5. Billing and Payment

It is your responsibility to submit itemized claims for Services provided to Members in a complete and timely manner in accordance with your Agreement, this Provider Manual and applicable law. For Self-Funded products, KPIC utilizes a TPA, HealthPlan Services, a Wipro Company (formally known as Harrington Health), to process claims. The TPA reviews and adjusts claims (including coding) based on commonly accepted standards of coding and billing, and adjusts payment on claims in accordance with the terms of your Agreement, this Provider Manual and applicable law. The TPA's claim processing operation is supported by a set of policies and procedures, which direct the appropriate handling and reimbursement of claims received. KPIC also utilizes another TPA, Zelis Healthcare, to review claims to identify errors and anomalies, and to determine the appropriateness of billing. Appropriateness may include a determination of whether items are separately billable/payable under industry standard guidelines. Items or services that are considered inclusive of, or an integral part of, another procedure or service will not be reimbursed when billed separately. The Member's Plan Sponsor is responsible for payment of claims in accordance with your Agreement, this Provider Manual and applicable law. Please note that this Provider Manual does not address submission of claims under the HMO product.

5.1 Whom to Contact with Questions

If you have any questions relating to the submission of claims for services provided to Members for processing, please contact Self-Funded Customer Service at **(866) 213-3062.**

5.2 Methods of Claims Submission

Claims may be submitted by mail or electronically. Whether submitting claims on paper or electronically, only the UB-04 form will be accepted for facility/institutional services billing and only the CMS-1500 form (v 02/12), which will accommodate reporting of the individual (Type 1) NPI, will be accepted for professional services billing. Submitting claims that are handwritten, faxed or photocopied will be subject to process delay and/or rejection**.**

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

5.3 Claims Filing Requirements

5.3.1 Record Authorization Number

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

Claim Type	Electronic Claim Form	Paper Claim Form
Professional Claims	837P Loop 2300, REF01=9F, REF02=Authorization Number	CMS-1500 Box 23
Institutional (Facility Claims	837I Loop 2300, REF01=9F, REF02=Authorization Number	UB-04 Box 63

5.3.2   One Member and One Provider per Claim Form

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

- Do not bill for different Members on the same claim form
- Do not bill for different Providers (either billing or rendering) on the same claim form

5.3.3   Submission of Multiple Page Claim (CMS-1500 Form and UB-04 Form)

CMS 1500 (0212)

The CMS 1500 claim form supports 6 charge lines per form page. Multipage claim form submissions are supported to a maximum of 50 charge lines. The individual pages of the multipage claim are to be sequentially identified by printing the page numbers in the Carrier Block of the form on line 3 beginning at column 32 using the following format: Page XX of YY. The multiple pages should be attached to each other. Enter the TOTAL CHARGE on the last page of your claim submission.

UB04

The UB04 claim form supports 22 charge lines per form. Multipage claim form submissions are supported to a maximum of 999 charge lines. The individual pages of the multipage claim are to be sequentially identified by printing the page numbers in box 43 row 23. The multiple pages should be attached to each other. Enter the TOTAL CHARGE on the last page of your claim submission. Leave the TOTAL CHARGE on preceding pages of the claim blank.

5.3.4   Billing for Claims That Span Different Years

5.3.4.1 Billing Inpatient Claims that Span Different Years

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

claim form (if possible), reflecting the actual date of admission and the actual date of discharge. However, when billing professional fees on a CMS-1500 for an inpatient stay, you must submit separate claims for those services based on the year of service.

5.3.4.2 Billing Outpatient Claims That Span Different Years

All outpatient claims, SNF claims and non- Medicare Prospective Payment System (PPS) inpatient claims (e.g., critical access hospitals), which are billed on an interim basis should be split at the calendar year end. Splitting claims is necessary for the following reasons: Proper recording of deductibles, separating expenses payable on a cost basis from those paid on a charge basis, or for accounting and statistical purposes. Expenses incurred in different calendar years cannot be processed as a single claim. A separate claim is required for the expenses incurred in each calendar year.

5.3.5 Interim Inpatient Bills

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

5.4 Paper Claims

5.4.1 Submission of Paper Claims

Mail all paper claims to:

<div align="center">

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

</div>

5.5 Supporting Documentation for Paper Claims

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

- Authorization if necessary
- Discharge summary
- Operative report(s)
- Emergency room records with respect to all emergency services
- Treatment notes as reasonably relevant and necessary to determine payment

- A physician report relating to any claim under which a physician is billing a CPT-4 code with a modifier, demonstrating the need for the modifier

- A physician report relating to any claim under which a physician is billing an "Unlisted Procedure", a procedure or service that is not listed in the current edition of the CPT codebook

- Physical status codes and anesthesia start and stop times whenever necessary for anesthesia services

- Therapy logs showing frequency and duration of therapies provided for SNF services

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

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

5.6 Submission of Electronic Claims

5.6.1 Electronic Data Interchange (EDI)

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

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 U.S. Mail Delivery: The usage of envelopes and stamps is eliminated. Providers save time by bypassing the U.S. mail delivery system.

- Standardized Transaction Formats: Industry-accepted standardized medical claim formats may reduce the number of "exceptions" currently required by multiple Plan Sponsors.

5.6.2   Where to Submit Electronic Claims

Submit all electronic claims to:

Kaiser Permanente Insurance Company Payor ID #94320

5.6.3   Supporting Documentation for Electronic Claims

If submitting claims electronically, the 837 transaction contains data fields to house supporting documentation through free-text format (exact system data field within your billing application varies). If supporting documentation is required, 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 the TPA claim processor. The TPA cannot accept electronic attachments at this time.

COB remittance information can be handled directly on the 837; attachments do not need to be sent in separately via paper.

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

5.6.4   To Initiate EDI Submissions

Providers initiate EDI submissions. Providers may enroll with Change Healthcare to submit EDI directly or ensure their clearinghouse of choice has an established connection with Change Healthcare. 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 **(866) 213-3062**.

5.6.5 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 its claims processing system, the Provider then electronically "sends" all of this information to a clearinghouse (either Change Healthcare or another clearinghouse which has an established connection with Change Healthcare) 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 claim form at the following address:

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

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

- 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 information (Explanation of Payment (EOP)) via paper to the address below:

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

Clearinghouse receives electronic claims and sends to TPA: Providers should work with their EDI vendors to route their electronic claims within the Change Healthcare clearinghouse network. Change Healthcare 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 TPA 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 TPA for processing

- Transmit the data to the TPA in a format easily understood by the TPA's computer system

- Transmit electronic claim status reports from TPA 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.

5.6.6   Electronic Claims Disposition

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

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 a "reject report", which identifies specific errors on non-accepted claims. Once the claims listed on the "reject report" are corrected, the Provider may resubmit 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.

<div align="center">

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

</div>

5.6.7   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.**

<div align="center">

www.dhhs.gov   www.wedi.org   www.wpc-edi.com

</div>

5.7 **Complete Claim**

A claim is considered complete when the following requirements are met:

- Correct Form: All professional claims should be submitted using preprinted red OCR CMS-1500 and all facility claims (or appropriate ancillary services) should be submitted using preprinted red OCR UB-04based on CMS guidelines.

- Standard Coding: All fields should be completed using industry standard coding, including the use of ICD-10 code sets.

- Applicable Attachments: Attachments should be included in the submission when circumstances require additional information.

- Completed Field Elements for CMS-1500 or UB-04: All applicable data elements of CMS forms, including correct loops and segments on electronic submission, should be completed.

A claim is not considered to be complete 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 Provider information is missing, and or the applicable NPI is missing

- The billing Provider is missing, and/or the applicable NPI is missing

- The diagnosis is missing or invalid

- The place of service is missing or invalid, and/or the applicable NPI is missing

- 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.

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

5.8 Claims Submission Timeframes

It is preferred claims for services provided to Members be submitted for payment within 90 calendar days of such service. However, all EDI or paper claims and encounter data must be sent to the appropriate address no later than 365 calendar days (or any longer period specified in your Agreement or required by law) after the date of service or date of discharge, as applicable, as a condition for payment.

If a Self-Funded plan is the secondary payor, any COB claims must be submitted for processing within the same standard claims submission timeframe, determined from the date of the primary payor's Explanation of Benefits (EOB), instead of from the date of service. For example, where the standard timeframe for claim submission is 365 calendar days from date of service, a COB claim must be submitted within 365 calendar days from the date of the primary payor's EOB.

Timely filing requirement for Self-Funded claim submission is based on Payor contract specifications and may vary from Payor to Payor (contract to contract). Please contact Self-Funded Customer Service **(866) 213-3062** to obtain Payor-specific information.

5.9 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 to which the claim was submitted. Please note that hand-written or typed documentation is not acceptable proof of timely filing.

5.10 Claim Corrections

A claim correction can be submitted via the following procedures:

- **Paper Claims**—Write "CORRECTED CLAIM" in the top (blank) portion of the CMS-1500 or UB-04 claim form. Attach a copy of the corresponding page of the EOP to each corrected claim. Mail the corrected claim(s) to the standard claims mailing address listed below.

- **Electronic Claims (CMS-1500)**—Corrections to CMS-1500 claims which were already accepted (regardless whether these claims were submitted on paper or

electronically) may be submitted electronically. 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 (xx<u>X</u>) in the "Type of Bill" code will be denied.

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

5.11 <u>Incorrect Claims Payments</u>

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

- Explain the error by calling Kaiser Permanente Insurance Company at **(866) 213-3062**.

- You may also explain the error by writing to:

<div align="center">

Kaiser Permanente Insurance Company
PO Box 30547
Salt Lake City, UT 84130-0547

</div>

- Upon verification of the error, appropriate corrections will be made by the TPA.

- The underpayment amount owed will be added to/reflected in the next payment.

- Providers will be notified in writing of the overpayment amount. You may write a refund check to Kaiser Permanente Insurance Co. (KPIC) for the exact excess amount paid to you within the timeframe specified by the Agreement. Attach a copy of the EOP to your refund check, as well as a brief note explaining the error. Mail the refund check to:

<div align="center">

Kaiser Permanente Insurance Co.
Attn: Claims Recovery Unit
P.O. Box 741025
Los Angeles, CA 90074-1025

</div>

If an overpayment refund is not received by KPIC in accordance with the terms and timeframe specified by the Agreement, the overpayment amount will be automatically deducted from your next claim payment.

5.12 **Federal Tax ID Number**

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

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

- Name: This should be the Provider's "entity name," which is used to file tax forms with the IRS.

- Sole Provider/Proprietor: List your name, as registered with the IRS.

- Group Practice/Facility: List the "group" or "facility" name, as registered with the IRS.

- Business Name: Leave this field blank unless you have registered with the IRS as a "Doing Business As" (DBA) entity. If you are doing business under a different name, enter that name on the IRS Form W-9.

- Address/City, State, Zip Code: Enter the address where IRS Form 1099 should be mailed.

- 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.

  o Sole Provider/Proprietor: Enter the Provider's taxpayer identification number, which will usually be a social security number (SSN), unless the Provider has been assigned a unique employer identification number (because the Provider is "doing business as" an entity under a different name).

  o Group Practice/Facility: Enter the Provider's taxpayer identification number, which will usually be the Provider's 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.

5.13 **Federal Tax ID Number Changes**

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

5.14 Self-Funded Member Cost Share

Please verify applicable Member cost share at the time of service. Depending on the benefit plan, Members may be responsible to share some cost of the services provided. Co-payments, co-insurance and deductibles (collectively, "Cost Share") are the fees a Member is responsible to pay a Provider for certain covered services. This information varies by plan. All Providers are responsible for collecting Cost Share in accordance with the Member's benefits. Cost Share information can be obtained from:

Option	Description
#1	Self-Funded Customer Service **(866) 213-3062** Monday–Friday from 7 A.M. to 9 P.M. Eastern Time Zone (ET) (4 A.M. to 6 P.M. Pacific Time Zone (PT) Self-Service IVR System is available 24 hours / 7 days a week
#2	Self-Funded Plan Website **https://kpclaimservices.com** 24 hours / 7 days a week

5.15 Self-Funded Member Claims Inquiries

Direct claims inquiries to Self-Funded Customer Service at **(866) 213-3062**.

5.16 Billing for Services Provided to Visiting Self-Funded Members

When submitting claims for services rendered to a visiting Member, the following process should be followed. Reimbursement for services provided to visiting Members will reflect the visiting Member's benefits:

- Claims must be submitted to the "Mail claims to" address on the back of the visiting Member's Health Insurance ID Card.

- If the Member does not have their Health Insurance ID Card, submit your claims to:

KPIC Self-Funded Claims Administration
P. O. Box 30547
Salt Lake City, UT 84130-0547

- **Always** use the visiting Member's "Home" region MRN (ID number on the card) on the claim form

- Claims for services requiring prior KP authorization **must** include the authorization number

Please contact KPIC Self-Funded Customer Service at **(866) 213-3062** during the hours of 7:00 am to 9:00 pm EST.

5.17 <u>Coding for Claims</u>

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 they are in compliance with KPIC's coding standards. Incorrect and invalid coding may result in delays in payment or denial of payment. All coding must follow KPIC's standards, including those specified in Section 5.18below. Submitting claims that use nonstandard, outdated or deleted CPT, HCPCS, ICD-10, or Revenue codes, or are otherwise outside the coding standard adopted by KP will subject the claim to processing delay and/or rejection.

5.18 <u>Coding Standards</u>

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

ICD-10
To code diagnoses and hospital procedures on inpatient claims, use the International Classification of Diseases- 10th Revision-Clinical Modification (ICD-10-CM) and International Classification of Diseases – 10th Revision – Procedure Coding System (ICD-10-PCS) developed by the Commission on Professional and Hospital Activities. ICD-10-CM codes appear as three-, four-, five-, six-, or seven-digit codes, depending on the specific disease or injury being described. ICD-10-PCS hospital inpatient procedure codes appear as seven-digit codes.

CPT-4
The Physicians' Current Procedural Terminology, 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.

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 Codes & Condition Codes
Consult your NUBC UB-04 Data Specifications Manual for a complete listing.

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

5.19 Modifiers Used in Conjunction with CPT and HCPCS Codes

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

When submitting claims, use modifiers to:

- Identify distinct or independent services performed on the same day

- Reflect services provided and documented in a Member's medical record

5.20 Modifier Review

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

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

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

5.21 Coding Edit Rules

The table below identifies common edit rules.

Edit Category	Description	Self-Funded Edit
Rebundling	Recoding a claim featuring two (2) or more component codes billed for a group of procedures which are covered by a single comprehensive code	Apply
Incidental	Procedure performed at the same time as a more complex primary procedure	Deny if procedure deemed to be incidental

Edit Category	Description	Self-Funded Edit
	Procedure is clinically integral component of a global service	Deny if procedure deemed to be incidental
	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
Duplicate Procedures	Category I--Bilateral: Shown twice on submitted claim	Allow one procedure per date of service; second procedure denied
	Category II- Unilateral/Bilateral shown twice on submitted claim;	Allow only one procedure per date of service; second procedure denied
	Category III- Unilateral/single CPT shown twice	Replace with corresponding Bilateral or multiple code
	Category IV- Limited by date of service, lifetime or place of service	Allow/deny based on Plan's Allowable Limits
	Category V--Not addressed by Category I-IV	Pend for Review
Medical Visits/Pre- & Post-Op Visits	Based on Surgical Package guidelines; Audits across dates	Deny E&M services within Pre- and Post-op Timeframe
Cosmetic	Identifies procedures requiring review to determine if they were performed for cosmetic reasons only	Review for appropriateness and indication
Experimental	Codes defined by CMS and AMA in CPT and HCPCS manuals to be experimental	Pend for Review
Obsolete	Procedures no longer performed under prevailing medical standards	Review for appropriateness and indication

5.22 Do Not Bill Events (DNBE)

Depending on the terms of your Agreement, you may not be compensated for Services directly related to any Do Not Bill Event (as defined below) and may be required to waive Member Cost Share associated with and hold Members harmless from any liability for Services directly related to any DNBE. KP expects you to report every DNBE as set forth in Section 7.4.5of this Provider Manual. KP ASO will reduce compensation for Services directly related to a DNBE when the value of such Services can be separately quantified in accordance with the applicable payment methodology. DNBE shall mean the following:

In any care setting, the following surgical errors identified by CMS in its National Coverage Determination issued June 12, 2009[2] (SE):

- Wrong surgery or invasive procedure[3] on patient

- Surgery or invasive procedure on wrong patient

- Surgery or invasive procedure on wrong body part

Specifically, in an acute care hospital setting, the following hospital acquired conditions identified by CMS on August 19, 2008[4] (together, with RFO-HAC, as defined below (HACs)) if not present upon admission:

- Intravascular air embolism

- Blood incompatibility (hemolytic reaction due to administration of ABO/HLA incompatible blood or blood products)

- Pressure ulcer (stage three or four)

- Falls and trauma (fracture, dislocation, intracranial injury, crushing injury, burn, electric shock)

- Catheter-associated urinary tract infection

- Vascular catheter-associated infection

- Manifestation of poor glycemic control (diabetic ketoacidosis, nonketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, secondary diabetes with hyperosmolarity)

- Surgical site infection, mediastinitis, following coronary artery bypass graft

- Surgical site infection following orthopedic procedures (spine, neck, shoulder, elbow)

- Surgical site infection following bariatric surgery for obesity (laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery)

- Surgical site infection following Cardiac Implantable Electronic Device (CIED)

- Iatrogenic Pneumothorax with Venous Catheterization

---

[2] See, CMS Manual System, Department of Health and Human Services, Pub 100-03 Medicare National Coverage Determinations, Centers for Medicare and Medicaid Services, Transmittal 101, June 12, 2009 (https://www.cms.gov/transmittals/downloads/R101NCD.pdf).

[3] 'Surgical and other invasive procedures' is defined by CMS as "operative procedures in which skin or mucous membranes and connective tissue are incised or an instrument is introduced through a natural body orifice. 'Invasive procedures' include a "range of procedures from minimally invasive dermatological procedures (biopsy, excision, and deep cryotherapy for malignant lesions) to extensive multi-organ transplantation. They include all procedures described by the codes in the surgery section of the Current Procedural Terminology (CPT) and other invasive procedures such as percutaneous transluminal angioplasty and cardiac catheterization. They include minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through needle or trocar."

[4] See, 73 Federal Register 48433, pages 48471-48491 (August 19, 2008) (http://edocket.access.gpo.gov/2008/pdf/E8-17914.pdf; https://www.cms.gov/HospitalAcqCond/Downloads/HACFactsheet.pdf).

- Deep vein thrombosis or pulmonary embolism following orthopedic procedures (total knee or hip replacement)

- Any new Medicare fee-for-service HAC later added by CMS

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

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

5.23 <u>Claims for Do Not Bill Events</u>

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

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

- <u>UB-04</u> – If you submit a UB-04 Claim (or its successor) for inpatient or outpatient facility Services provided to a Member wherein a HAC (Including an RFO-HAC) has occurred, you must include the following information:

  o **DRG.** If, under the terms of your Agreement, such Services are reimbursed on a DRG basis, you must include the applicable ICD-10 codes, present on admission indicators, and modifiers as set forth in the following table and as otherwise required for the Medicare fee-for-service program.

  o **Other Payment Methodologies.** If, under the terms of your Agreement, such Services are reimbursed on a payment methodology other than a DRG and the terms of your Agreement state that you will not be compensated for Services directly related to a DNBE, you must split the Claim and submit both a Type of Bill (TOB) '110' (no-pay bill) setting forth all Services directly related to the DNBE including the applicable ICD-10) codes, present on admission indicators, and modifiers as set forth in the following table and as otherwise required for the Medicare fee-for-service program, and a TOB '11X (with the exception of 110)' setting forth all Covered Services not directly related to the DNBE.

Completion of the Present on Admission (POA) field is required on all primary and secondary diagnoses for inpatient Services for all bill types. Any condition labeled with a

POA indicator other than 'Y' [5] shall be deemed hospital-acquired.[6] All claims must utilize the applicable HCPCS modifiers with the associated charges on all lines related to the surgical error, as applicable.

5.24 CMS-1500 (02/12) Field Descriptions

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

Field Number	Field Name	Required Fields for Claim Submissions	Instructions/Examples
1	MEDICARE/ MEDICAID/ TRICARE / 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 patient's KP Medical Record Number (MRN)
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). Example: 01/05/2006
4	INSURED'S NAME	Required	Enter the name of the insured, i.e., policyholder (Last Name, First Name, and Middle Initial), unless the insured and the patient are the same—then the word "SAME" may be entered. If this field is completed with an identity different than that of the patient, also complete Field 11.
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 nine digits ZIP CODE and PHONE NUMBER.

---

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

[6] See, CMS Manual System, Department of Health and Human Services, Pub 100-04 Medicare Claims Processing, Centers for Medicare and Medicaid Services, Transmittal 1240, Change Request 5499, May 11, 2007 (https://www.cms.gov/transmittals/downloads/R1240CP.pdf).

Field Number	Field Name	Required Fields for Claim Submissions	Instructions/Examples
6	PATIENT'S RELATIONSHIP TO INSURED	Required	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 nine digits ZIP CODE) and telephone number. When the address is the <u>same</u> as the patient's—the word "SAME" may be entered.
8	RESERVED FOR NUCC USE	Not Required	Leave blank.
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. NOTE: For each entry in Field 9A, there must be a corresponding entry in Field 9D.
9B	RESERVED FOR NUCC USE	Not Required	Leave blank.
9C	RESERVED FOR NUCC USE	Not Required	Leave blank.
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'S 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. NOTE: If "yes" there must be a corresponding entry in Field 14 (Date of Current Illness/Injury). Place (State) - enter the State postal code.
10D	CLAIM CODES (Designated by NUCC)	Not Required	Leave blank.
11	INSURED'S POLICY NUMBER OR FECA NUMBER	Required if Applicable	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

Field Number	Field Name	Required Fields for Claim Submissions	Instructions/Examples
11B	OTHER CLAIM ID (Designated by NUCC)	Not Required	Leave blank.
11C	INSURANCE PLAN OR PROGRAM NAME	Required if Applicable	Enter the insured's 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.\n\nIf "yes" then fields 9 and 9A-9D must be completed.
12	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Required if Applicable	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	Required	Have the patient or an authorized representative SIGN this block unless the signature is on file.
14	DATE OF CURRENT ILLNESS, INJURY, PREGNANCY (LMP)	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).\n\nExample: 01/05/2006
15	OTHER DATE	Not Required	Leave blank.
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).\n\nExample: 01/05/2003
17	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	Required if Applicable	Enter the FIRST and LAST NAME of the KP referring or KP ordering physician.
17A	OTHER ID #	Not Required	
17B	NPI NUMBER	Required	Enter the NPI number of the KP referring provider
18	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	Required if Applicable	Complete this block when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

Field Number	Field Name	Required Fields for Claim Submissions	Instructions/Examples
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	Not Required	Leave blank.
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-10 code number. Enter up to 12 diagnosis codes, in PRIORITY order (primary, secondary condition). Enter the ICD indicator in the upper right corner of this field ("9" = ICD9 "0" = ICD10)
22	RESUBMISSION	Not Required if Applicable	If submitting a corrected claim, please enter one of the following codes: 7 – Replacement claim 8 – Voided claim
23	PRIOR AUTHORIZATION NUMBER	Required if Applicable	For ALL inpatient and outpatient claims, enter the KP referral/authorization number, if applicable, for the episode of care being billed. NOTE: this is a 9-digit numeric identifier.

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

Field Number	Field Name	Required Fields for Claim Submissions	Instructions/Examples
24B	PLACE OF SERVICE	Required	Enter the place of service code for each item used or service performed.
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. IMPORTANT: 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 reference number (pointer) as it relates the date of service and the procedures shown in Field 21. When multiple services are performed, the primary reference number for each service should be listed first, and other applicable services should follow. The reference character(s) should be an A through L; or multiple letters as explained. IMPORTANT: (ICD-10-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.

Field Number	Field Name	Required Fields for Claim Submissions	Instructions/Examples
24G	DAYS OR UNITS	Required	Enter the number of days or units in this block. (For example: units of supplies, etc.)
			IMPORTANT: As noted in the instructions for Field Number 24D, enter the total anesthesia time in minutes, reported as the "beginning" and "end" times, in military.
			When entering the NDC units in addition to the HCPCS units, enter the applicable NDC 'units' qualifier and related units in the shaded line. The following qualifiers are to be used:
			F2 - International Unit
			ML - Milliliter
			GR - Gram
			UN Unit
			ME – Milligram
24H	EPSDT FAMILY PLAN	Not Required	
24I	ID. QUAL	Required if provider does not qualify for NPI	Enter the 2-digit qualifier of the non-NPI identifier. In the shaded area. The non-NPI identifier number for the qualifier of the rendering provider is reported in 24J in the <u>shaded area</u>. The NUCC defines the following qualifiers:
			0B - State License Number
			1B - Blue Shield Provider Number
			1C - Medicare Provider Number
			1D - Medicaid Provider Number
			1G - Provider UPIN Number
			1H - CHAMPUS Identification Number
			EI - Employer's Identification Number
			G2 - Provider Commercial Number
			LU - Location Number
			N5 - Provider Plan Network Identification Number
			SY - Social Security Number (The social security number may not be used for Medicare.)
			X5 - State Industrial Accident Provider Number
			ZZ - Provider Taxonomy

Field Number	Field Name	Required Fields for Claim Submissions	Instructions/Examples
24J	RENDERING PROVIDER ID #	NPI required unless provider does not qualify for one OTHERWISE Other ID number as applicable	Enter the NPI number for the rendering provider in the non-shaded area of the field OTHERWISE Enter the non-NPI identifier number in the shaded area of the field. Report the Identification Number in Items 24I and 24J only when different from data recorded in Fields 33A and 33B.
25	FEDERAL TAX ID NUMBER	Required	Enter the physician/supplier federal tax I.D. number or Social Security number of the billing provider identified in Field 33. Enter an X in the appropriate box to indicate which number is being reported. Only one box can be marked. IMPORTANT: The Federal Tax ID Number in this field must match the information on file with the IRS.
26	PATIENT'S ACCOUNT NO.	Required	Enter the patient's account number assigned by the Provider's accounting system, i.e., patient control number. IMPORTANT: This field aids in patient identification by the Provider.
27	ACCEPT ASSIGNMENT	Not Required	
28	TOTAL CHARGE	Required	Enter the total charges for the services rendered (total of all the charges listed in Field 24F).
29	AMOUNT PAID	Required if Applicable	Enter amount paid by other payer. Do not report collections of patient cost share
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	Enter the signature of the physician/supplier or their representative, and the date the form was signed. For claims submitted electronically, include a computer printed name as the signature of the health care Provider or person entitled to reimbursement.

Field Number	Field Name	Required Fields for Claim Submissions	Instructions/Examples
32	SERVICE FACILITY LOCATION INFORMATION	Required if Applicable	The name and address of the facility where services were rendered (if other than patient's home or physician's office).
			Enter the name and address information in the following format:
			1st Line – Name
			2nd Line – Address
			3rd Line – City, State and Zip Code
			Do not use commas, periods, or other punctuation in the address (e.g., "123 N Main Street 101" instead of "123 N. Main Street, #101). Enter a space between town name and state code; do not include a comma. When entering a 9-digit zip code, include the hyphen.
32A	NPI #	Required unless provider does not qualify for one	Enter the NPI number of the service facility if it is an entity external to the billing provider.
32B	OTHER ID #	Required if facility does not qualify for an NPI in field 32A	Enter the 2-digit qualifier (See filed 24 I, "ID QUAL") identifying the non-NPI identifier followed by the ID number of the service facility. Do not enter a space, hyphen, or other separator between the qualifier and number.
33	BILLING PROVIDER INFO & PH #	Required	Enter the name, address and phone number of the billing entity.
33A	NPI #	Required unless provider does not qualify for one	Enter the NPI number of the billing provider.
33B	OTHER ID #	Required if provider does not qualify for an NPI in field 33A	Enter the 2-digit qualifier (See filed 24 I, "ID QUAL") identifying the non-NPI number followed by the ID number of the billing provider. Do not enter a space, hyphen, or other separator between the qualifier and number. If available, please enter your unique provider or vendor number assigned by KP.

KAISER PERMANENTE®

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

CARRIER

[ ] [ ] [ ] PICA

PICA [ ] [ ]

1. MEDICARE (Medicare#) **MEDICAID** (Medicaid#) **TRICARE** (ID#/DoD#) **CHAMPVA** (Member ID#) **GROUP HEALTH PLAN** (ID#) **FECA BLK LUNG** (ID#) **OTHER** (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 [ ] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY **STATE**

8. RESERVED FOR NUCC USE

CITY **STATE**

ZIP CODE **TELEPHONE (Include Area Code)** ( )

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 [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY **SEX** M [ ] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [ ] **PLACE (State)**

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes, complete items 9, 9a, and 9d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED_____ DATE_____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED_____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] **$ CHARGES**

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) **ICD Ind.**
A. ___ B. ___ C. ___ D. ___
E. ___ F. ___ G. ___ H. ___
I. ___ J. ___ K. ___ L. ___

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE						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. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
From			To											
MM	DD	YY	MM	DD	YY									
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 [ ] NO [ ]

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED_____ DATE_____

32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.

33. BILLING PROVIDER INFO & PH # ( ) a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

5.25 UB-04 (CMS-1450) Field Descriptions

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

Field Number	Field Name	Required Fields for Claim Submissions	Instructions/Examples
1	PROVIDER NAME and ADDRESS	Required	Enter the name and address of the billing provider which rendered the services being billed.
2	PAY-TO NAME, ADDRESS, CITY/STATE, ID #	Required if Applicable	Enter the name and address of the billing provider's designated pay-to entity.
3a	PATIENT CONTROL NUMBER	Required	Enter the patient's account number assigned by the Provider's accounting system, i.e., patient control number. IMPORTANT: This field aids in patient identification by the Provider.
3b	MEDICAL / HEALTH RECORD NUMBER	Required if Applicable	Enter the number assigned to the patient's medical/health record by the Provider. Note: this is not the same as either Field 3a or Field 60.
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 in NN-NNNNNNN format.
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 / ID	Required	Enter the patient's name, together with the patient ID (if different than the insured's ID).
9	PATIENT ADDRESS	Required	Enter the patient's mailing address.
10	PATIENT BIRTH DATE	Required	Enter the patient's birth date in MM/DD/YYYY format.
11	PATIENT SEX	Required	Enter the patient's gender.
12	ADMISSION DATE	Required if Applicable	For inpatient and Home Health claims only, enter the date of admission in MM/DD/YYYY format.
13	ADMISSION HOUR	Required	For either inpatient OR outpatient care, enter the 2-digit code for the hour during which the patient was admitted or seen.

Field Number	Field Name	Required Fields for Claim Submissions	Instructions/Examples
14	ADMISSION TYPE	Required	Indicate the type of admission (e.g., emergency, urgent, elective, and newborn).
15	ADMISSION SOURCE	Required	Enter the code for the point of origin of the admission or visit.
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 as of the "Through" date of the billing period.
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 (in MM/DD/YYYY format) defining a significant event relating to this billing period that may affect claims processing.
35-36	OCCURRENCE SPAN CODES AND DATES	Required if Applicable	Enter the occurrence span code and associated dates (in MM/DD/YYYY format) defining a significant event relating to this billing period that may affect claims processing.
37	BLANK	Not Required	Leave blank.
38	RESPONSIBLE PARTY	Not Required	Enter the name and address of the financially responsible party.
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 to each charge.
43	REVENUE DESCRIPTION	Required if Applicable	Enter the narrative revenue description or standard abbreviation to assist clerical bill review. The National Drug Code (NDC) number is REQUIRED in this field on claims for which a clinic-administered medication (CAM) was provided.
44	PROCEDURE CODE AND MODIFIER	Required if Applicable	For ALL outpatient claims, enter BOTH a revenue code in Field 42 (*Rev. CD.*), and the corresponding CPT/HCPCS procedure code in this field.

Field Number	Field Name	Required Fields for Claim Submissions	Instructions/Examples
45	SERVICE DATE	Required	Outpatient Series Bills: A service date must be entered for all outpatient series bills whenever the "from" and "through" dates in Field 6 (*Statement Covers Period: From/Through*) are not the same. Submissions that are received without the required service date(s) will be rejected with a request for itemization. Multiple/Different Dates of Service: 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 (*Field 42*), procedure code (*Field 44*), and total charges (*Field 47*).
46	UNITS OF SERVICE	Required	Enter the units of service to quantify each revenue code category. IMPORTANT: SNF Providers billing for Supportive Services and Home Health Providers billing for Services in excess of a 2-hour visit should enter the **total number of 15 minute units** of authorized Services provided to Members, regardless of the time unit assigned to the applicable payment rate in your contract (e.g., rate per hour).
47	TOTAL CHARGES	Required	Indicate the total charges pertaining to each related revenue code for the current billing period, as listed in Field 6.
48	NON COVERED CHARGES	Required if Applicable	Enter any non-covered charges.
49	BLANK	Not Required	Leave blank.
50	PAYER NAME	Required	Enter (in appropriate ORDER on lines A, B, and C) the NAME and NUMBER of each payer organization from which you are expecting payment towards the claim.
51	HEALTH PLAN ID	Not Required	Enter the Plan Sponsor identification number.
52	RELEASE OF INFORMATION (RLS INFO)	Required if Applicable	Enter the release of information certification indicator(s).
53	ASSIGNMENT OF BENEFITS (ASG BEN)	Required	Enter the assignment of benefits certification indicator.

KAISER PERMANENTE.

Field Number	Field Name	Required Fields for Claim Submissions	Instructions/Examples
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 (*Payer*) prior to the billing date, enter the amounts here.
55	ESTIMATED AMOUNT DUE	Required if Applicable	Enter the estimated amount due from patient. Do not report collection of patient's cost share.
56	NATIONAL PROVIDER IDENTIFIER (NPI)	Required	Enter the billing provider's NPI.
57	OTHER PROVIDER ID	Required	Enter the service Provider's KP-assigned Provider ID, if any
58	INSURED'S NAME	Required	Enter the insured's name, i.e., policyholder.
59	PATIENT'S RELATION TO INSURED	Required	Enter the patient's relationship to the insured.
60	INSURED'S UNIQUE ID	Required	Enter the patient's KP Medical Record Number (MRN).
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. For Prepaid Services claims enter "PPS".
63	TREATMENT AUTHORIZATION CODE	Required if Applicable	For ALL inpatient and outpatient claims, enter the KP referral/authorization number, if applicable, for the episode of care being billed. NOTE: this is a 9-digit numeric identifier.
64	DOCUMENT CONTROL NUMBER	Not Required	Enter the document control number related to the patient or the claim as assigned by KP.
65	EMPLOYER NAME	Required if Applicable	Enter the name of the insured's (Field 58) employer.
66	DX VERSION QUALIFIER	Not Required	Indicate the ICD version indicator of codes being reported. ("9" = ICD9; "0" = ICD10)
67	PRINCIPAL DIAGNOSIS CODE	Required	Enter the principal diagnosis code, on all inpatient and outpatient claims. Enter POA (Present on Admit) indicator in the shaded area on the right side of the principal ICD.

Field Number	Field Name	Required Fields for Claim Submissions	Instructions/Examples
67A-Q	OTHER DIAGNOSES CODES	Required if Applicable	Enter other diagnoses codes corresponding to additional conditions that coexist or develop subsequently during treatment. Diagnosis codes must be carried to their highest degree of detail. At the time of printing, KP only accepts ICD-10-CM diagnosis codes on the UB-04. ICD-10 standards for paper and EDI claims will be implemented by KP for outpatient dates of service and inpatient discharge dates on/after October 1, 2015. Enter POA (Present on Admit) indicator in the shaded area on the right side of the principal ICD.
68	BLANK	Not Required	Leave blank.
69	ADMITTING DIAGNOSIS	Required	Enter the admitting diagnosis code on all inpatient claims.
70a-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 to 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-10 "VWXY" code in this field (*if applicable*).
73	BLANK	Not required	Leave blank.
74	PRINCIPAL PROCEDURE CODE AND DATE	Required if Applicable	Enter the ICD-10 procedure CODE and DATE on all inpatient AND outpatient claims for the principal surgical and/or obstetrical procedure which was performed (*if applicable*).
74a-e	OTHER PROCEDURE CODES AND DATES	Required if Applicable	Enter other ICD-10 procedure CODE(S) and DATE(S) on all inpatient AND outpatient claims (*in fields "A" through "E)* for any additional surgical and/or obstetrical procedures which were performed (*if applicable).*
75	BLANK	Not required	Leave blank.

Field Number	Field Name	Required Fields for Claim Submissions	Instructions/Examples
76	ATTENDING PHYSICIAN / NPI / QUAL / ID	Required	Enter the NPI and the name of the attending physician for inpatient bills or the KP physician that requested the outpatient services. Inpatient Claims—Attending Physician Enter the full name (first and last name) of the physician who is responsible for the care of the patient. Outpatient Claims—Referring Physician For ALL outpatient claims, enter the full name (first and last name) of the KP physician who referred the Patient for the outpatient services billed on the claim.
77	OPERATING PHYSICIAN / NPI/ QUAL/ ID	Required If Applicable	Enter the NPI and the name of the lead surgeon who performed the surgical procedure.
78-79	OTHER PHYSICIAN/ NPI/ QUAL/ ID	Required if Applicable	Enter the NPI and name of any other physicians.
80	REMARKS	Not Required	Special annotations may be entered in this field.
81	CODE-CODE	Required if Applicable	Enter the code qualifier and additional code, such as marital status, taxonomy, or ethnicity codes, as may be appropriate.

Form UB-04

5.26 Coordination of Benefits (COB)

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

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

Providers are required to cooperate with the administration of COB, which may include, without limitation, seeking authorization from another payor (if authorization is required) and/or responding to requests for medical records.

5.26.1 How to Determine the Primary Payor

Primary coverage is determined using the following guidelines. Examples are:

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

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

- Natural parent with custody pays first
- Stepparent with custody pays next
- Natural parent without custody pays next
- Stepparent without custody pays last

If the parents have joint custody of the dependent child, then benefits are applied according to the birthday rule referenced above. For questions, call Self-Funded Customer Service at **(866) 213-3062**.

- The Self-Funded plan is generally primary for working Medicare-eligible Members when the CMS Working Aged regulation applies.

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

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

- In cases of services for injuries sustained in vehicle accidents or other types of accidents, primary payor status is determined on a jurisdictional basis. Submit the claim as if the Self-Funded plan is the primary payor. The TPA will follow its standard payment procedures.

5.26.2 Description of COB Payment Methodology

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

5.26.3 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:

Paper Claims

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

- CMS-1500 claim form: Complete Field 29 (Amount Paid)

- UB-04 claim form: Complete Field 54 (Prior Payments)

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

5.26.4 Direct Patient Billing

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

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

5.26.5 Workers' Compensation

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

- Document that the Member indicates the illness or injury occurred "on the job" on the claim

- Complete applicable fields on the billing form indicating a work related injury

- Submit the claim to the Member's Workers' Compensation carrier/plan

If the Member's Workers' Compensation carrier/plan ultimately denies the Workers' Compensation claim, you may submit the claim for covered services to KP in the same manner as you submit other claims for services. You must also include a copy of the denial letter or Explanation of Payment from the Workers Compensation carrier

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

5.26.6 Members Enrolled in Two KP Plans

Some Members may be enrolled under 2 separate plans offered through KP (dual coverage). In these situations, Providers need only submit ONE claim under the primary plan and send to either the TPA (for Self-Funded plan) or KP (for fully insured plan) depending on which plan is primary. KP and the TPA will coordinate available benefits.

5.26.7 COB Claims Submission Timeframes

If a Self-Funded plan is the secondary payor, any COB claims must be submitted for processing within the timely filing period according to the standard claims submission timeframe as specified in Section 5.8 of this Provider Manual. The determination is based on the date of the primary payor's EOB, instead of from the date of service.

5.26.8 COB Fields on the CMS-1500 Claim Form

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

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

837P Loop#	Field Number	Field Name	Instructions/Examples
2330A NM	9	OTHER INSURED'S NAME	When **additional** insurance coverage exists (through a spouse, parent, etc.) enter the LAST NAME, FIRST NAME, and MIDDLE INITIAL of the insured. <u>**NOTE:**</u> 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. <u>**NOTE:**</u> Field 9a must be completed when there is an entry in Field 11D (Is there another health benefit plan?). <u>**NOTE:**</u> 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** <u>**NOTE:**</u> 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**. <u>**NOTE:**</u> This field must be completed when there is an entry in Field 11D (Is there another health benefit plan?).

837P Loop#	Field Number	Field Name	Instructions/Examples
2330B NM	9d	INSURANCE PLAN NAME or PROGRAM NAME	Enter the <u>name of the insurance plan or program</u>, of the insured individual named in **Field 9**. **NOTE:** This field must be completed when there is an entry in Field 11D (Is there another health benefit plan?).

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**.
			NOTE: 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). **NOTE:** 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. **NOTE:** 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.

5.26.9 COB Fields on the UB-04 Claim Form

The following fields should be completed on the **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 <u>electronically</u> 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	**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. <u>**NOTE**</u>: If the injuries are a result of an accident, please complete **Field 77 (E-Code)**
2330B NM	**50**	**PAYER** *(Payer Identification)*	Enter the **name** and **number** *(if known)* 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** *(Payers and Patient)*	Enter the **amount(s)**, if any, that the Provider has received **toward payment of the bill** <u>PRIOR</u> to the 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

837I Loop #	Field Number	Field Name	Instructions/Examples
2330A NM	58	**INSURED'S NAME**	Enter the **name** *(Last Name, First Name)* 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 **NOTE:** For each entry in *Field 58*, there MUST be corresponding entries in *Fields 59 through 62* (UB-92 and UB-04) AND *64 through 65 (Field 65 only on the UB-04).*
2320 SBR	59	**Patient's Relationship To Insured**	Enter the **code** indicating the **relationship** of the patient to the insured individual(s) listed in **Field 58** *(Insured's Name).* List entries in the **following order:** A = **primary** payer B = **secondary** payer C = **tertiary** payer
2330A NM	60	**CERT. – SSN – HIC – ID NO.** *(Certificate/Social Security Number/Health Insurance Claim/Identification Number)*	Enter the insured person's *(listed in Field 58)* unique **individual Member identification number** (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** *(Insured Group Name)*	Enter the **name** of the **group or plan** through which the insurance is being provided to the insured individual *(listed in Field 58).* Record entries in the **following order**: A = **primary** payer B = **secondary** payer C = **tertiary** payer
2320 SBR	62	**INSURANCE GROUP NO.**	Enter the **identification number, control number**, or **code** assigned by the carrier or administrator to identify the **GROUP** under which the individual *(listed in Field 58)* is covered. List entries in the **following order**: A = **primary** payer B = **secondary** payer C = **tertiary** payer

837I Loop #	Field Number	Field Name	Instructions/Examples
2320 SBR	64	**ESC** *(Employment Status Code of the Insured)* **_Note:_** *This field has been deleted from the UB-04.*	Enter the code used to define the **employment status** of the insured individual *(listed in **Field 58**).* Record entries in the **following order:** A = **primary** payer B = **secondary** payer C = **tertiary** payer
2320 SBR	65	**EMPLOYER NAME** *(Employer Name of the Insured)*	Enter the **name of the employer** who provides health care coverage for the insured individual *(listed in **Field 58**).* 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 **primary diagnosis** code should be reported in **Field 67**. Additional diagnosis code can be entered in **Field 68-76**.
2300H1	77 (UB-92) 72 (UB-04)	**EXTERNAL CAUSE OF INJURY CODE (E-CODE)**	If applicable, enter an ICD-10 "VWXY" code in this field.

5.27 EOP

Code Descriptions

EOP   Charges are priced according to the provider contract. Patient not responsible if charges are above contracted rate.

P9   Plan payment reduced by Patient's applicable copay amount

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

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

5.28 Provider Claims Payment Inquiries and Disputes

For disputes of claims payment and other payment inquiries, contact Kaiser Permanente Insurance Company at **(866) 213-3062**. Most questions regarding claim payments can be resolved quickly over the phone. The TPA will review the claim, to verify if the claim(s) was adjudicated correctly, according to the Member's benefits and the contracted rates. If the TPA determines the correct payment was made but you choose to pursue the matter as a payment dispute, please submit a written payment dispute to the Self Funded Customer Service department and provide detail of why you believe the payment was incorrect. Providers have up to 365 calendar days from the date of the TPA's claim processing to submit a payment dispute. Payment disputes must be submitted to:

Kaiser Permanente Insurance Co.
P.O. Box 30547
Salt Lake City, UT 84130-0537