2025
Northern California
HMO Provider Manual
Kaiser Foundation Health Plan, Inc.

KAISER PERMANENTE®

Welcome from Kaiser Permanente

It is our pleasure to welcome you as a contracted provider (Provider) participating under HMO plans offered by the Kaiser Permanente Medical Care Program Affiliated Payors. We want this relationship to work well for you, your medical support staff, and our Members.

This Provider Manual was created to help guide you and your staff in working with Kaiser Permanente's various systems and procedures applicable to our HMO products in Northern California. It is an important part of your relationship with Kaiser Permanente, but this Provider Manual does not cover all aspects of your relationship with us. Please continue to consult your Provider agreement with Kaiser Permanente.

During the term of such agreement, Providers are responsible for (i) maintaining copies of the Provider Manual and its updates as provided by Kaiser Permanente, (ii) providing copies of the Provider Manual to its subcontractors and (iii) ensuring that Provider and its practitioners and subcontractors comply with all applicable provisions. The Provider Manual, including but not limited to all updates, shall remain the property of Kaiser Permanente and shall be returned to Kaiser Permanente or destroyed upon termination of the obligations under such agreement.

If you have questions or concerns about the information contained in this HMO Provider Manual, you can reach our Medical Services Contracting Department by calling **(925) 924-5050**.

Additional resources can also be found on our Community Provider Portal website at: **http://kp.org/providers/ncal/**

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Introduction

This Northern California HMO Provider Manual applies to you as a Provider for HMO products offered by Kaiser Permanente Medical Care Program Affiliated Payors, as referenced in your Agreement with a Kaiser Permanente entity.

To the extent provided in your Agreement, if there is a conflict between this Provider Manual and your Agreement, the terms of the Agreement will control. The term "Member" as used in this Provider Manual refers to currently eligible enrollees of HMO plans offered by Kaiser Permanente Medical Care Program Affiliated Payors, including Kaiser Foundation Health Plan, and their beneficiaries. The term “Provider” as used in this Provider Manual refers to the practitioner, facility, hospital, or contractor subject to the terms of the Agreement. Additionally, unless the context otherwise requires, “you” or “your” in this Provider Manual refers to the practitioner, facility, hospital, or contractor subject to the terms of the Agreement and “we” or “our” in this Provider Manual refers to Kaiser Permanente. Operational instructions in this Provider Manual specifically relate to the HMO product. Capitalized terms used in this Provider Manual may be defined within this Provider Manual or if not defined herein, will have the meanings given to them in your Agreement.

1. Kaiser Permanente Medical Care Program (KPMCP)

1.1 History

The Kaiser Permanente Medical Care Program was founded in the late 1930's by an innovative physician, Sidney R. Garfield, MD, and an industrialist, Henry J. Kaiser, as a comprehensive affordable alternative to "fee-for-service" medical care. Initially, the health care program was only available to construction, shipyard, and steel mill workers employed by the Kaiser industrial companies during the late 1930's and 1940's. The program was opened for enrollment to the general public in 1945.

Today, Kaiser Foundation Health Plan, Inc. is one of the country's largest nonprofit, independent, prepaid group practice health maintenance organizations. We are proud of our over 70+ year history of providing quality health care services to our Members and of the positive regard we've earned from our Members, peers, and others within the health care industry.

1.2 Organizational Structure

Kaiser Permanente Northern California Region (KPNC) is comprised of 3 separate entities that share responsibility for providing medical, hospital and business management services. This group of entities is referred to in this Provider Manual as Kaiser Permanente (KP). The entities are:

- **Kaiser Foundation Health Plan, Inc. (KFHP):** KFHP is a California nonprofit, public benefit corporation that is licensed as a health care service plan under the Knox-Keene Act. KFHP offers HMO plans. KFHP contracts with Kaiser Foundation Hospitals and The Permanente Medical Group to provide or arrange for the provision of hospital and medical services, respectively.
- **Kaiser Foundation Hospitals (KFH):** KFH is a California nonprofit public benefit corporation that owns and operates community hospitals and outpatient facilities. KFH provides and arranges for hospital and other facility services, and sponsors charitable, educational, and research activities.
- **The Permanente Medical Group, Inc. (TPMG):** TPMG is a professional corporation of physicians in KPNC that provides and arranges for professional medical services.

1.3 KPNC Service Area

The KPNC was the first of KP's 8 regions. Currently covering an area from south of Fresno to El Dorado in the Sierra foothills, from Santa Cruz to Sonoma on the Pacific coast, KPNC spans more than twenty counties.

1.4 Integration

KP is unique. We integrate the elements of health care providers, hospitals, home health, support functions and health care coverage into a cohesive health care delivery system. Our integrated structure enables us to coordinate care to our Members across the continuum of care settings.

1.5 Nondiscrimination

The KPMCP in Northern California does not discriminate in the delivery of health care based on race/ethnicity, color, national origin, ancestry, religion, sex, sexual orientation, gender (including gender identity or gender related appearance/behavior whether or not stereotypically associated with the person's assigned sex at birth), marital status, veteran's status, age, genetic information, medical history, medical conditions, claims experience, evidence of insurability (including conditions arising out of acts of domestic violence), source of payment, or other status protected by applicable law.

It is also the policy of KPMCP to require that facilities and services be accessible to individuals with mental or physical disabilities in compliance with the Americans with Disabilities Act of 1990 ("ADA") including but not limited to the service animal requirements set forth in 28 C.F.R. § 36.302(c), and Section 504 of the Rehabilitation Act of 1973 ("Section 504") and other applicable federal and state laws and regulations that prohibit discrimination on the basis of disability.

As a Provider for HMO products offered by KP, you are expected to adhere to KP's "Nondiscrimination in the Delivery of Health Care Policy" (as may be amended from time to time) and to all applicable federal and state laws and regulations that prohibit discrimination. For a copy of the most current policy, Providers may contact Member Service Contact Center (MSCC) (see Section 2 of this Provider Manual).

KP continues to influence the practice of medicine by focusing on keeping the patient healthy and on treating illness and injuries. We encourage Members to seek care on a regular and preventive basis.

1.6 Other Products

In addition to our core HMO plans, KP also offers insurance plans and self-funded products issued or administered by Kaiser Permanente Insurance Company (KPIC). Fully insured and Self-Funded Exclusive Provider Organization, Point-of-Service, and Preferred Provider Organization (PPO) options are addressed in a separate manual.

1.6.1 Exclusive Provider Organization (EPO)

- Mirrors our HMO product, offered on a fully insured or self-funded basis

- EPO Members choose a KP primary care provider (PCP) and receive care at KP or (contracted) plan medical facilities
- Except when referred by a TPMG physician or designee (Plan Physician), EPO Members will be covered for non-emergency care only at designated plan medical facilities and from designated plan practitioners

1.6.2 Point of Service (POS)—Two-Tier

- Tier 1 is the HMO provider network
- Tier 2 is comprised of all other contracted Providers
- POS Members incur greater out-of-pocket expenses in the form of higher co-payments, co-insurance and/or deductibles when they use Tier 2 benefits
- The POS—Two Tier product is currently offered on a fully insured basis

1.6.3 Point of Service (POS)—Three-Tier

- Tier 1 is the HMO provider network
- Tier 2 is comprised of our contracted PPO network providers
- Tier 3 includes non-contracted providers
- POS Members incur greater out-of-pocket expenses in the form of higher co-payments, co-insurance 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)
- The POS—Three Tier product is offered on a fully insured or self-funded basis

1.6.4 Out of Area Preferred Provider Organization (PPO)

- In California, the PPO is currently offered to Members living outside the KP HMO or EPO service area. Members receive care from our PPO provider network, e.g., Private Healthcare Systems, Inc. (PHCS, MultiPlan's national network of providers).
- 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
- The Out of Area PPO is offered on a fully insured basis

1.7 Identification Cards and Medical Record Number (MRN)

Each Member is issued a Health Identification Card (Health ID Card) that shows their unique MRN. Members should present their Health ID Card and photo identification when they seek medical care. If a replacement card is needed, the Member can order a Health ID Card online at http://www.kp.org or call the Member Services Contact Center.

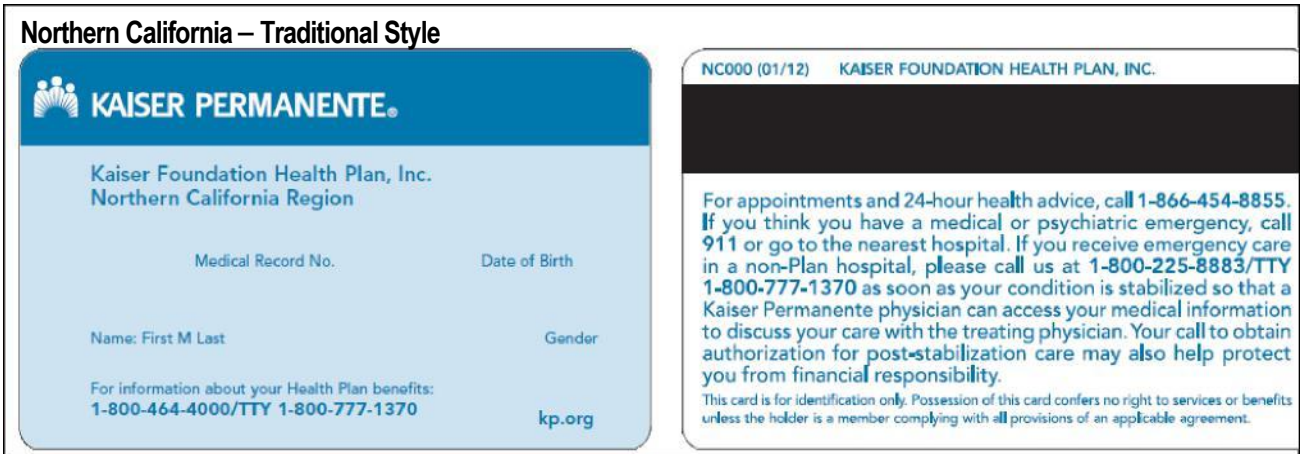
The Health ID Card is for identification only and does not give a Member rights to services or other benefits unless he/she is eligible and enrolled on the date of service. Anyone who is not eligible and enrolled at the time of service is responsible for paying for services provided.

For record-keeping purposes, your business office may wish to photocopy the front and back of a Member's Health ID card and place it in the Member's medical records file.

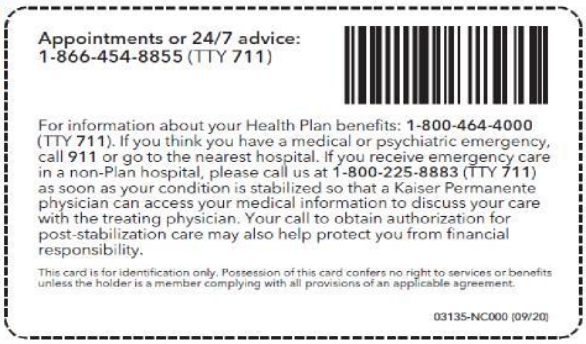
The MRN is used by KP to identify the Member's medical record, eligibility, and benefit level. If a Member's enrollment terminates and the Member re-enrolls at a later date, the Member retains the same MRN even though employer or other information may change including but not limited to their benefit information. The MRN enables medical records/history to be tracked for all periods of enrollment.

The MRN should be used as the "Patient ID" when submitting bills and encounter data.

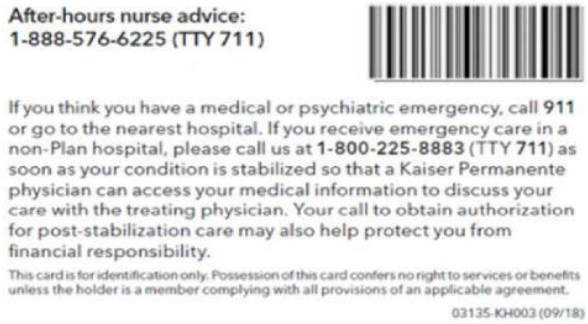
Sample Health ID Cards:



Northern California – New Laminate Style



Older Laminate Style



Northern California - Digital Style

2. Key Contacts

2.1 Northern California Region Key Contacts

Department	Area of Interest	Contact Information
KP Online Affiliate	Online Affiliate allows external providers the ability to: - Submit an online inquiry about payment, or overpayment - File a dispute and appeal - Submit KP Request for Information	To access the portal, visit: http://kp.org/providers/ncal/ and navigate to the **Online Provider Tools** section
KP MSCC	Membership Information* General enrollment questions Eligibility and benefit verification* Co-pay, deductible, and co-insurance information* Members presenting without KP identification number Member grievance and appeals Payment status on submitted claims* Appeals and disputes* Inquiry about a claim, payment, or overpayment*	(888) 576-6789 (Member cost share and eligibility verification) Weekdays: 8a-5p Pacific Interactive Voice Response (IVR) System available 24 hours / 7 days a week
Medical Services Contracting	Contract Network Development and Network Management • Updates to Provider demographics, such as Tax ID, address, and ownership changes • Practitioner additions/terminations to/from your group • Provider education and training • Contract interpretation • Form requests	(925) 924-5050 Fax: (877) 228-8306 5820 Owens Dr, Building E, Floor 2 Pleasanton, CA 94588 mscprovcontractinbox@kp.org
TPMG Consulting Services	Practitioner Credentialing	(510) 625-5608

Department	Area of Interest	Contact Information
Medical Services Contracting	Facility/Organizational Provider Credentialing	(925) 924-5050 MSCOPCRED@kp.org
Medical Staff Office	Kaiser Foundation Hospital Privileges	Facility Listing – Section 2.4
Referral Operations	Authorizations, Referrals by Service • Authorizations, referrals & billing questions for referred services • Coordination of Benefits • Third Party Liability • Workers' Compensation	Referral Coordinators - Facility Listing - Section 2.4
National Claims Administration	Emergency Medical Claims Billing questions for emergency (non-referred) services	(800) 390-3510 P.O. Box 12923 Oakland, CA 94604-2923
Department of Research	Clinical Studies	(866) 206-2979
Clinical Reviews	UM Reconsiderations and Appeals 72 Hour Expedited Appeals	(888) 987-7247 (888) 987-2252 (fax) M-F 7am-7pm; Sat 9am-1pm
Emergency Prospective Review Program (EPRP) CA Statewide Service	Emergency Notification	(800) 447-3777 Available 24 hours a day, 7 days a week
The "HUB"	Non-Emergency Ambulance and Medical Transportation	(800) 438-7404
Nephrology Specialty Department	Management of Adult Kidney Transplant patients 91 days and beyond after transplant	San Francisco: (415) 833-8726 So. Sacramento:(916) 688-6985
National Transplant Network	Transplants: All Other	(888) 551-2740 (510) 268-5448

Department	Area of Interest	Contact Information
EDI Support	Access the Electronic Claims, Payments and Remittance Advice digital book to get more information on how to enroll with EDI, ERA and EFT. https://online.flippingbook.com/view/704125376/	https://kpnationalclaims.my.site.com/EDI/s/

2.2 Member Services Interactive Voice Response System (IVR)

KP Member Services IVR can assist you with a variety of questions. Call **(888) 576-6789** 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 Identifier (NPI)
- Member's MRN
- Member's date of birth
- Date of service for claim in question

The IVR can assist you with status of a Member's accumulator (amount applied toward deductible, if any, or out-of-pocket maximum); claims and payment status; or connect you to a Member Services Contact Center (MSCC) representative. Follow the prompts to access these services.

2.3 KP Outside Services

Referral Coordinators and Outside Services Case Managers work directly with Plan Physicians to authorize services to Providers.

Referral inquiries, including requests for additional authorized services, pending authorizations and details regarding the scope of authorized services should be addressed with the Referral Operations department (see Section 2.4). The Member Services Contact

Center (MSCC) is an additional contact for questions about authorized referrals such as services and dates authorized.

Providers are invited and encouraged to request access to KP's **Online Affiliate** tool.

Online Affiliate is enabled with a robust set of features that can help simplify the process of obtaining KP member information and performing claim reconciliation. Many actions can be performed with Online Affiliate, such as viewing patient eligibility/benefits, viewing detailed claim status, downloading Explanations of Payment (EOPs), filing disputes/appeals, submitting an online claim or payment inquiry and responding to KP requests for information (RFI). With access to Online Affiliate, these features are available on a self-serve basis 24 hours per day, 7 days per week. For more information and to initiate the provisioning process, please visit KP's Northern California Community Provider Portal at:

http://kp.org/providers/ncal/

2.4 KP Facility Listing

KP Facilities, Referral Coordinators and Outside Services Case Managers may be reached at the telephone numbers listed on the following pages.

SERVICE AREA	FACILITY	GENERAL INFORMATION	REFERRAL COORDINATORS	RENAL CASE MANAGERS	UTILIZATION MANAGEMENT
East Bay	Oakland	(510) 752-1000	(510) 752-6610	(510) 752-7513 (510) 752-6526	(510) 752-7645
	Richmond	(510) 307-1500	(510) 307-2496	(510) 752-7518	(510) 307-2943
	San Leandro	(510) 454-1000	(510) 675-6759	(510) 784-2082	(510) 454-4892
	Fremont	(510) 795-3000	(510) 675-6759	(510) 248-3345	(510) 248-7039
Marin/Sonoma	San Rafael	(415) 444-2000	844-359-5661	(415) 492-6522	(415) 444-2638
	West Marin/ Coastal Health Alliance	(415) 899-7525	844-359-5661	(415) 492-6522	(415) 444-2638
	Santa Rosa	(707) 393-4000	(707) 571-3900	(707) 393-4301	(707) 393-3169
Greater San Francisco Service Area	San Francisco	(415) 833-2000	(844) 359-5661	(415) 833-8890	(415) 833-2801
	So. San Francisco	(650) 742-2000	(844) 359-5661	(650) 742-3141	(650) 742-2332
San Mateo	Redwood City	(650) 299-2000	(844) 359-5661	(650) 299-3726	(650) 299-3290
South Bay	Santa Clara	(408) 851-1000	(408) 851-3728	(408) 851-4405	(408) 851-7050
	San Jose	(408) 972-3000	(844) 359-5661	(408) 363-4544	(408) 972-7208
Santa Cruz	Watsonville Community Hospital	(831) 724-4741	(844) 359-5661	(408) 363-4544	NA
Diablo	Walnut Creek	(925) 295-4000	(844) 359-5661	(925) 295-4315	(925) 295-5175
	Antioch	(925) 813-6500	(844) 359-5661	(925) 813-3440	(925) 813-3720
Napa/Solano	Vacaville	(707) 624-4000	N/A -	N/A	(707) 624-2950
	Vallejo	(707) 651-1000	(707) 651-2520	(707) 651-4028	(707) 651-2061
	Vallejo Rehab-KFRC	(707) 651-2311	N/A	N/A	(707) 651-2313
North Valley/ S. Sacramento	Sacramento	(916) 973-5000	(844) 359-5661	(916) 973-6110	(916) 973-6903
	Roseville	(916) 784-4000	(844) 359-5661	(916) 973-6110	(916) 784-4802
	So. Sacramento	(916) 688-2000	(844) 359-5661	(916) 688-6837	(916) 688-2585
Central Valley	Manteca	(209) 825-3700	(844) 359-5661	(209) 476-5099	(209) 825-2441
	St. Joseph's Medical Center	(209) 943-2000	(844) 359-5661	N/A	N/A
	Modesto	(209) 557-1000	(844) 359-5661	(209) 735-4348	(209) 735-5600
Fresno	Fresno	(559) 448-4500	(559) 448-3348	(559) 448-5149	(559) 448-3352
Out of Service Area		(877) 520-4773			

SERVICE AREA	FACILITY	OUTSIDE SERVICES CASE MANAGEMENT HUBS	SKILLED NURSING FACILITY COORDINATOR Mon - Fri (8:30am - 5:00pm)	SKILLED NURSING FACILITY COORDINATOR Evenings, Weekends & Holidays	HOME HEALTH CASE MANAGERS	HOSPICE CASE MANAGERS
East Bay	Oakland	(925) 926-7303	(510) 675-5539	(877) 233-6752	(510) 752-6295	(510) 752-6390
	Richmond	(925) 926-7303	(510) 675-5539	(877) 233-6752	(510) 752-6295	(510) 752-6390
	San Leandro	(925) 926-7303	(510) 675-5539	(877) 233-6541	(510) 675-6620	(510) 675-5777
	Fremont	(925) 926-7303	(510) 675-5539	(877) 233-6541	(510) 675-6620	(510) 675-5777
Marin/Sonoma	San Rafael	(925) 926-7303	(415) 893-4046	(877) 829-8615	(415) 893-4132	(415) 893-4132
	West Marin/ Coastal Health Alliance	(925) 926-7303	(415) 893-4046	(877) 829-8615	(415) 893-4132	(415) 893-4132
	Santa Rosa	(925) 926-7303	(707) 571-3869	(877) 829-8615	(707) 566-5488	(707) 566-5488
Greater San Francisco Service Area	San Francisco	(925) 926-7303	(415) 833-4906	(877) 331-2110	(415) 833-2770	(415) 833-3655
	So. San Francisco	(408) 361-2140, Option 1	(650) 827-6405	(877) 263-5756	(415) 833-2770	(415) 833-3655
San Mateo	Redwood City	(408) 361-2140, Option 1	(650) 299-2708	(877) 263-5756	(650) 299-3940	(650) 299-3971
South Bay	Santa Clara	(408) 361-2140, Option 1	(408) 366-4322	(877) 263-5756	(408) 235-4000	(408) 235-4100
	San Jose	(408) 361-2140, Option 1	(408) 361-2164	(877) 263-5756	(408) 361-2100	(408) 361-2150
Diablo	Walnut Creek	(925) 926-7303	(925) 229-7765	(925) 229-7756	(925) 313-4600	(925) 229-7800
	Antioch	(925) 926-7303	(925) 229-7765	(925) 229-7756	(925) 313-4600	(925) 229-7800
Napa/Solano	Vacaville	(925) 926-7303	(707) 651-2085	(707) 651-2085	(707) 645-2720	(707) 645-2730
	Vallejo	(925) 926-7303	(707) 651-2085	(707) 651-2085	(707) 645-2720	(707) 645-2730
North Valley/ S. Sacramento	Sacramento	(916) 648-6770	(916) 977-3135	N/A	(916) 486-5400	(916) 486-5300
	Roseville	(916) 648-6770	(916) 977-3135	N/A	(916) 486-5400	(916) 486-5300
	So. Sacramento	(916) 648-6770	(916) 977-3135	(877) 829-8616	(916) 486-5400	(916) 486-5300
Central Valley	Manteca	(916) 648-6770	(209) 735-7333	(209) 602-7389	(209) 735-7333	(209) 735-7333
	St. Joseph's Medical Center	(916) 648-6770	(209) 735-7333	(209) 602-7389	(209) 735-7333	(209) 735-7333
	Modesto	(916) 648-6770	(209) 735-7333	(209) 602-7389	(209) 735-7333	(209) 735-7333
Out of Service Area		(877) 520-4773				

Community Based Adult Services (CBAS)	
All Northern California Service Areas	Stephanie.R.Smith@kp.org

SERVICE AREA	FACILITY	PSYCHIATRIC HOSPITAL AUTHORIZATION/ NOTIFICATION: Weekdays	PSYCHIATRIC HOSPITAL AUTHORIZATION/ NOTIFICATION: Evenings/Weekends	PSYCHIATRIC CASE MANAGERS
East Bay	Oakland	(925) 372-1103	(925) 229-7713	(925) 372-1103
	Richmond	(925) 372-1103	(925) 229-7713	(925) 372-1103
	San Leandro	(925) 372-1103	(925) 229-7713	(925) 372-1103
	Fremont	(925) 372-1103	(925) 229-7713	(925) 372-1103
Marin / Sonoma	San Rafael	(925) 372-1103	(925) 229-7713	(925) 372-1103
	West Marin/ Coastal Health Alliance	(925) 372-1103	(925) 229-7713	(925) 372-1103
	Santa Rosa	(925) 372-1103	(925) 229-7713	(925) 372-1103
Greater San Francisco Service Area	San Francisco	(925) 372-1103	(925) 229-7713	(650) 299-4112
	So. San Francisco	(925) 372-1103	(925) 229-7713	(650) 299-4112
San Mateo	Redwood City	(925) 372-1103	(925) 229-7713	(650) 299-4112
South Bay	Santa Clara	(925) 372-1103	(925) 229-7713	(650) 299-4112
	San Jose	(925) 372-1103	(925) 229-7713	(650) 299-4112
Diablo	Walnut Creek	(925) 372-1103	(925) 229-7713	(925) 372-1103
	Antioch	(925) 372-1103	(925) 229-7713	(925) 372-1103
Napa/Solano	Vacaville	(925) 372-1103	(925) 229-7713	(925) 372-1103
	Vallejo	(925) 372-1103	(925) 229-7713	(925) 372-1103
North Valley/ S. Sacramento	Sacramento	(925) 372-1103	(925) 229-7713	(916) 499-4645 – Pager
	Roseville	(925) 372-1103	(925) 229-7713	(916) 499-4645 – Pager
	So. Sacramento	(925) 372-1103	(925) 229-7713	(916) 522-8792 – Pager
Central Valley	Manteca	(925) 372-1103	(925) 229-7713	(209) 476-3111 (925) 372-1103
	Modesto	(925) 372-1103	(925) 229-7713	(209) 476-3111
Fresno	Fresno	(925) 372-1103	(925) 229-7713	(925) 372-1103
Out of Service Area		(925) 372-1336	(925) 372-1336	

Addiction Medicine Recovery Services (AMRS) Day Treatment Programs

Service Area	Facility	Department Number	Program Director/Manager	Email Address
Central Valley	Manteca Modesto Stockton Tracy	(855) 268-4096	Ester Baldwin	Ester.Baldwin@kp.org
Diablo	Antioch Martinez Pleasanton Walnut Creek	(925) 295-4145	Curtis Arthur	Curtis.John.Arthur@kp.org
East Bay	Oakland Richmond	(510) 251-0121	Olena Geller	Olena.A.Geller@kp.org
Fresno	Fresno	(559) 448-4620	Michael Nunes	Michael.A.Nunes@kp.org
Greater Southern Ala meda	Fremont Union City San Leandro	(510) 675-2377	Jennifer Miller	Jennifer.K.Miller@kp.org
Napa/Solano	Petaluma/San Rafael Vallejo Vacaville	(707) 651-2619	Kurt Meyers	Kurt.A.Meyers@kp.org
North Valley	Roseville Sacramento South Sacramento	(916) 482-1132	Kristy Schwee	Kristy.N.Schwee@kp.org
San Francisco	Redwood City San Francisco San Rafael South San Francisco	(415) 833-9402	Sofia Gonzalez	Sofia.N.Gonzalez@kp.org
Santa Clara	Redwood City San Jose Santa Clara Santa Cruz	(408) 366-4200	H.B.(Tresy) Wilder	H.B.Wilder@kp.org
Santa Rosa	San Rafael Santa Rosa	(707) 571-3778	Christopher Evans	Christopher.S.Evans@kp.org

2.5 Northern California Resource Management (RM) Contacts

Coordination of Care Service Directors (COCSD), UM/RM Managers, and Social Workers may be reached at the telephone numbers listed on the following pages.

Location	Address	COCSD	UM/RM Manager	Social Worker
Antioch	4501 Sand Creek Road Antioch, CA 94531	**Haeyong Sohn** (925) 813-6997 (925) 303-8816 (cell)	**Dena Grosse (ANM)** (925) 813-3736 (925) 813-3721	**Charles Brigham** (925) 813-3760

Location	Address	COCSD	UM/RM Manager	Social Worker
Fremont	39400 Paseo Padre Pkwy Fremont, CA 94538	**Elsamma Babu** (510) 248-7601	**Winnie Huang** (510) 248-5302	**Jenny Vo** (510) 248-5327
Fresno	7300 North Fresno Street Fresno, CA 93720	**Michelle Garcia-Wilkins** (559) 448-3323	**Sheila Brillante** (559) 448-3193 (559) 352-2358 (cell)	**Iris DeYoung** (559) 448-5174
Manteca	1777 West Yosemite Ave Manteca, CA 95337	**Julie Ann Gist** (209) 735-4207 (209) 402-6953 (cell)	**Kristine Biehl** (209) 825-2442 (209) 573-3880 (cell)	**Debbie Vieira** (209) 735-5602
Modesto	4601 Dale Road, Ste 1H7 Modesto, CA 95356	**Julie Ann Gist** (209) 735-4207 (209) 402-6953 (cell)	**Lexlee Cunningham** (209) 402-4349 (209) 402-6633 (cell)	**Debbie Vieira** (209) 735-5602
Oakland	275 West MacArthur Blvd Oakland, CA 94611	**Shannon D Bradley** (510) 752-5569 (510) 871-7913 (cell)	**Natalie Archangel-Montijo** (510) 752-8120 (510) 915-6830 (cell)	**Reva Levias** (510) 752-6306 (510) 507-0800 (cell)
Redwood City	1100 Veterans Blvd Redwood City, CA 94063	**Ursula Lavelle** (650) 299-2829 (650) 207-7968 (cell)	**Monica Moniz** (650) 299-4601 (650) 2128-8297 (cell)	**Kathleen Steele** (650) 299-3194
Richmond	901 Nevin Avenue Richmond, CA 94801	**Shannon D Bradley** (510) 752-5569 (510) 871-7913 (cell)	**Heather Rodriguez** (510) 307-2893	**Nancy Jacobson** (510) 307-2972
Roseville	1600 Eureka Road Roseville, CA 95661	**Dee Ford** (916) 784-5297	**Ronaviv M Garcia** (916) 784-4802 (916) 297-1000 (cell)	**Erica Menzer** (916) 784-4483
Sacramento	2025 Morse Avenue Sacramento, CA 95825	**Yvonne Speer** (916) 973-7528 (916) 297-3725 (cell)	**David J Thomas** (916) 973-6931	**VACANT**
San Francisco	2425 Geary Blvd San Francisco, CA 94115	**Rochelle (Marie) Arenas** (415) 833-6686 (415) 314-8531 (cell)	**Joan Ngando-Agbor** (415) 833-7837	**VACANT**
San Jose	250 Hospital Parkway San Jose, CA 95119	**Evigeniy Satanovskiy** (408) 728-1264 (cell)	**Maria C. Arevalo** (408) 972-6424 **Christyle Tabuan** (Interim)	**Greg Dalder** (408) 927-9817
San Leandro	2500 Merced Street San Leandro, CA 94577	**Irina Y. Lewis** (510) 454-4831	**Shirley Ng (Mgr)** (510) 363-6041 **Paula Breen (ANM)** (510) 362-6497	**Clay Van Batenburg** (510) 454-4954

Location	Address	COCSD	UM/RM Manager	Social Worker
San Rafael	99 Montecillo Road San Rafael, CA 94903	**Ruth Vosmek** (415) 444-4689	**Cyntia Boter** (415) 444-4880	**Ruth Vosmek** (415) 444-4689
Santa Clara	700 Lawrence Expressway Dept. 312 Santa Clara, CA 95051	**VACANT**	**Janarei Castillo** (408) 851-7047 (408) 529-7616 (cell) **Shefalia Singla** (408) 594-6383 **Teresa Raya (ANM)** (408) 594-6686 (cell)	**George Fogle** (408) 851-7090
Santa Rosa	401 Bicentennial Way Santa Rosa, CA 95403	**Janet A Cappurro** (707) 393-4619 (707) 328-7098 (cell)	**Karen Hulsey** (707) 393-4302 (707) 806-4617 (cell) **Diana Samour (ANM)** (707) 867-2313	**Diane Sloves** (707) 393-3149
South Sacramento	6601 Bruceville Road, South Sacramento, CA 95823	**Baljinder (Pepi) Lall** (916) 688-2997 (916) 203-0347 (cell)	**Sukheet (Sukhee) Gill** (916) 688-6519 (916) 531-9491 (cell)	**Jennifer Park** (916) 686-2998
South San Francisco	1200 El Camino Real South San Francisco, CA 94080	**Margaret Williams** (925) 788-1278 (cell)	**VACANT**	**Sharmila Grant** (650) 742-3085
Stockton	1800 N California St Stockton, CA 95204	**Julie Ann Gist** (209) 735-4207 (209) 402-6953 (cell)	**Kelly Widger** (209) 402-1840 (cell)	**N/A** **(See Modesto)**
Vacaville	One Quality Drive Vacaville, CA 95687	**Deborah Aragon** (707) 624-1007	**VACANT** (See COCSD)	**Charlotte Richardson** (707) 624-2572
Vallejo and Vallejo Rehab	975 Sereno Boulevard Vallejo, CA 94589	**Carrie Robertshaw** (707) 651-3521 (707) 334-8417 (cell)	**Joan Divinagracia** (707) 651-1593	**Jean Broadnax** (707) 651-4423
Walnut Creek	1425 South Main Street Lilac Building #29 Walnut Creek, CA 94596	**Miraslava Harter** (925) 295-4473 (925) 239-9391 (cell)	**Joanna Macinning** (925) 393-1749 (cell) **Bernadette Yee** (925) 393-4768 (cell)	**Carol McMenamy** (925) 295-5128

Location	Address	COCSD	UM/RM Manager	Social Worker
Watsonville Community Hospital		**See San Jose: Evgeniy Satanovskiy** (408) 728-1264		

Resource Management Functional Unit
5820 Owens Drive, Building E, 4th Floor
Pleasanton, CA 94588

Health Plan Utilization Management
Jeffrey Trinidad, MSN, RN
Interim Regional Director Health Plan Regulatory Services (925) 354-1204

3. Eligibility and Benefits Determination

3.1 Eligibility and Benefit Verification

Providers are responsible for verifying Members' eligibility and benefits. Each time a Member presents at the office for services, Providers 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 Health ID Card. Please check a form of photo identification to verify the identity of the Member. Except in an emergency situation, the Provider must verify that the Member has a benefit for the service prior to providing services.

Providers are invited and encouraged to utilize KP's **Online Affiliate** to verify member eligibility and benefits.

To access the KP Online Affiliate portal, click on the following link, choose your region and nagivate to the Online Provider section: **https://kp.org/providers**

Alternately, contact the Member Services Contact Center (MSCC) to verify the Member's eligibility and benefits. It is important to verify the availability of benefits for services before rendering the service so the Member can be informed of any potential payment responsibility. If services are provided to a Member and the service is not a benefit or the benefit has been exhausted, denied or not authorized, KFHP may not be obligated to pay for those services.

Member Services Contact Center representatives are available Monday - Friday from 8AM to 5PM, Pacific Time (PT) at (888) 576-6789

By calling MSCC, providers may verify Member eligibility and benefits, and/or speak with a Member Services representative. Please be prepared to provide the Member's name and MRN which is located on the KP Health ID card.

Self-Service is available in the IVR System 24 hours per day, 7 days per week at (888) 576-6789.

3.1.1 After Hours Eligibility Requests

Providers may contact KP 24 hours per day, 7 days per week to verify benefits and eligibility. Providers are invited and encouraged to request access to KP's Online Affiliate tool. Please see the Northern California Community Provider Portal (CPP) for more information at:

http://kp.org/providers/ncal/

Alternately, you may call the IVR system of the KP Member Services Contact Center to verify benefits and eligibility 24 hours per day, 7 days per week at: **(888) 576-6789**. You may also request the patient complete a financial responsibility form that places payment responsibility on the patient in the event they are later found to be ineligible as a Member or the care provided is not a covered benefit. A financial responsibility form is not required for provision of emergency services; however, KFHP will not pay for emergency or unauthorized services provided if the person is not a Member.

3.1.2 Benefit Coverage Determination

In addition to eligibility, Providers must confirm that the Member has coverage for the services at issue prior to providing such services to a Member, usually by requesting an authorization or receiving a referral from KP. Section 4.3 of this Provider Manual provides further details on the process for obtaining referrals and authorizations, except in cases of emergency.

3.2 Membership Types

The table below generally describes the different HMO membership types.

Membership Type	Membership Defined	Covered Benefits Defined By:
Commercial	Members who purchase HMO coverage on an individual basis (other than Medicare) Members who are covered as part of an employer group and are not Medicare-eligible	Evidence of Coverage (EOC)
Medicare Advantage (formerly known as Medicare + Choice) (aka Senior Advantage)	Individual Medicare beneficiaries who have assigned their Medicare benefits to KP by enrolling in the KP Senior Advantage Program	Medicare, with additional benefits provided by KP as described in the EOC
	Employer group retirees or otherwise Medicare- eligible employees who are also Medicare beneficiaries and have assigned their Medicare benefits to KP by enrolling the KP Senior Advantage Program	Medicare, with additional benefits provided by KP as described in the EOC
State Programs (Medi-Cal, Healthy Families)	Contact the Member Services Contact Center (MSCC) for detailed information specific to your geographic area.	Contact MSCC for detailed information specific to your geographic area.

3.3 Benefit Exclusions and Limitations

KFHP benefit plans may be subject to limitations and exclusions. Before rendering services, it is important to contact MSCC to obtain information on, and verify the availability of, Member benefits for services so the Member can be informed of any potential payment responsibility.

If services are provided to a Member and the service is not a benefit, the benefit has been exhausted, denied or was not authorized, KFHP will not be obligated to pay for those services, except to the extent required by law.

3.4 Drug Benefits

The drug benefits vary based on the benefit plan. To verify if a Member has a drug benefit, please contact MSCC.

4. Utilization Management (UM) and Resource Management (RM)

4.1 Overview of Utilization Management and Resource Management Program

KFHP, KFH, and TPMG share responsibility for Utilization Management (UM) and Resource Management (RM). KFHP, KFH, and TPMG work together to provide and coordinate RM through retrospective monitoring, analysis and review of the utilization of resources for a full range of outpatient and inpatient services delivered to our Members by physicians, hospitals, and other health care practitioners and providers. RM does not affect service authorization. KP does, however, incorporate the utilization of services rendered by Providers into the data sets we study through RM.

UM is a process used by KP for a select number of health care services requested by the treating provider to determine whether or not the requested service is medically indicated and appropriate. If the requested service is medically indicated and appropriate, the service is authorized and the Member will receive the services in a clinically appropriate place consistent with the terms of the Member's health coverage. UM activities and functions include the prospective (prior to authorization), retrospective (claims review), or concurrent review (while Member is receiving care) of health care services. The decisions to approve, modify, delay, or deny the request are based in whole or in part on appropriateness and indication. The determination of whether a service is medically indicated and appropriate is based upon criteria developed with the participation of actively practicing physicians. The criteria are consistent with sound clinical principles and processes reviewed and approved annually and updated as needed.

KP's utilization review program and processes follow statutory requirements contained in California's Health and Safety Code (H&SC)/Knox-Keene Health Care Service Plan Act. In addition, the UM process adheres to managed care plan NCQA accreditation, CMS, DMHC, and DHCS standards.

4.1.1 Data Collection and Surveys

KP collects UM data to comply with state and federal regulations and accreditation requirements. Evaluation of UM data identifies areas for improvement in inpatient and outpatient care.

KP conducts Member and practitioner satisfaction surveys on a regular basis to identify patterns, trends, and opportunities for performance improvement related to UM processes.

UM staff also monitor and collect information about the appropriateness and indication of health care services and benefits-based coverage decisions. Appropriately licensed health care professionals supervise all UM and RM processes.

4.2 Medical Appropriateness

In making UM decisions, KP relies on written criteria of appropriateness and indication developed in collaboration with practicing physicians. The criteria are based on sound clinical evidence and developed in accordance with established policies and compliance with statutory requirements. Only appropriately licensed health care professionals make UM decisions to deny, delay or modify provider requested services. All UM decisions are communicated in writing to the requesting physician. Each UM denial notification includes a clinical explanation of the reasons for the decision and the criteria or guidelines used to determine appropriateness and indication of care or services. UM decisions are never based on financial incentive or reward to the reviewing UM physician.

Plan Physicians designated as UM reviewers may be physician leaders for Outside Referral Services, physician experts and specialists (e.g., DME), and/or members of physician specialty boards or committees (e.g., Organ Transplant, Autism Services). These physicians have current, unrestricted licenses to practice medicine in California and have appropriate education, training, and clinical experience related to the requested health care service. When necessary, consultation with board certified physicians in the associated subspecialty is obtained to make a recommendation with respect to a UM decision.

4.3 "Referral" and "Authorization" – General Information

Prior authorization is a UM process that is required for certain health care services. However, no prior authorization is required for Members seeking emergency care.[1]

Plan Physicians offer primary medical, behavioral health, pediatric, and OB-GYN care as well as specialty care. However, Plan Physicians may refer a Member to a non-plan Provider when the Member requires covered services and/or supplies that are not available in Plan or cannot be provided in a timely manner. The referrals process originates at the

[1]An emergency medical condition means (i) as defined in California Health & Safety Code 1317.1 for Members subject to the Knox-Keene Act (a) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the Member's health in serious jeopardy, or serious impairment to bodily functions, or serious dysfunction of any bodily organ or part; or (b) a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the Member an immediate danger to themselves or others, or immediately unable to provide for, or utilize, food, shelter or clothing due to the mental disorder; or (ii) as otherwise defined by applicable law (including but not limited to Emergency Medical Treatment and Active Labor Act (EMTALA) in 42 United States Code 1395dd and its implementing regulations)

facility level and the Assistant Physicians-In-Chief (APICs) for Outside Services (Referrals) are responsible for reviewing the appropriateness, indication and availability of services for which a referral has been requested.

The request for a referral to a non-Plan provider (Outside Referrals) is subject to prior authorization and managed at the local facility level. Once the referral is submitted, it is reviewed by the facility and the APICs for Outside Referrals to determine whether services are available in Plan. If not, the APIC will confirm appropriateness and indication with the requesting physician or designated specialist based on their clinical judgment and approve the Outside Referral request. Outside Referrals for specific services such as DME, solid organ and bone marrow transplants and behavioral health treatment for autism spectrum disorder are subject to prior authorization using specific UM criteria. These health care service requests are reviewed for appropriateness and indication by specialty boards and physician experts.

When KP approves Referrals for a Member, the provider receives a written Authorization for Medical Care communication, which details the name of the referring Plan Physician, the level and scope of services authorized, and the number of visits and/or duration of treatment. The Member receives a letter that indicates a referral has been approved for the Member to see a specific Provider. Any additional services beyond the scope of the authorization must have prior approval. To receive approval for additional services, the Provider must contact the referring physician.

Authorized services must be rendered before the authorization expires or before notice from KP that the authorization is canceled. The expiration date is noted in the Authorization for Medical Care communication and/or the Patient Transfer Referral form.

For assistance in resolving administrative and patient issues (e.g., member benefits and eligibility), please contact MSCC. For authorization status or questions about the referral process, please call the number for Referral Questions listed on the Authorization form.

4.4 Authorization of Services

Prior authorization is required as a condition of payment for any inpatient and outpatient services (excluding emergency services) that are otherwise covered by a Member's benefit plan.

In the event additional services were rendered to the Member without prior authorization (other than investigational or experimental therapies or other non-covered services), the Provider will be paid for the provision of such services in a licensed acute care hospital if the services were related to services that were previously authorized and when all the following conditions are met:

1. The services were medically necessary at the time they were provided;
2. The services were provided after KP normal business hours; and

3. A system that provides for the availability of a KP representative or an alternative means of contact through an electronic system, including voice mail or electronic mail, was not available. For example, KP could not/did not respond to a request for authorization within 30 minutes after the request was made.

NOTE: Authorization from KP is required even when KP is the secondary payor.

4.4.1 Hospital Admissions Other Than Emergency Services

A Plan Physician may refer a Member to a hospital for admission without prior UM review. The RM staff conducts an initial review within 24 hours of admission using hospital stay criteria to confirm the appropriate level of care and the provision of services. KP Referral Patient Care Coordinator Case Managers (PCC-CMs) are responsible for notifying the treating physician of the review outcome.

4.4.2 Admission to Skilled Nursing Facility (SNF)

If the level of care is an issue or other services better meet the clinical needs of the Member, a PCC-CM will notify the ordering/treating physician to discuss alternative treatment plans, including admission to a SNF.

A Plan Physician may refer a Member for skilled level of care at a SNF. The service authorization is managed by a PCC-CM and includes a description of specific, approved therapies and other medically necessary skilled nursing services per Medicare Guidelines.

The initial skilled care authorizations are based on the Member's medical needs at the time of admission, the Member's benefits, and eligibility status. The Member is informed by a PCC-CM as to what their authorized and anticipated length of stay may be. The Member's clinical condition and physician assessment will inform the final determination during the Member's course of care in the SNF.

The SNF may request an extension of an authorization for continued stay. This request is submitted to the SNF Care Coordinator. This request is reviewed for appropriateness and indication and may be denied when the patient does not meet skilled services criteria per Medicare Guidelines. The SNF Care Coordinator conducts telephonic or onsite reviews at least weekly to evaluate the Member's clinical status, level of care needs, and to determine if continuation of the authorization is appropriate. Based on the Member's skilled care needs and benefit eligibility, more SNF days may be approved. If additional days are authorized, the SNF will receive a written authorization from KP.

Other services associated with the SNF stay are authorized when either the Member's Plan Physician or other KP designated specialist expressly orders such services. These services may include, but are not limited to, the following items:

- Laboratory and radiology services

- Special supplies or DME
- Ambulance transport (when Member meets criteria)

4.4.2.1 Authorization Numbers are Required for Payment

KP requires that authorization numbers be included on all claims submitted by not only SNFs, but all ancillary providers that provide services to KP Members (e.g., mobile radiology vendors).

These authorization numbers **must** be provided by the SNF to the rendering ancillary services provider, preferably at time of service. Because authorization numbers may change, it is critical that the authorization number reported on the claim be valid for the date of service provided. Please note that the correct authorization number for the ancillary service providers may not be the latest authorization issued to the SNF.

It is the responsibility of the SNF to provide the correct authorization number(s) to all ancillary service providers at time of service. If SNF personnel are not sure of the correct authorization number, please contact KP's SNF Care Coordinator for confirmation.

4.4.3 Home Health/Hospice Services

Home health and hospice services require prior authorization from KP. Both home health and hospice services must meet the following criteria to be approved:

- A Plan Physician must order and direct the requests for home health and hospice services
- The patient is an eligible Member
- Services are provided in accordance with benefit guidelines
- The patient requires the care in the patient's place of residence. Any place that the patient is using as a home is considered the patient's residence
- The home environment is a safe and appropriate setting to meet the patient's needs and provide home health or hospice services
- There is a reasonable expectation that the patient's clinical needs can be met by the Provider

4.4.3.1 Home Health Specific Criteria

Prior authorization is required for home health care services. Criteria for coverage include:

- The services are medically necessary for the Member's clinical condition
- The patient is homebound, which is defined as an inability to leave home without the aid of supportive devices, special transportation or the assistance of another person.

A patient may be considered homebound if absences from the home are infrequent and of short distances. A patient is not considered homebound if lack of transportation or inability to drive is the reason for being confined to the home

- The patient and/or caregiver(s) are willing to participate in the plan of care and work toward specific treatment goals

4.4.3.2 Hospice Care Criteria

Prior authorization is required for Hospice Care. Criteria for coverage include:

- The patient is certified as being terminally ill and meets the criteria of the benefit guidelines for hospice services.

4.4.4 Durable Medical Equipment (DME)/ Prosthetics and Orthotics (P&O)

Prior Authorization is required for DME and P&O. KP evaluates authorization requests for appropriateness based on, but not limited to:

- The Member's care needs
- The application of specific benefit guidelines
- For further information on ordering DME, please contact the assigned KP Case Manager

4.4.5 Psychiatric Hospital Services Other Than Emergency Services

Plan Physicians admit Members to psychiatric facilities by contacting the KP Psychiatry/ Call Center Referral Coordinator. Once a bed has been secured, KP will generate an authorization confirmation for the facility Provider.

4.4.6 Non-Emergent Transportation

To serve our Members and coordinate care with our Providers, KP has a 24 hour, 7 day per week, centralized medical transportation department called the "HUB", to coordinate and schedule non-emergency medical transportation. The HUB can be reached at **(800) 438-7404**.

4.4.6.1 Non-Emergency Medical Transport (Gurney Van/Wheelchair Van)

Non-Emergency Medical Transport services requires prior authorization from KP. Providers must call the KP HUB to request non-emergency medical transportation.

Non-emergency medical transportation may or may not be a covered benefit for the Member. Payment may be denied for non-emergency medical transportation unless KP issued a prior authorization and the transportation was coordinated through the HUB.

4.4.6.2 Non-Emergency Ambulance Transportation

Non-emergency ambulance transportation must be authorized and coordinated by the KP HUB. If a Member requires non-emergency ambulance transportation to a KP Medical Center or any other location designated by KP, Providers may contact KP to arrange the transportation of the Member through the HUB. Providers should not contact any ambulance company directly to arrange an authorized non-emergency ambulance transportation of a Member.

Non-emergency ambulance transportation may or may not be a covered benefit for the Member. Payment may be denied for ambulance transport of a Member unless KP issued a prior authorization and the transportation was coordinated through the HUB.

4.4.7 Transfers to a KP Medical Center

If, due to a change in a Member's condition, the Member requires a more intensive level of care than your facility can provide, you can request a transfer of the Member to a KP Medical Center. The Care Coordinator or designee will arrange the appropriate transportation through KP's medical transportation HUB.

Transfers to a KP Medical Center should be made by the facility after verbal communication with the appropriate KP staff, such as a TPMG SNF physician or the Emergency Department physician. Contact a Care Coordinator for a current list of telephone numbers for emergency department transfers.

If a Member is sent to the Emergency Department via a 911 ambulance and it is later determined by KP that the 911 ambulance transport or emergency department visit was not medically necessary, KP may not be obligated to pay for the ambulance transport.

4.4.7.1 Required Information for Transfers to KP

Please send the following written information with the Member:

1. Name of Member's contact person (family member or authorized representative) and telephone number
2. Completed inter-facility transfer form
3. Brief history (history and physical, discharge summary, and/or admit note)
4. Current medical status, including presenting problem, current medications and vital signs

5. A copy of the patient's Advance Directive/Physician Orders for Life Sustaining Treatment (POLST)
6. Any other pertinent medical information, i.e., lab/x-ray

If the Member is to return to the originating facility, KP will provide the following written information:

1. Diagnosis (admitting and discharge)
2. Medications given; new medications ordered
3. Labs and x-rays performed
4. Treatment(s) given
5. Recommendations for future treatment; new orders

4.4.8 Visiting Member Guidelines

KP Members who access routine and specialty health services while they are visiting another KP region are referred to as "visiting Members." Certain KP health benefit plans allow Members to receive non-urgent and non-emergent care while traveling in other KP regions. The KP region being visited by the Member is referred to as the "Host" region, and the region where a Member is enrolled is their "Home" region.

Visiting Members to KPNC are subject to the UM and prior authorization requirements set forth in the visiting Member's coverage documents.

Your first step when a visiting Member has been referred to you by KP:

- Review the Member's Health ID Card. The KP "Home" region is displayed on the face of the card. Confirm the Member's "Home" region MRN.

- Verify "Home" region benefits, eligibility and cost share via Online Affiliate (see Section 3.1).or by calling the "Home" region's Member Services Contact Center (number provided on the identification card).

- If the Member does not have their Health ID Card, call the Member's "Home" region at the number provided in the table at the end of this section.

- Services are covered according to the Member's contract benefits, which may be subject to exclusions as a visiting Member. Providers should identify the Member as a visiting Member when verifying benefits with the "Home" region.

The KP MRN identified on the KP authorization will not match the MRN on the visiting Member's KP ID card:

- Visiting Members require KPNC to establish a "Host" MRN for all authorizations. * When communicating with KPNC about authorization matters, reference the "Host" MRN. The "Home" MRN should only be used on claims, as detailed in Section 5.13.

- Contractors should always verify any Member's identity by requesting a picture ID prior to rendering services.

*EXCEPTION: for DME authorizations, contact the "Home" region at their number below.

Regional Member Services Call Centers	
Northern California	(800)-464-4000
Southern California	(800)-464-4000
Colorado	(800) 632-9700
Georgia	(888) 865-5813
Hawaii	(800) 966-5955
Mid Atlantic	(800) 777-7902
Northwest	(800) 813-2000
Washington (formerly Group Health)	(888) 901-4636

4.5 Emergency Admissions and Services; Hospital Repatriation Policy

Consistent with applicable law, KP Members are covered for emergency care to stabilize their clinical condition. An emergency medical condition means (i) as defined in California Health & Safety Code 1317.1 for Knox-Keene Members (a) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the Member's health in serious jeopardy, or serious impairment to bodily functions, or serious dysfunction of any bodily organ or part or (b) a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the Member an immediate danger to themselves or others, or immediately unable to provide for, or utilize, food, shelter, or clothing due to the mental disorder; or (ii) as otherwise defined by applicable law (including but not limited to Emergency Medical Treatment and Active Labor Act (EMTALA) in 42 United States Code 1395dd and its implementing regulations).

Emergency Services to screen and stabilize a Member suffering from an emergency medical condition as defined above **do not** require prior authorization.

Emergency Services

- If Emergency Services are provided to screen and stabilize a patient in California, they are covered in situations when an emergency condition (as defined above) existed
- Once a patient is stabilized, the treating physician is required to communicate with KP for approval to provide further care (see Section 4.5.1) or to effect transfer

Emergency Claim

The following circumstances will be considered when the bill is processed for payment:

- Whether services and supplies are covered under the Member's benefit plan
- Members have varying benefit plans, and some benefit plans may not cover continuing or follow-up treatment at a non-plan facility. Therefore, the Provider should contact KP's Emergency Prospective Review Program (EPRP) prior to furnishing post-stabilization services.

4.5.1 Emergency Prospective Review Program (EPRP)

EPRP provides a statewide notification system relating to emergency services for Members. Prior authorization is not required for emergency admissions. Post-stabilization care at a non-Plan facility must have prior authorization by EPRP. EPRP must be contacted prior to a stabilized Member's admission to a non-Plan facility. KP may arrange for medically necessary continued hospitalization at the facility or transfer of the Member to another hospital after the Member is stabilized.

When a Member presents in an emergency room for treatment, we expect the Provider to triage and treat the Member in accordance with EMTALA requirements, and to contact EPRP once the Member has been stabilized or stabilizing care has been initiated.* The Provider may contact EPRP at any time, including prior to stabilization to the extent legally and clinically appropriate, to receive relevant patient-specific medical history information which may assist the Provider in its stabilization efforts and any subsequent post-stabilization care. EPRP has access to Member medical history, including recent test results, which can help expedite diagnosis and inform further care.

* Under the EMTALA regulations Providers may, but are not required to, contact EPRP once stabilizing care has been initiated but prior to the patient's actual stabilization if such contact will not delay necessary care or otherwise harm the patient.

EPRP
(800) 447-3777
Available 7 days a week
24 hours a day

EPRP is available 24 hours a day, every day of the year and provides:

- Access to clinical information to help the Provider in evaluating a Member's condition and to enable our physicians and the treating physicians at the facility to quickly determine the appropriate treatment for the Member
- Emergency physician to emergency physician discussion regarding a Member's condition
- Authorization of post-stabilization care or assistance with making appropriate alternative care arrangements

4.5.2 Post-Stabilization Care

If there is mutual agreement at the time of the phone call as to the provision of post-stabilization services, EPRP will authorize the Provider to provide the agreed services and issue a confirming authorization number. If requested, EPRP will also provide, by fax or other electronic means, a written confirmation of the services authorized and the confirmation number. KP will send a copy of the authorization to the facility's business office within 24 hours of the authorization decision. This authorization number must be included with the claim for payment for the authorized services. The authorization number is required for payment, along with all reasonably relevant information relating to the post-stabilization services on the claim submission consistent with the information provided to EPRP as the basis for the authorization.

EPRP must have confirmed that the Member was eligible for and had benefit coverage for the authorized post-stabilization services provided prior to the provision of post-stabilization services.

If EPRP authorizes the admission of a clinically stable Member to the facility, KP's Outside Services Case Manager will follow that Member's care in the facility until discharge or transfer.

EPRP may request that the Member be transferred to a KP-designated facility for continuing care or EPRP may authorize certain post-stabilization services in your facility. In many cases, such post-stabilization services will be rendered under the management of a physician who is a member of your facility's medical staff and who has contracted with KP to manage the care of our Members being treated in community hospitals.

EPRP may deny authorization for some or all post-stabilization services. The verbal denial of authorization will be confirmed in writing. If EPRP denies authorization for requested post-stabilization care, KP shall not have financial responsibility for services if the Provider

nonetheless chooses to provide the care. If the Member insists on receiving such unauthorized post-stabilization care from the facility, we strongly recommend that the facility require that the Member sign a financial responsibility form acknowledging and accepting his or her sole financial liability for the cost of the unauthorized post-stabilization care and/or services.

If the Member is admitted to the facility as part of the stabilizing process and the facility has not yet been in contact with EPRP, the facility must contact the local Outside Services Case Manager at the appropriate number (see contact information in Section 2 of this Provider Manual) in order to discuss authorization for continued admission as well as any additional appropriate post-stabilization care once the Member's condition is stabilized.

4.6 Concurrent Review

The Northern California Outside Utilization Resource Services (NCAL OURS) Office and Plan Physicians will conduct concurrent review in collaboration with facilities. The review may be done telephonically or on site in accordance with the facility's protocols and KP's onsite review policy and procedure, as applicable.

Prior authorization is not required for out-of-plan hospitals rendering screening and stabilizing services in California. Outside Services Case Managers work with physicians to concurrently evaluate the appropriateness and indication of the out-of-plan care. KP will facilitate transfer and coordinate the continuing care needed by Members who are determined to be clinically stable for transfer to a KFH or contracting hospital.

When utilization problems are identified, KP will work with the facility to develop and implement protocols that are intended to improve the provision of services for our Members. A joint monitoring process will be established to observe for continued improvement and cooperation.

NCAL OURS and the Providers collaborate on concurrent review activities that include, but are not limited to:

- monitoring length of stay/visits
- providing day/service authorization, recertification, justification
- attending patient care conferences and rehabilitation meetings
- utilizing community benchmarking for admissions and average length of stay (ALOS)
- setting patient goal for Members
- conducting visits or telephonic reports, as needed
- developing care plans

4.7 Case Management Hub Contact Information

The specific contact information for NCAL OURS is as follows:

Main Phone Line:	**(925) 926-7303**
Toll free phone line:	**1-888-859-0880**
eFax:	**1-877-327-3370**

The NCAL OURS office is located in Walnut Creek, providing support for all Northern California KP Members admitted in any non-KP hospital, including those Members admitted out of the KP service area and out of the country.

4.8 Denials and Provider Appeals

Information about a denial or the appeal procedures is available via **Online Affiliate** (see section 3.1) or by contacting the Coverage Decision Support Unit (CDSU) or Member Services Contact Center (MSCC). Please refer to the written denial notice for applicable contact information or contact MSCC.

When a denial is made, the Provider is sent a UM denial letter accompanied by the name and direct telephone number of the decision-maker. All decisions concerning appropriateness and indication are made by physicians or licensed clinicians (as appropriate for behavioral health services). Physician UM decision-makers include, but are not limited to, DME physician champions, APICs for Outside Services, Pediatric Developmental Care Coordination Program (PDCP), other board-certified physicians or behavioral health practitioners.

If the physician or behavioral health practitioner does not agree with a decision concerning appropriateness and indication, the Provider may contact the UM decision-maker on the cover page of the letter or the Physician-in-Chief for discussion at the local facility. Providers may also contact the issuing department that is identified in the letter for additional information.

4.9 Discharge Planning

Providers such as hospitals and inpatient psychiatric facilities are expected to provide discharge planning services for Members, and to cooperate with KP to assure timely and appropriate discharge when the treating physician determines that the member no longer needs acute inpatient level care.

Providers should designate staff to provide proactive, ongoing discharge planning. Discharge planning services should begin upon the Member's admission and be completed by the medically appropriate discharge date. The Provider's discharge planner must be able

to identify barriers to discharge and determine an estimated date of discharge. Upon request by KP, Providers will submit documentation of the discharge planning process.

The Provider's discharge planner, in consultation with the Care Coordinator, will arrange and coordinate transportation, DME, follow-up appointments, appropriate referrals to community services and any other services requested by KP.

The Provider must request prior authorization for medically necessary follow-up care after discharge.

4.10 UM Information

To facilitate KP UM oversight, the Provider may be requested to provide information to the KP UM staff concerning the Provider's facility. Such additional information may include, but is not limited to, the following data:

- Number of inpatient admissions
- Number of inpatient readmissions within the previous 7 days
- Number of emergency department admissions
- Type and number of procedures performed
- Number of consults
- Number of deceased Members
- Number of autopsies
- ALOS
- Quality Assurance/Peer Review process
- Number of cases reviewed
- Final action taken for each case reviewed
- Committee Membership (participation as it pertains to Members and only in accordance with the terms of your contract)
- Utilization of psychopharmacological agents
- Other relevant information KP may request

4.11 Case Management

Care Coordinators work with treating Providers to develop and implement plans of care for acutely ill, chronically ill or injured Members. KP case management staff may include nurses and social workers, who assist in arranging care in the most appropriate setting and help coordinate other resources and services.

The PCP continues to be responsible for managing the Member's overall care. It is the Provider's responsibility to send reports to the referring physician, including the PCP, of

any consultation with, or treatment rendered to, the Member. This includes any requests for authorization or Member's inclusion in a case management program.

4.12 Clinical Practice Guidelines (CPGs)

Clinical Practice Guidelines (CPGs) are clinical references used to educate and support clinical decisions by practitioners at the point of care in the provision of acute, chronic and behavioral health services. The use of CPGs by practitioners is discretionary. However, CPGs can assist Providers in providing Members with evidence-based care that is consistent with professionally recognized standards of care.

The development of CPGs is determined and prioritized according to established criteria, which include number of patients affected by a particular condition/need, quality of care concerns and excessive clinical practice variation, regulatory issues, payor interests, cost, operational needs, leadership mandates and prerogatives.

Physicians and other practitioners are involved in the identification of CPG topics, as well as the development, review, and endorsement of all CPGs. The CPG team includes a core, multi-disciplinary group of physicians representing the medical specialties most affected by the CPG topic, as well as health educators, pharmacists, or other medical professionals.

The CPGs are sponsored and approved by one or more Clinical Chiefs groups, as well as by the Guidelines Medical Director. Established guidelines are routinely reviewed and updated. CPGs are available by contacting MSCC or the referring Plan Physician.

4.13 Pharmacy Services / Drug Formulary

KP has developed a quality, cost effective pharmaceutical program which includes therapeutics and formulary management. The Regional Pharmacy and Therapeutics (P&T) Committee reviews and promotes the use of the safest, most effective, and cost-effective drug therapies, and shares "Best Practices" with all KP Regions. The Regional P&T Committee's Formulary evaluation process is used to develop the applicable KP Drug Formulary (Formulary) for use by KP practitioners. Contracted practitioners are encouraged to use and refer to the Regional Drug Formulary when prescribing medication for Members (available at **http://kp.org/formulary**). Drug Coverage and Benefit policies can be found at:

https://kpnortherncal.policytech.com/ under the section, Pharmacy Policies: Drug Coverage Benefits.

For KP Medi-Cal Members without an alternate, primary coverage, medically necessary drugs, supplies and supplements are covered by DHCS, not KP. Coverage is based on the

DHCS Contract Drug List guidelines and Medi-Cal coverage criteria. The DHCS Drug Formulary, called the Contract Drug List, can be accessed on-line at:

https://medi-calrx.dhcs.ca.gov/home/cdl/

Pharmacy Benefits

Pharmacy services are available for Members who have benefit plans that provide coverage for a prescription drug program. For information on specific member benefit plans, please contact MSCC.

4.13.1 Filling Prescriptions

The Formulary can be accessed online in a searchable format. It provides the list of drugs approved for general use by prescribing practitioners. For access to the online version of the Formulary on the Internet or to request a paper copy, please refer to the instructions at the end of this section.

KP pharmacies do not cover prescriptions written by non-Plan Physicians unless an authorization for care by that non-Plan Physician has been issued. Please remind Members they must bring a copy of their authorizations to the KP pharmacy when filling the prescription. In limited circumstances, members may have a benefit plan design that covers prescriptions from non-KP Providers, such as for psychotropic drugs or IVF medications.

Practitioners are expected to prescribe drugs included in the Formulary unless at least one of the exceptions listed under "Prescribing Non-Formulary Drugs" in this section is met. If there is a need to prescribe a non-Formulary drug, the exception reason must be indicated on the prescription.

A Member may request a Formulary exception by contacting their KP physician directly through secure messaging or through the MSCC and will typically receive a response, including the reason for any denial, within 2 Business Days from receipt of the request.

Members will be responsible for paying the full price of their medication if the drugs requested are (i) non-Formulary drugs not required by their health condition, (ii) excluded from coverage (i.e., cosmetic use) or (iii) not prescribed by an authorized or Plan Provider. Any questions should be directed to the MSCC.

4.13.1.1 Prescribing Non-Formulary Drugs

Non-Formulary drugs are those that have not yet been reviewed, and those drugs that have been reviewed but given non-Formulary status by the Regional P&T Committee. However, the situations outlined below may allow a non-Formulary drug to be covered by the Member's drug benefit.

- **New Members**
  If needed and the Member's benefit plan provides, new Members may be covered for an initial supply (up to 100 days for Commercial Members and at least a month's supply of medication for Medicare Members) of any previously prescribed "non-Formulary" medication to allow the Member time to make an appointment to see a KP provider. If the Member does not see a KP provider within the first 90 days of enrollment, they must pay the full price for any refills of non-Formulary medications.
- **Existing Members**
  A non-Formulary drug may be prescribed for a Member if they have an allergy, or intolerance to, or treatment failure with all Formulary alternatives or has a special need that requires the Member to receive a non-Formulary drug. In order for the Member to continue to receive the non-Formulary medication covered under their drug benefit, the exception reason must be provided on the prescription.

NOTE: Generally, non-Formulary drugs are not stocked at KP pharmacies. Therefore, before prescribing a non-Formulary drug, call the pharmacy to verify the drug is available at that site.

The KP Formulary may be found at **http://kp.org/formulary**

4.13.1.2 Pharmacies

KP pharmacies provide a variety of services including: filling new prescriptions, transferring prescriptions from another pharmacy, providing refills and medication consultations.

4.13.1.3 Telephone and Internet Refills

Members may request refills on their prescriptions, with or without refills remaining, by calling the pharmacy refill number on their prescription label. All telephone requests should be accompanied by the Member's name, MRN, daytime phone number, prescription number and credit or debit card information.

Members may also refill their prescriptions online by accessing the KP Member website at **http://www.kp.org/refill**.

4.13.1.4 Mail Order

Members with a prescription drug benefit are eligible to use the KP "Prescription by Mail" service. For more information regarding mail order prescriptions please contact the Mail Order Pharmacy at **(888) 218-6245**.

Only maintenance medications should be ordered for delivery by mail. Acute prescriptions such as antibiotics or pain medications should be obtained through a KP pharmacy to avoid delays in treatment.

4.13.1.5 Restricted Use Drugs

Some drugs (i.e., chemotherapy) are restricted to prescribing only by approved KP specialists. Restricted drugs are noted in the Formulary. If you have any questions regarding prescribing restricted drugs, please call the main pharmacy at the local KP facility.

4.13.1.6 Emergency Situations

If emergency medication is needed when KP pharmacies are not open, Members may use non-KP pharmacies. The Member will have to pay the full retail price in this situation, they should be instructed to download a claim form on KP.org or to call Member Services at **(800) 464-4000** (**TTY: 711)** to obtain a claim form in order to be reimbursed for the cost of the prescription less any copayments, co-insurance and/or deductibles (sometimes called Member Cost Share) which may apply.

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. KFHP is responsible for payment of claims in accordance with your Agreement. Please note that this Provider Manual does not address submission of claims for fully insured or self-funded products underwritten or administered by Kaiser Permanente Insurance Company (KPIC).

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. Please note that this Provider Manual does not address submission of claims for fully insured or self-funded products underwritten or administered by Kaiser Permanente Insurance Company (KPIC). See Northern California Self-Funded Provider Manual.

You are encouraged to submit claims to KP via the Electronic Data Interchange (EDI) process identified in section 5.5 (Submission of Electronic Claims). The EDI submission process is simple, efficient, and results in KP receiving your claims more quickly than paper submissions. When you utilize the EDI claims submission process you will receive an Electronic Remittance Advice (ERA) via your clearinghouse. You also have the option to receive claims payment via Electronic Funds Transfer (EFT). KP in collaboration with Citi® Payment Exchange Network (PMTX) has developed a one-stop portal for ERA/EFT processing and account management. For more information about these programs see section 5.24 (Explanation of Payment and Remittance Advice) or visit the Electronic Claims, Payments, and Remits resource guide at **https://online.flippingbook.com/view/704125376/i/.**

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 see Sections 5.4.1 and 5.4.2 below.

5.2 Methods of Claims Submission

Providers are encouraged to submit claims electronically via Electronic Data Interchange (EDI) for prompt and efficient claims processing, payment and results in KP receiving your claims more quickly than paper submissions. Providers must submit itemized claims for covered services rendered to KP members using a CMS approved Claims Billing Form.

- KP does not accept claims that are handwritten, faxed or photocopied.
- Institutional charges must be submitted using HIPAA compliant 837I EDI file or preprinted OCR red lined UB-04 (or successor) Claim form, with appropriate coding, and mandatory entries in accordance with National Uniform Billing Committee (NUBC) directives federal statutes and regulations. Ref: WWW.NUBC.ORG.

- Professional charges must be submitted using HIPAA compliant 837P EDI file or preprinted OCR red lined CMS-1500 v 0212 form (or successor) with current ICD-10 diagnostic and CPT-4 procedure coding (or successor coding accepted commonly in the industry). Entries must be completed in accordance with National Uniform Claim Committee (NUCC) directives and contain all mandatory entries, as required by federal statutes and regulations. Ref: **WWW.NUCC.ORG.**

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. Leave the TOTAL CHARGE on preceding pages of the claim blank.

UB04

The UB04 claim form supports 22 charge lines per form page. 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

For inpatient services only, we will accept separate claims on a weekly basis for services provided in an inpatient facility to the extent required by California Law (28 CCR 1300.71(a)(7)(B)). Interim facility claims should be submitted using the facility's same patient control number/account number as used on the facility's initial claim. KP will accept the initial interim claim billed with Bill Type 112. All subsequent interim claims must be billed as an adjusted claim with Bill Type 117, including the cumulative charges accrued to each subsequent "through" date (see sample below). Interim inpatient facility claims must follow then-effective CMS billing requirements as provided in the CMS Claims Processing Manual. Interim claims not billed in accordance with the guidelines in this section 5.3.5 will be denied.

Example of Interim Billing Process Prior to 01/01/2024:

Bill Type	Discharge Status	From and Through Dates	Billed Charges
112	30	01/01/2023 – 01/31/2023	$ 150,000.00
113	30	02/01/2023 – 02/28/2023	$ 250,000.00
113	30	03/01/2023 – 03/31/2023	$ 175,000.00
114	01	04/01/2023 – 04/10/2023	$ 55,000.00

Example of Interim Billing Process Effective 01/01/2024:

Bill Type	Discharge Status	From and Through Dates	Billed Charges
112	30	01/01/2023 – 01/31/2023	$ 150,000.00
117	30	02/01/2023 – 02/28/2023	$ 400,000.00
117	30	03/01/2023 – 03/31/2023	$ 575,000.00
117	01	04/01/2023 – 04/10/2023	$ 630,000.00

5.3.6 Psychiatric and Recovery Services Provided to Medi-Cal Members

Depending upon the county in which a Medi-Cal Member resides, claims for such Member's psychiatric and recovery services may be processed directly by the county. Providers will be notified at the time a Member is referred to the Provider of the Member's Medi-Cal status, and whether the claim will be processed by KP or by the county agency. Additionally, KP will give the Provider a telephone number to obtain authorization and billing information from the county for these Members.

5.4 Paper Claims

5.4.1 Submission of Paper Claims

All Claims should be sent to:

Kaiser Foundation Health Plan, Inc.
National Claims Administration
P.O. Box 12923
Oakland, CA 94604-2923
Phone: 1-800-390-3510

Claims as part of a **transplant** case should be sent to:

Kaiser Referral Invoice Service Center (RISC)
2829 Watt Avenue, Suite #130
Sacramento, CA 95821-6242

5.4.1.1 Contacting KP Regarding Referred Services Claims

Inquiries regarding referred services may be directed to KP by calling **(800) 390-3510**.

5.4.1.1 Contacting KP Regarding Referred Services Claims

Inquiries regarding referred services may be directed to KP by calling **(800) 390-3510**.

5.4.1.2 Online Provider Tools (KP Online Affiliate)

KP offers an online provider portal designed to streamline processes for both contracted and non-contracted provider groups. This portal includes several time-saving features, such as:

- Accessing patient eligibility, benefits, and demographics
- Viewing referrals and authorizations (for contracted providers)
- Viewing and downloading Explanation of Payments (EOP)
- Checking the status of submitted claims and viewing claim details including service date, billed amount, allowed amount, and claim codes.
- Confirming payment information such as check number, payment date, and total amount.

Additionally, you can manage your submitted claims through the portal using the Claims "Take Action" functionality. This feature allows you to:

- Respond to KP Request for Information.
- Submit a claim inquiry related to 'denied' or 'in progress' claims.
- Submit appeals or disputes to request a reconsideration of a payment.
- Submit an inquiry related to a check payment, request a copy of a check, or report a change of address for a specific claim.

To access the KP Online Affiliate portal, please visit the following link, choose your region, and navigate to the **Online Provider Tools** section: **https://kp.org/providers**

5.4.2.1 Calling KP Regarding Emergency Claims

For submission requirements or status inquiries regarding claims for emergency services, please visit **Online Affiliate** (see section 3.1) or contact KP by calling **(800) 390-3510**.

5.4.3 Supporting Documentation for Paper Claims

In general, additional information is not required and the standard claims forms and EDI are sufficient in most instances. When additional information is required it will be requested. Note this additional information can be submitted via KP's **Online Affiliate** tool. Additional information may include the following, to the extent applicable to the services provided:

- Admitting face sheet
- Discharge summary
- Operative report(s)
- Emergency room records with respect to all emergency services
- Treatment and visit 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

Under certain circumstances, KP is required by law to report and verify appropriate supporting documentation for Member diagnoses, in accordance with industry-standard coding rules and practices. As a result, KP may from time to time, in accordance with your Agreement, request that you provide, or cause to be provided by any subcontractors or other parties, copies of or access to (including on-site or remote access by KP personnel) medical records, books, materials, notes, paper or electronic files, and any other items or data to verify appropriate documentation of the diagnoses and other information reflected on claims or invoices submitted to KP. KP expects that the medical records properly indicate the diagnoses in terms that comply with industry-standard coding rules and practices. Further, it is essential that access to, or copies of, this documentation be promptly provided, and in no event should you do so later than five (5) Business Days after a request has been made so KP may make any necessary corrections and report to appropriate governmental programs in a timely fashion.

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

5.4.4 Ambulance Services

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

Relation Insurance
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
1-888-505-0468
EDI Payor ID: 59299

5.5 Submission of Electronic Claims

5.5.1 Electronic Data Interchange (EDI)

KP encourages Providers to submit electronic claims (837I/P transaction). Electronic claim transactions eliminate the need for paper claims. 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. KP requires all EDI claims be HIPAA compliant.

For information or questions regarding EDI with KP, please reference:

https://online.flippingbook.com/view/704125376/i/

5.5.2 Where to Submit Electronic Claims

Providers must submit their EDI claim via a clearinghouse. Clearinghouses frequently supply the required PC software to enable direct data entry in the Provider's office. Providers may use their existing clearinghouse if their clearinghouse is able to forward the EDI claim to one of KP's direct clearinghouses.

Each clearinghouse assigns a unique identifier for KFHP. Payer IDs for KP's direct clearinghouses are listed below:

Clearinghouse	NCAL Payer IDs
Emdeon	94135
Office Ally	94135
Relay Health	RH009
SSI	NKAISERCA

When a Provider sends an EDI claim to their clearinghouse, the clearinghouse receives the claim, may edit the data submitted by the Provider in order for it to be HIPAA compliant, and then sends it on to KP or one of KP's direct clearinghouses.

5.5.3 EDI Claims Acknowledgement

When KP receives an EDI claim we transmit an electronic acknowledgement (277CA transaction) back to the clearinghouse. This acknowledgement includes information about whether claim was accepted or rejected. The Provider's clearinghouse should forward this confirmation for all claims received or rejected by KP. Electronic claim acknowledgements also identify specific errors on rejected claims. Once the claims listed on the reject report are corrected, the Provider may resubmit these claims electronically. Providers are responsible for reviewing clearinghouse acknowledgment reports. If the Provider is unable to resolve EDI claim errors, please contact EDI Support by submitting a support case to:

https://kpnationalclaims.my.site.com/EDI/s/

NOTE: If you are not receiving electronic claim reports from the clearinghouse, contact your clearinghouse to request them.

5.5.4 Supporting Documentation for Electronic Claims

If supporting documentation is required to process an EDI claim, KP will request the supporting documentation and let you know where to send the information. Note, this additional information can be submitted via KP's **Online Affiliate** tool.

Providers are invited and encouraged to submit KP Request for Information via Online Affiliate.

To access the KP Online Affiliate portal, click on the following link, choose your region, and navigate to the **Online Provider Tools** section:

https://kp.org/providers

5.5.5 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. HIPAA Implementation Guides can also be ordered by calling Washington Publishing Company (WPC) at **(301) 949-9740**.

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

5.6 Complete Claim

The provider is required to submit "complete claims" as defined in 28 CCR 1300.71(a)(2) for the services provided. A "complete claim" must include the following information, as applicable:

- Correct Form: All professional claims should be submitted using preprinted red OCR CMS-1500 or the EDI 837P file, and all facility claims (or appropriate ancillary services) should be submitted using preprinted red OCR UB-04 or EDI 837I file based 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, or this additional information can be submitted via KP's **Online Affiliate** tool. Providers are invited and encouraged to request access to KP's Online Affiliate tool. These and other functions are available on a self-serve basis, 24/7. Please see the Northern California Community Provider Portal (CPP) for more 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.

In addition, depending on the claim, additional information may be necessary if it is "reasonably relevant information" and "information necessary to determine payer liability" (as each such term is defined in 28 CCR 1300.71(a)(10) and (11)).

A claim is not considered to be complete or payable if one or more of the following exists:

- 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
- A claim submitted without a National Drug Code (NDC), as applicable
- 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 complete claim.

For further information and instruction on completing claims forms, please refer to the CMS website (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.

5.7 Claims Submission Timeframes

KP requests that Providers submit claims for services provided to Members 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.

To the extent required by law, claims that are denied because they are filed beyond the applicable claims filing deadline shall, upon a Provider's submission of a provider dispute notice as described in Section 6 of this Provider Manual and the demonstration of good cause for the delay, be accepted and adjudicated in accordance with the applicable claims adjudication process.

5.8 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. KP will consider system generated reports that indicate the original date of claim submission. Please note that handwritten or typed documentation is not acceptable proof of timely filing.

5.9 Claims Receipt Verification and Status

Claim status inquiries are supported exclusively by our KP **Online Affiliate** tool. Whether you submit your claims via paper or EDI, the portal should be used to answer simple claim status questions such as:

- Did KP receive my claim?
- What is the status of my claim; is my claim in process or has adjudication been finalized?
- What is the status of my claim; has my claim been paid or denied?
- What is the amount paid on my claim?
- When was the check/payment sent? What is the check number?

Providers are invited and encouraged to check claim status via KP's **Online Affiliate.**

To access the KP Online Affiliate portal, click on the following link, choose your region, and navigate to the **Online Provider Tools** section: **https://kp.org/providers**

Your clearinghouse is an alternative method to verify KP has received your claim. When KP receives an EDI claim we transmit an electronic acknowledgement (277CA transaction) back to the clearinghouse.

5.10 Claim Corrections

A claim correction can be submitted via the following procedures. KP will identify a corrected claim based on the coding described below:

Paper Claims - Corrected claims should be submitted using CMS standards that include the use of Frequency Code 7 in field 22 on the CMS form along with the original claim number. Claims submitted without the original claim number will be rejected. For UB Claims use Frequency Code 7 in the bill type field, and again provide the original claim number in the document control number field (box 64). Claims submitted without the original claim number will be rejected. Late charges (late posting of billed charges) must be submitted with appropriate Type of Bill code (e.g., xx5)

Electronic Replacement/Corrected Claim Submissions

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

Claim Frequency Codes

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

Code	Description	Filing Guidelines	Action
5 Late Charge(s)	Use to submit additional charges for the same date(s) of service as a previous claim	File electronically as usual. Include only the additional charges that were not included on the original claim.	KP recommends using the replacement claims process for this scenario.
7 Replacement of Prior Claim	Use to replace an entire claim (all but identity information)	File electronically as usual. File the claim in its entirety, including all services for which you are requesting reconsideration.	KP will adjust the original claim. The corrections submitted represent a complete replacement of the previously processed claim.
8 Void/Cancel of Prior Claim	Use to eliminate a previously submitted claim for a specific provider, patient, insured and "statement covers period"	File electronically, as usual. Include all charges that were on the original claim.	KP will void the original claim from records based on request. If original claim was paid, a refund will be requested of the previously paid amount

For information about electronic claims submission please visit the KP EDI resource guide at **https://online.flippingbook.com/view/704125376/i/** or

contact the Northern California Kaiser Permanente EDI team by clicking on the following link: **https://kpnationalclaims.my.site.com/EDI/s/**

When submitting claims noted with claims frequency code 7 or 8, the original KP claim number, also referred to as the Document Control Number (DCN) **must** be submitted in

Loop 2300 REF02 – Payer Claim Control Number with qualifier F8 in REF01. The DCN can be obtained from the 835 Electronic Remittance Advice (ERA). Alternately, providers may contact MSCC to obtain the original KP DCN if needed. Without the original KP DCN, adjustment requests will generate a compliance error and the claim will reject. KP only accepts claim frequency code 7 to replace a prior claim or 8 to void a prior claim.

Electronic Claims (CMS 1500) - Corrections to CMS-1500 claims which were already accepted can be re-submitted electronically. The claim must include the appropriate resubmission code and the original KP claim number/DCN. Claim corrections submitted without the appropriate frequency code will deny and the original KP claim number will not be adjusted. For additional information on submitting electronic replacement claims please refer to the table and example below.

Code	Action
7 - Replacement of Prior Claim	KP will adjust the original claim. The corrections submitted represent a complete replacement of the previously processed claim.
8 – Void/Cancel Prior Claim	KP will void the original claim from records based on request. If original claim was paid, a refund of the previously paid amount will be requested.

An example of the ANSI 837 CLM segment containing the Claim Frequency Code 7, along with the required REF segment and Qualifier in Loop ID 2300 – Claim Information, is provided below.

CLM*12345678*500***11:B:7*Y*A*Y*I*P~

REF*F8*(Enter the Original Claim Number, also known as Document Control Number)

Electronic Claims (UB-04) - Corrections to UB-04 claims which were already accepted can be re-submitted electronically. The claim must include the appropriate frequency code, the appropriate Type of Bill code (e.g., xx7) and the original KP claim number/DCN. For additional information on submitting electronic replacement claims, refer to the table and example below.

Code	Action
5 – Late Charge(s)	KP will review claim/charges independently to determine if an additional amount is owed to the provider. Please see Note below for KP's recommendation on late charge submission. This frequency code applies ONLY to institutional claims.
7 – Replacement of Prior Claim	KP will adjust the original claim. The corrections submitted represent a complete replacement of the previously processed claim. This code is not intended to be used in lieu of late charges.
8 – Void/Cancel Prior Claim	KP will void the original claim from records based on request. If original claim was paid, a refund of the previously paid amount will be requested.

When submitting corrected institutional claims, take note of CLM05-2, the Facility Code Qualifier. In this instance, the CLM05-2 field requires a value of "A" indicating an institutional claim, along with the appropriate frequency code (7) as illustrated in the example below.

CLM*12345678*500***11:**A**:7*Y*A*Y*I*P~

REF*F8(Enter the Original Claim Number, also known as Document Control Number)

Note: KP recommends that if a charge was left off the original claim, submit the additional charge with all the previous charges as a replacement claim using frequency code 7. All charges for the same date of service should be filed on a single claim.

5.11 Incorrect Claims Payments

Most questions regarding claim payments can be resolved by submitting a Claim Inquiry using the KP **Online Affiliate** tool or over the phone by contacting the number indicated on the Explanation of Payment (EOP). KP's Claim Services **(800) 390-3510** can also assist with all claim payment inquiries.

5.11.1 Underpayments

If an underpayment has been confirmed, KP will issue a supplemental payment to the Provider.

5.11.2 Overpayments

5.11.2.1 Overpayment Identified by Provider

If you receive an overpayment directly from KP or as a result of coordination of benefits, you must notify KP promptly upon discovery and return the overpayment to the appropriate address below as soon as possible. In addition, you must return any overpayment identified by KP within thirty (30) working days after receipt from KP of a notice of overpayment, unless you contest such notice. If you contest all or any portion of the overpayment described in the KP notice, you must send a written notice identifying the contested amount and the basis upon which you believe the claim(s) was (were) not overpaid, within thirty (30) working days after receipt of the notice of overpayment. Such required written notice must be provided to KP in accord with the terms of your Agreement or as described in the notice of overpayment. If your Agreement so provides, KP may offset from future claims payments the amount of any uncontested overpayment not paid by you within the thirty (30) working day repayment period.

- You may return the original, KP-issued check, the EOP, and a note regarding the erroneous payment to KP and a check will be reissued less the erroneous payment, or
- You may issue a refund check payable to Kaiser Permanente and return it to the address listed below along with a copy of the EOP and a note explaining the erroneous payment

Please include the following information when returning uncontested overpayments:

- Name of each Member who received care for which an overpayment was received
- Copy of each applicable remittance advice
- Primary carrier information, if applicable
- Each applicable Member's Kaiser Permanente medical record number MRN
- Authorization number(s) for all applicable non-emergency services
- Claim Number(s)
- Date(s) of Service

To return overpayments for **referred (non-emergency) services**, either send the **original, KP-issued check** to:

KP Referral Invoice Service Center (RISC)
2829 Watt Avenue, Suite 130
Sacramento, CA 95821-6242

or send your **Provider-issued refund check** to:

Kaiser Permanente
TPMG Claims Referral Refund, NCAL
P.O. Box 743375
Los Angeles, CA 90074-3375

To return overpayments for **emergency services**, either send the **original, KP-issued check** to:

KP National Claims Administration
P.O. Box 12923
Oakland, CA 94604

or, send your **Provider-issued refund check** to:

KP Claims Recovery, NCAL
P.O. Box 742120
Los Angeles, CA 90074-2120

5.11.2.2 Overpayment Identified by KP

If KP determines that we have overpaid a claim, we will notify you in writing through a separate notice clearly identifying the claim, the name of the patient, the date(s) of service and a clear explanation of the basis upon which we believe the amount paid on the claim was in excess of the amount due. The refund request will include interest and penalties on the claim where applicable.

5.11.2.3 Contested Notice

If you contest our notice of overpayment of a claim, we ask that you send us a letter within 30 Business Days of your receipt of the notice of overpayment to the address indicated by KP in the notice of overpayment. Such letter should include the basis upon which you believe that the claim was not overpaid. If your contested claim notice to KP does not include the basis upon which you believe the claim was not overpaid, then that basis must be provided in writing no more than 365 Calendar Days following your initial receipt of the KP notice of overpayment. We will process the completed letter of contest in accordance with the KP payment dispute resolution process described in this Provider Manual.

5.11.2.4 No Contest

If you do not contest our notice of overpayment of a claim, you must reimburse us within 30 Business Days of your receipt of our notice of overpayment of a claim. Interest will begin to accrue at the rate of ten (10) percent per annum on the amount due beginning with the first Business Day following the initial 30 Business Day period.

5.11.2.5 Offset to Payments

We will only offset an uncontested notice of overpayment of a claim against a Provider's current claim submission when: (i) the Provider fails to reimburse KP within the timeframe set forth above, and (ii) KP's contract with the Provider specifically authorizes KP to offset an uncontested overpayment of a claim from the Provider's current claims submissions or KP has obtained other written offset authorization from the Provider. In the event an overpayment of a claim or claims is offset, the Explanation of Payment (EOP) includes a Recoupment Detail Report. This report provides additional details about your vendor balance and offset, including which claims the offset was applied to.

5.11.3 Inconsistent Payments

If you identify a consistent and large number of tracer/follow-up claims or payment errors every month, a potential problem in the workflow/processing cycle—whether in the billing process or payment operation—may exist.

If the payment issue involves claims submitted for Referred Services, contact TPMG-ProviderClaims@kp.org (see also Section 2.4).

If the payment issues involve claims submitted for Emergency Services, Skilled Nursing Facility (SNF), Home Health or Hospice Services, contact National Claims Administration (see also Section 2.1).

The responsible department will work with the Provider's office to identify and correct the source of the problem. Before contacting KP in either of these situations, please consider the following items in the Provider's billing process:

- Are the original claims being submitted in a timely fashion?
- Are follow-up dates based on the date the original claim was mailed to KP versus the date-of-service?
- Have all payments been posted to patient accounts?
- Is the information (health plan, patient name, etc.) correct on the claim?
- Did the payment received match the expected reimbursement rate on allowed charges?

5.12 Member Cost Share

Member Cost Share refers to the amount a Member is responsible to pay a Provider for certain covered services, for example, in the form of a co-payment, co-insurance or deductible. Depending on the benefit plan and type of service, Members may be responsible to share some cost of the services provided.

Providers are invited and encouraged to check member cost share via the KP **Online Affiliate** portal**.**

To access the KP Online Affiliate portal, please visit the following link, choose your region, and navigate to the **Online Provider Tools** section: https://kp.org/providers

Please verify applicable copayments, co-insurance and/or deductibles (Member Cost Share) at the time of service by utilizing Online Affiliate or, alternately, contacting one of the resources below:

KP Claims and Referrals Member Services
(800) 390-3510
Monday - Friday from 8 A.M. to 5 P.M., Pacific Time Zone (PT)

Self-Service is available in the IVR System
(888) 576-6789
24 hours / 7 days a week

- Providers are responsible for collecting Member Cost Share as explicitly required by your Agreement and in accordance with Member benefits
- Claims submitted by Providers who are responsible for collecting Member Cost Share will be paid at the applicable rate(s) under your Agreement, less the applicable Member Cost Share amount due from the Member
- You must not waive any Member Cost Share you are required to collect, except as expressly permitted under applicable law and your Agreement

When a Medicare Advantage Member is also enrolled in Medi-Cal (or another State's Medicaid program) and any such Medicaid program is responsible for the Member's Medicare Advantage Cost Share. Providers should either accept payment pursuant to their Agreement as payment in full or bill the applicable Medicaid program for the Member's Cost Share. As required by Medicare regulations and as outlined in your Agreement, you are prohibited from collecting cost-sharing for Medicare covered services from Members dually enrolled in the Medicare and Medicaid programs. This requirement also applies to individuals enrolled in the Qualified Medicare Beneficiary (QMB) Program, a program that pays for Medicare premiums and cost-sharing for certain low-income Medicare beneficiaries. Accordingly, it is imperative that you take steps to avoid inappropriate billing/collection of cost-sharing from dual eligible beneficiaries, including QMB enrollees. KP's contract with the Medicare program requires that we actively educate contracted providers about this requirement and promptly address any complaints from dual-eligible beneficiaries/Members alleging that cost-sharing was inappropriately requested or collected. If you have questions about these requirements or regarding a Member's eligibility status, please contact the MSCC.

5.13 Billing for Service Provided to Visiting Members

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

- Claims must be submitted to the visiting Member's "Home" region, as shown on the visiting Member's Health ID Card
    - If the Member does not have their Health ID Card or the "Home" region's claim submission address is not on their Health ID Card, call the corresponding "Home" region's number listed below to obtain the claims address.
- **Always** use the visiting Member's "Home" region MRN on the claim form
- Claims for services requiring prior KP authorization **must** include the authorization number

Please contact the "Home" region's number below for status inquiries on your visiting Member claims:

Regional Member Services Call Centers	
Northern California	(800)-464-4000
Southern California	(800)-464-4000
Colorado	(800) 632-9700
Georgia	(888) 865-5813
Hawaii	(800) 966-5955
Mid Atlantic	(800) 777-7902
Northwest	(800) 813-2000
Washington (formerly, Group Health)	(888) 901-4636

5.14 Coding for Claims

It is the Provider's responsibility to ensure that billing codes used on claim forms are current and accurate, that codes reflect the services provided and that coding complies with commonly accepted standards adopted by KP, including those specified in Section 5.15 below. Claims that use nonstandard, outdated or deleted CPT, HCPCS, ICD-10, or Revenue codes or are otherwise outside the coding standards adopted by KP will be subject to processing delay, rejection, and/or adjustment.

5.15 Coding Standards

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

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

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

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) maintained by the ICD-10-CM and ICD-10-PCS Coordination and Maintenance Committee which includes the 4 cooperating parties: the American Hospital Association (AHA), the CMS, the National Center for Health Statistics (NCHS) and the American Health Information Management Association (AHIMA), 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 (CPT), Fourth Edition 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 Health Care 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)
Codes for 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-V (American Psychiatric Services)
For psychiatric services, codes distributed by the American Psychiatric Association

5.16 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, assign modifiers according to the current CPT guidelines.

5.17 Modifier Review

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

KP 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.

5.18 Claims Review and Adjustments; Coding and Billing Validation

KP reviews claims (including coding) based on commonly accepted standards of coding and billing and adjusts payment on claims in accordance with your Agreement, the provisions below, and applicable law.

If you believe we have made an incorrect adjustment to a claim that has been paid, please contact the office that issued the payment identified on the remittance advice and EOP. Additionally, you may refer to Section 6.2 of this Provider Manual for information on how to dispute such adjustment. When submitting the dispute resolution documentation, please clearly state the reason(s) you believe the claim adjustment was incorrect.

5.18.1 Compensation Methodologies

The terms of your Agreement and this Provider Manual govern the amount of payment for services provided under your Agreement. Depending on your specific Agreement provisions, KP utilizes various compensation methodologies including, but not limited to, case rates, fee schedules, the Average Wholesale Price from the most recently published IBM Micromedex® Red Book®, and/or Medicare guidelines. KP calculates anesthesia units

in 15-minute increments. KP also uses PPS rates. Notwithstanding the effective date of any rate or rate exhibit to the Agreement, and unless provided otherwise in the Agreement, inpatient services for which the episode of care spans multiple days are generally paid in accordance with the rate(s) in effect on the date the episode began (i.e., the admit date or first date of service). This may include application of compensation methodologies such as per diems, percentage of charges, case rates, etc. When payment for inpatient hospital services is based on the Medicare allowable payment, the payment rate is based on the MS-DRG determined upon discharge. Outpatient services are generally paid in accordance with the applicable rate in effect on the date of service. Please refer to your Agreement for more detailed information on the compensation methodologies which apply to you.

5.18.2 Code Review and Editing

KP's claims payment practices for provider services generally follow industry standards, including those specified below, as well as those described in our policy entitled "POL-020 Clinical Review Payment Determination Policy," a copy of which is attached hereto as Appendix A.

Routinely updated code editing software from national vendors is used for processing all relevant bills in a manner consistent with industry standards, including guidelines from CMS, the National Correct Coding Initiative, the National Library of Medicine, the National Center for Health Statistics, the American Medical Association, and medical and professional associations. Our claims adjudication systems accept and identify all active CPT and HCPCS codes as well as all coding modifiers. Claims for services such as multiple procedures, bilateral procedures, assistant surgeons, co-surgeons and application of modifiers are adjudicated and paid in accordance with the terms of your Agreement, Medicare guidelines, and other commonly accepted standards. We use Medicare's parameters to define global surgery periods. When applicable, we request supportive documentation for "unlisted" procedure codes and the application of Modifier 26, 59, XE, XP, XS, XU, and/or other modifiers if needed. Billing as a co-surgeon with Modifier 62 or for increased services with Modifier 22 requires submission of a separate operative report.

We do not allow code unbundling for procedures for which all-inclusive codes should be used, and we will re-bundle the procedures and pay according to the appropriate all-inclusive codes. KP 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.

Notwithstanding the above, unless your Agreement provides otherwise, for Medi-Cal member claims we will apply Medi-Cal coding policies as published from time to time by the Department of Health Care Services, as required by and in accordance with Medi-Cal program requirements.

5.18.3 Coding Edit Rules

The table below identifies common edit rules.

Edit Category	Description	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	Deny component codes, replace with a comprehensive code
Incidental	Procedure performed at the same time as a more complex primary procedure	Deny if procedure deemed to be incidental
	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

5.18.4 Clinical Review

Claims may be reviewed by a physician or other appropriate clinician to ensure providers comply with commonly accepted standards of coding and billing, that services rendered are

appropriate and medically necessary, and payment is made in accordance with applicable requirements set forth in your Agreement, this Provider Manual, and KP's claims payment policies. If we do not have enough information to adjudicate a claim, we will mail you a request for specific additional medical records. We may also request itemized bills.

KP's claims payment policies are available on the Community Provider Portal website, at:

http://kp.org/providers/ncal/

KP will review for items or services that are considered inclusive of, or an integral part of, another procedure or service, and where appropriate deny. The standards applied by KP to determine whether billed items or services are payable are described in POL-020, "Clinical Review Payment Determination Policy." A copy of POL-020 is attached hereto as Appendix A.

5.18.5 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 copayments, co-insurance and/or deductibles (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 9.6 of this Provider Manual. KP 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

[2] See, CMS Provider 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."

Specifically, in an acute care hospital setting, the selected conditions was not present on admission. That is, the case would be paid as though the secondary diagnosis were not present.

- The 14 categories of HACs are listed below:
- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Stage III and IV Pressure Ulcers
- Falls and Trauma
  Fractures
  Dislocations
  Intracranial Injuries
  Crushing Injuries
  Burn
  Other Injuries
- Manifestations of Poor Glycemic Control
  Diabetic Ketoacidosis
  Nonketotic Hyperosmolar Coma
  Hypoglycemic Coma
  Secondary Diabetes with Ketoacidosis
  Secondary Diabetes with Hyperosmolarity
- Catheter-Associated Urinary Tract Infection (UTI)
- Vascular Catheter-Associated Infection
- Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG):
- Surgical Site Infection Following Bariatric Surgery for Obesity
  Laparoscopic Gastric Bypass
  Gastroenterostomy
  Laparoscopic Gastric Restrictive Surgery
- Surgical Site Infection Following Certain Orthopedic Procedures
  Spine
  Neck
  Shoulder
  Elbow
- Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)
- Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures:
  Total Knee Replacement
  Hip Replacement
- Iatrogenic Pneumothorax with Venous Catheterization
- Any new Medicare fee-for-service HAC later added by CMS

[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.pdfhttps://www.cms.gov/HospitalAcqCond/Downloads

5.18.6 Claims for Do Not Bill Events

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.

- **CMS 1500** – If you submit a CMS 1500 Claim (or its successor) or an 837P 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.
- **UB-04** – If you submit a UB-04 Claim (or its successor) or an 837I 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:
  - **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.
  - **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.
  - **Present on Admission (POA)**. This 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.

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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 Provider 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).

5.19 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.

5.19.1 How to Determine the Primary Payor

Primary coverage is determined using the guidelines established under applicable law. Examples are:

- With respect to adults, the plan that covers an individual as an employee, subscriber, policy holder or retiree, but not as, a dependent, is the primary plan. The plan that covers the individual as a dependent is the secondary plan. If the adult is a Medicare beneficiary, then Centers for Medicare & Medicaid Services (CMS) Guidelines apply. CMS Guidelines may be found at:

  https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Overview

- When a dependent child whose parents are married or are living together is covered by both parents' plans, the "birthday rule" applies. The payor for the parent whose birthday falls earlier in the calendar year (month and day) is the primary payor.

A commercial benefit plan is primary to Medicare Fee For Service or a Medicare Advantage plan when the Medicare beneficiary is covered by a Large Employer Group Health Plan (EGHP) as a result of their own current employment status, or a family member's current employment status when the CMS Working Aged or Disabled Beneficiaries provisions apply.

- Medicare Fee For Service or a Medicare Advantage plan is primary for beneficiaries who are covered by an EGHP and whose subscriber is a retiree of the EGHP when the CMS Working Aged or Disabled Beneficiaries provisions apply.
- Medicare Fee For Service or a Medicare Advantage plan is primary to EGHP for individuals eligible for or entitled to Medicare benefits based on an End Stage Renal Disease (ESRD) diagnosis after the coordination period as stipulated the Medicare Secondary Payer Provisions for ESRD Beneficiaries.
- 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 benefit plan is the primary payor

Please visit **Online Affiliate** (see section 3.1) or contact the Member Services Contact Center (MSCC) with any questions you may have about COB.

5.19.2 Description of COB Payment Methodology

Coordination of Benefits allows benefits from multiple health benefit plans or carriers to be considered cumulatively so the Member receives the maximum benefit from their primary and secondary health benefit plans together.

Please note that the primary payor payment must be specified on the claim, and the primary payor's EOP needs to be submitted as an attachment to the claim.

When KP is secondary to another payor, KP will coordinate benefits and determine the amount payable to the Provider, where the standard payment determination methodology is to pay up to the primary payor's allowable, not to exceed what KP would have paid as a primary payor.

5.19.3 COB Claims Submission Requirements and Procedures

If a claim is submitted to KP without the appropriate primary payment information and patient responsibility included on the EDI claim submission, or the primary payor's EOP is not provided when another payor is primary, KP will deny payment of the claim. The Provider needs to first submit a claim to the other (primary) payor. Within 90 Calendar Days (or longer period if required under applicable law or expressly permitted under your Agreement) after the primary payor has paid its benefit, please resubmit the claim to KP. The claim will be reviewed and the amount of payment due, if any, will be determined based on the terms of your Agreement.

Secondary claims can be submitted to KP via EDI.

Specific 837 data elements are used to ensure benefits are coordinated between KP and other plans. This is known as the "Provider-to-Payer-to-Provider" model.

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

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

Upon receipt of the 835, the provider sends a second 837 with COB information populated in Loops 2320, 2330A-G, and/or 2430 to the secondary payor. The secondary payor adjudicates the claim and sends an 835 Payment Advice to the provider.

KP recognizes submission of an 837 transaction to a sequential payor populated with data from the previous payor's 835. Based on the information provided the claim will be adjudicated without the paper copy of the Explanation of Benefits from Medicare or the primary payor.

When more than one payor is involved in a claim, data elements for all prior payors must be present, i.e., if a tertiary payor is involved, then all the data elements from the primary and secondary payors must also be present.

If data elements from previous payor(s) are omitted, KP will deny the claim.

Contact your clearinghouse for assistance sending COB claims electronically.

5.19.4 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 only situations in which a Member can be billed directly for covered services. See also Section 5.23 below (Prohibited Member Billing Practices).

5.20 Medi-Cal Cost Avoidance

You are responsible for identifying the primary payor, seeking authorization from the primary payor (if authorization is required), and billing the appropriate party. See section 3, Eligibility and Benefit Determination.

In addition, to ensure your continued compliance with laws governing Medicaid programs with respect to services provided to Medi-Cal Members, Providers must adhere to requirements related to cost avoidance for Medi-Cal Members who have other health coverage (OHC). Requirements include, without limitation, the following:

- To determine whether a Medi-Cal Member may have other health coverage (OHC) prior to delivering services, please access the DHCS Automated Eligibility

Verification System at **800-427-1295** or the Medi-Cal Online Eligibility Portal available at:

https://www.medi-cal.ca.gov/Eligibility/Login.aspx

- If a Medi-Cal Member has active OHC and the requested service is covered by the OHC, you must instruct the Member to seek the service through the OHC carrier. **Regardless of the presence of OHC, however, you must not refuse to provide covered services to Medi-Cal Members as authorized by Kaiser Permanente.**

In connection with any denied claim for services due to the presence of OHC for Medi-Cal Members, KP will include OHC information in its payment denial notification. If you believe payment on a claim was adjudicated incorrectly, please refer to section 6, Provider Dispute Resolution Process.

5.21 Third Party Liability (TPL)

In the state of California, KP may seek reimbursement from a member's settlement or judgement due to injuries or illnesses caused by a third party. In order to prevent duplicate payments for health care costs that are also paid by another responsible party, Providers are required to assist KP in identifying all potential TPL situations and to provide KP with information that supports KP's TPL inquiries.

5.21.1 First and Third Party Liability Definitions

First Party Liability refers to situations in which the Member's own auto or other policy covers healthcare costs related to injuries or illnesses due to an accident, regardless of fault. In the event you receive a partial payment from an auto or other carrier which falls under the category of First Party Liability (such as Med-Pay, Personal Injury Protection, etc.), please submit your claim and indicate the carrier name and amount paid with the Explanation of Benefits (EOB).

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

Both definitions of alternate liability here shall be considered Third Part Liability (TPL) for the purposes of this Section 5.20.

5.21.2 First and Third Party Liability Guidelines

Providers are required to assist and cooperate with KP's efforts to identify TPL situations by entering the following on the billing form as applicable:

- Carrier information in appropriate fields, along with payment information
- ICD-10 diagnosis data in appropriate fields

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

5.22 Workers' Compensation

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

- Document that the Member indicates the illness or injury occurred "on the job" on the claim
- Complete applicable fields on the billing form indicating a work-related injury
- Submit the claim to the patient's Workers' Compensation carrier/plan

If the Member's Workers' Compensation carrier/plan ultimately denies the Workers' Compensation claim, you may submit the claim for covered services to Kaiser Permanente in the same manner as you submit other claims for services. You must 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 Kaiser Permanente in the same manner as you submit other claims for services. Your Agreement may specify a different payment rate for these services.

5.23 Prohibited Member Billing Practices

Providers may not bill, charge, collect a deposit from, impose surcharges, or have any recourse against a Member or a person acting on a Member's behalf for covered services provided under the terms of the Agreement. Balance billing Members for services covered by KFHP is prohibited by California and federal law, as may be applicable, and under your Agreement.

Except for Member Cost Share, and as otherwise expressly permitted in your Agreement and under applicable law, Providers must look solely to KP or other responsible payor (e.g., Medicare) for compensation of covered services provided to Members.

If the Provider has clearly informed the Member in writing that KP may not cover or continue to cover a specific service, the Provider and Member may agree that the Member is solely responsible for paying for continued services and non-covered services.

Fees for missed appointments or "no-show fees," and fees for late cancellations, may not be charged to and are not payable by KP. Additionally, consistent with applicable law, such fees may not be charged to, collected from, or required of Medicare Members or Medi-Cal Members. Missed appointment fees or "no-show" fees, and late cancellation fees, may be collected from a Commercial Member only if (i) Provider maintains and has provided to the Commercial Member a written policy describing the circumstances under which such fees may be imposed and (ii) the Commercial Member has agreed in writing to be financially responsible for such fees prior to the Commercial Member's receipt of services.

Claims received beyond the applicable filing period will be denied for untimely submission. In these instances, you, as a contracted provider of service, **may not** bill the Member but may resubmit the claim as a provider dispute. The resubmitted claim must include the reason for initial late submission of the claim, along with the other required information and submission requirements described in Section 6.2.2 of this Provider Manual.

5.24 Explanation of Payment and Remittance Advice

Payment is made to the Provider within 45 Business Days of receipt of a properly submitted complete claim or as otherwise stated in your Agreement or allowed by applicable law. For paper checks, the Explanation of Payment (EOP) information is located on the remittance advice or "check skirt" received.

Alternately, you may view and print your EOP by logging into KP Online Affiliate and searching for the EOP under the Remittance Advice tab.

Providers are invited and encouraged to request access to KP's **Online Affiliate** tool. Online Affiliate is enabled with a robust set of features that can help simplify the process of obtaining KP member information and performing claim reconciliation. Many actions can be performed with Online Affiliate, such as viewing patient eligibility/benefits, viewing detailed claim status, downloading Explanations of Payment (EOPs), filing disputes/appeals, submitting an online claim or payment inquiry and responding to KP request for information (RFI). With access to Online Affiliate, these features are available on a self-serve basis 24 hours per day, 7 days per week. For more information and to initiate the provisioning process, please visit KP's Northern California Community Provider Portal at:

http://kp.org/providers/ncal/

If the billing codes submitted are not paid, the Provider will be notified of the rationale for denial of payment.

5.25 Invoices

Some Providers are contracted to perform certain services which are not appropriately billed on a form like the UB-04 or the CMS-1500. Often such services are provided at a KP facility or clinic, or other location and are not billed based upon a specific procedure performed, or on a per Member basis, rather, the Provider may be required to bill for such services using an invoice. Billing for services using an invoice is not subject to certain Knox-Keene Act or Medicare provisions related to standard claims for services that are traditionally billed on the UB-04 or the CMS-1500.

This section does not apply to Intermediate Care Facilities for the Developmentally Disabled (ICF/DD, ICF/DD-H or ICD/DD-N). Billing guidelines will be provided under separate cover for use by ICF/DD homes that are unable to submit claims in accordance with Section 5 of this Provider Manual.

Following are the billing requirements for submitting invoices for payment:

All invoices for services furnished at a KP facility, clinic or other location must be submitted on letterhead or other pre-printed invoice with the Provider's name, address, and tax identification number on a monthly basis, within 30 Calendar Days of the end of the month in which services were rendered, or such other frequency as may be communicated to the Provider by KP. In addition, all invoices must:

- Reflect the amount due, dates of service, and, if applicable, patient names and MRNs. Any supplies that are being furnished by the Provider and invoiced to KP should be specifically identified
- Include a unique invoice number. KP will create a unique number if one is not provided
- Identify each KP facility where services were provided, as applicable
- Be marked "Duplicate" or "Tracer", when the original invoice is lost or subsequently replaced by a copy
- Be accurate, complete and in the form directed by the applicable KP administrative personnel or as established in the Agreement. Balance forward invoicing and interim invoicing will not be approved or accepted by the facility chief of service/designee or other appropriate KP administrative personnel as a condition of payment

5.25.1 Other Contracted Functions Related to Professional Services

In addition to the invoice requirements described above, invoices for professional services delivered for TPMG can be submitted electronically or on paper. Regardless of the method of submission, all invoices must be produced on letterhead or other pre-printed invoice with the following information:

- Provider's name, address and tax identification number
- The amount due and the pay-to address
- The KP contact name, KP national user identification number (NUID), KP general ledger (GL) number that is provided by KP to Contractor. Contractor shall ensure that it has the most current information prior to submitting invoices for payment
- Date(s) on which Services provided
- Patient's name and MRN, if applicable
- Dated signature of Contractor

Electronic invoices (as a PDF file) may be submitted via email to:

Medical Center Name	Locations	Email Address for Invoices
Central Valley (CVL)	Stockton, Manteca, Tracy, Modesto	TPMG-AP-Central-Valley@kp.org
Diablo Service Area (DSA)	Walnut Creek, Livermore, Pleasanton, Martinez, Antioch	TPMG-AP-Diablo-Service-Area@kp.org
East Bay (EBA)	Oakland, Alameda, Richmond, Pinole	TPMG-AP-East-Bay@kp.org
Fresno (FRS)	Fresno, Clovis, Oakhurst, Selma	TPMG-AP-Fresno@kp.org
Greater So Alameda (GSA)	San Leandro, Union City, Fremont	TPMG-AP-Greater-Southern-Alameda-Area@kp.org
Napa Solano (NSA)	Vallejo, Napa, Vacaville, Fairfield	TPMG-AP-Napa-Solano@kp.org
North Valley (NVL)	Sacramento, Roseville, Folsom, Lincoln, Davis, Rancho Cordova	TPMG-AP-North-Valley@kp.org
Redwood City (RWC)	Redwood City, San Mateo	TPMG-AP-Redwood-City@kp.org
Regional Offices	Regional Depts	TPMG-AP-Regional-Office@kp.org
San Francisco (SFO)	San Francisco, French Campus	TPMG-AP-San-Francisco@kp.org
San Jose (SJO)	San Jose, Gilroy, Santa Cruz	TPMG-AP-San-Jose@kp.org
San Rafael (SRF)	San Rafael, Petaluma, Novato	TPMG-AP-San-Rafael@kp.org
Santa Clara (SCL)	Santa Clara, Mountain View, Campbell, Milpitas	TPMG-AP-Santa-Clara@kp.org
Santa Rosa (SRO)	Santa Rosa, Rohnert Park	TPMG-AP-Santa-Rosa@kp.org
South Sacramento (SSC)	So. Sacramento, Elk Grove	TPMG-AP-South-Sacramento@kp.org
South San Francisco (SSF)	So. San Francisco, San Bruno, Daly City	TPMG-AP-South-San-Francisco@kp.org

To submit paper invoices, please direct mail to:

TPMG Accounts Payable
{Insert Name of KP Medical Center}
P.O. Box 214269
Sacramento, CA 95821-214269

Inquiries on payments or receipt of invoices may be made by emailing the customer service staff at the appropriate email address at the medical center listed above.

5.25.2 Other Contracted Functions Related to Services Delivered at KFH (Non-Professional)

In addition to the invoice requirements described above, invoices for services delivered at KFH can be submitted electronically or on paper. Regardless of the method of submission, all invoices must be produced on letterhead or other pre-printed invoice with the following information:

- Provider's name, address and tax identification number
- The amount due and the pay-to address
- The KP contact name, KP reference number, KP general ledger (GL) number that is provided by KP to Contractor. Contractor shall ensure that it has the most current information prior to submitting invoices for payment
- Date(s) on which Services provided
- Patient's name and MRN, if applicable
- Dated signature of Contractor

Electronic invoices (as a PDF file) may be submitted via email to:

KP-AP-Invoice@kp.org

The Subject Line of the email must contain the phrase "VENDOR INVOICE". The rest of the subject line may then be typed.

To submit paper invoices, please direct mail to:

KP Accounts Payable
P.O. Box 12929
Oakland, CA 94604-3010

Inquiries on payments or any other questions may be made by contacting the customer service line either by mailing KP-AP-Customer@kp.org with the subject line "Supplier Inquiry", or by calling **(866) 858-2226**.

5.25.3 1099 Tax Documents

KP mails 1099 forms to the TIN address identified by Providers and in accordance with state and federal regulations controlling timeliness of tax documents. Duplicate copies of 1099 forms may be obtained by sending a written request to 1099misc@kp.org, or by calling KP at **(510) 627-2798**. To avoid errors, email requests are preferred. All requests,

either by email or phone, must include **all** the following detail to allow KP to validate requests:

- Federal Tax Identification Number (TIN)
- Legal Name of entity to which TIN belongs
- TIN address
- Full name of person making the request
- Phone number of the person making the request

6. Provider Dispute Resolution Process

KP actively encourages our contracted Providers to utilize MSCC staff to resolve billing and payment issues.

If you remain unable to resolve your billing and payment issues, KP makes available to all Providers a fast, fair and cost-effective dispute resolution mechanism for disputes regarding invoices, billing determinations, or other contract issues. This dispute resolution mechanism is handled in accordance with applicable law and your Agreement. Please note that the process described in this section applies to disputes subject to the Knox-Keene Act. While we expect to use this process for other types of disputes, we are not required to do so.

This section of the Provider Manual gives you information about our dispute resolution process, but it is not intended to be a complete description of the law or the provisions of your Agreement. Please make sure that you review your Agreement and the applicable law for a complete description of the dispute resolution process. To the extent your Agreement expressly sets forth any longer time frame or additional process than as described below, the contractual provisions will apply to the extent not prohibited under applicable law.

6.1 Types of Disputes

The following describes the most common types of disputes:

- **Claims Payment Disputes:** Challenging, appealing or requesting reconsideration of a claim (or bundled group of claims) that has been denied, adjusted or contested by KP
- **Responding to Requests for Overpayment Reimbursements:** Disputing a request initiated by KP for reimbursement by you of overpayment of a claim
- **Other Disputes:** Seeking resolution of a contract dispute (or bundled group of contract disputes) between you and KP

6.2 Submitting Payment Disputes

If you have a dispute relating to the adjudication of a claim or a billing determination (collectively referred to herein as "payment dispute") you may submit such payment disputes online via **Online Affiliate** or as a written notice to KP by U.S. Mail or other physical delivery. Either notice of a payment dispute is referred to in this Provider Manual as a "Provider Dispute Notice".

6.2.1 Directions for Submission of Payment Disputes

6.2.1.1 Payment Disputes Related to Referred Services or Emergency Services Claims

If the payment dispute is related to a claim for emergency services provided to a Member, the dispute may be submitted online via **Online Affiliate** or by U.S. Mail or other physical delivery.

Online submission:	For more information or to register for Online Affiliate, please visit KP's Northern California Community Provider Portal at: **http://kp.org/providers/ncal/**
By U.S. Mail:	**Kaiser Foundation Health Plan, Inc.** **National Claims Administration** **Attention: Provider Dispute Services Unit** **P.O. Box 12923** **Oakland, CA 94135**

6.2.1.2 Payment Disputes Related to Visiting Member Claims

For information concerning provider payment disputes related to claims for services rendered to visiting Members, please contact the Member's "Home" region's Medical Service call Center at their number provided in Section 5.13 of this manual.

6.2.2 Required Information for Provider Payment Dispute Notices

Your Provider Dispute Notice must contain at least the information listed below, as applicable to your payment dispute. If your Provider Dispute Notice does not contain all the applicable information listed below, we will reject the Provider Dispute Notice and will identify in writing the missing information necessary for us to consider the payment dispute. If you choose to continue the payment dispute, you must submit an amended Provider Dispute Notice to us within 30 Business Days from the date of such notification letter (but in no case later than 365 Calendar Days from KP's last action on the claim), making sure to include all elements noted therein as missing from your payment dispute. If KP does not receive your amended payment dispute within this time, our previous decision will be considered final, and you will have exhausted our provider payment dispute process.

Required Information

- Your name, the tax identification number under which services were billed and your contact information

- If the payment dispute concerns a claim or a request for reimbursement of an overpayment of a claim, a clear identification of the disputed item using KP's original claim number, the date of service, and a clear explanation of the basis upon which you believe that the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect
- If the payment dispute involves a Member or a group of Members, the name(s) and KP Medical Record Number(s) (MRN(s)) of the Member(s) must be included in addition to the information above

Your Provider Dispute Notice may be submitted by you or by a representative (for example, a billing service, a collection agency or an attorney) authorized by you to perform this function. If your authorized representative submits your Provider Dispute Notice, that representative will be required to provide confirmation that an executed business associate agreement between you, as the provider of health care services, and such representative is in place and that it complies with HIPAA. If the copy of the business associate agreement is not included, the dispute documentation will be returned to the submitting third party/representative until the business associate agreement is included.
We recommended you or your representative submit each Provider Dispute Notice, related to either an emergency or referred services claim, with KP's Provider Dispute Resolution Request form (PDRR). You may contact KP at the telephone number indicted on the explanation of payment (EOP) or call KP's Provider Dispute Resolution Unit at **(925) 924-5050** to obtain the PDRR form. Alternately, you or your representative may submit a payment dispute in writing without a PDRR, including all the required information outlined above, or online via Online Affiliate (see Section 6.2.1).

6.2.3 Time Period for Submission of Provider Dispute Notices

Subject to any longer period specifically permitted under your Agreement or required under applicable law, Provider Dispute Notices must be received by KP within 365 Calendar Days from our action (or the most recent action if there are multiple actions) that led to the dispute, or in the case of inaction, the Provider Dispute Notice must be received by KP within 365 Calendar Days after our time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.

6.2.4 Timeframes for Acknowledgement of Receipt and Determination of Provider Dispute Notices

We will acknowledge receipt of your Provider Dispute Notice submitted in accordance with the above requirements within 15 Business Days after KP's receipt of hardcopy submission, or within 2 Business Days after KP's receipt of online submission. We will reject any payment dispute you submit that does not include all required information as described above as an incomplete payment dispute and will take no further action on that incomplete submission unless it is resubmitted completely as required above and within the applicable time frame. KP will issue a resolution letter explaining the reasons for our determination, to the extent required by applicable law, within 45 Business Days after the date of receipt of the complete Provider Dispute Notice.

6.2.5 Instructions for Resolving Substantially Similar Payment Disputes

If you are considering submitting more than twenty (20) substantially similar payment disputes, you are encouraged to first reach out to one of the following KP resources as we may be able to identify a root cause and streamline the resolution process:

Referral and Continuum of Care claims payment disputes: **(925) 924-**

5050. Emergency services claims payment disputes: (**800) 390-3510**

Online Affiliate cannot be utilized to submit batches of substantially similar payment disputes. If you proceed with filing substantially similar multiple payment disputes, they may be filed in writing in batches, submitted via U.S. Mail or other physical delivery, and include the following information:

Each claim being disputed must be individually numbered and contain the provider's name, the provider's tax identification number, the provider's contact information, the original KP claim number (if the dispute is claim related), the Member's MRN (if the dispute concerns care provided to a specific Member or Members), date(s) of service, clear identification of the item(s) being disputed for each claim and an explanation of the basis for each dispute.

The submission must include all these data elements as well as any documentation you wish to submit to support your dispute. Any submission of substantially similar payment disputes that does not include all required elements will be rejected as incomplete and will need to be re-submitted with all necessary information.

6.3 Disputing Requests for Overpayment Reimbursements

Follow the instructions of this Section 6, Provider Dispute Resolution Process.

6.4 Other Disputes

For disputes not based on claim adjudication or billing determination(s), refer to your KP Health Care Services Agreement.

7. Member Rights and Responsibilities

KP recognizes that Members have both rights and responsibilities in the management of their health care.

Providers may direct Members to the Member Resource Guide at:

kp.org/resourceguide

Members have certain rights to which they are entitled when they interact with representatives of KP: Providers, and the employees of those Providers, as well as KP employees and physicians.

Members are also expected to be responsible for knowing about their health care needs and coverage. They are also responsible for maintaining appropriate attitudes and behavior when receiving health care as a Member.

This section addresses our Members' rights and responsibilities as well as their opportunities to address any situation where they may believe that they have not received appropriate services, care, or treatment.

7.1 Member Rights and Responsibilities Statement

KP has developed a statement of Member rights which includes a Member's right to participate in the Member's own medical care decisions. These decisions range from selecting a PCP to making informed decisions regarding recommended treatment plans. Providers and their staff are expected to accept and honor these Member Rights and Responsibilities.

The Member Rights and Responsibilities Statement also includes a Member's responsibility to understand the extent and limitations of their health care benefits, to follow established procedures for accessing care, to recognize the impact lifestyle has on physical condition, to provide accurate information to caregivers, and to follow agreed upon treatment plans.

Upon enrollment and annually thereafter, KP provides notification to each subscriber that a Member Rights and Responsibilities Statement is available which includes the following statements directed to Members:

> Active communication between you and your physician as well as others on your health care team helps us to provide you with the most appropriate and effective care. We want to make sure you receive the information you need about your Health Plan, the people who provide your care, and the services available, including important preventive care guidelines. Having this information contributes to your being an active participant in your own medical care.

We also honor your right to privacy and believe in your right to considerate and respectful care.

This section details your rights and responsibilities as a Kaiser Permanente member and gives you information about member services, specialty referrals, privacy and confidentiality, and the dispute resolution process.

As an adult member, you exercise these rights yourself. If you are a minor or are unable to make decisions about your medical care, these rights will be exercised by the person with the legal responsibility to participate in making these decisions for you.

YOU HAVE THE RIGHT TO:

Receive information about Kaiser Permanente, our services, our practitioners and providers, and your rights and responsibilities.

We want you to participate in decisions about your medical care. You have the right and should expect to receive as much information as you need to help you make decisions. This includes information about:

- Kaiser Permanente
- The services we provide, including behavioral health services
- The names and professional status of the individuals who provide you with service or treatment
- The diagnosis of a medical condition, its recommended treatment, and alternative treatments
- The risks and benefits of recommended treatments
- Preventive care guidelines
- Ethical issues
- Complaint and grievance procedures

We will make this information as clear and understandable as possible. When needed, we will provide interpreter services at no cost to you.

Participate in a candid discussion of appropriate or medically necessary treatment options for your condition(s), regardless of cost or benefit coverage. You have the right to a candid discussion with your Plan Physician about appropriate or medically necessary treatment options for your condition(s), regardless of cost or benefit coverage. Ask questions, even if you think they're not important. You should be satisfied with the answers to your questions and concerns before consenting to any treatment. You may refuse any recommended treatment if you don't agree with it or if it conflicts with your beliefs.

Kaiser Permanente does not discriminate on the basis of age, race, ethnicity, color, national origin, cultural background, ancestry, religion, sex, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, source of payment, genetic information, citizenship, primary language, or immigration status.

Medical emergencies or other circumstances may limit your participation in a treatment decision. However, in general, you will not receive any medical treatment before you or your representative gives consent. You and, when appropriate, your family will be informed about the outcomes of care, treatment, and services that have been provided, including unanticipated outcomes.

Participate with practitioners and providers in making decisions about your health care. You have the right to choose an adult representative, known as your agent, to make medical decisions for you if you are unable to do so and to express your wishes about your future care. Instructions may be expressed in advance directive documents such as an advance health care directive. See http://www.kp.org/advancedirectives for more information about advance directives.

For more information about these services and resources, please contact our Member Service Contact Center 24 hours a day, 7 days a week (closed holidays) at **1800-464-4000** (English), **1-800-788-0616** (Spanish), **1-800-757-7585** (Chinese dialects), or **TTY**: **711**.

Have ethical issues considered. You have the right to have ethical issues that may arise in connection with your health care considered by your health care team. Kaiser Permanente has a Bioethics/Ethics Committee at each of our medical centers to assist you in making important medical or ethical decisions.

Receive personal medical records. You have the right to review and receive copies of your medical records, subject to legal restrictions and any appropriate copying or retrieval charge(s). You can also designate someone to obtain your records on your behalf. Kaiser Permanente will not release your medical information without your written consent, except as required or permitted by law.

To review, receive, or release copies of your medical records, you'll need to complete and submit an appropriate written authorization or inspection request to our Medical Records Office at the facility where you get your care. They can provide you with these forms and tell you how to request your records. Visit http://www.kp.org to find addresses and phone numbers for these departments.

Receive care with respect and recognition of your dignity. We respect your cultural, psychosocial, spiritual, and personal values; your beliefs; and your personal preferences.

Kaiser Permanente is committed to providing high-quality care for you and to building healthy, thriving communities. To help us get to know you and provide culturally competent care, we collect race, ethnicity, language preferences (spoken and written) and religion data. This information can help us develop ways to improve care for our members and communities. This information is kept private and confidential and not used in underwriting, rate setting, or benefit determination. We believe that providing quality health care includes a full and open discussion regarding all aspects of medical care and want you to be satisfied with the health care you receive from Kaiser Permanente.

Use interpreter services. When you call or come in for an appointment or call for advice, we want to speak with you in the language you are most comfortable using. For more about our interpreter services, please refer to http://info.kaiserpermanente.org/html/gethelp/california.html or call our Member Services Contact Center at **1-800-464-4000** or **TTY: 711**.

Be assured of privacy and confidentiality. All Kaiser Permanente employees and physicians, as well as practitioners and providers with whom Kaiser Permanente contracts, are required to keep your protected health information (PHI) confidential. PHI is information that includes your name, Social Security number, or other information that reveals who you are, such as race, ethnicity, and language data. For example, your medical record is PHI because it includes your name and other identifiers.

Kaiser Permanente has strict policies and procedures regarding the collection, use, and disclosure of member PHI that includes the following:

- Kaiser Permanente's routine uses and disclosures of PHI
- Use of authorizations
- Access to PHI
- Internal protection of oral, written, and electronic PHI across the organization
- Protection of information disclosed to Plan sponsors or employers

Please review the section titled "Privacy Practices" at:
https://healthy.kaiserpermanente.org/privacy-practices

For more information about your rights regarding PHI as well as our privacy practices, please refer to our Notice of Privacy Practices on our website http://www.kp.org, or call MSCC at **1-800-464-4000** or **TTY: 711**.

Participate in physician selection without interference. You have the right to select and change your personal physician within the Kaiser Permanente Medical Care Program without interference, subject to physician availability. To learn more

about nurse practitioners, physician assistants, and selecting a primary care practitioner, please visit http://www.kp.org "Doctors and Locations".

Receive a second opinion from an appropriately qualified medical practitioner. If you want a second opinion, you can either ask your Plan physician to help you arrange for one, or you can make an appointment with another Plan physician. Kaiser Foundation Health Plan, Inc., will cover a second opinion consultation from a non-Permanente Medical Group physician only if the care has been pre-authorized by a Permanente Medical Group physician. While it is your right to consult with a physician outside the Kaiser Permanente Medical Care Program without prior authorization, you will be responsible for any costs you incur.

Receive and use member satisfaction resources, including the right to voice complaints or make appeals about Kaiser Permanente or the care we provide. You have the right to resources such as patient assistance and member services, and the dispute-resolution process. These services are provided to help answer your questions and resolve problems.

A description of your dispute-resolution process is contained in your *Evidence of Coverage* booklet, *Certificate of Insurance*, or the Federal Employees Health Benefits Program materials. If you need a replacement, contact your local Member Services Department or our Member Service Contact Center to request another copy. If you receive your Kaiser Permanente coverage through an employer, you can also contact your employer for a current copy. When necessary, we will provide you with interpreter services, including Sign Language, at no cost to you.

For more information about our services and resources, please contact our Member Service Contact Center at **1-800-464-4000** (English), **1-800-788-0616** (Spanish), **1-800-757-7585** (Chinese dialects), or **TTY: 711.**

Make recommendations regarding Kaiser Permanente's member rights and responsibilities policies. If you have any comments about these policies, please contact our Member Services Contact Center at **1-800-464-4000** or **TTY: 711.**

YOU ARE RESPONSIBLE FOR THE FOLLOWING:

Being civil and respectful. Kaiser Permanente, is committed to ensuring a safe, secure, and respectful environment for everyone, including our members, patients, visitors, clinicians, providers, health care teams, and employees. We expect all individuals to demonstrate civil and respectful behavior while on our premises or in virtual or home health care interactions.

As part of our new Member/Patient/Visitor Code of Conduct, we expressly prohibit the following:

- Abusive language including threats and slurs
- Sexual harassment
- Physical assault
- Possession or use of weapons, including firearms

We reserve the right to take appropriate measures to address abusive, disruptive, inappropriate, or aggressive behavior.

Knowing the extent and limitations of your health care benefits. A detailed explanation of your benefits is contained in your *Evidence of Coverage* booklet, *Certificate of Insurance*, or the Federal Employees Health Benefits Program materials. If you need a replacement, contact your local Member Services Contact Center office to request another copy. If you receive your Kaiser Permanente coverage through your employer, you can also contact your employer for a current copy of your *Evidence of Coverage* booklet or *Certificate of Insurance*.

Notifying us if you are hospitalized in a non–Kaiser Permanente Hospital. If you are hospitalized in any hospital that is not a Plan Hospital, you are responsible for notifying us as soon as reasonably possible so we can to monitor your care. You can contact us by calling the number on your Kaiser Permanente ID card.

Identifying yourself. You are responsible for carrying your KP identification (ID) card and photo identification with you at all times to use when appropriate, and for ensuring that no one else uses your ID card. If you let someone else use your card, we may keep your card and terminate your membership.

Your Kaiser Permanente ID card is for identification only and does not give you rights to services or other benefits unless you are an eligible member of our Health Plan. Anyone who is not a member will be billed for any services we provide.

Keeping appointments. You are responsible for promptly canceling any appointment that you do not need or are unable to keep.

Supplying information (to the extent possible) **that Kaiser Permanente and our practitioners and providers need in order to provide you with care**. You are responsible for providing the most accurate information about your medical condition and history, as you understand it. Report any unexpected changes in your health to your physician or medical practitioner.

Understanding your health problems and participating in developing mutually agreed treatment goals to the highest degree possible. You are responsible for telling your physician or medical practitioner if you don't clearly understand your treatment plan or what is expected of you. You are also responsible

for telling your physician or medical practitioner if you believe you cannot follow through with your treatment plan.

Following the plans and instructions for care you have agreed on with your practitioners. You are responsible for following the plans and instructions that you have agreed to with your physician or medical practitioner.

Recognizing the effect of your lifestyle on your health. Your health depends not only on care provided by Kaiser Permanente but also on the decisions you make in your daily life—poor choices such as smoking or choosing to ignore medical advice or positive choices such as exercising and eating healthy foods.

Being considerate of others. You are responsible for treating physicians, health care professionals, and your fellow Kaiser Permanente members with courtesy and consideration. You are also responsible for showing respect for the property of others and of Kaiser Permanente.

Fulfilling financial obligations. You are responsible for paying on time any money owed to Kaiser Permanente.

Knowing about and using the member satisfaction resources available to you, including the dispute-resolution process.

For more about the dispute resolution process, see http://www.kp.org. A description of your dispute-resolution process is also contained in your *Evidence of Coverage* booklet, *Certificate of Insurance*, or the Federal Employees Health Benefits Program materials. If you need a replacement, contact our Member Services Contact Center to request a copy. If you receive your Kaiser Permanente coverage through an employer, you can also contact your employer for a current copy of your *Evidence of Coverage* booklet or *Certificate of Insurance*. Our Member Services Contact Center can also give you information about the various resources available to you and about Kaiser Permanente's policies and procedures. If you have any recommendations or comments about these policies, please contact our Member Services Contact Center 24 hours a day, 7 days a week (closed holidays) at **1-800-464-4000** (English), **1-800-788-0616** (Spanish), **1-800-757-7585** (Chinese dialects), or **TTY: 711.**

7.2 Non-Compliance with Member Rights and Responsibilities

Failure to act in a way that is consistent with the Member Rights and Responsibilities Statement can result in action against the Member, the Provider, or KP, as appropriate.

7.2.1 Members

In the event a Member has a complaint or grievance, the Member may file a complaint using the grievance form, as instructed on http://www.kp.org and their EOC, or *Certificate of Insurance*, or discuss the situation with MSCC online, by mail, or by chat with Member Services. Members can file a grievance for any issue, including complaints against the Provider and/or the Provider's staff. Resolution of the problem or concern is processed through the Member Complaint and Grievance procedure that is described later in this section.

Although the Member should contact the Member Services Contact Center about a grievance, you may be approached directly by the Member. If you do receive a complaint from or on behalf of a Member which, in your reasonable judgment, is not resolvable within 2 Business Days, you must notify Provider Services as soon as possible.

KP's grievance forms for Medicare and non-Medicare Members can be downloaded at: http://providers.kp.org/nca/grievances.html.

7.2.2 Providers

If a Member fails to meet an obligation as outlined in the Member Rights and Responsibilities Statement and you have attempted to resolve the issue, please contact the KP Threat Management office of the Member's primary KP service facility. If you are uncertain of the Member's primary KP service facility, please contact the Member Services Contact Center (MSCC) and have the Member's KP Medical Record Number available.

You should advise a KP Threat Management office if a Member performs any of the following acts. Please see Section 2.4 for General Information phone numbers of local KP facilities.

- Displays disruptive behavior or is not able to develop a positive provider/patient relationship
- Unreasonably and persistently refuses to follow your instructions/ recommendations to the extent that you believe it is jeopardizing the patient's health
- Commits a belligerent act or threatens bodily harm to physicians, physician staff, hospital personnel, and/or home health/hospice/SNF staff
- Purposely conceals or misrepresents medical history or treatment
- Uses documents with your signature without proper authorization or forges/falsifies your name to documents, including prescriptions
- Allows someone to misrepresent the Member as a KFHP Member

KP reserves the right at its discretion to:

- Conduct informal mediation to resolve a relationship issue
- Move the Member to another provider
- Pursue termination of the individual's membership or take other appropriate action, as allowed under that Member's specific EOC and applicable law

7.3 Health Care Decision-Making

KP and contracted hospitals, physicians, and health care professionals make medical decisions based on the appropriateness of care for Members' medical needs. KP does not compensate anyone for denying coverage or services, nor does KP use financial incentives to encourage denials. In order to maintain and improve the health of Members, all Providers should be especially vigilant in identifying any potential underutilization of care or service.

KP encourages open Provider-patient communication regarding available treatment alternatives. We do not penalize Providers for discussing all available care options with our Members.

Our Members have the right to choose among treatment or service options, regardless of benefit coverage limitations. Providers are expected to inform our Members of appropriate care options, even when one or more of the options are not covered benefits under the Member's benefit plan. If the Provider and the patient decide upon a course of treatment that is not covered in the Member's EOC, the Member must be advised they are responsible for the cost of that care.

If the Member is dissatisfied with this arrangement, the Member should be advised to contact MSCC for an explanation of the Member's benefit plan. If the Member persists in requesting non-covered services and the Provider is willing to provide such service, the Provider should make payment arrangements with the Member in advance of any non-emergent treatment to be provided.

KP's UM program and procedures are:

- Based on objective guidelines adopted by KP
- Used to determine appropriateness and indication of care
- Designed to establish whether services provided or to be provided are covered under a Member's benefit plan

Please refer to Section 4 and Section 9 of this Provider Manual for more details.

The ultimate decision on whether to proceed with treatment rests with the Provider and the Member.

7.4 Advance Directives

An Advance Directive is a written instruction recognized under California and/or federal law, such as a living will or a Durable Power of Attorney for Health Care. An Advance Directive allows Members to appoint a representative to make personal health care decisions on their behalf. A Member's representative must be at least 18 years old. The Member's representative is referred to as a Health Care Agent. To avoid potential conflicts of interest, neither Kaiser Permanente Medical Care Program (KPMCP) personnel nor physicians may serve as witnesses for a Member's Advance Directive.

KP requires that all Providers comply with the federal Patient Self-Determination Act of 1990, which mandates that a patient must have the opportunity to participate in determining the course of their medical care, even when the patient is unable to speak for themself. The federal law applies to emancipated minors but does not apply to all other minors. Providers must also comply with California's Health Care Decisions law and any other California State Laws concerning Advance Health Care Directives.

To ensure compliance with governing law, the existence of any Advance Directive must be documented in a prominent place in the medical record. An institutional Provider is required to provide written information regarding Advance Directives to all Members admitted to the facility and provide staff and patient education regarding Advance Directives.

Members should be encouraged to provide copies of their completed Advance Directives to all Providers of their medical care. Members should also be informed that they can register their Advance Directive with California Secretary of State's Office. The State will provide the Member with a Registry Card that the Member can carry with them.

If a Member who is a patient wishes to execute or modify an Advance Directive, the attending physician should be notified so that the physician has an opportunity to discuss the decision with the Member. The attending physician must document any changes to an Advance Directive in the Member's medical record.

An Advance Directive may be revoked by the Member at any time, orally or in writing if the Member is capable of doing so. Upon divorce, if the spouse was designated as the surrogate decision-maker, by law, the chosen agent is invalidated unless the patient specifically states to the contrary in their Advance Directive. If a Member has more than one written Advance Directive, then the most recently executed document should be recognized. Please note, revoked forms should not be discarded but remain a part of the Member's Medical Record.

Members are provided with information regarding Advance Directives in the Evidence of Coverage and the website at **https://healthy.kaiserpermanente.org/northern-california/health-wellness/life-care-plan** Members may also contact MSCC regarding Advance Directives for an informational brochure and appropriate forms.

7.4.1 Physician Orders for Life Sustaining Treatment (POLST)

A POLST form is a document that is completed with the Member's input (or that of their decision maker) and is signed by their physician. It documents the Member's choices about resuscitation, medical interventions, use of antibiotics, and use of artificially administered fluids and nutrition.

POLST is a physician's order form that outlines a plan of care that reflects the Member's wishes concerning end-of life care. It is voluntary and is intended only for people who are seriously ill. It can be revoked by the Member at any time. This form can assist physicians, nurses, health care facilities, and emergency personnel in honoring the Member's wishes for life-sustaining treatment.

The POLST form complements the advance directive and is not intended to replace that document. Information on the POLST form will be incorporated into the medical record when presented to the individual's Provider.

For more information on POLST, visit **http://www.capolst.org**.

7.5 Member Grievance Process

Members are assured a fair and equitable process for addressing their complaints, grievances and appeals ("grievances") against Providers, their staff, and KP employees. Providers may act as a Member's Authorized Representative is duly appointed in accordance with the Member's applicable EOC. This review process is designed to evaluate all aspects of the situation and arrive at a solution that strives to be mutually satisfactory to the Member and the organization, including you, our Provider. Members are notified of the processes available for resolving grievances in their *Evidence of Coverage* and on **http://www.kp.org**.

A Member grievance may relate to dissatisfaction with quality of care, access to services, Provider or staff attitude, operational policies and procedures, benefits, eligibility and requests for services and care they believe are available under their coverage. Valid Member complaints and grievances against a Provider are included in the Provider's quality file at KP and reviewed as part of the recredentialing process. Grievances are tracked and trended on an ongoing basis to identify potential problems with a Provider or with our own policies and procedures.

The grievance information provided in this Provider Manual is a general overview and is not all inclusive. There are variations to the Member's rights and remedies depending on the membership type (e.g., Medicare, Medi-Cal, etc.), Therefore, Members should be referred to MSCC or to their *Evidence of Coverage* brochure for more information.

7.5.1 Provider Participation in Member Grievance Resolution

The established procedures for resolving Member grievances may require the Provider's participation under certain circumstances. KP will advise you of any involvement required or information that must be provided. Grievances about clinical issues will be reviewed by at least one practitioner provided by KP and practicing in the same or a similar specialty that typically manages the related medical condition, procedure or treatment who was not previously involved in the patient's care. As a result of this review, you may be asked as part of the investigation to respond by email or by an Investigative Review Form to MSCC with your clinical opinion regarding the Member's concern or request.

7.5.2 Member Grievance Resolution Procedure

One of the rights that Members are apprised of on http://www.kp.org is that they have the right to participate in a candid discussion with the Provider of all available options regardless of cost or benefit coverage. Members are told, "You have the right to a candid discussion with your Plan Physician about appropriate or medically necessary treatment options for your condition(s), regardless of cost or benefit coverage. Ask questions, even if you think they're not important. You should be satisfied with the answers to your questions and concerns before consenting to any treatment. You may refuse any recommended treatment if you do not agree with it or if it conflicts with your beliefs."

If the issue cannot be resolved this way, we encourage the Member to contact a Patient Assistance Coordinator or a Member Services representative at the local KP facility (see also MSCC contact information in Section 2.1). If the Provider presents a grievance on behalf of a Member, and the issue is felt to be of an emergent nature, one that could seriously jeopardize the Member's life, health, or ability to regain maximum function, the Provider or the Member may contact the Expedited Review Unit (ERU) through the Member Service Contact Center to request a review.

7.5.3 Processes for Grievance Resolution

If the problem is not amenable to immediate resolution at the point of service, the Member may submit a grievance through any of the following methods:

- in person to a Patient Assistance Coordinator or Member Services Representative in the Member Services Department at the local KP facility
- via our website at **http://www.kp.org**
- by calling the Member Service Contact Center at **(800) 464-4000** (English), **1-800-788-0616** (Spanish), **1-800-757-7585** (Chinese dialects), or **TTY: 711**
- by completing a Grievance Form or writing a letter and mailing it to a Member Services office at a Plan Facility (member can refer to **http://www.kp.org** for addresses)

Our representatives will advise the Member about the resolution process and ensure that the appropriate parties review the complaint.

Sample Medicare and Non-Medicare Grievance Forms can be found at the end of this section.

Grievances reviewed through the standard process are generally acknowledged within 5 Calendar Days, and resolved as quickly as the member's health requires, but no longer than regulatory timeframes. Depending on the issue and the applicable regulatory requirements, the resolution time frame is generally within 14-30 days.

NOTE: For expedited processing, see Section 7.5.3.2.

7.5.3.1 Quality of Care Grievances

Members' grievances which contain potential quality of care concerns are forwarded by Member Services to the Member Services Clinical Consultants for case review. Clinical Consultants will forward cases to the responsible Quality departments as appropriate. The treating practitioner is expected to respond Promptly to requests from KP Quality representatives for supporting documentation related to the Member's care, including medical records, questionnaires, outcome assessments, appointment scheduling and/or other pertinent information. The grievance process is governed by regulation and is time sensitive. The process is protected by peer review rules and therefore all exchanges of information must remain confidential between the treating practitioner and KP Quality representatives.

For Medicare members, the written response to a quality of care grievance will inform the Member of the right to file the quality of care complaint with the Quality Improvement Organization (QIO). The QIO is an organization comprised of practicing doctors and other health care experts under contract with the federal government to monitor and improve the care given to Medicare members. In California, the QIO is Livanta.

7.5.3.2 Expedited Review

A Member who believes that the standard timeframe of grievance resolution could seriously jeopardize their life, health, or ability to regain maximum function may request an expedited review. Providers, Members, or the Member's advocate may contact MSCC for further support on an expedited review.

The Member will be notified of the expedited decision verbally and in writing, as quickly as the member's health requires but no later than the required expedited timeframes – generally within 72 hours.

Requests that do not meet the qualifying criteria for expedited review will be processed in accordance with standard review timeframes.

7.5.3.3 Instructions for Filing a Grievance

The following instructions are to be included with any Grievance Form supplied by Providers to our Members. Providers may reproduce this page and the forms immediately following for that purpose.

HOW TO FILE A GRIEVANCE

KP is committed to providing Members with quality care and with a timely response to their concerns. Members can discuss their concerns with our Member Services representatives at most Plan Facilities, or they can call the MSCC.

Members can file a grievance for any issue. Their grievance must explain the issue, such as the reasons why they believe a decision was in error or why they are dissatisfied about Services they received. Members must submit their grievance orally or in writing within 60 Calendar Days (Medicare) or 180 Calendar Days (Commercial) of the date of the incident that caused their dissatisfaction, or without time limitation (Medi-Cal) as follows:

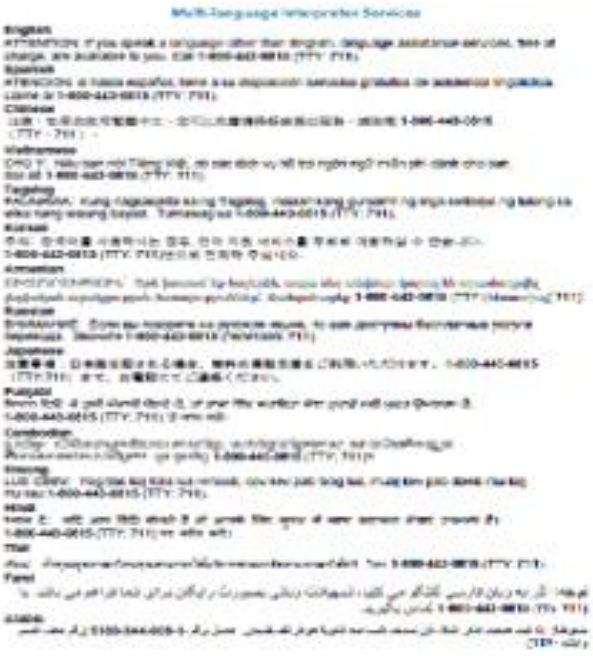
- To a Member Services representative at their local Member Services Department at a Plan Facility (Member should refer to **http://www.kp.org** for locations), or by calling our Member Service Contact Center:

English:	**1-800-464-4000**
Spanish:	**1-800-788-0616**
Chinese dialects:	**1-800-757-7585**
TTY:	**711**

- Through our website at: **http://www.kp.org**

We will acknowledge receipt of a Member's grievance after receiving it and provide a resolution as soon as their health requires but no later than regulatory time frames allow, which is generally within 14-30 Calendar Days. If we do not approve a Member's request, we will tell them the reason and inform them about additional dispute resolution options.

NOTE: If we resolve a Member's issue by the end of the next business day after we receive their grievance and Member Services representative notifies them orally about our decision, we will not send them a written decision unless their grievance involves a quality of care issue, breach of privacy, Hospital grievances, coverage dispute, a dispute about whether a service is medically necessary, an experimental or investigational treatment, or those grievances for which they request a written response.



Multi-language Interpreter Services

English
ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-800-443-0815 (TTY: 711).

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-443-0815 (TTY: 711).

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-443-0815（TTY：711）。

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có sẵn dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-443-0815 (TTY: 711).

Tagalog
PAUNAWA: Kung nagsasalita kayo ng Tagalog, maaari kayong gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-443-0815 (TTY: 711).

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-443-0815 (TTY: 711)번으로 전화하여 주십시오.

Armenian
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-443-0815 (TTY՝ 711):

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-443-0815 (TTY: 711).

Japanese
注意事項：日本語をお話しの場合、無料の言語支援をご利用いただけます。1-800-443-0815（TTY：711）まで、お電話にてご連絡ください。

Punjabi
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। 1-800-443-0815 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Cambodian
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរ សេវាជំនួយផ្នែកភាសា ដោយឥតគិតថ្លៃ គឺមានសម្រាប់បម្រើអ្នក។ ចូរទូរស័ព្ទ 1-800-443-0815 (TTY: 711)។

Hmong
LUS CEEV: Yog koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-443-0815 (TTY: 711).

Hindi
ध्यान दें: यदि आप हिंदी बोलते हैं तो भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। 1-800-443-0815 (TTY: 711) पर कॉल करें।

Thai
ข้อควรทราบ: หากคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี โทร 1-800-443-0815 (TTY: 711)

Farsi
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-443-0815 (TTY: 711) تماس بگیرید.

Arabic
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-443-0815 (رقم هاتف الصم والبكم: 711).

You may file your Grievance/Appeal by one of the following ways:

- By mail to Kaiser Foundation Health Plan:
  Member Case Resolution Center (For non-urgent/emergent standard grievances)
  P.O. Box 1809
  Pleasanton, CA 94566
  OR
  Expedited Review Unit and Part D Unit (For urgent/emergent pre-service grievances when the non-urgent time frame (a) could seriously jeopardize your life, health, or ability to regain maximum function, (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the services that are subject of the grievance, or (c) a provider has told us that the matter is urgent)
  P.O. Box 1809
  Pleasanton, CA 94566
- To a Member Services representative at your local Member Services Department
- Orally, to the Member Services Contact Center, 24 hours a day, seven days a week, excluding holidays
  English: 1-800-464-4000
  Spanish: 1-800-788-0616
  Chinese dialects: 1-800-757-7585
  TTY: 711
- Online, through our Web site at kp.org

Notice of Nondiscrimination

Kaiser Foundation Health Plan (KFHP) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. KFHP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters.
  - Written information in other formats, such as large print, audio, and accessible electronic formats.
- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters.
  - Information written in other languages.

If you need these services, call Member Services at 1-800-443-0815 (TTY 711), 8 a.m. to 5 p.m., seven days a week.

If you believe that KFHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator by writing to One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612 or calling Member Services at the number listed above. You can file a grievance by mail or phone. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

In California, Kaiser Permanente is an HMO plan and a Cost plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

KAISER PERMANENTE®

KAISER PERMANENTE® GRIEVANCE/APPEAL FORM – Medicare California

Member/patient name | Medical record number

Address: Street | City | ZIP code

Daytime telephone number | Alternate telephone number | Birth date

Name of person filing, if different than above, a Statement of Authorized Representative form will be mailed to the member for completion) | Relationship | Daytime telephone number

Department, location and facility where issue occurred | Date issue occurred

Please describe the nature of the issue (attach additional sheets if needed):

Please explain how you tried to resolve this issue:

What action you consider a proper solution to this issue?

Signature | Date

For Program Representative Use Only

Name of Program Representative | Facility | Date Received

☐ Medicare Grievance ☐ Part D Drug Coverage Determination ☐ Part D Drug Redetermination ☐ Medicare Organization Determination ☐ Medicare Reconsideration ☐ MediMode ☐ Fed Med ☐ PERS Medi

You will be advised of any additional procedural and appeal rights to which you are entitled as we move forward with your issue.

DO NOT FILE IN PATIENT CHART

KAISER PERMANENTE®

COMPLAINT OR BENEFIT CLAIM/REQUEST FORM – Non-Medicare California

Member/Patient Name		Medical Record Number	
Address Street		City	ZIP Code
Daytime Telephone Number	Alternate Telephone Number	Birth Date	
Name of Person Filing: (If different than above, a Statement of Authorized Representative form will be mailed to the member for completion)	Relationship	Daytime Telephone Number	
Department Location and Medical Facility where issue occurred		Date Issue Occurred	

Please describe the nature of the issue (attach additional sheets if needed):

Please explain how you tried to resolve this issue.

What would you consider a proper solution to this issue?

Signature		Date
For Program Representative Use Only		
Name of Program Representative	Facility	Date Received

14 DO NOT FILE IN PATIENT CHART

Department of Managed Health Care Complaint Process*

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone Kaiser Foundation Health Plan at **1-800-464-4000** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions online.

* Not available to Medi-Cal members in Cal-Optima, Gold Coast Health Plan, and Partnership HealthPlan of California.

If you have an issue that involves an imminent and serious threat to your health (such as severe pain or potential loss of life, limb, or major bodily function), you can contact the California Department of Managed Health Care directly at any time without first filing a grievance with us.

Please mail this form to the P.O. Boxes listed on page 15 for processing. If you prefer, you may file a grievance online at kp.org, in person at your local Member Service office, or by phone by calling **1-800-464-4000**.

Questions, Concerns, Service Request, or Dissatisfaction with Care or Service

Kaiser Permanente's goal is to provide the highest possible member satisfaction. Each physician, employee, and volunteer is responsible for creating an outstanding care experience for every member, every time. This includes responding to any concerns or dissatisfaction that you might have. Our highest priority is to resolve every concern or dissatisfaction wherever you receive care.

Please ask to speak to the manager of the department if you have a question, concern, or are dissatisfied regarding the care or service you received. If you prefer to request a service, voice an issue or complaint, or file a benefit claim, you may file it with the Health Plan using the form provided here.

How to File a Grievance

You can file a grievance for any issue. Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied with the services you received. You must submit your grievance orally or in writing within 180 days of the date of the incident that caused your dissatisfaction. However, if you are a Medi-Cal member, you may submit your grievance at any time. You may submit a grievance in any one of the following ways included below.

- By mail to Kaiser Foundation Health Plan,

  Member Case Resolution Center (For non-urgent/non-expedited grievances)

  P.O. Box 939021

  San Diego, CA 92193-9021

  OR

  Expedited Review Unit (For urgent/emergency grievances when the non-urgent timeframe (a) could seriously jeopardize your life, health, or ability to regain maximum function, (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the services that are the subject of the grievance, or (c) a provider has indicated the matter is urgent)

  P.O. Box 1809

  Pleasanton, CA 94566
- To a Member Services representative at your local Member Services Department
- Orally to the Member Services Contact Center, 24 hours a day, seven days a week (excluding holidays):

English	1-800-464-4000
Spanish	1-800-788-0616
Chinese dialects	1-800-757-7585
TTY	711
- Online through our website at kp.org

California Department of Health Care Services Office of the Ombudsman (For Medi-Cal members)

You may also call the California Department of Health Care Services Office of the Ombudsman. They can offer help and tell you more about your rights and responsibilities. Call them at **1-888-452-8609**.

7.5.4 Department of Managed Health Care Complaint Process—Non-Medicare

The DMHC is responsible for regulating health care service plans. If a Member has a grievance against KP, the Member should notify Kaiser Foundation Health Plan at **(800) 464-4000** (English), **1-800-788-0616** (Spanish), **1-800-757-7585** (Chinese dialects), or **TTY: 711** to lodge the grievance with MSCC. The Member will have the opportunity to seek resolution of the problem using KP's grievance process. If the Member is not satisfied with the outcome of the grievance process, or if the grievance has remained unresolved for more than 30 Calendar Days, the Member may contact the DMHC for assistance. The DMHC will determine whether the Member is eligible to participate in the Independent Medical Review Program, described below.

7.5.4.1 Independent Medical Review Program Availability—Non-Medicare

California law requires health plans to offer an independent medical review program to Members who have been denied services because the services were deemed not medically necessary or considered experimental or investigational. This includes denial of emergency and urgent care services from non-KP providers. The Independent Medical Review Program ("IMR") is administered by the California DMHC. If the DMHC determines that the Member's case qualifies for an IMR, medical experts not affiliated with KP will conduct the review. KP will honor the DMHC decision.

A Member may qualify for IMR if the issue has been denied or is unresolved after 30 Calendar Days, or 3 Calendar Days for requests that meet expedited review criteria, if KP:

- Denies, changes, or delays a service or treatment because the plan determines it is not medically necessary
- Will not cover an experimental or investigational treatment for a serious medical condition
- Will not pay for emergency or urgent medical services that you have already received

Members can request an IMR by completing an IMR Application Form, which comes with a grievance resolution letter. Along with the Application, Members should attach copies of letters or other documents about the treatment or service that KP denied. Members can Mail or fax the form and any attachments to:

Department of Managed Health Care
980 9th Street Suite 500
Sacramento CA 95814-2725

Help Center FAX: **(916) 255-5241**

The numbers to the DMHC are: **(888) 466-2219** and **(877) 688-9891** (TDD). The DMHC web address is http://www.dmhc.ca.gov.

7.5.5 Demand for Arbitration

Under certain circumstances, a Member may file a demand for arbitration after receiving an appeal decision, or at any earlier step in the process. For more information on arbitration procedures, please advise the Member to contact the Member Services Department at the local KP facility or contact MSCC at **(800) 464-4000** (English), **1-800-788-0616** (Spanish), **1-800-757-7585** (Chinese dialects), or **TTY: 711.**

NOTE: The complaint and appeals information provided in this Provider Manual may not address the rights and remedies of every category of Member, for example, Medicare, Medi-Cal, as well as Members employed/retired from the State of California and/or the Federal Government, each of whom may have different rights and remedies. Members in these categories should be directed to contact MSCC for applicable grievance and appeal provisions, or they may refer to their Evidence of Coverage brochure for more information.

8. Provider Rights and Responsibilities

As a Provider, you are responsible for understanding and complying with 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 of the Provider Manual, we encourage you to call the Provider Services Department.

8.1 Providers' Rights and Responsibilities

All Providers are responsible for:

- Providing health care services without discriminating on the basis of health status or any other unlawful category
- Upholding all applicable responsibilities outlined in the Member Rights & Responsibilities Statement in this Provider Manual
- Maintaining open communication with a Member to discuss treatment needs and recommended alternatives, without regard to any covered benefit limitations or KP administrative policies and procedures. KP encourages open provider-patient communication regarding appropriate treatment alternatives and does not restrict Providers from discussing all available care options with Members
- Providing all services in a culturally competent manner
- Providing for timely transfer of Member medical records when care is to be transitioned to a new provider, or if your Agreement terminates
- Participating in KP Quality Improvement and UM Programs. KP Quality Improvement and UM Programs are designed to identify opportunities for improving health care provided to Members. These programs may interact with various functions, including, but not limited to, the complaint or grievance process, disease management, preventive health, or clinical studies. KP will communicate information about the programs and extent of Provider participation through special mailings and updates to the Provider Manual. These programs are also described in various sections of this Provider Manual
- Securing authorization or referral from KP prior to providing any non-emergency services
- Verifying eligibility of Members prior to providing services
- Collecting applicable copayments, co-insurance and/or deductibles from Members as required by your Agreement and this Provider Manual
- Complying with this Provider Manual and the terms of your Agreement
- Cooperating with and participating in the Member complaint and grievance process, as necessary

- Encouraging all Providers and their staff to include patients as part of the patient safety team by requesting patients to speak up when they have questions or concerns about the safety of their care
- Discussing adverse outcomes related to errors with the patient and/or family
- Ensuring patients' continuity of care including coordination with systems and personnel throughout the care delivery system
- Fostering an environment which encourages all Providers and their staff to report errors and near misses
- Pursuing improvements in patient safety including incorporating patient safety initiatives into daily activities
- Ensuring compliance with patient safety accreditation standards, legislation, and regulations
- Providing orientation of this Provider Manual to all subcontractors and participating practitioners, and ensuring that downstream providers adhere to all applicable provisions of the Provider Manual and the Agreement
- Notifying Provider Services in writing of any practice changes that may affect access for Members
- Reporting to the appropriate state agency any abuse, negligence or imminent threat to which the Member might be subject. You may request guidance and assistance from the local KP's Social Services Department to help provide you with required information that must be imparted to these agencies
- Contacting your local county Public Health Department if you treat a patient for a reportable infectious disease

Providers also have the right to:

- Receive payment in accord with applicable laws and applicable provisions of your Agreement
- File a provider dispute
- Participate in the dispute resolution processes established by KP in accord with your Agreement and applicable law

8.2 Complaint and Patient Care Problems

KP will work with a Provider to resolve complaints regarding administrative or contractual issues, or problems encountered while providing health care to Members.

8.2.1 Administrative and Patient Related Issues

For assistance in resolving administrative and patient related issues, please contact a Referral Coordinator (or assigned Outside Services Case Manager), if applicable from the referring KP facility. Examples of administrative issues include clarification of the authorization or referral process, and billing and payment issues.

8.2.2 Claim Issues

Regarding claims for referred services or emergency services, you may contact KP by calling **(800) 390-3510**.

For questions and clarification on how payments were computed, you may contact the office that issued the payment identified on the remittance advice and EOP. The phone number will be listed on the remittance advice.

For assistance in filing a Provider Dispute, please refer to Section 6.2 of this Provider Manual.

8.3 Required Notices

8.3.1 Provider Changes That Must Be Reported

Providers may notify Provider Services of the changes identified below by calling **(925) 924-5050**. Verbal notification must be followed by faxed documentation to **(877) 228-8306** or email to **TPMG-MSC-ProvSvcs@kp.org**. Please check your contract as it may contain provisions that limit your ability to add, delete or relocate practice sites, service locations or practitioners.

8.3.1.1 Provider Illness or Disability

If an illness or disability leads to a reduction in work hours or the need to close their practice or location, Providers must immediately notify Provider Services.

8.3.1.2 Practice Relocations

Notify Provider Services at least 90 Calendar Days prior to relocation to allow for the transition of Members to other Providers, if necessary.

8.3.1.3 Adding/Deleting New Practice Site or Location

Notify Provider Services at least 90 Calendar Days prior to opening an additional practice site or closing an existing service location.

8.3.1.4 Adding/Deleting Practitioners to/from the Practice

Notify Provider Services immediately when adding/deleting an employed or subcontracted practitioner to/from your practice. Before Members can be seen by the new practitioner, the practitioner must be credentialed according to applicable KP policy.

8.3.1.5 Changes in Telephone Numbers

Notify Provider Services at least 30 Calendar Days prior to the implementation of a change in telephone number. If the initial notification is given verbally, you must send written confirmation to the Notice address in your contract.

8.3.1.6 Federal Tax ID Number and Name Changes

If your Federal Tax ID Number or name should change, please notify us immediately so that appropriate corrections can be made to KP's files. The notification should include a copy of your W9 to support the requested change(s).

8.3.1.7 Mergers and Other Changes in Legal Structure

Please notify us in advance and as early as possible of any planned changes to your legal structure, including pending merger or acquisition.

8.3.1.8 Provider Directories Information per Health and Safety Code § 1367.27

Provider shall provide the following information to KP regarding Provider and all practitioners contracted with Provider who are eligible for referrals to provide professional services to Members. Provider shall notify KP in writing on a weekly basis when any changes to the following occur:

1. A Provider is not accepting new patients;
2. A Provider, who had previously not accepted new patients, is currently accepting new patients;
3. A Provider has retired or otherwise has ceased to practice; and
4. There is a change to the following information:
    a. A Provider's name, practice location or locations, and contact information;
    b. National Provider Identifier number;
    c. Area of specialty, including board certification, if any;
    d. Office email address, if available;
    e. The name of each affiliated provider group currently under contract with KP through which the provider sees Members;

f. A listing for each of the following practitioners that are under contract with the Provider or part of the Provider Group:

   i. For physicians and surgeons, the provider group, and admitting privileges, if any, at hospitals contracted with KP.

   ii. Nurse practitioners, physician assistants, psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists, professional clinical counselors, qualified autism service providers, as defined in H&S Code Section 1374.73, nurse midwives, and dentists.

   iii. For federally qualified health centers or primary care clinics, the name of the federally qualified health center or clinic.

   iv. For any provider described in subparagraph (i) or (ii) who is employed by a federally qualified health center or primary care clinic, and to the extent their services may be accessed and are covered through the contract with Provider, the name of the provider, and the name of the federally qualified health center or clinic.

g. Non-English language, if any, spoken by a health care provider or other medical professional as well as non-English language spoken by a qualified medical interpreter, in accordance with H&S Code Section 1367.04, if any, on the Provider's staff.

h. Identification of Participating Practitioners who no longer accept new patients for some or all the Benefit Plans.

If KP receives a report regarding the possible inaccuracy of information relating to a Provider, whether from a Member, a participating practitioner, or KP, KP shall promptly investigate, and either verify the accuracy of the information or, if necessary, update the Provider information. When investigating a report, KP shall comply with the requirements of H&S Code section 1367.27(o)(2), including:

1. Contacting the affected Provider no later than five Business Days following receipt of the report; and
2. Documenting the receipt and outcome of each report. The documentation shall include the Provider's name, location, and a description of KP's investigation, the outcome of the investigation, and any changes or updates made to the information provided to KP. KP shall make this documentation available in a timely manner as requested by the DMHC.

In accordance with your Agreement, you must cooperate with KP in maintaining our compliance with the Knox-Keene Laws. Providers are therefore required to periodically attest to the accuracy of your directory profile information in accordance with KP protocols, as may be updated from time to time.

8.3.2 Contractor Initiated Termination (Voluntary)

Your Agreement requires that you give advance written notice if you plan on terminating your contractual relationship with KP. The written notice must be sent in accordance with the terms of your Agreement.

When you give notice of termination, you must immediately advise Provider Services of any Members who will be in the course of treatment during the termination period.

Provider Services may contact you to review the termination process, which may include transferring Members and their medical records to other providers designated by KP.

KP will make every effort to notify all affected Members of the change in providers at least 60 Calendar Days prior to the termination, so that the Members can be given information related to their continuity of care rights, and to assure appropriate transition to ensure that they will have appropriate access to care. KP will implement a transition plan to move the Members to a provider designated by KP, respecting each Member's legal continuity of care rights, and making every effort to minimize any disruption to medical treatment. You are expected to cooperate and facilitate the transition process. You will remain obligated to care for the affected Members in accordance with the written terms of the Agreement, state and federal law.

8.3.3 Other Required Notices

You are required to give KP notice of a variety of other events, including changes in your insurance, ownership, adverse actions involving your license(s), participation in Medicare or Medicare certification, 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.

From time to time, KP will request Providers complete a Provider Profile Information Form (PPIF). When requested, you must provide updated information listing the name, location, and address of each physical site at which you and your practitioners and subcontractors provide services to Members under the Agreement. This information is needed to assure that our payment systems appropriately recognize your locations and practitioners. Additionally, it facilitates verification that Providers seeing Members are appropriately credentialed and is essential for KP to continue to meet its legal, business and regulatory requirements.

8.4 Call Coverage Providers

Your Agreement may require that you provide access to services 24 hours per day, 7 days per week. If you arrange for coverage by practitioners who are not part of your practice or contracted directly with KP, the practitioners must agree to all applicable terms of your

Agreement with KP, including prohibition against balance billing Members, the KP accessibility standards, our Quality Assurance & Improvement and UM Programs and your fee schedule.

8.5 Health Information Technology

As Providers implement, acquire, or upgrade health information technology systems, your office or organization should use reasonable efforts to utilize, where available, certified health information technology systems and products that meet interoperability standards recognized by the Secretary of Health and Human Services ("Interoperability Standards"), have already been pilot tested in a variety of live settings, and demonstrate meaningful use of health information technology in accordance with the HITECH Act. Providers should also encourage their subcontracted providers to comply with applicable Interoperability Standards.

9. Quality Assurance and Improvement (QA & I)

9.1 Northern California Quality and Patient Safety Program

The KP Quality Program includes many aspects of clinical and service quality, patient safety, behavioral health, accreditation and licensing and other elements. The KP quality improvement program assures that quality improvement is an ongoing, priority activity of the organization. Information about our quality program is available to you in the "Quality Program at Kaiser Permanente Northern California" document, including:

- Awards and recognition for our quality program presented to KP
- Programs and systems within KP that promote quality improvement
- Our quality improvement structure
- Areas targeted by our quality goals

To obtain a copy of the "Quality Program at Kaiser Permanente Northern California" document, call the Member Services Contact Center at **1-(800) 464-4000** or **TTY: 711**. Additional information on KP's Northern California Quality and Patient Safety Program can be found at: http://www.kp.org/quality.

Patient safety is a central component of KP's care delivery model. We believe our distinctive structure as a fully integrated health care delivery system provides us unique opportunities to design and implement effective, comprehensive safety strategies to protect our Members. Providers play a key role in the implementation and oversight of patient safety efforts.

At KP, patient safety is every patient's right and everyone's responsibility. As a leader in patient safety, our program is focused on safe culture, safe care, safe staff, safe support systems, safe place, and safe patients.

If you would like independent information about KP's health care quality and safety, the following external organizations offer information online:

The National Committee for Quality Assurance (NCQA) works with consumers, purchasers of health care benefits, state regulators, and health plans to develop standards that evaluate health plan quality. KP is responsible to manage, measure, and assess patient care in order to achieve NCQA accreditation which includes ensuring that all Members are entitled to the same high level of care regardless of the site or provider of care.

KP is currently accredited by NCQA, and we periodically undergo re-accreditation. KP Northern California Region (KPNC) provides the appropriate information related to quality and utilization upon request, so that KP may meet NCQA standards and

requirements, and maintain successful NCQA accreditation. You can review the report card for KFHP, Northern California, at **http://www.ncqa.org**.

The Leapfrog Group is a national nonprofit organization founded by large employers and purchasers to drive movement in quality and safety in American health care. The group gathers information about medical care and patient safety relevant to urban hospitals via an annual Leapfrog Survey. The survey assesses hospital safety, quality, and efficiency based on national performance measures that are of specific interest to health care purchasers and consumers. All KP hospitals in California participated in the most recent survey. Survey results are publicly reported and provide hospitals with information to benchmark their progress in improving the care that is delivered.

To review KP hospital survey results, visit:

http://www.leapfroggroup.org/cp

To review the hospital's Safety Grades, visit:

https://www.hospitalsafetygrade.org/

The Office of the Patient Advocate (OPA) provides data to demonstrate the quality of care delivered at KPNC, as well as a comparison of our performance to other health plans in the state. To view the Clinical and Patient Experience Measures along with explanations of the scoring and rating methods used visit: http://reportcard.opa.ca.gov/rc2013/medicalgroupcounty.aspx

The Joint Commission (TJC) is a hospital accreditation organization that is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards. To earn and maintain its accreditations, KFH hospitals must undergo an onsite surveying by The Joint Commission survey team at least every 3 years. Providers who are privileged to practice at any KFH hospital are expected to adhere to TJC standards when practicing within the facility(ies). For further information visit: http://www.jointcommission.org.

9.2 Quality Assurance and Improvement (QA & I) Program Overview

KP's Quality Assurance and Improvement Program uses a multi-disciplinary and integrated approach, which focuses on opportunities for improving operational processes, health outcomes, and Member and Provider satisfaction.

The quality of care Members receive is monitored by KP's oversight of Providers. You may be monitored for various indicators and required to participate in some KP processes. For example, we monitor and track the following:

- Patient access to care
- Patient complaint and satisfaction survey data of both administrative and quality of care issues
- Compliance with KP policies and procedures
- UM statistics
- Quality of care indicators and provision of performance data as necessary for KP to comply with requirements of NCQA, CMS (Medicare), TJC, and other regulatory and accreditation bodies
- Performance standards in accordance with your Agreement
- Credentialing and recredentialing of Providers

In any of the above situations, when KP reasonably determines that the Provider's performance may adversely affect the care provided to Members, KP may take corrective actions in accordance with your Agreement. As a Provider, you are expected to investigate and respond in a timely manner to all quality issues and work with KP to resolve any quality and accessibility issues related to services for Members. Each Provider is expected to remedy, as soon as reasonably possible, any condition related to patient care involving a Member that has been determined by KP or any governmental or accrediting agencies to be unsatisfactory.

9.3 Provider Credentialing and Recredentialing

As an important part of KP's Quality Management Program, all credentialing and recredentialing activities are structured to assure applicable Providers are qualified to meet KP policy, NCQA standards, and other regulatory requirements for the delivery of quality health care and service to Members.

The credentialing and recredentialing policies and procedures approved by KP are intended to meet or exceed the managed care organization standards outlined by the NCQA.

KP has developed and implemented credentialing and recredentialing policies and procedures for Providers. Practitioners include, but are not limited to, MDs, DOs, oral surgeons, podiatrists, chiropractors, physician assistants, advanced practice nurses, licensed nurse midwives, behavioral health practitioners, acupuncturists and optometrists. Organizational Providers (OPs) include, but are not limited to, hospitals, SNFs, home health agencies, hospice agencies, dialysis centers, congregate living facilities, behavioral health facilities, ambulatory surgical centers, clinical laboratories, comprehensive outpatient rehabilitation facilities, portable x-ray suppliers, federally qualified health centers and community based adult services centers. Services to Members may be provided only when the Provider meets KP's applicable credentialing criteria and has been approved by the appropriate Credentials and Privileges Committee.

Providers must also submit, upon renewal, ongoing evidence of current licensure, insurance, accreditation/certification, as applicable, and other credentialing documents subject to expiration.

9.3.1 Practitioners

KP requires that all practitioners within the scope of KP's credentialing program be credentialed prior to treating Members and must maintain credentialing at all times. Recredentialing will occur at least every 36 months. Recredentialing may be adjusted to 24 months if privileges are required at a Kaiser Foundation Hospital. Credentialing may occur more frequently.

Requirements for initial and recredentialing for practitioners include, but are not limited to:

- Complete, current, and accurate credentialing/recredentialing application
- Current, valid healing arts licenses, certificates and/or permits to practice in the State of California
- Clinical privileges are current and in good standing, if applicable
- Evidence of board certification or other national certification is current and in good standing, if applicable
- Evidence of appropriate education, clinical training, and current competence in practicing specialty
- Evidence of professional liability coverage equal to, or greater than, current KP standards
- Supporting References of Competence
- No history of State, Federal, Medicaid or Medicare sanctions/limitations/exclusions
- No significant events as identified through KP performance data (at recredentialing only)

KP adheres to the NCQA standards for credentialing and recredentialing of hospitalists. Hospitalists who provide services exclusively in the inpatient setting and provide care for Members only as a result of Members being directed to the hospital setting are deemed appropriately credentialed and privileged in accordance with state, federal, regulatory and accreditation standards when credentialed and privileged by the hospital in which they treat Members. However, KP reserves the right to credential any practitioner.

A KP Credentials and Privileges Committee will communicate credentialing determinations in writing to practitioners. In the event the committee decides to deny initial credentialing, terminate existing credentialing or make any other adverse decision regarding the practitioner's ability to treat Members, appeal rights will be granted in accordance with

applicable legal requirements and KP policies and procedures. The practitioner will be notified of those rights when notified of the committee's determination.

All information obtained by KP during the practitioner credentialing and recredentialing process is considered confidential as required by law. For additional information regarding credentialing and recredentialing requirements and policies, please contact TPMG Consulting Services.

9.3.2 Practitioner Rights

9.3.2.1 Practitioner Right to Correct Erroneous or Discrepant Information.

The credentials staff will notify the practitioner, orally or in writing of information received that varies substantially from the information provided during the credentialing process. The practitioner will have 30 Calendar Days in which to correct the erroneous or discrepant information. The notice will state to whom, and in what format, to submit corrections.

9.3.2.2 Practitioner Rights to Review Information

Upon written request, and to the extent allowed by law, a practitioner may review information submitted in support of their credentialing application and verifications obtained by KP that are a matter of public record. The credentials file must be reviewed in the presence of KP credentialing staff. Upon receipt of a written request, an appointment time will be established during which practitioners may review the file.

9.3.2.3 Practitioner Right To Be Informed of the Status of the Credentialing Application

The credentials staff will inform the practitioner of their credentialing or recredentialing application status upon request. Requests and responses may be written or oral. Information regarding status is limited to:

- Information specific to the practitioner's own credentials file
- Current credentialing status
- Estimated committee review date, if applicable and available
- Outstanding information needed to complete the credentials file

9.3.2.4 Practitioner Right to Credentialing and Privileging Policies

Upon written request, a practitioner may receive a complete and current copy of KFHP, Northern California Region Credentialing & Privileging Policies and Procedures. For those hospitals where the practitioner maintains active privileges, the practitioner may also

request and receive complete and current copies of Professional Staff Bylaws and The Rules and Regulations of the Professional Staff of Kaiser Foundation Hospital.

9.3.3 Organizational Providers (OPs)

KP requires that all OPs within the scope of its credentialing program be credentialed prior to treating Members and maintain credentialing at all times. Recredentialing will occur at least every 36 months and may occur more frequently. Requirements for both initial and recredentialing for OPs include, but are not limited to:

- Completed credentialing/recredentialing application
- California License in good standing, as applicable
- Medicare and Medicaid certification, if applicable
- Accreditation by a KP-recognized accreditation body and/or site visit by KP
- Evidence of current professional and general liability insurance, in amounts as required by KP
- Other criteria specific to organizational specialty

9.3.3.1 Corrective Action Plan or Increased Monitoring Status for OPs

Credentialing and recredentialing determinations are made by the KP Regional Credentials and Privileges Committee (RCPC). At the time of initial credentialing, newly operational OPs may be required to undergo monitoring.

Newly operational OPs are typically monitored for at least 6 months. These providers may be required to furnish monthly reports of applicable quality and/or clinical indicators for a minimum of the first 3 months of the initial credentialing period. This monitoring may include onsite visits.

If deficiencies are identified through KP physicians, staff or Members, the OP may be placed on a Corrective Action Plan (CAP) or Performance Improvement Plan (PIP) related to those deficiencies.

The OP will be notified in writing if deficiencies are identified. The notice will include the reason(s) for which the CAP or PIP is required, the monitoring time frames and any other specific requirements that may apply regarding the monitoring process. Within 2 weeks of such notice, the OP must create, for KP review, a time-phased plan that addresses the reason for the deficiency and their proposed actions toward correcting the deficiency. KP will review the draft CAP or PIP and determine whether it adequately addresses identified issues. If the plan is not acceptable, KP representatives will work with the OP to make necessary revisions to the plan. OPs subject to a CAP or PIP will be monitored for 6 months or longer.

For additional information regarding credentialing and recredentialing requirements and policies, please contact Provider Services.

9.4 Monitoring Quality

9.4.1 Compliance with Legal, Regulatory and Accrediting Body Standards

KP expects all Providers to be in compliance with all applicable legal, regulatory and accrediting requirements, to have and maintain accreditation as appropriate, to maintain a current certificate of insurance, and to maintain current licensure. If any entity takes any adverse action regarding licensure or accreditation, this must be reported to KP's Medical Services Contracting Department, along with a copy of the report, the action plan to resolve the identified issue or concern, within 90 Calendar Days of the receipt of the report.

9.4.2 Member Complaints

Written complaints by Members about the quality of care provided by the Provider or Provider's medical staff or KP representatives must be reported within 30 Calendar Days. The above aggregate reporting is part of the quality management process and is independent of any other requirements contained in your Agreement concerning the procedure for addressing specific complaints made by Members (either written or oral). If the problem is not amenable to immediate resolution at the point of service, the Member may submit a grievance. Refer to Section 7.5.3 for information on Member grievances.

9.4.3 Infection Control

KP requests the cooperation of Providers in monitoring their own practice for reporting of communicable diseases including COVID-19 during the pandemic, aimed at prevention of hospital associated infection (HAI) including, but not limited to, multi-drug resistant organisms such as MRSA, VRE, and C.difficile (C.diff), postoperative surgical site infections, central line associated bloodstream infections, and catheter-associated urinary tract infection. When a potential infection is identified, notify the local Infection Preventionist. Confirmed HAI cases in the facility are tracked and entered into the Centers for Diseases and Control (CDC) database called National Health and Safety Network (NHSN) as required per mandated public reporting. When a trend is identified by the affiliated practitioner or Provider, this should be shared with local Infection Control Committee (ICC) and a collaborative approach should be undertaken to improve practices related to infection prevention and control. All HAI summary reports and analysis should be submitted for review on an ongoing basis to the KP ICC and Quality Management (QM) Departments. Results of this review should then be shared with the affiliated practitioner or Provider. The IP and QM Departments will request certain actions and interventions be taken to maximize patient safety, as appropriate.

9.4.4 Practitioner Quality Assurance and Improvement Programs

KP ensures that mechanisms are in place to continually assess and improve the quality of care provided to Members to promote their health and safety through a comprehensive and effective program for practitioner peer review and evaluation of practitioner performance. This policy supports a process to conduct a peer review investigation of a health care practitioner's performance or conduct that has affected or could affect adversely the health or welfare of a Member.

9.5 Quality Oversight

The peer review process is a mechanism to identify and evaluate potential quality of care concerns or trends to determine whether standards of care are met and to identify opportunities for improvement. The process is used to monitor and facilitate improvement at the individual practitioner and system levels to assure safe and effective care. Peer review provides a fair, impartial, and standardized method for review whereby appropriate actions can be implemented and evaluated. The peer review process includes the following:

- Practitioner Performance Review and Oversight—Practitioner profiling for individual re-credentialing as well as oversight and evaluation of the quality of care provided by practitioners in a department
- Practitioner Peer and System Review—Quality of care concern
- Focused Practitioner Review and Practice Improvement Plan—provides an objective evaluation of all or part of a practitioner's practice when issues are identified around the performance of that practitioner

The primary use of the information generated from these activities is for peer review and quality assurance purposes. Such information is subject to protection from discovery under applicable state and federal law. All such information and documentation will be labeled "Confidential and Privileged," and stored in a separate, secured, and appropriately marked manner. No copies of peer review documents will be disclosed to third parties unless consistent with applicable KP policy and/or upon the advice of legal counsel. Information, records, and documentation of completed peer review activity (along with other information on practitioner performance) shall be stored in the affected individual practitioner's confidential quality file.

Individuals involved in the peer review process shall be subject to the policies, principles, and procedures governing the confidentiality of peer review and quality assurance information.

When a peer review investigation results in any adverse action reducing, restricting, suspending, revoking, or denying the current or requested authorization to provide health care services to Members based upon professional competence or professional conduct, such adverse actions will be reported by the designated leaders of the entities responsible to

make the required report (e.g., the chief of staff or hospital administrator) to the National Practitioner Data Bank and/or regulatory agencies, as appropriate.

9.5.1 Quality Review

Criteria that trigger a referral for Quality Review are identified through multiple mechanisms. Some sources include, but are not limited to:

- Allegations of professional negligence (formal or informal)
- Member complaints / grievances related to quality of care
- Risk Management (adverse events)
- Medical legal referrals
- Inter- or intra-departmental or facility referrals
- Issues identified by another practitioner
- UM
- Member complaints to external organizations

Cases referred for quality review are screened for issues related to the professional competence of a practitioner, which may be subject to peer review. These may include, but are not limited to:

- Concerns regarding the possibility of any breach of professional judgment or conduct towards patients
- Concerns regarding the possibility of failure to appropriately diagnose or treat a Member/patient
- Adverse patterns of care identified through aggregate review of performance measures (e.g., automatic triggers)

To assist in review, the reviewer will use appropriate information from sources that include, but are not limited to:

- Nationally recognized practice standards, preferably evidence based
- Professional practice requirements
- KP and other Clinical Practice Guidelines
- KP Policies and procedures, including policies related to patient safety
- Regulatory and accreditation requirements
- Community standard of care

9.5.2 OPs' Quality Assurance & Improvement Programs (QA & I)

Each OP must maintain a QA & I program, described in a written plan approved by its governing body that meets all applicable state and federal licensure, accreditation and certification requirements. When quality problems are identified, the OP must show evidence of corrective action, ongoing monitoring, revisions of policies and procedures, and changes in the provision of services. Each OP is expected to provide KP with its QA & I Plan and a copy of all updates and revisions.

9.5.3 Sentinel Events / Reportable Occurrences for OPs

This section is applicable to Acute Hospitals, Chronic Dialysis Centers, Ambulatory Surgery Centers, Psychiatric Hospitals, Skilled Nursing Facilities and Transitional Residential Recovery Services Providers. All Providers must report sentinel events and reportable occurrences as defined below. OPs must report events and occurrences at its facility or facilities covered by its Agreement.

9.5.3.1 Definitions: Sentinel Events and Reportable Occurrences

Sentinel event is a subcategory of adverse events. A sentinel event is a patient safety event (not primarily related to the natural course of a patient's illness or underlying condition) which results in a patient's death, severe harm (regardless of the duration of harm), or permanent harm (regardless of the severity of harm), and other adverse events defined by the Joint Commission and National Quality Forum.

- **Severe Harm**: An event or condition that results in life-threatening bodily injury to an individual (including pain or disfigurement) that interferes with or results in loss of functional ability or quality of life and requires continuous physiological monitoring and/or surgery, invasive procedure, or treatment to resolve the condition.

- **Permanent Harm**: An event or condition that results in any level of harm that permanently alters and/or affects an individual's baseline health.

Examples of sentinel events and reportable occurrences include, but are not limited to the following:

- Member falls resulting in serious injury, requiring subsequent medical intervention
- Medication error requiring medical intervention, including transfer
- Surgical or invasive procedure resulting in a retained foreign item, or was performed on a wrong Member, wrong side/site, wrong body part, or was a wrong procedure, or used a wrong implant

- Member suicide or attempted suicide resulting in permanent or severe temporary harm while being cared for in a healthcare setting
- A stage 3, 4 or unstageable pressure ulcer acquired after admission
- A cluster of nosocomial infections or significant adverse deviation events
- Outbreaks of infectious disease reportable to the County Health Department
- Official notice concerning revocation (requested or actual) of Medicare/Medi-Cal Certification or suspension of Medicare/Medi-Cal admissions

9.5.3.2 Notification Timeframes

Practitioners and OPs will report sentinel events and reportable occurrences within 24 hours of becoming aware of the event or occurrence. The KP contact will notify the local KP Risk Management Department about all reports. Providers should make reports to KP as follows:

Provider	KP Contact	Timeframe
Practitioner	Referral Coordinator	Within 24 hours
Acute Hospital	Care Coordinator	Within 24 hours
Chronic Dialysis Center	Renal Case Manager or Nephrologist	Within 24 hours
Ambulatory Surgery Center	Care Coordinator	Within 24 hours
Psychiatric Hospital	Care Coordinator	Within 24 hours
SNF	Care Coordinator	Within 24 hours
Transitional Residential Recovery Services (TRRS)	Care Coordinator	Within 24 hours

9.5.4 Sentinel Event/Reportable Occurrences—Home Health & Hospice Agency Providers

9.5.4.1 Report Within 24 Hours

Immediately upon discovery, verbally report to the referring KP Home Health Agency, Hospice Agency or facility any sentinel event (as defined above in Section 9.5.3.1) and the following adverse events. The verbal report must be followed by a written notification sent within 24 hours or by the end of the next Business Day email. The KP contact will notify the local KP Risk Management Department about all the reports.

- Falls resulting in death or serious injury

- Any unexpected death or any Member safety events resulting in severe, permanent or temporary Member harm not primarily related to the natural course of the Member's illness or underlying condition
- The event or related circumstances has the potential for significant adverse media (press) involvement
- Significant drug reactions or medication errors resulting in harm to the Member
- Severe permanent or temporary harm to a Member associated with the use of physical restraints or bedrails
- Member is a perpetrator or victim of a crime or of reportable abuse while under home health or hospice care
- Loss of license, certification or accreditation status
- Release of any toxic or hazardous substance that requires reporting to a local, state or federal agency

9.5.4.2 Report Within 72 Hours

You must report to the referring KP Home Health Agency, Hospice Agency or facility during KP business hours the following events involving Members that may impact the quality of care and/or have the potential for a negative outcome. Such report should be made within 72 hours of the occurrence. KP will notify the local KP Risk Management Department about all reports. These include but are not limited to the categories below.

- Reportable, communicable diseases, outbreaks of scabies or lice, and breaks in infection control practices
- Medication administration errors without harm (wrong patient, wrong drug, wrong dose, wrong route, wrong time, wrong day, or an extra dose, or an omission of an ordered drug)
- Disciplinary action taken against a practitioner caring for a KP Member that requires a report to the applicable state board or the National Practitioner Data Bank

9.6 QA & I Reporting Requirements for Chronic Dialysis Providers

9.6.1 Reporting Requirements

Providers who deliver chronic dialysis services are expected to send, on a monthly basis via hard copy or electronic file, a Patient Activity Report form containing the following information for Members who are:

- dialyzing for the first time
- transferring into the contracted dialysis center from another dialysis center
- returning after transplant
- recovering renal function
- receiving a transplant
- transferring to another dialysis center
- deceased
- changing treatment modality

Providers must also submit the above information for patients who were on dialysis prior to joining KP.

9.6.2 Vascular Access Monitoring (VAM)

Pursuant to your Agreement, the chronic dialysis Provider is responsible for monitoring the blood flow in all grafts and fistulas of Members at the levels prescribed by the assigned nephrologist. Your Agreement will specify whether you are obligated to perform VAM services either using the Transonic Flow QC System® or another method of VAM approved by Governing Body or office of Chief Medical Officer (CMO).

Desirable levels for flow rates are >400 ml/min for fistulas and >600 ml/min for grafts. When blood flow rates fall below the desirable targets, notify the nephrologist and/or KP renal case manager so that an appropriate intervention to prevent the access from clotting can be planned.

9.6.2.1 Surveillance Procedure for an Established Access

1. Obtain an access monitoring order from the nephrologist.

2. The Provider performs monthly access flow measurements once prescribed blood flow and optimal needle size are achieved at the intervals described below:

Grafts

- VAM services testing frequency
  - Transonic Flow QC System®—Monthly*
  - Another method of VAM approved by Governing Body or office of CMO
  - As otherwise prescribed by a Nephrologist
- Graft flow > 600 ml/min—continue to test at monthly intervals and trend results
- Graft flow rate 500 to 600 ml/min - review test results and trend. If trending indicates that flows are decreasing, refer the patient for angiogram and evaluation
- If trends remain constant and are not decreasing, repeat the test at the scheduled time
- Graft flow rate < 500 ml/min—refer for angiogram and evaluation

Fistula

- VAM services testing frequency
  - Transonic Flow QC System®—Every other month*
  - Another method of VAM approved by Governing Body or office of CMO
  - As otherwise prescribed by a nephrologist
- Fistula flow rate >400 ml/min—continue to test at monthly intervals and trend results.
- Fistula flow rate 300 to 400 ml/min - Review test results and trend. If trending indicates that flows are decreasing, refer the patient for angiogram and evaluation.
- If trends remain constant, use slower blood flows and perform a clinical evaluation to verify the adequacy of the treatments at a lower pump speed.
- Fistula flow rate < 300 ml/min—Refer for angiogram and evaluation

*In the case of the Transonic Flow QC System®, recirculation should be zero percent (0%) when testing the vascular access.

The Provider performs access flow measurements at frequencies other than that outlined above under the following conditions:

- After a surgical procedure to create a new vascular access
- Within a week following an access intervention, including but not limited to, a fistulogram, de-clotting, angioplasty or a surgical revision
- As ordered by a Nephrologist

9.6.3 Performance Target Goals/Clinical Indicators

9.6.3.1 Chronic Dialysis Patients

The following performance targets are the clinical indicators for hemodialysis and peritoneal dialysis KP Members and shall be reported by the Provider to KP within 15 Calendar Days from the end of the calendar quarter. The submission of the indicators shall be in a format acceptable to KP via an electronic file or other method designated by KP. Each contracted dialysis company must report the indicators on a quarterly basis for each of its participating dialysis centers in their Agreement:

REGIONAL RENAL ESRD QUALITY IMPROVEMENT PROGRAM DIALYSIS FACILITY SPECIFIC TARGETS			
MODALITY	**MEASUREMENT**	**DESCRIPTION**	**TARGET**
In-Center HD	Vascular Access	Percentage of patients in a given reporting period with a central venous catheter in place. If Fistula or Graft in use, but CVC in place, CVC will count as the highest risk access.	< 20%
	Adequacy of Dialysis	Percent of all patients at clinic whose last valid Kt/V of the month ≥ 1.2	≥ 95%
	Positive Blood Cultures	Report all positive blood cultures according to NHSN guidelines	100% of known positive blood cultures are reported
PD	Adequacy of Dialysis	Percent of all patients at clinic whose last valid Kt/V of the month ≥ 1.7	≥ 95%
	Peritonitis Rates	12-month rolling peritonitis rate	</= to 0.33 episodes per patient year

9.6.4 DNBE/Reportable Occurrences for Providers

As part of its required participation in KP's QI Program and in addition to the Claims submission requirements in Section 5.18.5 of this Provider Manual, and to the extent permitted by Law, the Provider must promptly notify KP and, upon request, provide information about any DNBE (as defined in Section 5.18.5) that occurs at its Location or Locations covered by its Agreement in connection with Services provided to a Member. Notices and information provided pursuant to this section shall not be deemed admissions of liability for acts or omissions, waiver of rights or remedies in litigation, or a waiver of evidentiary protections, privileges or objections in litigation or otherwise. Notices and information related to DNBEs should be sent to:

Regional Medical Services Contracting Department
Attn: Provider Services
5820 Owens Drive, Building E, Floor 2
Pleasanton, CA 94588
Phone: **(925) 924-5050**
Fax: **(877) 228-8306**

At a minimum, Providers should include the following elements in any DNBE notice sent to KP:

- KP Medical Record Number (MRN)
- Date(s) of service
- Place of service
- Referral number or emergency claim number
- General category description of DNBE(s) experienced by the Member

9.7 QA & I Reporting Requirements for Home Health & Hospice Providers

Quality monitoring activities will be conducted at each individual home health and hospice agency site and branch location.

9.7.1 Annual Reporting

On an annual basis, Providers of Home Health and Hospice services, and licensed/certified Providers who manage Members' plan of care on referral, must submit to KP:

- Copies of current license and insurance
- Reports of any accreditation and/or regulatory site visits occurring within the last 12 calendar months
- Copy of current quality plan and indicators
- Results of most recent patient satisfaction survey
- Action plans for all active citations, conditions, deficiencies and/or recommendations

9.7.2 Site Visits and/or Chart Review

A site visit and/or chart review may be requested by KP at any time to monitor quality and compliance with regulations. When onsite reviews are requested by the referring KP Home Health Agency, Hospice Agency, or facility or regional representative, your agency will make the following available:

- Personnel records
- Quality plan and indicators
- Documentation for Member complaints and follow-up
- Member medical records
- Policy and procedure manuals
- Other relevant quality and compliance data

9.7.3 Personnel Records

Providers providing home health and hospice services shall cooperate with KP audits of staff personnel records. Audits are designed to assure personnel providing care to KP Members are qualified and competent. Information reviewed may include but not be limited to:

- Professional License
- Current CPR certification
- Tuberculin or PPD testing
- Evidence of competency for those services provided to KP Members
- Continuing education
- Annual evaluation

9.8 QA & I Reporting Requirements for SNFs

The KP QA & I plan includes quality indicators that are collected routinely. Some of these indicators KP will collect; others will be collected by the SNF Providers. These indicators will be objective, measurable, and based on current knowledge and clinical experience. They reflect structures, processes or outcomes of care. KP promotes an outcome-oriented quality assessment and improvement system and will coordinate with SNF Providers to develop reportable outcomes.

9.8.1 Quarterly Reporting

Quarterly, SNF Quality Assessment indicator trend reports will include, at a minimum, the following:

- Patient falls
- Pressure Ulcers/Injuries
- Medication errors
- Previously reported adverse events and DNBEs
- Any CMS deficiency with a CAP or California Department of Public Health (CDPH) deficiency or citation with a CAP
- Reports to CDPH of unusual occurrences involving KP Members

9.8.2 Medical Record Documentation

KP procedures regarding medical record documentation for SNF Providers are detailed below. Any contradiction with a SNF Provider's own policies and procedures should be declared by the SNF, so that steps can be taken to satisfy both the SNF Provider and KP.

All patient record entries shall be written (preferably printed), made in a timely manner, dated, signed, and authenticated with professional designations by individuals making record entries.

Medical record documentation shall include at least the following:

- Member information, including emergency contact and valid telephone number
- Diagnoses and clinical impressions
- Plan of care
- Applicable history and physical examination
- Immunization and screening status when relevant
- Allergic and adverse drug reactions when relevant
- Documentation of nursing care, treatments, frequency and duration of therapies for Member, procedures, tests and results
- Information/communication to and from other providers
- Referrals or transfers to other providers
- Recommendations and instructions to patients and family members
- For each visit: date, purpose and updated information
- Advance Directive

9.9 Medical Record Review and Standards

KP recommends that all Providers maintain their medical records following standards applicable to their specialty to assure the consistency and completeness of patient medical records.

NOTE: A Provider may demonstrate compliance with these standards by preparing a sample medical record and discussing it with the reviewer or by redacting several medical records for existing patients.

KP MEDICAL RECORD STANDARDS

Summary of Medical Record Standards	Information Required
Patient Identification*	All entries (entry, page, or screen) in a patient's medical record must include the patient's last name, first name, and the patient's unique KP medical record number (MRN).
Personal/Biographical Data*	Patient demographic information which includes: • Birth date • Gender • Marital status • Home address and • Home/work telephone numbers NOTE: For pediatric medical records, this information should also address the child's parent/guardian.
Medical Record Entries*	All notes/entries • Include the name of the rendering provider and, if paper documentation, are authenticated by the provider • Are dated and in sequential order • Are legible to someone other than the writer • Are done in a timely manner
Problem List (PCP only) *	Medical records include a completed "problem list" which notes significant illnesses or medical conditions.
Allergies*	Allergies and adverse reactions to medications or immunizations are noted and prominently displayed inside or on the cover of a hard copy of a medical record, and in any computer based program. If the patient has no known allergies or history of adverse reactions, this must be also noted.

Summary of Medical Record Standards	Information Required
Medical History"	Medical history must include: ● Date of birth ● Documentation of past medical history for which includes serious illnesses, past surgeries, or significant procedures. ● Pertinent family and social history For **Pediatric Patients**, the history should also include: ● Birth history including location, child's birth weight, and any special circumstances regarding the birth. ● Growth chart with height, weight, and head circumference to (HC age 2) ● Operations and childhood illnesses ● Immunizations
Substance Abuse/Tobacco Products	For patients 14 years and older, medical records should document use/non-use of tobacco products, alcohol, or other substances. If the patient has been seen 3 or more times, they should be asked about substance abuse history.
Pertinent History/Exams for Patient "Complaints"	Pertinent history, physical exam for presenting complaints is completed and noted. The patient's vital signs are also noted.
Laboratory/Radiology Tests	Lab and Radiology and other testing are ordered as appropriate, and the ordering practitioner must make a notation in the record indicating abnormal results.
Working Diagnosis Consistent With Findings	Impression/working diagnosis clearly documented for each visit (except for preventive visits where no illness, complaint, etc. is identified.)
Treatment Plans	Treatment plans are consistent with diagnosis.
Follow-up Care/Visits	Date for return visit or other follow-up plan(s) for each encounter are noted when appropriate. The specific time of the follow-up visit is noted in weeks, months, or as needed.
Instruction in Self-Care	Date training/instruction on self-care provided to patient noted.
Unresolved Problems	Problems from previous visits are addressed in subsequent visits.
Use of Consultants	There is evidence of appropriate use of consultants.
Consultant Notes	There is evidence of continuity and coordination of care between primary and specialty providers. If consults are requested, copies of consultant notes are included in the medical record.

Summary of Medical Record Standards	Information Required
PCP Review of Consult/Lab Reports	Consultation summaries and lab & imaging reports indicate provider review. There is evidence that follow-up plans are in place for significant abnormal
Patient at Inappropriate Risk	There is no evidence that patient is placed at inappropriate risk by diagnostic or therapeutic intervention.
Immunizations*	An immunization record is present and up to date for all pediatric patients. Adult immunizations are noted as appropriate.
Advance Directive	Document in record, prominently placed, to denote whether an Advance Directive has been executed.
Preventive Services	There is evidence that preventive screening and services are offered according to nationally accepted standards and practice guidelines.
Medications	A medication list is included.
NOTE: Information and data recorded in the Medical Record and in other Member health & enrollment records must be accurate, complete, and truthful.	

* Medical records must comply with these standards if only general medical recordkeeping practices are being reviewed.

9.10 Access and Availability Guidelines

Access to care is evaluated according to applicable law and regulation and considers responses to member satisfaction questions from the Consumer Assessment of Healthcare Providers and Systems (CAHPS), provider surveys, and Member complaints and grievances.

To assure all Members can access medical care in a safe and timely manner, KP utilizes access guidelines. KP's compliance with regulated access guidelines is measured by DHCS and/or DMHC through email or phone surveys conducted among contracted providers of professional services. Providers may be contacted by a regulator's third party contractor requesting information about available appointment times. HSAG/DataStat surveys providers on behalf of DHCS; Mazars surveys providers on behalf of DMHC. Results of such surveys are part of KP's QI Program because they help KP monitor our success in providing accessible care. In accordance with the Quality Assurance and Quality Improvement section of your KP Agreement (typically section 2.4.1 therein), Providers have an obligation to cooperate with KP's QI Program, including participation in phone surveys evaluating access to care.

Safe, efficient, and accessible practice sites are also essential components to delivering accessible, high quality care and services to Members. Facility standards are measured through KP office site reviews (for select Provider types). Results are used to inform KP quality improvement activities. Adhering to the guidelines in this section 9.10 increases access to care and overall Member satisfaction.

Access Indicator	Maximum Appointment/Response Timeframe
Primary Care Practitioners	
Preventive Gynecological Exam	7 Business Days
Non-urgent Care	7 Business Days
Routine/Preventive Care	7 Business Days
Behavioral Health Providers	
Urgent Care	Within 48 hours
Non-Urgent Care	Within 10 Business Days (therapist and any other non-physician treating providers) Within 15 Business Days (physician)
Routine Follow-Up (for Members undergoing a course of treatment for an ongoing mental health or substance use disorder condition)	Within 10 Business Days of the previous appointment (therapist and any other non-physician treating providers)
Specialists and Ancillary Services Practitioners	
Non-urgent symptomatic visit	14 Business Days. The timeframe begins on the day a referral is generated by the PCP and ends the day the patient is scheduled to see the specialist.
Routine Follow-Up	14 Business Days
ALL Providers	
Urgent care (non-life threatening, if left untreated could lead to harmful outcome)	Within 24 hours
Emergency care	Immediately
Wait times in physician's office	Less than 30 minutes. If an emergency occurs that will substantially lengthen a Member's waiting time, the office staff should inform the patient of the delay as soon as possible, and offer to: Reschedule appointments for Members if medically acceptable Have Members see another provider in the office if one is available, and the option is acceptable to the Member
Access to after-hours care	Continuous coverage must be available

Access Indicator	Maximum Appointment/Response Timeframe
Calls Placed to a Provider's	
During business hours	Returned same day the call is received
After business hours	Returned within 24 hours

Providers shall ensure covered services are available (i) during normal business hours, (ii) when medically indicated, on a prompt or same-day basis, and (iii) as otherwise specified in the Agreement, this Provider Manual or applicable laws. Providers shall ensure covered services are readily available and accessible to Members; provided in a timely manner, without delays in appointment scheduling and waiting times; and provided in a manner appropriate for the nature of a Member's condition, and consistent with good professional practice, KP policies and applicable laws. If it is necessary for Provider, a Commercial or Medi-Cal Member to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the Member's health care needs, and ensures continuity of care consistent with good professional practice, and as otherwise required by applicable law.

If Provider provides covered services to treat Commercial or Medi-Cal Members who are undergoing a course of treatment for an ongoing mental health (including an autism diagnosis) or substance use disorder condition, Provider must offer follow-up appointments as follows, except as otherwise required or permitted by applicable laws:

- Nonurgent follow-up appointments with a nonphysician mental health care or substance use disorder Provider must be offered within 10 business days of the Member's prior appointment, except as otherwise permitted by law and as described in below. This requirement does not limit coverage for nonurgent follow up appointments with a nonphysician mental health care or substance use disorder provider to once every 10 business days.
- The 10 business day timeframe for a follow-up appointment may be extended if the referring or treating health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of their practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the Member.

When Members request same day or future appointments and their medical condition warrants, the appointment should be scheduled as close to the requested day and time as possible. If the Member does not request a specific day or time, an appointment within the time frames noted in the table above should be offered.

The applicable waiting time for an appointment may be extended if the KP referring or treating licensed health care provider, or the KP health professional providing triage or screening services to Members, as applicable, has determined that a longer waiting time

will not have a detrimental impact on the health of the Member. If any Member declines an appointment offered within these guidelines, or if the Provider, in consultation with the KP referring or treating health care provider, determines that a longer waiting time will not have a detrimental impact on the health of the Member, the declination or the professional determination and underlying clinical basis for a delayed appointment should be documented in the Member's medical record maintained by the treating Provider.

For inquiries regarding timeliness of referrals, providers should contact the KP office which issued the referral as noted in the authorization communication. If Members have inquiries regarding timeliness of referrals, Members may contact the Member Services Contact Center. If a Member's plan is regulated by the DMHC, the Member or a Provider may file a complaint with the DMHC regarding timeliness of referrals. Members can file a DMHC complaint as provided in Section 7.5.4, and Providers may file a complaint by contacting the DMHC's provider complaint line at **(877) 525-1295**.

10. Compliance

KP strives to demonstrate high ethical standards in our business practices. The Agreement details specific laws and contractual provisions with which you are expected to comply. This section of the Provider Manual details additional compliance obligations.

10.1 Compliance with Law

Providers are expected to conduct their business activities in full compliance with all applicable state and federal laws.

10.2 Code of Ethical Conduct and Compliance Hotline

The Code of Ethical Conduct - KP Principles of Responsibility (POR) is the code of conduct for KP physicians, employees and contractors working in KP facilities (KP Personnel) in their daily work environment. If you are working in a KP facility, you will be given a copy of the POR for your reference.

You should report to KP any suspected wrongdoing or compliance violations by KP Personnel under the POR. The KP 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 **(888) 774-9100.**

Additionally, Providers may review the POR at: Code of Ethical Conduct - Kaiser Permanente's Principles of Responsibility v.10 (policytech.com) and are encouraged to do so. The POR is applicable to interactions between you and KP and failure to comply with provisions of these standards may result in a breach of your Agreement with KP.

10.3 Gifts and Business Courtesies

Even if certain types of remuneration are permitted by law, KP discourages Providers from giving gifts, meals, entertainment or other business courtesies to KP Personnel, in particular the following strictly prohibited items:

- Gifts or entertainment of any kind or value
- Gifts, meals or entertainment that are provided on a regular basis
- Cash or cash-equivalents, such as checks, gift certificates/cards, stocks, or coupons
- Gifts from government representatives

- Gifts or entertainment that reasonably could be perceived as a bribe, payoff, deal or any other attempt to gain advantage
- Gifts or entertainment given to KP Personnel involved in KP purchasing and contracting decisions
- Gifts or entertainment that violate any laws or KP policy

10.4 Conflicts of Interest

Conflicts of interest between a Provider and KP Personnel or the appearance of it, should be avoided. There may be some circumstances in which members of the same family or household may work for KP and for a Provider. However, if this creates an actual or potential conflict of interest, you must disclose the conflict at the earliest opportunity, in writing, to a person in authority at KP (other than the person who has the relationship with the Provider). You may call the toll free Compliance Hotline number at **(888) 774-9100** for further guidance on potential conflicts of interest.

10.5 Fraud, Waste and Abuse

Providers must be aware that funds received from KP are in whole or in part derived from federal funds. You are expected to comply with all applicable state and federal laws governing remuneration for health care services, including anti-kickback and physician self-referral laws. KP will investigate allegations of Provider fraud, waste or abuse, related to services provided to 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). No individual may be threatened, harassed or in any manner discriminated against in retaliation for exercising their rights under the False Claims Act or similar state laws.

10.6 Providers Ineligible for Participation in Government Health Care Programs

KP requires the Provider to (a) disclose whether any of its officers, directors, employees, or subcontractors are or become 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 health care and (b) assume full responsibility for taking all necessary steps to assure that Provider's employees, subcontractors and agents directly or indirectly involved in KP business have not been and are not currently excluded from participation in any federal program and this shall include, but not be limited to, routinely screening all such names against all applicable lists of individuals or entities sanctioned by, excluded from, debarred from, or ineligible to participate in any federal

program published by government agencies (including the U.S. Department of Health and Human Services, Office of Inspector General, List of Excluded Individuals and Entities at http://oig.hhs.gov/exclusions/exclusions_list.asp and U.S. General Services Administration, Excluded Parties List System at https://www.sam.gov as and when those lists are updated from time to time, but no less often than upon initial hiring or contracting and annually thereafter. Providers are required to document their actions to screen such lists, and upon request certify compliance with this requirement to KP. KP will not do business with any entity or individual who is or becomes excluded by, precluded from, debarred from, or otherwise ineligible to participate in any federal health care program or is convicted of a criminal offense related to the provision of health care.

10.7 Visitation Policy

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

10.8 Compliance Training

KP requires certain providers, including those who provide services in a KP facility, to complete KP's Compliance Training, as required by your Agreement, applicable law or regulatory action or as required by any government health care program contract to which KP is a party. Where applicable, you must ensure that your employees and agents involved in KP business complete, and provide evidence of completion of, the relevant KP Compliance Training. Please refer to your KP Contracts Manager for more guidance regarding these requirements.

10.9 Confidentiality and Security of Patient Information

Health care providers, including KP and you or your facility, are legally and ethically obligated to protect the privacy of patients and Members. KP requires that Providers keep Members' medical information confidential and secure. These requirements are based on state and federal laws both applicable to Providers and KP, as well as policies and procedures created by KP. Services provided via telehealth through any medium must meet all laws regarding confidentiality of medical information and a Member's right to the Member's own medical information.

Providers may not use or disclose the personal health information of a Member, except as needed to provide medical care to Members or patients, to bill for services or as necessary to regularly conduct business. Personal health information refers to medical information, as well as information that can identify a Member, for example, a Member's address or telephone number.

Medical information may not be disclosed without the authorization of the Member, except when the release of information is either permitted or required by Law.

10.9.1 HIPAA and Privacy and Security Rules

As a Provider, you may have signed a document that creates a “Business Associate” relationship with KP, as such relationship is defined by federal regulations commonly known as HIPAA. If you are providing standard patient care services that do not require a business associate agreement, you still must preserve the confidentiality, privacy and security of our common patients’ medical information.

If you did not sign a business associate agreement, you are likely a "Covered Entity" as that term is defined under HIPAA, and the Privacy and Security Rules issued by the Department of Health and Human Services. As a Covered Entity, you have specific responsibilities to limit the uses and disclosures and to ensure the security of protected health information (PHI), as that term is defined by the Privacy Rule (45 CFR Section 160.103).

Certain data which may be exchanged as a consequence of your relationship with KP is subject to the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-91) and its regulations or as updated and amended by Health Insurance Portability and Accountability Act of 1996 (Public Law 104-91) and the Health Information Technology and Economic and Clinical Health Act (HITECH), Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5), as each are codified in the United States Code, and all regulations issued under any of the foregoing statutes, as and when any of them may be amended from time to time (collectively “HIPAA”). To the full extent applicable under HIPAA, you must comply with HIPAA, including but not limited to the HIPAA standards for (i) privacy, (ii) code set, (iii) data transmission standards, and (iv) security regarding physical storage, maintenance, transmission of and access to individual health information.

Providers must use and disclose PHI only as permitted by HIPAA and the Privacy Rule, subject to any additional limitations, if any, on the use and disclosure of that information as imposed by your Agreement or any Business Associate Agreement you may have signed with KP. You must maintain and distribute your Notice of Privacy Practices (45 CFR Section 164.520) to and obtain acknowledgements from Members receiving services from you, in a manner consistent with your practices for other patients. You must give KP a copy of your Notice of Privacy Practices upon request and give KP a copy of each subsequent version of your Notice of Privacy Practices whenever a material change has been made to the original Notice.

Providers are required by HIPAA to provide a patient with access to his or her PHI, to allow that patient to amend his or her PHI, and to provide an accounting of those disclosures identified under the Privacy Rule as reportable disclosures. You must extend these same rights to Members who are patients.

10.9.2 Confidentiality of Alcohol and Drug Abuse Patient Records

In receiving, storing, processing or otherwise dealing with any patient records, Provider is fully bound by the federal substance abuse confidentiality rules set forth at 42 CFR Part 2 and if necessary, must resist in judicial proceedings any efforts to obtain access to patient records, except as permitted by these regulations.

10.10 Provider Resources

- KP's National Compliance Office: **(510) 271-4699**
- KP's Compliance Hotline: **(888) 774-9100**
- Regional Compliance Office: **(510) 625-2400**
- Medical Services Contracting Department: **(844) 343-9370**
- TPMG Regional Compliance: **(510) 625-3885**

11. Additional Information

11.1 Affiliated Payors

In accordance with the terms of your Agreement with KP, the mutually agreed upon rates in the Agreement may be extended to Affiliated Payors as identified below:

Kaiser Foundation Health Plan, Inc. (Northern California, Southern California, Hawaii)

Kaiser Foundation Health Plan of Colorado

Kaiser Foundation Health Plan of Georgia, Inc.

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

Kaiser Foundation Health Plan of the Northwest

Kaiser Foundation Health Plan of Washington

Kaiser Foundation Health Plan of Washington Options, Inc.

Kaiser Foundation Hospitals

Kaiser Permanente Insurance Company

KP Cal, LLC

The Permanente Medical Group, Inc.

Southern California Permanente Medical Group

Colorado Permanente Medical Group, P.C.

Hawaii Permanente Medical Group, Inc.

Mid-Atlantic Permanente Medical Group, P.C.

Northwest Permanente, P.C.

Permanente Dental Associates

The Southeast Permanente Medical Group, Inc.

Washington Permanente Medical Group, P.C.

11.2 Subcontractors and Participating Practitioners

KP defines a "subcontractor" as an individual participating practitioner, participating practitioner group, or any other entity that provides or arranges for services to KP Members pursuant to a direct or indirect contract, agreement, or other arrangement with a Provider contracted with KP.

Subcontractor participating practitioners may be locum tenens, members of the Provider's call group, and others who may provide temporary coverage excluding employees, owners and/or

partners of the contracting entity. For assistance in determining whether a participating practitioner is a subcontractor, please contact Provider Services.

All rights and responsibilities of the Provider extend to the subcontractor, individual participating practitioner, participating practitioner group and facilities providing services to Members. The Provider is responsible to distribute this Provider Manual and subsequent updates to all its subcontractors and participating practitioners, assuring that its subcontractors and participating practitioners and facilities adhere to all applicable provisions of this Provider Manual.

11.2.1 Regulatory Compliance

CMS, DHCS, DMHC, NCQA and other state and federal agencies and accrediting organizations conduct surveys of KP to measure compliance with legal, regulatory and accreditation requirements and standards. Regulatory requirements related to the use of subcontractors obligate KP to validate subcontracts are in place where applicable, and they meet all regulatory and contractual requirements. Upon request, Provider must provide KP a copy of its subcontract template along with executed signature pages for each subcontractor. When a subcontract is amended or altered, Provider should notify KP within 30 Calendar Days. Provider must furnish copies of executed subcontracts, and other documents related to subcontractors, upon the request of governmental, regulatory or accreditation agency personnel and/or when KP is preparing for internal and/or regulatory or accreditation agency audits.

Additionally, upon request, the Provider is responsible to furnish copies of its policies and procedures related to any economic profiling information that is used to evaluate participating practitioner or subcontractor performance. Further the Provider is responsible to provide a copy of the information, upon request, to the subcontractor or participating practitioner. Economic profiling is defined as an evaluation based in whole or in part on the economic costs or utilization of services associated with providing medical care.

11.2.2 Licensure, Certification and Credentialing

Subcontractors and participating practitioners are subject to the same credentialing and recredentialing requirements as the Provider. The Provider is responsible to ensure that all subcontractors and participating practitioners are properly licensed by the State of California or the state(s) in which services are provided, and that the licensure and/or certification is in good standing in accordance with all applicable local, state, and federal laws. Further, the Provider is responsible to ensure that its subcontractors and participating practitioners participate in KP's credentialing and recredentialing processes and that any site where Members may be seen is properly licensed. For additional information on credentialing requirements, please refer to Section 9.3 of this Provider Manual.

11.2.3 Billing and Payment

Services provided for KP Members should be billed by the Provider to include services provided by any of its subcontractors. KP will not pay subcontractor bills directly but will return them to the subcontractor for submitting to the Provider.

11.2.4 Encounter Data

KP is required to certify the accuracy, completeness and truthfulness of data that CMS and other state and federal governmental agencies and accrediting organizations request. Such data includes encounter data, payment data, and any other information provided to KP by its contractors and subcontractors. As such, KP may request such certification from the Provider in order to meet regulatory and accreditation requirements.

11.2.5 Identification of Subcontractors

Each Provider at the time of initial contracting, and periodically thereafter, is required to complete and submit to KP a completed PPIF (incorporated by reference in your Agreement). This form identifies all participating facilities and practitioners, including those practitioners that are employed by the Provider, facilities that are operated by the Provider and those which are subcontractors.

11.3 KP's Health Education Programs

KP is dedicated to providing quality care for its Members. A key step towards this goal is to make available and encourage the use of health education programs and to provide preventive health services and screenings which are based on the latest scientific information presented in medical specialty journals, sub-specialty organization guidelines, and the US Preventive Services Task Force Guide.

KP's health education programs support KP clinicians by providing expertise in evidence-based patient health communication, behavior change, and technology. Health Education supports physicians in motivating and informing patients at the point of care while enhancing KP's reputation for excellence in prevention, health promotion, and care of chronic conditions.

The local health education departments oversee the development and implementation of educational services for KP Members. All Members and Providers have access to the KP health education departments for information and patient education materials. Health education departments can also offer Providers assistance with the planning or delivery of health education programs.

For more information contact your local KP facility and ask to be connected to the health education department.

11.3.1 Health Education Program

KP health education programs generally include:

- Health Education Centers, located at or operated virtually by KP Medical Centers, provide free educational materials and support including direct services to patients to supplement or provide alternatives to doctor office visits. Members can also get answers to health questions from knowledgeable staff, help with registering on the Member website **(http://www.kp.org)** and downloading mobile apps exclusively for use by Members, watch training and self-care videos, sign up for classes and programs or purchase health products.
- Health education provides patients and clinicians easy access to understandable and actionable health information they need, when they need it, and in a form they can use. These resources include print materials, patient instructions, and a rich variety of online tools and information, which may also be used in classes and office visits.
- Health education classes and programs are available throughout Northern California and cover a wide variety of topics. Most classes are taught in groups, but for Members who prefer an individualized approach, one-to-one counseling is also available in person, by telephone, or by video visit. Each KP facility maintains its own schedule of classes, some which require a fee for enrollment. For more information, contact your local KP Health Education Center.
- Members can also find health information, preventive care recommendations, and access to interactive online tools on their physician's home page at **http://www.kp.org/mydoctor**
- The Appointment and Advice Call Center (Call Center) available to all Members, 24 hours a day, 7 days a week. The Call Center is staffed by registered nurses who have special training to help answer questions about certain health problems or concerns and to advise on an appropriate response to symptoms. The advice nurses are not an impediment to seeing a physician but serve as a complement to any appropriate physician or practitioner care.

11.3.2 Focused Health Education Efforts

As part of the Quality Management Program, KP conducts focused health education efforts to address clinical or preventive health quality improvement activities. Many of these programs are developed regionally and are intended to address the specific health care issues of Members and the general community. Practitioners are generally made aware of these programs to obtain their support or participation.

11.3.3 Preventive Health and Clinical Practice Guidelines (CPGs)

KPNC supports the development and use of evidence-based CPGs and Practice Resources to aid clinicians and Members in the selection of the best preventive health care and screening

options. The best options are those that have a strong basis in evidence regarding contribution to improved clinical outcomes, quality of care, cost effectiveness, and satisfaction with care and service. The Northern California guidelines portfolio includes CPGs for key preventive care services. These guidelines recommend the preferred course of action while recognizing the role of clinical judgment and informed decision making.

11.3.4 Telephonic Wellness Coaching Service

Wellness Coaching by phone is available at no charge for KP Members who want to get more active, manage weight, quit tobacco, eat healthier, sleep better or handle stress. Our Wellness Coaches are master's degree level Clinical Health Educators who are specially trained in Motivational Interviewing. They employ a collaborative approach designed to help Members overcome obstacles and tap into their own internal motivation for achieving behavior change. Coaches can also help match Members' needs, preferences, and readiness with the appropriate support resources.

Wellness coaching typically takes place through a series of up to 6 telephone sessions. Members can find out more about Wellness Coaching and book an appointment at: **http://www.kp.org/mydoctor/wellnesscoaching.** Members can also call toll free, **(866) 251-4514**, to schedule an appointment with a KP Wellness Coach. Spanish speaking coaches are available.

11.4 KP's Language Assistance Program

All Providers need to cooperate and comply with KP's Language Assistance Program by assisting any limited English proficient (LEP) Member with access to KP's Language Assistance Program services.

Providers must ensure that Members receive effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs, practices, and preferred language. Providers should offer language assistance to Members who appear to need it even if they do not ask for it or if their language preference was not indicated on the referral form. Should a LEP Member refuse to access KP's language interpreter services, the Provider must document that refusal in the Member's medical record.

If a companion/caregiver involved in care decisions for a Member requires language assistance to communicate with the Member or Provider regarding those care decisions, then all such encounters warrant the offer of free language assistance services to the companion/caregiver. The use of interpreter services in such encounters must be documented in the patient's chart. In addition, a note should be included that language assistance services were provided to the Member's companion or caregiver.

The offer of qualified interpreter services to Members and/or their companion/caregiver shall not be limited to in-person encounters only, but also applies to telehealth visits.

Questions regarding the following information on language assistance can be discussed with KP's Language Assistance Program by emailing

NCAL-Language-Assistance-Program@kp.org

11.4.1 Using Qualified Bilingual Staff

Our expectation is that you will provide interpreter services in-person using your own qualified bilingual staff if you have them.

Your qualified bilingual staff should meet the regulatory standards set out in KP's minimum quality standards for interpreters:

- Documented and demonstrated proficiency in both English and the other language
- Fundamental knowledge in both languages of health care terminology and concepts
- Education and training in interpreting ethics, conduct and confidentiality

11.4.2 When Qualified Bilingual Staff Is Not Available

If you do not have qualified bilingual staff at the time services are needed, KP has made the following arrangements available to Providers when providing services to Members. KP will directly reimburse the companies below for interpreter services provided to Members. Neither Members nor Providers will be billed by these companies for interpreter services.

11.4.2.1 Telephonic Interpretation

Language Line is a company with the capability to provide telephonic interpreter services in more than 150 different languages. Phone interpreter services are available 24 hours per day, 7 days per week through the Language Line by calling: **(888) 898-1301**. This phone number is dedicated to the interpreter needs of Members. While no lead time is needed to engage an interpreter through this service, Providers must have the following data elements available before placing the call:

- The KP Client ID number. This number will be provided to you, in writing, together with your authorization
- KP referral or authorization number
- Member's MRN

If you require access to language assistance for a KP Member but were not provided a KP Client ID number with your authorization, please contact the referrals staff which issued the authorization for a KP Client ID number. Language Line customer service can be reached at **(800) 752-6096** Option #2 (6:00AM–6:00 PM PST M–F). After hours and weekends, access Option #1 and request a Supervisor. In addition, Language Line offers an online support tool

called "Voice of the Customer" (VOC) to enter an issue (http://www.languageline.com/client-services/provide-feedback). You will receive an instant receipt acknowledgement and a follow-up response within 48 hours.

11.4.2.2 In-Person Interpreter: American Sign Language Support

Kaiser Permanente contracts with multiple companies to provide in-person interpreter services for Members requiring American Sign Language (ASL). In-person interpreter services require a minimum of 24 hours lead time for scheduling and are available 24 hours per day, 7 days a week. In-person interpreters are available according to the following schedule: Mon-Fri, 8:00am-5:00pm.

The Kaiser Permanente contracted American Sign Language companies are:

Company	Customer Service/Scheduling	Cancellation Policy
Interpreting and Consulting Services, Inc.	1-707-747-8200 1-888-617-0016 (After hours emergency)	Cancellations must be made 42 hours in advance of appointment
Partners in Communication LLC	1-800-975-8150 Please use extension 805 after hours and on weekends. partners@partnersincommunicationllc.com	Cancellations must be made 48 hours in advance of appointment. Note, time lapsed during weekends does not count towards 48 hours of advance notice.

Providers may arrange in-person interpreter services for multiple dates of service with one call, but must have the following data elements available before placing the call to schedule:

- KP referral or authorization number
- Member's KP referring facility
- Member's KP referring provider or MD
- Member's MRN
- Date(s) of Member's appointment(s)
- Time and duration of each appointment
- Specific address and location of appointment(s)
- Any access or security measures the interpreter will need to know and plan for to gain entry to the place of service

11.4.3 Documentation

Providers need to note the following in the Member's Medical Record:

- that language assistance was offered to an LEP Member and/or their companion/caregiver
- if the language assistance was refused by the Member
- what type of service was utilized (telephonic, in-person interpreter services or bilingual staff), for those Members who accept language assistance

Providers must capture information necessary for KP to assess compliance and cooperate with KP by providing access to that information upon request.

11.4.4 Family Members as Interpreters

The KP Language Assistance Program discourages using family members as interpreters. Members must first be offered language assistance and informed of the benefits of using professional language assistance. If after that offer, the Member refuses and prefers to use a family member, that refusal must be documented in the Member's medical record.

- Family members and friends typically may not understand the subtle nuances of language and culture that may influence the interaction and may not question the use of medical terminology that they and the patient do not understand.

- Minor children should not be used as interpreters, except in extraordinary situations such as medical emergencies where any delay could result in harm to a patient, and only until a qualified interpreter is available.

11.4.5 How to Offer Free Language Assistance

Asking Members if they would like to use an interpreter may be uncomfortable for both Providers and Members. Members may feel that their language skills are being questioned, or they may fear that use of an interpreter will delay care or incur extra cost. The following is scripting that may be used by your office staff to offer free language assistance:

- “We want to make sure you have the best possible communication with your Provider so that you receive the highest quality of care. I am going to arrange for <insert language assistance of choice> to help us. Don’t worry, language assistance services are free of charge.”
- “In case you’d like to use an interpreter, I’d be happy to call one. Don’t worry, language assistance services are free of charge.”

- "I can understand why you'd feel more comfortable with your husband interpreting for you today, however, interpreters are trained in medical terminology and can provide you and your Provider with quality interpretation and confidentiality. May I call an interpreter to help us? Don't worry, language assistance services are free of charge."

11.4.6 How to Work Effectively with an Interpreter

Knowing how to effectively work with an interpreter contributes to effective communication, which promotes a better health outcome and increases Member satisfaction. The following recommendations will contribute to a successful discussion:

- Ask one question at a time
- Keep statements short, pausing to allow for interpretation
- Don't say anything you don't want the Member to hear
- Speak in a normal voice, clearly, and neither too fast nor too slow
- Avoid slang and technical terms that may not be understood by the Member
- Be prepared to repeat yourself and rephrase statements if your message is not understood
- Observe the Member's body language for signs of misunderstanding
- Check to see if the message is understood by having the Member repeat important instructions/directions
- Avoid asking the interpreter for opinions or comments. The interpreter's job is to convey the meaning of the source of language
- Members and providers that speak directly to each other during the medical encounter will strengthen the Member-provider relationship. To do this:
    - Position yourself to look directly at the Member and not the interpreter
    - Address yourself to the Member, not to the person providing language assistance
    - Do not say "tell him" or "tell her"
- With respect to Deaf or Hard of Hearing Members:
    - Do not ask the interpreter if the deaf Member understands
    - Allow the interpreter time to finish signing a question before expecting a Deaf or Hard of Hearing Member to be able to respond
    - If the communication process breaks down, address the situation with the Deaf or Hard of Hearing Member first. You may need to explore using a different interpreter or communication.

12. Additional Service Specific Information

12.1 Service Authorizations for SNFs

Service Authorizations for SNFs are generated by the KP Continuum of Care team as part of discharge planning and case management processes and with consideration of the Member's benefits, eligibility and, if any, other healthcare coverage. SNFs may also request a service Authorization/reauthorization by contacting:

Northern California SNF Complex Hub
NCALSNFServiceDirMgr@kp.org
(510) 675-5090

12.2 General Assistance for SNFs

SNFs can contact their local KP Skilled Nursing Department for general assistance and requesting Authorizations for ancillary services to Members. Please refer to the Skilled Nursing Facility Coordinator contact list in section 2.4, KP Facility Listing.

12.2.1 Requesting Ancillary Services for SNFs

Members residing in SNFs may require ancillary services during their stay. These services may include, but are not limited to, therapies, physician specialty consultation, vision, hearing, podiatry, imaging, and lab services.

Once a Provider has written an order for an ancillary service, an Authorization should be requested by contacting your local KP Skilled Nursing Facility Coordinator (see Section 2.4, KP Facility Listing, of this Provider Manual). KP will work with you to determine the most appropriate provider and venue for providing the requested ancillary service to the Member.

12.2.2 Supplies, Drugs, Equipment and Services Excluded from the Long Term Care SNF Per Diem

SNFs should follow the procurement and reimbursement protocol for supplies, drugs, equipment and services excluded from the Long Term Care SNF per diem as directed in their Agreement.

12.2.3 Laboratory Services Ordering For SNFs

Below is information that will assist contracted SNFs, KP SNF managers, and KP's contracted laboratory vendors in managing claims for laboratory services provided to Members at SNFs as efficiently as possible.

Members receive covered services of a SNF under either their "skilled" or Long Term Care (i.e., "custodial") benefit. Identifying the Member's benefit is essential to processing the claim correctly. Lab services are paid in the following manner depending on the Member's benefit and whether the service has been authorized by a Plan Physician:

Benefit Category	Payment Responsibility
Skilled	Lab services are SNF responsibility
Custodial, if authorized by Plan Physician	KP responsibility
Custodial, not authorized by Plan Physician	CMS if patient has Medicare Part B coverage, or patient, or other responsible party

When a Member receives lab services at the SNF, the Member's benefit as described above, should be noted on the lab requisition form. This benefit is usually found in the patient's chart or in the SNF census reports.

12.3 Psychiatric Care Settings

KP authorizes psychiatric services for Members at different levels of care, depending on the Member's clinical conditions. Authorizations must be obtained as set forth in Section 4.4 of this Provider Manual.

The primary types of settings in which KP authorizes Members' care are:

Inpatient Hospitalization. This represents the highest level of control (involuntary) and treatment. Hospitalization is intended for interventions requiring very high frequency or intense treatment.

Psychiatric Health Facility. This is an inpatient-like setting, but not in an acute care hospital. This type of licensed facility provides a restrictive setting (involuntary) for high frequency or intense treatment.

23 Hour Observation. This level of care provides a restrictive setting for voluntary or involuntary patients and provides a high degree of safety and security for patients who may be dangerous to themselves or others. This level of care allows for an extended diagnostic assessment to permit a more targeted referral to the appropriate level of care and provides active crisis intervention and triage.

Partial Hospitalization. This level of care provides structured treatment and treatment comparable to that of an inpatient unit, however patients live and sleep at home. This level of care provides daily supervision of high risk patients, medication monitoring, milieu therapy, and other interventions.

Hospital Alternative Program. This is a hospital diversion program in a residential setting for voluntary patients. This level of care is less restrictive than inpatient and 23-hour holding units, but allows for relatively intensive or frequent interventions, and provides 24 hour monitoring and supervision by behavioral health clinicians with physician case supervision and consultation.

Intensive Outpatient Program. This level of care provides a short-term comprehensive program designed as an alternative to psychiatric hospitalization and is generally appropriate for persons at risk for hospitalization or recently discharged from an inpatient hospital and at risk for re-hospitalization.

12.4 Addiction Medicine and Recovery Services

Addiction Medicine and Recovery Services are offered at all KP Medical Centers. At 9 KP Medical Centers, comprehensive and intensive programming is available through KP's Addiction Medicine Recovery Services. Residential Recovery Services are authorized through Addiction Medicine and Recovery Services and are based on a determination of appropriateness and indication after evaluation by a department provider.

The 8 levels of addiction medicine and recovery services are listed below. It is important that you contact Addiction Medicine and Recovery Services in your sub-region for provision of services. All services are offered based on appropriateness and indication and in accordance with the patient's Evidence of Coverage (EOC).

Service	Description
Residential Recovery Services – Inpatient Detoxification	Residential/ "inpatient" detoxification, 3-5 days in a medical facility with nursing-level care overseen by a physician
Residential Recovery Services – Brief Residential Detoxification (BRD)	Brief residential treatment, 3-7 days, in a non-medical setting where Members may be dispensed detox medications within a sober living environment.
Residential Recovery Services – Residential Treatment Program (RTP)	Provides 24 hour/day residential programming with counseling and educational services. Medical support for detoxification may be offered with nursing-level care overseen by a physician. Length of stay is determined by appropriateness and indication but is typically 30 days.
Residential Recovery Services – Transitional Residential Recovery Services (TRRS)	Provides 24 hour/day non-medical residential programming with counseling and educational services. Length of stay is based on appropriateness and indication but is typically 30 days.
Day Treatment Program	Daily outpatient program, typically 14-21 days in length, providing therapy and educational services 6-8 hours each day

Service	Description
Intensive Recovery Program (IRP)	An 8 week program of outpatient therapy and educational services provided at least 4 days/week for 2-3 hours each day
Early Recovery Program	A program of outpatient therapy and educational services provided at least 1-3 days/week for 1-2 hours each day
Medication Assisted Treatment (MAT)	A program of office-based therapy, including Opioid agonist treatment using methadone therapy which is provided by KP contractors upon referral. Buprenorphine treatment and other medications as indicated are provided by KP.

Levels of Care and Description of Addiction Medicine and Recovery Services Provided by KP

Early Intervention Program. This is a 6 week program for individuals who are unsure whether they have a serious problem with substances, even though there is some evidence suggesting that they do. This program consists of at least one process group per week and is designed to help patients evaluate their relationship with addictive chemicals. If a patient decides at any time that the problem is indeed serious, they may transfer immediately to the appropriate level of treatment. The program may vary slightly by sub-region.

Family and Codependency Programs. These are a series of programs ranging from brief education for family members to intensive treatment for serious codependency issues. These programs are available to Members regardless of whether the chemically dependent person is in treatment.

Adolescent Treatment Program. This is a multilevel program designed to help adolescents and their parents evaluate the extent of their problems with psychoactive chemicals, to decide what steps they are willing to take to address these problems, and to provide more intensive treatment. The program may include adolescent groups, parent groups, multifamily groups, and individual and family sessions with a therapist.

12.5 KP Direct Mental Health Network

The KP Direct Mental Health Network (KP Direct) consists of behavioral health providers contracted with and credentialed by KP to expand access to outpatient mental health services. KP's local mental health clinics first conduct evaluations with KP Members seeking care to determine appropriate care and proper placement, including referral to contracted providers.

KP promotes measurement-based Feedback Informed Care, prioritizing the patient voice in their mental health treatment. To that end, KP provides KP Direct providers with access to Lucet's digital platform where KP Direct providers can:

Create and update a practice profile of patient facing information;

- Manage availability and facilitate scheduling of new referrals;
- Administer Treatment Progress Indicator (TPI) assessments at every session;
- Complete documentation of key care points, including initial evaluation, discharge summary, clinical reviews when requested, safety plan when clinically appropriate and free form notes as appropriate;
- Partner with our clinical quality review consultants to ensure members are engaged in treatment supporting improved patient outcomes;
- Facilitate referral renewals.

12.6 Special Needs Plan (SNP)

KFHP offers a Medicare Advantage Special Needs Plan (SNP) enrolling beneficiaries who are eligible for Medicare and full benefits under Medi-Cal. As a Special Needs Plan Sponsor, KFHP is required to provide a Model of Care (MOC) that addresses the special needs of these Members. All SNP MOCs must include the following elements:

- Description of Overall SNP Population
- Description of Subpopulation – Most Vulnerable Beneficiaries
- SNP Staff Structure
- Health Risk Assessment Tool
- Interdisciplinary Care Team
- Care Transition Protocols
- Specialized Expertise for Provider Network
- Use of Clinical Practice Guidelines and Care Transitions Protocols
- Training for the Provider Network
- Quality Improvement Performance Plan
- Measurable Goals and Health Outcomes
- SNP Member Satisfaction
- Ongoing Performance Evaluation of MOC
- Dissemination of SNP Quality Performance

SNPs must collect data on quality indices as required and in concert with the KP program plan.

Please contact your local SNP clinical lead or team members if you have additional questions about the program or your SNP patients.

12.7 Autism Spectrum Disorder (ASD) Services

If Provider provides covered services encompassing Behavioral Health Treatment (as defined by California Health and Safety Code Section 1374.73(c)(1), including applied behavior analysis and evidence-based behavior intervention programs for pervasive developmental disorder or autism, Provider shall provide such Behavioral Health Treatment in accordance with the requirements set forth in California Health and Safety Code Section 1374.73, including providing Services under a treatment plan described and administered by Qualified Autism Service Providers, Qualified Autism Service Professionals and/or Qualified Autism Service Paraprofessionals (as those terms are defined by California Health and Safety Code Section 1374.73(c)(3)). Providers must provide documentary evidence to KP upon request to demonstrate the criteria set forth in California Health and Safety Code Section 1374.73 for all Qualified Autism Service Providers, Qualified Autism Service Professionals and Qualified Autism Service Paraprofessionals have been met, including but not limited to making treatment plans available as required by California Health and Safety Code Section 1374.73(c)(1)(D).

POL-020 Clinical Review Payment Determination Policy

This policy applies to California for all lines of business.

1. Business Policy

This policy provides information on rules that govern National Payment Integrity (NPI) Clinical Review processes related to determining payment for claims under review. NPI Clinical Review is responsible for reviewing facility and professional claims to ensure that providers comply with billing and coding standards, that services rendered are appropriate and medically necessary, and that payment is made in accordance with applicable contract and/or provider manual requirements.

2. Rules

2.1. Itemized Bill Review (IBR)

2.1.1. National Claims Administration will not reimburse providers for items or services that are considered inclusive of, or an integral part of, another procedure or service, rather, non-separately payable services will be paid as part of the larger related service and are not eligible for separate reimbursement.

2.1.1.1. NPI Clinical Review will apply commonly accepted standards to determine what items or services are eligible for separate reimbursement. Commonly accepted standards include CMS guidelines, National Uniform Billing Committee (NUBC) standards, National Correct Coding Initiative (CCI) standards, and professional and academic journals and publications.

2.1.1.2. NCA staff will submit a request for information (RFI) to the provider to request an itemized bill and/or medical records if financial liability cannot be determined based on the submitted claim.

2.1.1.3. NCA intake staff will scan and attach itemized bills to related claims in order to complete claims processing.

2.1.2. National Claims Administration will not separately reimburse items and services as defined below.

2.1.2.1. Charges for use of capital equipment, whether rented or purchased, are not to be separately payable. The use of such equipment is part of the administration of a service. NPI Clinical Review will review claims for these charges and provide instructions to Claims staff to deny these services as not payable. Examples include: automatic blood pressure

machines/monitors, anesthesia machines, cameras, cardiac monitors, fetal monitors, EMG, temperature monitor, apnea monitors, cautery machines, cell savers, instruments, IV/feeding pumps, lasers, microscopes, neuro monitors, oximetry monitors, scopes, specialty beds, thermometers, ventilators, balloon pumps, EKG machines, and hemodynamic monitoring catheters.

2.1.2.2. Charges for IV flushes (for example, heparin and/or saline) and solutions to dilute or administer substances, drugs, or medications, are not separately payable. The use of these is part of the administration of a service. NPI Clinical Review will review claims for these charges and provide instructions to Claims staff to deny these services as not payable. Examples include IV start, access of indwelling catheter, subcutaneous catheter or port, flush at the end of an infusion, standard tubing/syringes/supplies, and preparation of chemotherapy agents.

2.1.2.3. Charges for hydration are not separately payable unless the hydration services are therapeutic, based on patient medical records. NPI Clinical Review will review claims for these charges, along with supporting medical records, to determine whether the services are therapeutic and therefore payable.

2.1.2.4. Charges for services that are necessary or otherwise integral to the provision of a specific service and/or delivery of services in a specific location are considered routine services and are not separately payable. This applies to both the inpatient and outpatient settings. These services are part of the room and board charges. NPI Clinical Review will review claims for these charges and provide instructions to Claims staff to deny these services as not payable. Examples include, but are not limited to venipuncture, chemotherapy administration, IV insertion, saline flushes, infusion of IV fluids, administration of medications (IV, PO, IM), urinary catheterization, and dressing changes. Other examples include but are not limited to tube feeding, respiratory treatment or care, such as sputum induction, airway clearance (For example, suctioning), incentive spirometer, nebulizer, Point of care testing, nasogastric tube (NGT) insertion, incremental nursing care, measuring blood oxygen levels, specimen collection, or if a potent drug was administered.

2.1.2.5. Under the OPPS (Outpatient Prospective Payment System), any charges for line items or Healthcare Common Procedure Coding System (HCPCS) codes that are bundled together under a single payment. This is because the cost of these items and services is already included in the overall payment for the associated service. These bundled and/or packaged items are considered an essential component of the procedure and included in the Ambulatory Payment Classification (APC) and payment for the service of which they are an integral part.

2.1.2.6. Bundled and/or packaged services denials are NOT exclusive to OPPS and APC methodology. When the claim contains services payable under cost reimbursement or services payable under a fee schedule, and the services billed are considered packaged, the packaged services can be

deemed as not separately payable. Packaged services are identified with Status indicator of "N."

2.1.2.7. Personal Care Items These items do not contribute to the meaningful treatment of the patient's condition. NPI Clinical Review will review claims for these charges and provide instructions to Claims staff to deny these services as not payable. Examples include but are not limited to admission kits, oral swabs/mouthwash, footies/slippers.

2.1.2.8. Charges for respiratory therapy services provided at a Specialty Care Unit (such as ICU, Pediatric ICU, CCU, ED, or intermediate intensive care units) are not separately payable. The use of these services is part of the administration of care at a Specialty Care Unit. NPI Clinical Review will review claims for these charges and provide instructions to Claims staff to deny these services as not payable. Examples include but not limited to ventilator supplies, heated aerosol/heated aerosol treatments while patient on ventilator, oxygen, oximetry reading or trending, CO2 monitoring/trending, arterial punctures, endotracheal suctioning, and extubation.

2.1.2.8.1. Allow one daily ventilator management charge or BiPAP while the patient is in the specialty care unit.

2.1.2.8.2. Allow Continuous Positive Airway Pressure (CPAP) while the patient/neonate is in the neonatal intensive care unit (NICU).

2.1.2.8.3. CPAP for routine use, including use for obstructive sleep apnea is not separately payable.

2.1.2.8.4. Charges for respiratory services provided in the inpatient setting other than at a specialty care unit are limited to 1 unit/charge per date of service regardless of the number of respiratory treatments and/or procedures provided. Examples include but are not limited to CPT if done by a respiratory therapist, nebulizers, heated aerosol and oxygen, chest percussions if done by a respiratory therapist, and demonstration of MDI use or respiratory equipment by a respiratory therapist. Examples of non-specialty care units:

2.1.2.8.4.1. Telemetry units

2.1.2.8.4.2. Medical surgical units

2.1.2.9. Charges for Routine Floor Stock items and supplies necessary or otherwise integral to the provision of a specific service or delivery of service in a specific location are considered routine and are not separately payable. The use of these services is part of the administration of care at a hospital or skilled nursing facility and are used during the normal course of treatment, which may be related to and/or part of a separately payable treatment. NPI Clinical Review will review claims for these charges and provide instructions to Claims staff to deny these services as not payable.

2.1.2.10. Charges for Point of Care (POC) tests are not separately payable. These tests are performed at the site where the patient care is provided by the nursing staff at the facility as part of the room and board services. Under the Clinical Laboratory Amendments of 1988 (CLIA), a POC must have a Certificate of Waiver license in order for the site to allow POC testing. NPI Clinical Review will review claims for these charges and provide instructions to Claims staff to deny these services as not payable.

2.1.2.11. Implants. According to the Food and Drug Administration (FDA), implants are devices or materials placed surgically inside the body or surface of the body. Implants can be permanent or removed when no longer needed. Many implants are intended to replace body parts, monitor body functions or provide support to organs or tissues.

2.1.2.11.1. An implant is not defined as one that primarily achieves its intended purpose through chemical action within or on the human body, nor as one that relies on being metabolized by the body. Examples of liquids and absorbable include but are not limited to: advanced hemostats and sealants, synthetic sealants, topical absorbable hemostats and topical thrombins, bone morphogenetic protein, and bone putty or cement.

2.1.2.11.2. A medical device must meet the following requirements to be eligible for reimbursement:

2.1.2.11.2.1. If required by the FDA, the device must have received FDA approval or clearance (except for a device that has received an FDA investigational device exemption (IDE) and has been classified as a Category B device by the FDA in accordance with §§405.203 through 405.207 and 405.211 through 405.215 of the regulations) or another appropriate FDA exemption.

2.1.2.11.2.2. The device is reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body part (as required by section 1862(a)(1)(A) of the Social Security Act).

2.1.2.11.2.3. The device is an integral and subordinate part of the service furnished, is used for one patient only, comes in contact with human tissue, is surgically implanted or inserted through a natural or surgically created orifice or surgical incision in the body, and remains in the patient when the patient is discharged from the hospital.

2.1.2.11.3. The device is not any of the following:

2.1.2.11.3.1. Equipment, an instrument, apparatus implement, or item of this type for which depreciation and financing expenses are recovered as depreciable assets as defined in Chapter 1 of the Medicare Provider Reimbursement Manual (CMS Pub. 15-1).

2.1.2.11.3.2. A material or supply furnished to a service such as sutures, surgical clip, other than a radiological site marker.

2.1.2.11.3.3. A medical device that is used during a procedure or service and does not remain in the patient when the patient is released from the hospital.

2.1.2.11.3.4. Material that may be used to replace human tissue (for example, a biological, biodegradable or synthetic material).

2.2. Multiple Procedure Reduction and or Multiple Surgery Reduction

2.2.1. The following Multiple Procedure Payment Reduction (MPPRs) are applied specifically to the technical component of diagnostic imaging for cardiovascular and ophthalmology services if procedure is billed with another imaging procedure in the same diagnostic and coding family

2.2.1.1. Cardiovascular services: Full payment is made for the TC service with the highest payment under the MPFS (Medicare Physician Fee Schedule), and 75% (seventy-five percent) for subsequent TC services furnished by the same physician, or by multiple in the same group practice, to the same patient on the same day.

2.2.1.2. Ophthalmology services: Full payment is made for the TC service with the highest payment under the MPFS and 80% (eighty percent) for subsequent TC services furnished by the same physician, or by multiple in the same group practice, to the same patient on the same day.

2.2.1.3. Multiple Procedure Payment Reduction (MPPR). Kaiser Permanente will reimburse the highest-valued procedure at the full fee schedule or contracted/negotiated rate and will reduce payment for the second and subsequent procedures. The National Correct Coding Initiative (NCCI) policy states, "Most medical and surgical procedures include pre-procedure, intra- procedure, and post-procedure work. When multiple procedures and/or surgeries are performed at the same patient encounter, there is often overlap of the pre-procedure and post-procedure work. The payment methodologies for surgical procedures account for the overlap of the pre-procedure and post- procedure work. The primary or highest valued procedure will be reimbursed at 100% of the fee schedule value or contracted/negotiated rate. Second and/or subsequent procedures will be reimbursed at 50% of the fee schedule value or contracted/negotiated rate.

2.2.1.4. Kaiser Permanente will apply reductions to the secondary and subsequent technical component of imaging procedures when multiple services are ordered by the same physician for the same patient in the same session on the same day. The technical component is for the use of equipment, facilities, non-physician medical staff and supplies. The imaging procedure with the highest technical component is paid at 100% and the technical components for additional less-technical services in the same code family are reduced by 50%.

2.2.1.5. When more than one surgical procedure is performed during the same operative session by the same provider, all procedures should be billed on the same claim. Payment for multiple surgeries is based on whether the surgical procedure itself may be subject to a multiple surgery reduction. If the multiple surgery reduction applies, the procedure with the highest allowed amount will be allowed at 100% of the contracted/allowed rate. The multiple surgery reduction will be applied to the procedure(s) with a lesser allowed amount at 50% of the contracted/allowed rate.

2.3. Trauma Activation

2.3.1. Trauma activation will be considered for reimbursement only when all of the following criteria are met.

2.3.1.1. In order to receive reimbursement for trauma activation, a facility must:

2.3.1.1.1. Have received a pre-hospital notification based on triage information from EMS or pre-hospital caregivers who meets either local, state, or ACS field criteria and are given the appropriate team response.

2.3.1.1.2. Bill for trauma activation cost only. Clinical Review will request records to look for proper documentation of the team members being called to support the trauma activation.

2.3.1.1.3. Bill with type of admission/visit code 05 (trauma center).

2.3.1.1.4. Evaluation and Management codes for critical care must be billed under Revenue Code 450 in order to receive trauma activation reimbursement. When revenue code series 68x trauma response is billed in association with services other than critical care, payment for trauma activation is bundled into the other services provided on that day.

2.4. Diagnosis Related Group (DRG) Payment

2.4.1. The purpose of DRG validation is to ensure diagnostic and procedural information and discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician's description and the information contained in the beneficiary's medical records.

2.4.2. Clinical Review performs DRG reviews on claims with payment based on DRG reimbursement to determine the diagnosis and procedural information leading to the DRG assignment is supported by the medical record.

2.4.3. Validation must ensure diagnostic and procedural information and discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician's description and the information contained in the beneficiary's medical record.

2.4.4. Reviewers will validate principal diagnosis, secondary diagnoses, and procedures affecting or potentially affecting the DRG.

2.4.5. The comprehensive review of the patient's medical records will be conducted to validate:

- Physician-ordered inpatient status.
- Accuracy of diagnostic code assignment.
- Accuracy of the procedural code assignments.
- Accuracy of the sequencing of the principal diagnosis and procedure codes.
- Accuracy of present-on-admission (POA) indicator assignment.
- Accuracy of DRG grouping assignment and associated payment.
- Accuracy of Discharge Disposition Status Code assignment.
- Other factors that may impact DRG assignment and/or claim payment.
- Compliance with KP's payment policies including but not limited to those policies that address DRG inpatient facility, never events, hospital-acquired conditions, and readmissions or transfers to another acute care hospital.

2.5. Medical Necessity Review

2.5.1. A decision by Clinical Review may be made that a request for benefit coverage under the patient's plan does not meet the requirements for Medical Necessity. Such requests are reviewed for: appropriateness of treatment, levels of care billed, or the request may be determined to be cosmetic in nature, experimental, or investigational. The requested benefit may therefore be denied, reduced, or payment not provided or made, in part or in whole. All medical necessity reviews resulting in a denial of coverage, in part or in whole, are subject to review and approval by a physician.

2.5.2. Determinations of medical necessity should adhere to the standard of care and always be made on a case-by-case basis that applies to the actual direct care and treatment of the patient. Considerations include:

2.5.2.1. Appropriate for the symptoms and diagnosis or treatment of the member's condition, illness, disease, or injury.

2.5.2.2. Provide for the diagnosis, direct care, and treatment of the medical condition.

2.5.2.3. Meet the standard of good medical practice and is not mainly for the convenience of the provider or patient.

2.6. Level of Care Review

2.6.1. Level of Care (LOC) Review applies to inpatient claims. Review of facility claims ensure that the level of care being billed matches the LOC that was authorized so that appropriate reimbursement is made.

2.6.2. The review involves assessing whether the billed days for each level care are both authorized and medically necessary.

2.6.3. If provider bills for additional days on a higher level of care than what is authorized, the claim will be denied, and provider will submit a corrected claim for payment.

2.7. Short Stay/2 Midnight Rule

2.7.1. Kaiser Permanente will reimburse a provider for an inpatient admission if the medical records support inpatient admission and if at time of or before admission, the admitting physician reasonably expects the patient's hospital care would cross two midnights. Medical records must clearly demonstrate the medical necessity of the member's inpatient admission. This is demonstrated by the severity of the condition or injury and the intensity of the required services, justifying the need for inpatient medical care.

2.7.2. Exceptions to the 2 Midnight Rule:

2.7.2.1. Unforeseen circumstances such as the patient's death or transfer that will result in a shorter patient stay than what the admitting physician expected.

2.7.2.2. For admissions not meeting 2 Midnight Rule, inpatient admission less than 2 days will be considered on a case-by-case basis where the medical records support the physician's determination that the patient requires inpatient care despite the lack of a two-midnight expectation.

2.7.2.3. An inpatient admission for a surgical procedure specified by Medicare as inpatient only.

2.8. Post Stabilization

2.8.1. The non-Plan treating providers or the member are required to contact Kaiser Permanente to request prior authorization for post-stabilization care. After receiving a request for authorization, Kaiser Permanente must either authorize care or arrange for transfer to a Plan provider. Kaiser Permanente does not reimburse for unauthorized post-stabilization services.

2.9. Neonatal Intensive Care Level of Care (NICU)

2.9.1. This medical criteria provides guidance for NICU and neonatal care levels 2 through 4. Level 1 admission and discharge criteria as coupling or mother/baby care was intentionally omitted as it now replaces routine nursery care.

2.9.2. Specific information regarding neonatal level of care may be requested through National Clinical Review.

2.10. Thirty-Day Readmission

2.10.1. Kaiser Permanente does not allow separate reimbursement for claims that have been identified as a readmission to the same hospital reimbursed by DRG pricing for the same, similar or related condition unless provider, state, federal or CMS contracts and/or requirements indicate otherwise. In the absence of provider, federal, state and/or contract mandates, Kaiser will use the following standards: (a) readmission within 30 days from discharge; (2) same diagnosis or diagnoses that fall into the same grouping.

2.10.2. Kaiser Permanente will use clinical criteria and licensed clinical professionals as part of the review process for readmissions from day 2 to day 30 in order to determine if the second admission is for: (a) the same or closely related condition or procedure as the prior discharge; (b) an infection or other complication of care; (c) a condition or procedure indicative of a failed surgical intervention; (d) an acute decompensation of a coexisting chronic disease; (e) a need that could have reasonably been prevented by the provision of appropriate care consistent with accepted standards in the prior discharge or during the post discharge follow-up period; (f) an issue caused by a premature discharge from the same facility; (g) a reason that is medically unnecessary.

2.10.3. Exclusions: (a) Admissions for the medical treatment of cancer; (b) primary psychiatric disease and rehabilitation care; (c) Planned readmissions; (d) Patient transfers from one acute care hospital to another; (e) Patient discharged from the hospital against medical advice.

2.10.4. Kaiser does not apply the inpatient readmission criteria to Critical Access Hospitals (CAH) and considers the following as exclusions for the (a) Readmission due to patient nonadherence; (b) End-of-life and hospice care; (c) Obstetrical readmissions for birth after an antepartum admission; (d) Neonatal readmissions; (e) Transplant readmissions within 180 days of transplant.

2.11. Emergency Department (ED) Facility Evaluation and Management (E&M) Coding

2.11.1. Kaiser Permanente utilizes EDC Analyzer™ tool to determine the appropriate and fair level of facility reimbursement for outpatient emergency department (ED) services.

2.11.2. This policy will apply to all facilities that submit ED claims with level 3, 4, or 5 E/M codes for members of the affected plans, regardless of whether they are under contract to participate in our in our network.

2.11.3. Certain claims are excluded from review:

2.11.3.1. Claims with certain diagnosis codes (e.g. sexual assault, homicidal ideations, bipolar disorder, schizophrenia).

2.11.3.2. Claims for children under 2.

2.11.3.3. Claims for patients who died in the emergency department or were discharged/transferred to another care setting.

2.11.3.4. Claims for patients who received critical care services.

2.11.4. The review is based upon presenting problems as defined by the ICD 10 reason for visit, intensity of the diagnostic workup as measured by the diagnostic CPT codes, and based upon the complicating conditions as defined by the ICD 10 principal, secondary, and external cause of injury diagnosis codes.

2.11.5. To learn more about the EDC Analyzer ™ tool, see EDC Analyzer.com.

2.12. Provider Preventable Conditions (PPC) review applies to the Medicaid line of business. Per CMS guidelines, reimbursement is prohibited to providers for services which meet certain conditions, for example, surgery performed on the wrong body parts.

2.12.1. The Clinical Review department reviews claims that have been pended for review to determine whether the claim contains any PPC services based upon a defined list of Health Care Acquired Conditions (HAC) and Other Provider Preventable Conditions (OPPCs).

2.12.2. The Clinical Review department will determine if the service provided meets the clinical guidelines set forth by CMS to ensure PPC services are not reimbursed.

2.12.3. The Clinical Review department will instruct the claims examiner not to reimburse any non-payable service lines or portion of those service lines.

2.13. Do not bill events (DNBE)

2.13.1. Per CMS guidelines, providers will not be reimbursement for certain DNBE also known as 'never events.' DNBEs (never events), are errors in medical care that are of concern to both the public and health care. Examples include, but are not limited to, the below. KP may reduce payment for services directly related to a Do Not Bill Event.

2.13.1.1. Wrong surgery or invasive procedure on patient

2.13.1.2. Surgery or invasive procedure on wrong patient

2.13.1.3. Surgery or invasive procedure on wrong body part

2.13.2. Hospital Acquired Condition is a condition that could reasonably have been prevented through the application of evidence-based guidelines. The charges for these events will be disallowed. Medical records are used to confirm

the DNBE/HAC/Sentinel Event and an Itemized Statement is used to identify related charges.

3. Guidelines

N/A

4. Definitions

4.1. Capital Equipment - Items that are used by multiple patients during the lifetime of that piece of equipment.

4.2. Center for Medicare and Medicare Services (CMS) - Part of the Department of Health and Human Services (HHS) who administers programs such as Medicare, Medicaid, and Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace.

4.3. Diagnosis Related Group (DRG) - A system of classifying or categorizing inpatient stay into relatively homogenous groups for the purpose of payment by CMS.

4.4. Medical Necessity - Medical Necessity is the standard terminology that all health care professionals and entities use for the review process to determine whether medical care is appropriate and essential, and is an appropriate health care service and supply provided by health care entities, appropriate to the evaluation and treatment of a disease, condition, illness or injury, and is consistent with the applicable standard of care. Criteria used to determine whether services are medically necessary are evidence based. All medical necessity reviews resulting in a denial of coverage, in part or in whole, are subject to review and approval by a physician.

4.5. Personal Care Items - Items used by the patient for non-medical use such as hygiene and comfort. Examples include: admission kits, pillows/blankets/linens/towels, cosmetics/cleansers/soap/deodorizers, diapers/wipes, lotions/creams, oral swabs/mouthwash/shaving supplies/toothpaste/toothbrush, nutritional supplies, bath comfort kits (shampoo, conditioner, hairspray), slippers/footies, hairbrush/comb, and facial tissues.

4.6. Point of Care (POC) Tests - Tests that are performed at the same site or location where patient care is being provided. Point of care (POC) tests require neither the equipment or supplies of a CLIA certified lab nor the skills of licensed or certified technicians or technologists. Equipment and Supplies include but are not limited to, microscopes, chemistry analyzers, histology and cytology equipment, and gamma counters.

4.7. Post Stabilization Care - Medically necessary services related to the member's emergency condition that the member receives after the treating physical determines the member's condition is stabilized.

4.8. Routine Floor Stock - Supplies that are available to all patients in the floor or area of a hospital or skilled nursing facility. These are supplies provided to a patient

during the normal course of treatment. Personal care items are non-chargeable because they do not contribute to the meaningful treatment of the patient's condition. Examples of routine supplies or floor stock include: thermometers, respiratory supplies such as oxygen masks/ambu bags, suction tips, tubing, oxygen, preparation kits, irrigation solutions (sterile water, normal saline), gauze/sponge sterile or non-sterile, oximeters/oximeter probes, syringes, gloves/masks, supplies used ordinarily for surgery such as surgery drapes/sutures, sequential compression socks, bedpans/urinals, hypo/hyperthermia blankets, EKG electrodes, lab supplies, hypodermic needles, and personal care items.

4.9. Specialty Care Unit - A specialized unit located within a hospital that must be physically identified as separate from general care areas; the unit's nursing personnel must not be integrated with general care nursing personnel. The unit must be one in which the nursing care required is extraordinary and on a concentrated and continuous basis. Extraordinary care incorporates extensive lifesaving nursing services of the type generally associated with nursing services provided in burn, coronary care, pulmonary care, trauma, and intensive care units. Special life-saving equipment should be routinely available in the unit.

5. References

N/A

(Updated: 10/07/24)

Revision History

Approvals