will have similar documentation and/or prenatal and birth information
15. If a consultation is requested, there is a note from the consultant in the record
16. Significant illnesses and medical conditions are indicated on the problem list
17. There is a notation concerning use/non-use of cigarettes, alcohol, and substance abuse for patients 12 years of age and over
18. The history and physical document examination results with appropriate subjective and objective information for presenting complaints

19. There is evidence that preventive screening and services are offered in accordance with KPMAS's practice guidelines
20. The care appears to be medically appropriate
21. There is a completed immunization record and problem list

## 8 Section 8: Compliance

Kaiser Permanente is committed to meeting the many compliance and regulatory guidelines which are implemented in the best interest of patient quality service and overall care. Compliance and regulatory policies represent guidelines, which are both monitored and reported to many outside agencies.

For questions regarding any compliance policy or to obtain a copy of “Principles of Responsibility”, a compliance guide available to Participating Providers of Kaiser Permanente, please contact the Provider Relations Department at ☎ 1 (877) 806-7470.

Kaiser Permanente (KP) strives to demonstrate high ethical standards in its business practices. Because Providers are an integral part of KP’s business, it is important that we communicate and obtain your support for these standards. The Agreement details specific laws and contractual provisions with which you are expected to comply. This section of the guide highlights some provisions in the Agreement and provides some additional information about compliance.

### 8.1 Compliance with Law

Providers are expected to conduct their business activities in full compliance with applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and all applicable implementing regulations.

### 8.2 Kaiser Permanente Principles of Responsibility and Compliance Hotline

The Kaiser Permanente Principles of Responsibility (“POR”) is the code of conduct for Kaiser Permanente physicians, employees and contractors working in KP facilities (“KP Personnel”) in their daily work environment. You should report to Kaiser Permanente any suspected wrongdoing or compliance violations by KP Personnel under the POR. The Kaiser Permanente Compliance Hotline is a convenient and anonymous way to report a suspected wrongdoing without fear of retaliation. It is available 24 hours per day, 365 days per year. The toll free Compliance Hotline number is 1-888-774-9100.

For a copy of Kaiser Permanente Principles of Responsibility (“POR”), you may call Provider Relations at 1-877-806-7470

### **8.3 Fraud, Waste and Abuse**

Kaiser Permanente will investigate allegations of Provider fraud, waste or abuse, related to services provided to SF Members, and where appropriate, will take corrective action, including but not limited to civil or criminal action. The Federal False Claims Act and similar state laws are designed to reduce fraud, waste and abuse by allowing citizens to bring suit on behalf of the government to recover fraudulently obtained funds (i.e., “whistleblower” or “qui tam” actions). KP Personnel may not be threatened, harassed or in any manner discriminated against in retaliation for exercising their rights under the False Claims Act or similar state laws.

### **8.4 Providers Ineligible for Participation in Government Health Care Programs**

Under Kaiser Permanente policy, we will not do business with a provider if it or any of its officers, directors or employees involved in Kaiser Permanente business is, or becomes excluded by, debarred from, or ineligible to participate in any federal health care program or is convicted of a criminal offense related to the provision of health care. Kaiser Permanente expects you to (a) disclose whether any of its officers, directors or employees becomes sanctioned by, excluded from, debarred from, or ineligible to participate in any federal program or is convicted of a criminal offense related to the provision of healthcare and (b) assume responsibility for taking all necessary steps to assure that your employees and agents directly or indirectly involved in Kaiser Permanente business have not or are not currently excluded from participation in any federal program.

### **8.5 Visitation Policy**

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

### **8.6 Compliance Training**

Kaiser Permanente requires certain providers, including those who provide services in a Kaiser Permanente facility, to complete Kaiser Permanente’s Compliance Training, as required by your Agreement, applicable law or regulatory action. Where applicable, you must ensure that your employees and agents involved in Kaiser Permanente business complete the relevant Kaiser Permanente Compliance Training. Please refer to your Kaiser Permanente contract manager for more guidance regarding these requirements.

### **8.7 Provider Resources:**

- Kaiser Permanente Provider Compliance Website: [www.providers.kp.org](http://www.providers.kp.org)
- Kaiser Permanente's National Compliance Office ☎ (510) 271-4699
- Kaiser Permanente's Compliance Hotline ☎ (888) 774-9100
- Regional Compliance Office ☎ 301-816-2424
- Provider Contracting Department ☎ 1-877-806-7470

## 9 Glossary of Terms

TERM	ACRONYM	DEFINITION
Accumulator		A running total of the expenses that apply to the SF Member's deductible and out-of-pocket expenses maximum. This determines how much the Member cost share will be for current services or treatment.
AffiliateLink Website		Available in selected regions. A website that allows Providers select access to the electronic health records of any SF Member.
Avidyn		A wholly owned subsidiary of Harrington Health which will facilitate integration of utilization management information into the claims system.
ClaimCheck		A commercial code editor application utilized by the TPA for the Self-Funded product.
Coordination of Benefits	COB	A method for determining the order in which benefits are paid and the amounts which are payable when a Patient is covered under more than one plan.
Community Provider Website		A website maintained by Kaiser Permanente for Provider's ease of access to information, such as guides, and in some Regions eligibility and benefits.  <a href="http://providers.kp.org">http://providers.kp.org</a>
Current Procedural Terminology	CPT	A standard, universal medical procedures and services coding language developed and maintained by the American Medical Association (AMA). A CPT code usually consists of five digits that indicate a service or procedure. The AMA approves and updates CPT codes annually.
Electronic Data Interchange	EDI	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. KPIC encourages electronic submission of claims.
Employers Mutual Inc.	EMI	The Third Party Administrator for ambulance claims.
Explanation of Benefits	EOB	Statement notice from the TPA to the SF Member which indicates services that were billed and amounts that were paid.
Explanation of Payment	EOP	Statement notice from the TPA to the Provider when a claim is adjudicated.
Harrington Health		The Third Party Administrator for the Self-Funded program.
Harrington Health Website		Website maintained by Harrington Health that will allow Providers to check eligibility, benefit, and claims information for SF Members. <a href="http://provider.kphealthservices.com">http://provider.kphealthservices.com</a>

TERM	ACRONYM	DEFINITION
In-Network		Refers to the most restrictive level of a HMO or POS plan or the only network in an EPO plan. Customers have limited choice among providers but receive richer benefits and pay less in out-of-pocket expenses than in the other tiers.
Integrated Voice Response System	IVR	A telephone based voice response system utilized by the TPA to provide Self-Funded program related support to Providers.
Kaiser Permanente Insurance Company	KPIC	Kaiser Permanente Insurance Company (KPIC), an affiliate of Kaiser Foundation Health Plan, Inc., will be administering Kaiser Permanente's Self Funded Program. Each Self-Funded Plan Sponsor will contract with KPIC to provide administrative services for the Plan Sponsor's Self-Funded plan.
Member Cost Share		Any amount an SF Member owes for a benefited service. This can be a copay, deductible, or coinsurance.
Non-ERISA		Group health plans not regulated by the Employee Retirement Income Security Act of 1974.
Out-of-Network		Out-of-Network refers to the less restrictive, level of a POS plan. It requires higher deductibles and co- insurance for services, and usually has restrictions on certain types of benefits (such as transplants). In exchange, the customer can choose to receive care from a much broader range of providers, often from doctors who haven't contracted with the insurer for any other services.
Other Payor		For Self-Funding, the Plan Sponsor that is responsible for payment of claims in accordance with your Agreement.
Plan Sponsor		An employer or other entity that has set up a self-funded health benefits plan and has contracted with KPIC to provide administrative services for the plan.
Point-of-Service Plan	POS	A category of products in which SF Members can choose different providers and receive different levels of benefits depending on their choice at the point of care. For example, in a two-tier Point of Service (POS), SF Members receive the highest level of benefits when they use the KP system. They can also use other providers and pay a higher percentage of the cost.
Self-Funded Plan		A health plan under which an employer or other group sponsor is financially responsible for paying plan expenses, including claims made by group plan participants. Under ERISA, Self-Funded or self-insured plans are exempt from many state laws and regulations relating to premium taxes and mandated benefits. Self-Funded plans contract with KPIC for administrative services.

TERM	ACRONYM	DEFINITION
Summary Plan Description	SPD	A document provided to SF Members which describes the plan specifications as it relates to benefits coverage and administrative requirements specified by the Plan Sponsor (i.e. employer group).
Third Party Administrator	TPA	A firm that provides such services as actuarial, benefit plan design, claim processing, data recovery and analysis, and stop-loss benefits to a Self-Funded plan. These services are provided on a contract basis to a group or an insurer.
Utilization Management	UM	The process of reviewing the use of hospital resources, such as patient days, ancillary tests, medications, and surgical procedures, in order to insure appropriateness of medical care and level of care.