2025
Kaiser Permanente Northern California
Self-Funded Program Provider Manual
Administered by Kaiser Permanente Insurance Company (KPIC)

KAISER PERMANENTE®

Welcome to the Kaiser Permanente Northern California Self-Funded Program

It is our pleasure to welcome you as a Contracted Provider (Provider) participating in the Self-Funded Program administered by the Northern California Kaiser Permanente Insurance Company (KPIC). We want this relationship to work well for you, your medical support staff, and our Members.

This Provider Manual is to help guide you and your staff in understanding Northern California KPIC's policies and procedures for the Kaiser Permanente Self-Funded Program and related administrative procedures.

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 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 Provider Manual for Kaiser Permanente Northern California Self-Funded Program is referenced in your agreement (Agreement) with a Kaiser Permanente (KP) entity. The information in this Provider Manual is proprietary and may not be used, circulated, reproduced, copied or disclosed in any manner whatsoever, except as permitted by your Agreement, or with prior written permission from KP.

This Provider Manual will be updated in the manner described in your Agreement. Updates will be distributed periodically.

To the extent provided in your Agreement, if there is a conflict between this Provider Manual and your Agreement, as described in your Agreement, the terms of this Provider Manual will control. The term "Member" as used in this Provider Manual refers to currently eligible enrollees of Self-Funded Plans 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 KP. Operational instructions in this Provider Manual specifically relate to the Self-Funded Exclusive Provider Organization product. Some 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. Self-Funded Program Overview

1.1 Kaiser Permanente Insurance Company (KPIC)

Kaiser Permanente Insurance Company (KPIC), an affiliate of Kaiser Foundation Health Plan, Inc. (KFHP), administers KP's Self-Funded Program. KPIC contracts with each Self-Funded Plan Sponsor (an "Other Payor" under your Agreement) to provide administrative services for the Plan Sponsor's Self-Funded plan. KPIC has a dedicated team to coordinate administration with the Plan Sponsors. KPIC provides network management and certain other administrative functions through an arrangement with KFHP.

1.2 Third Party Administrator (TPA)

KPIC has contracted with a Third Party Administrator (TPA), HealthPlan Services, a Wipro Company (formally known as Harrington Health), to provide certain administrative services for KP's Self-Funded Program, including claims processing, eligibility information, and benefit administration.

The TPA administers the Customer Service System, with automated functions as well as access to customer service representatives, which allows you to check eligibility, benefit, and claims information for Members.

The automated system (interactive voice response or IVR) is available 24 hours a day, 7 days a week. Customer service representatives are available Monday–Friday from 7 A.M. to 9 P.M. Eastern Time Zone (ET) (4 A.M. to 6 P.M. Pacific Time Zone) – see Section 2.2 of this Provider Manual.

1.3 Self-Funded Products

KP offers a Self-Funded Exclusive Provider Organization product administered by KPIC.

Exclusive Provider Organization (EPO)

- Mirrors our HMO product, offered on a Self-Funded basis
- Self-Funded EPO Members choose a KP primary care provider and receive care at KP or (contracted) plan medical facilities
- Except when referred by The Permanente Medical Group, Inc. (TPMG) physician or their designee, Self-Funded EPO Members will be covered for non-emergency care only at designated plan medical facilities and from designated plan practitioners

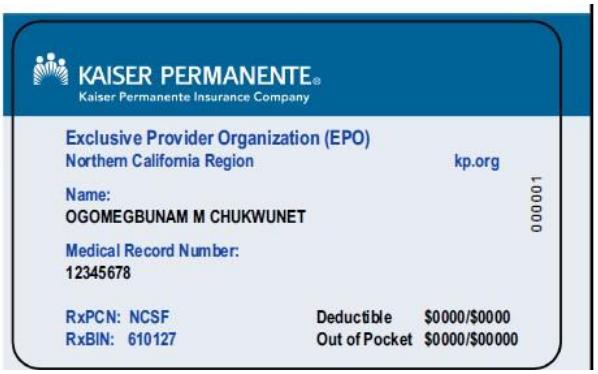
1.4 Identification Cards

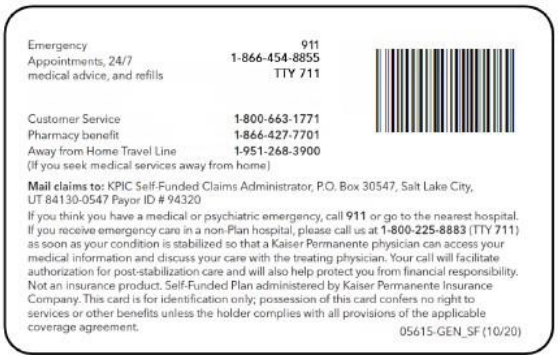
Each Member is issued a Health Identification Card (Health ID Card). Members should present their Health ID Card and photo identification when they seek medical care.

Each Member is assigned a unique Medical Record Number (MRN), which is used to locate membership and medical information. Every Member receives a Health ID Card that shows their unique number. If a replacement card is needed, the Member can order a Health ID Card online or call Self-Funded Customer Service.

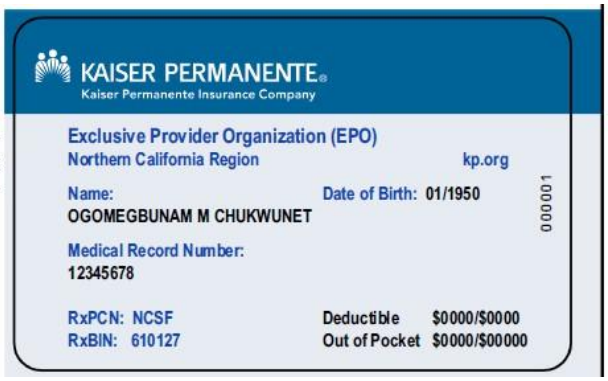
The Health ID Card is for identification only and does not give a Member rights to services or other benefits unless they are eligible. Anyone who is not eligible at the time of service is responsible for paying for services provided.

Exclusive Provider Organization (EPO)

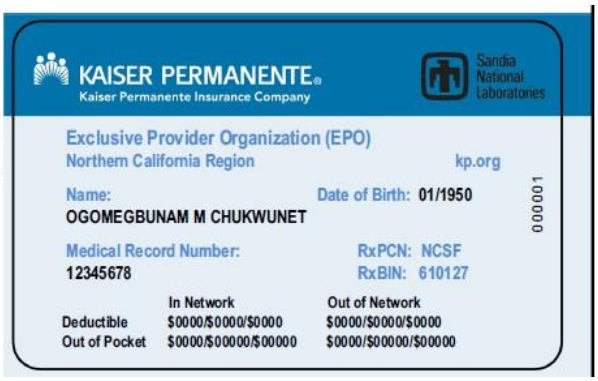




Exclusive Provider Organization (EPO)



Exclusive Provider Organization (EPO)



2. Key Contacts

2.1 Key Contacts for Self-Funded Member Inquiries

Department	Contact information	Help or Information Available from this Department
Self-Funded Customer Service	Customer service representatives are available Monday through Friday 7 A.M. to 9 P.M. Eastern Time Zone (4 A.M. to 6 P.M. Pacific Time Zone) Self-Service Interactive Voice Response (IVR) System available: 24 hours / 7 days a week **(866) 213-3062** Website available: 24 hours / 7 days a week **https://kpclaimservices.com**	• General enrollment questions • Eligibility and benefit verification • Claims management • Billing and payment inquiries • Electronic Data Interchange (EDI) questions • Member appeals • Claims inquiries and disputes • Co-pay, deductible and co-insurance information • Members presenting without Health ID Card or MRN • Verifying Member's PCP assignment

2.2 Self-Funded Customer Service Interactive Voice Response System (IVR)

Self-Funded Customer Service IVR can assist you with a variety of questions. Call **(866) 213-3062** 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 verification of eligibility, benefits, authorizations, referrals, status of a Member's accumulator (amount applied toward deductible); claims and payment status; or connect you to a customer service representative. Follow the prompts to access these services.

2.3 Self-Funded Website

KPIC's TPA maintains a website that allows you and your staff to easily access claims, benefits, and eligibility information for our Self-Funded Members.

The Self-Funded website is mobile compatible and can be directly accessed at https://kpclaimservices.com. Utilizing this website is recommended as the most efficient method for obtaining claims, benefits, and eligibility information. Registration instructions are on the website.

NOTE: This website is restricted to information for individuals enrolled in Self-Funded plans administered by Northern California KPIC only. Information regarding Members enrolled in KP's fully funded plans (e.g., HMO), cannot be accessed from the Self-Funded website.

2.4 Northern California Region Key Contacts

Department	Area of Interest	Contact Information
Medical Services Contracting	Contract Network Development and Provider Services • 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 Drive, Building E, Floor 2 Pleasanton, CA 94588 mscprovcontractinbox@kp.org
TPMG Consulting Services	Practitioner Credentialing	(510) 625-5608
Medical Services Contracting	Facility/Organizational Provider Credentialing	(925) 924-5050 MSCOPCRED@kp.org
Referral Operations	Authorizations, Referrals by Service	Referral Coordinators - Facility Listing - Section 2.5
Outside Services Case Management	Case Management by Service	Facility Listing - Section 2.6
Emergency Prospective Review Program (EPRP) CA Statewide Service	Emergency Notification	(800) 447-3777 Available 24 hours a day, 7 days a week

Department	Area of Interest	Contact Information
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

2.5 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.

KP Facilities and Referral Operations departments 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	N/A
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 (8:30A.M. - 5:00P.M.)	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
Fresno	Fresno	(408) 361-2140, Option 1	(559) 448-5763	(559) 448-5763	(559) 448-5507	(559) 448-3535
Out of Service Area		(877) 520-4773				

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) 525-3114
	Roseville	(925) 372-1103	(925) 229-7713	(916) 525-3114
	So. Sacramento	(925) 372-1103	(925) 229-7713	((916) 525-3114
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 Alameda	Fremont Union City	(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

2.6 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
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**

Location	Address	COCSD	UM/RM Manager	Social Worker
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
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

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

Resource Management Functional Unit
5820 Owens Dr, 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 a Member's eligibility and benefits. Each time a Member presents at the office for services, Providers should:

- Verify the Member'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. The effective date of eligibility varies according to the terms of the contract between the Plan Sponsor and KPIC. Therefore, you must verify that the Member has a benefit for the service prior to providing services.

Certain services require prior authorization. Section 4 of this Provider Manual further details which services require authorization and the process for obtaining referrals and authorizations.

Contact Self-Funded Customer Service at **(866) 213-3062** or use one of the methods detailed below to verify a 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 you provide services to a Member and the service is not a benefit or the benefit has been exhausted, denied or not authorized, the Plan Sponsor will not be obligated to pay for those services.

Option	Description
#1	Self-Funded Website **https://kpclaimservices.com** 24 hours / 7 days a week To verify Member eligibility, benefit, and claims information.
#2	Self-Funded Customer Service **(866) 213-3062** Monday–Friday from 7 A.M. to 9 P.M. Eastern Time Zone (ET) (4 A.M. to 6 P.M. Pacific Time) To speak with a customer service representative to verify Member eligibility, benefits or PCP assignment**.** Please provide the Member's name and MRN, inclusive of suffix, which is located on the Health ID Card.

3.2 Benefit Exclusions and Limitations

Self-Funded benefit plans may be subject to limitations and exclusions. Before rendering services, it is important to contact Self-Funded Customer Service 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 you provide services to a Member and the service is not a benefit, the benefit has been exhausted, denied or was not authorized, the Plan Sponsor will not be obligated to pay for those services.

3.3 Drug Benefits

The drug benefits may vary based on the benefit plan. To verify a Member's drug benefit or for general questions, please contact the Pharmacy Benefit Information (866) 427-7701 Customer Service.

3.4 Retroactive Eligibility Changes

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

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

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

4.1 Overview of Utilization Management/Resource Management Program

KFHP, KFH, and TPMG share responsibility for Utilization Management (UM) and Resource Management (RM), which has been delegated to them by KPIC. 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 the requested service is indicated and appropriate. If is the requested service is 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 the 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 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.

KP 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 sub-specialty is obtained to make 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 Member's seeking emergency care.[1]

Plan Physicians offer primary medical, behavioral, pediatric, and OB-GYN care as well as specialty care. However, KP 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 outside referrals process originates at the facility level and the Assistant Physicians-In-Chief (APICs) for Outside Services (Referrals)

[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.

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 durable medical equipment (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 outside provider receives an Authorization for Medical Care communication, which details the name of the referring KP 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 outside Provider. Any additional services beyond the scope of the authorization must have prior approval by KP. To receive approval, the outside 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 Member issues (e.g., Member benefits and eligibility), please contact Self-Funded Customer Service. 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.

Authorization can be requested from KP by contacting the appropriate Referral Coordinator or Outside Services Case Manager.

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 Member 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 primary care 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 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. 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 Member requires the care in the Member's place of residence. Any place that the Member is using as a home is considered the Member's residence
- The home environment is a safe and appropriate setting to meet the Member's needs and provide home health or hospice services
- There is a reasonable expectation that the Member'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 Member 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 Member 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 Member 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 Member 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 Plan Sponsor's 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 the 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 Member'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 temporarily 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 KP Northern California (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 by calling Self-Funded Customer Service at **(866) 213-3062** or online at https://kpclaimservices.com/**.** If the Member does not have their Health ID Card, call Self-Funded Customer Service.

- 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 Self-Funded Customer Service.

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 Self-Funded Customer Service about authorization matters, reference the "Host" MRN. The "Host" MRN should only be used on claims, as detailed in Section 5.16.

- 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 the number below or according to the number displayed on the back of the Member ID cared.

Regional Member Services Call Centers	
Northern California	(800) 663-1771
Southern California	(800) 533-1833
Colorado	(877) 883-6698
Georgia	(866) 800-1486
Mid Atlantic	(877) 740-4117
Northwest	(888) 901-4636

4.5 Emergency Admissions and Services; Hospital Repatriation Policy

Consistent with applicable law, 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 provided to Members 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 Member in California, they are covered in situations when an emergency condition (as defined above) existed
- Once a Member 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 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 Member-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 Member's actual stabilization if such contact will not delay necessary care or otherwise harm the Member.

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-upon 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 their 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 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 goals for Members
- Conducting visits or telephonic reports, as needed
- Developing care plans

4.7 Case Management Hub Contact Information

The specific contact for information 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 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 by contacting the Coverage Decision Support Unit (CDSU) or Self-Funded Customer Service. Please refer to the written denial notice for applicable contact information or Self-Funded Customer Service.

When a denial is made, the requesting Provider is given the information below. Providers may also contact the issuing department that is identified in the letter for additional information.

The name and direct telephone number of the decision-maker accompanies a copy of the denial letter that is sent to the requesting Provider. 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 (Referrals), Pediatric Developmental Disabilities Office or 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, Provider 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
- Average length of stay
- 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.

4.13.1 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 Self-Funded Benefit Pharmacy Information 866-427- 7701 Customer Service.

4.13.2 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 Member Services Contact Center 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 Self-Funded Customer Service.

4.13.2.1 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) 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, the Member 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. 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.

4.13.2.2 Pharmacies

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

4.13.2.3 Telephone and Internet Refill Lines

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 card or debit card information.

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

4.13.2.4 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.

4.13.2.5 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.

4.13.2.6 Emergency Situations

If emergency medication is needed when KP pharmacies are not open, Members may use pharmacies outside of KP. Since 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 call Self-Funded Customer Service at **(866) 213-3062** to obtain a claim form in order to be reimbursed for the cost of the prescription less any copayments, co-insurance and/or deductibles (Member Cost Share) which may apply.

4.13.3 Drug Utilization Review

Information regarding utilization of drugs is tracked for trending and review purposes. Utilization information assists the development of educational and information communications for Providers relative to prescribing decisions.

4.14 Grievances and Appeals

If a Member raises a question about grievances or appeals with your office, please refer the Member to Self-Funded Customer Service at **(866) 213-3062**. The phone number is also

located on the back of the Member's identification card. Self-Funded Customer Service will provide information to the Member on grievances and Member appeal rights.

4.14.1 Member Appeals

Adverse benefit determinations may be appealed by a Member or their authorized representative. Kaiser Permanente Insurance Company will only deem someone other than the member as an authorized representative when the member submits the request in writing.

Members are made aware of their right to appeal through their Summary Plan Description (SPD) provided by the Plan Sponsor, or by calling Self-Funding Customer Service at **866-213-3062**, which can provide information about the time frames for submitting appeals and for responses. Time frames may vary, depending on whether the adverse benefits determination relates to urgent care, or a pre-service or post-service claim.

4.14.1.1 Non-Urgent Member Appeals

Formal appeals should be submitted to:

Kaiser Permanente Member Relations
Appeals PO Box 1809
Pleasanton, CA 94566
Fax: 888-987-2252
Phone: 1-800-788-0710

with the following information included:

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

A complete review of the claim will be provided, and the Member and any authorized representative will be notified of the decision in writing. If the initial denial is upheld following the review of the appeal, an explanation of the decision will be sent along with any further appeal rights.

A non-ERISA Member should also call Self-Funding Customer Service at **866-213-3062** for a description of appeal rights applicable to Members of self-funded non-ERISA groups.

4.14.1.2 Urgent Member Appeals

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

Please call Self-Funded Customer Service at **(866) 213-3062** to initiate an urgent appeal.

For urgent appeals, the decision will be rendered as quickly as possible, contingent upon the promptness of the Member/Provider in providing necessary additional information requested, but no later than 72 hours after receipt of the appeal.

5. Billing and Payment

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

5.1 Whom to Contact with Questions

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

5.2 Methods of Claims Submission

We urge you to submit claims electronically in either the 837I (Institutional) or the 837P (Professional) transaction format, following all HIPAA standards and appropriate coding and regulatory requirements. Details are set forth below.

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.

Submitting claims that are handwritten, faxed or photocopied will be subject to process delay and/or rejection.

5.3 Claims Filing Requirements

5.3.1 Record Authorization Number

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

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

5.3.2 One Member and One Provider per Claim Form

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

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

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

CMS 1500 (0212)

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

UB04

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

5.3.4 Billing for Claims That Span Different Years

5.3.4.1 Billing Inpatient Claims that Span Different Years

When an institutional, inpatient claim spans different years (for example, the patient was admitted in December and was discharged in January of the following year), it is NOT necessary to submit 2 claims for these services. Bill all services for this inpatient stay on one claim form (if possible), reflecting the actual date of admission and the actual date of discharge. However, when billing professional fees on a CMS-1500 for an inpatient stay, you must submit separate claims for those services based on the year of service.

5.3.4.2 Billing Outpatient Claims That Span Different Years

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

5.3.5 Interim Inpatient Bills

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

5.4 Paper Claims

5.4.1 Submission of Paper Claims

Mail all paper claims to:

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

5.5 Supporting Documentation for Paper Claims

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

- Authorization if necessary
- Discharge summary
- Operative report(s)
- Emergency room records with respect to all emergency services
- Treatment notes as reasonably relevant and necessary to determine payment
- A physician report relating to any claim under which a physician is billing a CPT code with a modifier, demonstrating the need for the modifier
- A physician report relating to any claim under which a physician is billing an "Unlisted Procedure", a procedure or service that is not listed in the current edition of the CPT codebook
- Physical status codes and anesthesia start and stop times whenever necessary for anesthesia services
- Therapy logs showing frequency and duration of therapies provided for SNF services

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

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

5.6 Submission of Electronic Claims

5.6.1 Electronic Data Interchange (EDI)

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

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

Benefits of EDI Submission

- Reduced Overhead Expenses: Administrative overhead expenses are reduced, because the need for handling paper claims is eliminated.
- Improved Data Accuracy: Because the claims data submitted by the Provider is sent electronically, data accuracy is improved, as there is no need for re-keying or re-entry of data.
- Low Error Rate: Additionally, "up-front" edits applied to the claims data while information is being entered at the Provider's office, and additional payor-specific edits applied to the data by the clearinghouse before the data is transmitted to the appropriate payor for processing, increase the percentage of clean claim submissions.
- Bypass U.S. Mail Delivery: The usage of envelopes and stamps is eliminated. Providers save time by bypassing the U.S. mail delivery system.
- Standardized Transaction Formats: Industry-accepted standardized medical claim formats may reduce the number of "exceptions" currently required by multiple Plan Sponsors.

5.6.2 Where to Submit Electronic Claims

Submit all electronic claims to:

Kaiser Permanente Insurance Company Payor ID
Optum Payor ID = 94320 (EDI claims/835 Electronic Remittance Advise (ERA)
Navicure Payor ID = 21313 (EDI claims **No** 835 Electronic Remittance Advise (ERA)
Office Ally Payor ID =21313 (EDI claims **No** 835 Electronic Remittance Advise (ERA)

5.6.3 Supporting Documentation for Electronic Claims

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

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

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

5.6.4 To Initiate EDI Submissions

Providers initiate EDI submissions. Providers may enroll with Change Healthcare to submit EDI directly or ensure their clearinghouse of choice has an established connection with

Change Healthcare. It is not necessary to notify KPIC or the TPA when you wish to submit electronically.

If there are issues or questions, please contact the TPA at **(866) 213-3062**.

5.6.5 EDI Submission Process

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

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

Exceptions to TPA submission:

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

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

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

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

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

Clearinghouse receives electronic claims and sends to TPA: Providers should work with their EDI vendors to route their electronic claims within the Change Healthcare clearinghouse network. Change Healthcare will aggregate electronic claims directly from Providers and other clearinghouses for further data sorting and distribution.

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

In addition, clearinghouses:

- Frequently supply the required PC software to enable direct data entry in the Provider's office
- May edit the data which is electronically submitted to the clearinghouse by the Provider's office, so that the data submission may be accepted by the TPA for processing
- Transmit the data to the TPA in a format easily understood by the TPA's computer system
- Transmit electronic claim status reports from TPA to Providers

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

5.6.6 Electronic Claims Disposition

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

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

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

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

5.6.7 HIPAA Requirements

All electronic claim submissions must adhere to all HIPAA requirements. The following websites (listed in alphabetical order) include additional information on HIPAA and

electronic loops and segments. If a Provider does not have internet access, HIPAA

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

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

5.7 Complete Claim

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

- Correct Form: All professional claims should be submitted using preprinted red OCR CMS-1500 and all facility claims (or appropriate ancillary services) should be submitted using preprinted red OCR UB-04based on CMS guidelines.
- Standard Coding: All fields should be completed using industry standard coding, including the use of ICD-10 code sets.
- Applicable Attachments: Attachments should be included in the submission when circumstances require additional information.
- Completed Field Elements for CMS-1500 or UB-04: All applicable data elements of CMS forms, including correct loops and segments on electronic submission, should be completed.

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

- The format used in the completion or submission of the claim is missing required fields or codes are not active
- The eligibility of a Member cannot be verified
- The service from and to dates are missing
- The rendering Provider information is missing, and or the applicable NPI is missing
- The billing Provider is missing, and/or the applicable NPI is missing
- The diagnosis is missing or invalid
- The place of service is missing or invalid, and/or the applicable NPI is missing
- The procedures/services are missing or invalid
- The amount billed is missing or invalid
- The number of units/quantity is missing or invalid
- The type of bill, when applicable, is missing or invalid
- The responsibility of another payor for all or part of the claim is not included or sent with the claim
- Other coverage has not been verified

- Additional information is required for processing such as COB information, operative report or medical notes (these will be requested upon denial or pending of claim)
- The claim was submitted fraudulently

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

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

5.8 Claims Submission Timeframes

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

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

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

5.9 Proof of Timely Claims Submission

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

5.10 Claim Corrections

A claim correction can be submitted via the following procedures:

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

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

5.11 Incorrect Claims Payments

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

- Explain the error by calling Kaiser Permanente Insurance Company at **(866) 213-3062**.
- You may also explain the error by writing to:

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

- Upon verification of the error, appropriate corrections will be made by the TPA.
- The underpayment amount owed will be added to/reflected in the next payment.
- Providers will be notified in writing of the overpayment amount. You may write a refund check to Kaiser Permanente Insurance Co. (KPIC) for the exact excess amount paid to you within the timeframe specified by the Agreement. Attach a copy of the EOP to your refund check, as well as a brief note explaining the error. Mail the refund check to:

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

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

5.12 Federal Tax ID Number

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

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

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

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

5.13 Federal Tax ID Number Changes

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

5.14 Self-Funded Member Cost Share

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

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

5.15 Self-Funded Member Claims Inquiries

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

5.16 Billing for Services Provided to Visiting Self-Funded Members

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

- Claims must be submitted to the "Mail claims to" address on the back of the visiting Member's Health Insurance ID Card.
- If the Member does not have their Health Insurance ID Card, submit your claims to:

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

Or Submit EDI Claims using Payer ID#94320

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

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

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

5.17 Coding for Claims

It is the Provider's responsibility to ensure that billing codes used on claims forms are current and accurate, that codes reflect the services provided and they compliant with KPIC's coding standards. Incorrect and invalid coding may result in delays in payment or denial of payment. All coding must follow KPIC's standards, including those specified in Section 5.18 below. Submitting claims that use nonstandard, outdated or deleted CPT, HCPCS, ICD-10, or Revenue codes, or are otherwise outside the coding standard adopted by KP will subject the claim to processing delay and/or rejection.

5.18 Coding Standards

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

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

CPT-4
The Physicians' Current Procedural Terminology, Fourth Edition (CPT) code set is a systematic listing and coding of procedures and services performed by Providers. CPT codes are developed by the American Medical Association (AMA). Each procedure code or service is identified with a five-digit code.

HCPCS
The Healthcare Common Procedure Coding System (HCPCS) Level 2 identifies services and supplies. HCPCS Level 2 begin with letters A–V and are used to bill services such as, home medical equipment, ambulance, orthotics and prosthetics, drug codes and injections.

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

NDC (National Drug Codes)
Prescribed drugs, maintained and distributed by the U.S. Department of Health and Human Services

ASA (American Society of Anesthesiologists)
Anesthesia services, the codes maintained and distributed by the American Society of Anesthesiologists

DSM-IV (American Psychiatric Services)
For psychiatric services, codes distributed by the American Psychiatric Association

5.19 Modifiers Used in Conjunction with CPT and HCPCS Codes

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

When submitting claims, use modifiers to:

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

5.20 Modifier Review

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

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

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

5.21 Coding Edit Rules

The table below identifies common edit rules.

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

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

5.22 Do Not Bill Events (DNBE)

Depending on the terms of your Agreement, you may not be compensated for Services directly related to any Do Not Bill Event (as defined below) and may be required to waive Member Cost Share associated with and hold Members harmless from any liability for Services directly related to any DNBE. KP expects you to report every DNBE as set forth in Section 8.4.5of this Provider Manual. KP ASO will reduce compensation for Services

directly related to a DNBE when the value of such Services can be separately quantified in accordance with the applicable payment methodology. DNBE shall mean the following:

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

- Wrong surgery or invasive procedure[3] on patient
- Surgery or invasive procedure on wrong patient
- Surgery or invasive procedure on wrong body part

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

- Intravascular air embolism
- Blood incompatibility (hemolytic reaction due to administration of ABO/HLA incompatible blood or blood products)
- Pressure ulcer (stage three or four)
- Falls and trauma (fracture, dislocation, intracranial injury, crushing injury, burn, electric shock)
- Catheter-associated urinary tract infection
- Vascular catheter-associated infection
- Manifestation of poor glycemic control (diabetic ketoacidosis, nonketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, secondary diabetes with hyperosmolarity)
- Surgical site infection, mediastinitis, following coronary artery bypass graft
- Surgical site infection following orthopedic procedures (spine, neck, shoulder, elbow)
- Surgical site infection following bariatric surgery for obesity (laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery)

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

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

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

- Surgical site infection following Cardiac Implantable Electronic Device (CIED)
- Iatrogenic Pneumothorax with Venous Catheterization
- Deep vein thrombosis or pulmonary embolism following orthopedic procedures (total knee or hip replacement)
- Any new Medicare fee-for-service HAC later added by CMS

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

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

5.23 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) 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) 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.

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

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

5.24 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.

5.24.1 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

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

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

- 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) after the first 30 months of dialysis treatment (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 call or contact the Member Services Contact Center (MSCC) with any questions you may have about COB.

5.24.2 Description of COB Payment Methodology

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

5.24.3 COB Claims Submission Requirements and Procedures

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

<u>Paper Claims</u>

If the Self-Funded plan is the secondary payor, send the completed claim form with a copy of the corresponding EOP or Explanation of Medicare Benefits (EOMB)/Medicare

Summary Notice (MSN) from the primary payor attached to the paper claim to ensure efficient claims processing/adjudication. The TPA will not process a claim without an EOP or EOMB/MSN from the primary payor.

- CMS-1500 claim form: Complete Field 29 (Amount Paid)
- UB-04 claim form: Complete Field 54 (Prior Payments)

Electronic Claims

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

Summary Notice (MSN) from the primary payor attached to the paper claim to ensure efficient claims processing/adjudication. The TPA will not process a claim without an EOP or EOMB/MSN from the primary payor.

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

5.24.4 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.

5.24.5 Third Party Liability (TPL)

Unless and to the extent your Agreement expressly provides to the contrary, KP has the exclusive right of recovery for TPL claims. TPL for health care costs may arise from sickness or injury caused or alleged to be 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.

KP may seek reimbursement from a Member's settlement or judgement due to injuries or illnesses caused by a third party. These activities are managed by our third party vendors, Optum.

5.24.6 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.

5.24.7 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

Accident-related claims codes (e.g., occurrence codes, condition codes, etc.)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.

5.24.8 Workers' Compensation

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

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

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

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

5.24.9 Members Enrolled in Two KP Plans

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

5.24.10 COB Claims Submission Timeframes

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

5.25 EOP

KAISER PERMANENTE®

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

[redacted]

Client ID: 00080001
Customer Service Number: 1-866-213-3062

See Last Page for Explanation of Code

Provider #: [redacted]
Tax # [redacted]
Date: 05/16/2017
Check# [redacted]0
EDI Payer ID: 94320

Patient Name Account #	Member ID # Claim #	Dates of Service	Code	Submitted Charges	Negotiated Discount	EXPL code	Non COVD Charges	Allowed Amount	Copay	Deductible	Co-ins	Total Benefit
[redacted]	[redacted]	03/28/2017	124	$2,199.98	$1,446.99	P9 EOP	$0.00	$752.99	$250.00	$0.00	$0.00	$502.99
		03/28/2017	124	$4,400.02	$2,894.01	P9 EOP	$0.00	$1,506.01	$0.00	$0.00	$0.00	$1,506.01
	Claim Totals			**$6,600.00**	**$4,341.00**		**$0.00**	**$2,259.00**	**$250.00**	**$0.00**	**$0.00**	**$2,009.00**
	Previous Claim Amount			**$0.00**				**Other Insurance**	**$0.00**	**Payment to Provider**		**$2,009.00**
								Patient Responsibility	**$250.00**	**Payment to Member**		**$0.00**
										Total Paid		**$2,009.00**

Code Descriptions

EOP Charges are priced according to the provider contract. Patient not responsible if charges are above contracted rate.
P9 Plan payment reduced by Patient's applicable copay amount

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

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

Provider Claims Payment Inquiries and Disputes

For disputes of claims payment and other payment inquiries, contact Kaiser Permanente Insurance Company at **(866) 213-3062**. Most questions regarding claim payments can be resolved quickly over the phone. The TPA will review the claim, to verify if the claim(s) was adjudicated correctly, according to the Member's benefits and the contracted rates. If the TPA determines the correct payment was made but you choose to pursue the matter as a payment dispute, please submit a written payment dispute to the Self-Funded Customer

Service department and provide detail of why you believe the payment was incorrect. Providers have up to 365 calendar days from the date of the TPA's claim processing to submit a payment dispute. Payment disputes must be submitted to:

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

6. 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.

6.1 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, contact Customer Service at **800-663-1771** on the back of your ID Card.

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 Customer Service at **800-663-1771** on the back of your ID Card.

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 Customer Service at **800-663-1771** on the back of your ID Card.

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. Please refer to your Summary Plan Description (SPD) for In-Network and Out of Network benefits.

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 Summary Plan Description (SPD). If you need a replacement, contact Customer Service at **800-663-1771** on the back of your ID Card or through http://www.kp.org. 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 Customer Service at **800-663-1771** on the back of your ID Card.

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 Summary Plan Description (SPD). If you need a replacement, contact Customer Service at **800-663-1771** on the back

of your ID Card or through http://www.kp.org. If you receive your Kaiser Permanente coverage through your employer, you can also contact your employer for a current copy of your Summary Plan Description (SPD).

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 or other providers.

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

For more about the appeal/dispute resolution process, refer to your Summary Plan Description (SPD) provided by the Plan Sponsor, or by calling Customer Service at 800-663-1771, which can provide information about the time frames for submitting appeals and for responses. Time frames may vary, depending on whether the adverse benefits determination relates to urgent care, or a pre-service or post-service claim.

6.2 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.

6.2.1 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 2.5 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 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 Provider Services.

7.1 Providers' Responsibilities

All Providers are responsible for the following:

- Providing health care services without discriminating on the basis of health status or any other unlawful category.
- 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 co-payments, co-insurance and/or deductibles from Members as required by your Agreement and the Provider Manual.
- Complying with this Provider Manual and the terms of your Agreement.
- Cooperating with and participate in the Member complaint and grievance process, as necessary.
- Encouraging all Providers and their staff to include Members as part of the patient

safety team by requesting Members to speak up when they have questions or concerns about the safety of their care.

- Discussing adverse outcomes related to errors with the Member and/or family.
- Ensuring Members' 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 Member 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
- Rely on eligibility information provided by KP about any Member in accordance with the contract between the Plan Sponsor and KPIC

7.2 Required Notices

7.2.1 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.

7.2.1.1 Provider Illness or Disability

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

7.2.1.2 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.

7.2.1.3 Adding/Deleting New Practice Site or Location

Notify Provider Services at least 90 calendar days prior to opening an additional practice site.

7.2.1.4 Adding/Deleting Practitioners to/from the Practice

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

7.2.1.5 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.

7.2.2 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 practitioners' licenses, participation in Medicare, and other occurrences that may affect the provision of services under your Agreement. Your Agreement describes the required notices and manner in which notice should be provided.

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.

7.3 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 the KP accessibility standards, our Quality Assurance & Improvement and UM Programs and your fee schedule.

7.4 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 its subcontracted providers to comply with applicable Interoperability Standards.

8. Quality Assurance and Improvement (QA & I)

8.1 Northern California Quality Program 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 by outside organizations
- 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 our Member Services Contact Center (MSCC) at **1-(800) 464-4000** or TTY: **711**. Ask for a copy of the "Quality Program at KP". Alternatively, you can view and print the document by visiting the KP website at **http://www.kaiserpermanente.org**. Click on "Locate our Services," select "Forms and Publications," then "Quality Report" and finally "Quality Program at Kaiser Permanente". Additional information on KP's Northern California Quality Program 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 Members. Providers play a key role in the implementation and oversight of patient safety efforts.

At KP, patient safety is every Member's right and everyone's responsibility. As a leader in patient safety, our program is focused on 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 larger 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**

8.2 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:

- Member access to care
- Member 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.

8.3 Provider Credentialing and Recredentialing

As an important part of KP's Quality Management Program, all credentialing, recredentialing, and privileging 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, recredentialing and privileging 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, behavioral health practitioners, acupuncturists and optometrists. Organizational Providers (OPs) include, but are not limited to, hospitals, SNFs, home health agencies, hospices, 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.

8.3.1 Practitioners

KP requires that all practitioners within the scope of KP's credentialing program be credentialed prior to treating Members and must maintain credentialing. 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 (RCPC) 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 negative decision regarding the practitioner, appeal rights will be granted in accordance with applicable legal requirements and KP policies and procedures. The practitioner will be notified of those rights at the time the practitioner is 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.

8.3.2 Practitioner Rights

8.3.2.1 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 notification will state to whom, and in what format, to submit corrections.

8.3.2.2 Practitioner Rights to Review Information

Upon written request, and to the extent allowed by law, a practitioner may review information submitted in support of the 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 in which to review the file.

8.3.2.3 Practitioner Rights 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:

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

8.3.2.4 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.

8.3 Organizational Providers (OPs)

KP requires all OPs within the scope of its credentialing program be credentialed prior to treating Members and maintain credentialing. 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

8.3.3.1 Corrective Action Plan or Increased Monitoring Status for OPs

Credentialing and recredentialing determinations are made by the KP Northern California 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.

8.4 Monitoring Quality

8.4.1 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.

8.4.2 Member Complaints

Written complaints lodged 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 broader requirements contained in your Agreement concerning the procedure for handling specific complaints (either written or oral).

8.4.3 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. Targeted HAI should be tracked, rates determined and compared to CDC benchmarks when available. 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.

8.4.4. 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.

8.4.5 DNBEs / 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 5.8 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 5.22 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:

Medical Services Contracting
Attn: Provider Services
5820 Owens Dr, 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 MRN
- Date(s) of service
- Place of service
- Referral number or emergency claim number
- General category description of DNBE(s) experienced by the Member

8.5 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.

8.5.1 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

- Utilization Management (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 Members
- Concerns regarding the possibility of failure to appropriately diagnose or treat a Member
- 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

8.5.2 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.

8.5.3 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.

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

8.5.3.2 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
Skilled Nursing Facility	Care Coordinator	Within 24 hours
Transitional Residential Recovery Services Provider	Care Coordinator	Within 24 hours

8.5.4 Sentinel Events/Reportable Occurrences—Home Health & Hospice Agency Providers

8.5.4.1 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 8.5.3.1) 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 by certified mail, return receipt.

- Falls resulting in death or serious injury
- Any unexpected death or any Member safety events resulting in permanent or severe 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
- Medication errors resulting in harm to the Member
- Permanent or severe temporary harm to a Member associated with the use of physical restraints or bedrails while being cared for in a health care facility
- Member is either a perpetrator or victim of a crime or 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

8.5.4.2 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
- Re-admission to a hospital
- Medication 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
- Noncompliance with regulatory and/or accreditation standards requiring corrective action plan

8.6 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.

8.6.1 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:

- Copy 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

8.6.2 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

8.6.3 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

8.7 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.

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 DHCS of unusual occurrences involving KP Members

8.7.2 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 Member 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 Members and family members
- For each visit: date, purpose and updated information
- Advance Directive

8.8 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 findings.
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.

8.9 QA & I Reporting Requirements for Chronic Dialysis Providers

8.9.1 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 ever
- 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

8.9.2 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® 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.

8.9.2.1 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 of 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 of 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.

3. 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. Compliance

KP strives to demonstrate high ethical standards in its 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.

9.1 Compliance with Law

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

9.2 KP Principles of Responsibility and Compliance Hotline

The 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 KP POR and Provider Code of Conduct at: **http://providers.kaiserpermanente.org/html/cpp_national/compliance.html** and are encouraged to do so. The KP POR and Code of Conduct are 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.

9.3 Gifts and Business Courtesies

Even if certain types of remuneration are permitted by law, KP discourages Providers from providing 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

9.4 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 **1-888-774-9100** for further guidance on potential conflicts of interest.

9.5 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.

9.6 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.

9.7 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.

9.8 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.

9.9 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.

9.9.1 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 their PHI, to allow that patient to amend their 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.

9.9.2 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.

9.10 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: **(925) 924-5050**
- TPMG Regional Compliance: **(510) 625-3885**

10. Additional Information

10.1 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 are extended 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.

10.1.1 Billing and Payment

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

10.1.2 Licensure, Certification & Credentialing

Subcontractors and participating practitioners are subject to the same credentialing, recredentialing, and privileging 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, recredentialing and privileging processes (privileging applies to practitioners providing services to Members at a KP facility), and that any site where Members may be seen is properly licensed. For additional information on credentialing requirements, please refer to Section 8.3 of this Provider Manual.

10.1.3 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.

10.1.4 Identification of Subcontractors

Each Provider at the time of initial contracting, and periodically thereafter, is required to complete and submit to KP a completed Provider Profile Information Form (PPIF) (incorporated into your Agreement by reference). 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.

10.2 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.

10.2.1 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.

10.2.2 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.

10.2.3 Preventive Health and Clinical Practice Guidelines (CPGs)

KP 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 in determining exceptions.

10.2.4 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.

10.3 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 companion/caregiver involved in care decisions for a Members require 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**.

10.3.1 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 and
- Fundamental knowledge in both languages of health care terminology and concepts and
- Education and training in interpreting ethics, conduct and confidentiality

10.3.2 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.

10.3.2.1 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 (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-sevices/provide-feedback**). You will receive an instant receipt acknowledgement and a follow-up response within 48 hours.

10.3.2.2 In-Person Interpreter: American Sign Language Support

KP 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 KP 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:

10.3.2.2.1 KP referral or authorization number

10.3.2.2.2 Member's KP referring facility

10.3.2.2.3 Member's KP referring provider or MD

10.3.2.2.4 Member's MRN

10.3.2.2.5 Date(s) of Member's appointment(s)

10.3.2.2.6 Time and duration of each appointment

10.3.2.2.7 Specific address and location of appointment(s)

10.3.2.2.8 Any access or security measures the interpreter will need to know and plan for to gain entry to the place of service

10.3.3 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.

10.3.4 Family Members as Interpreters

The KP Language Assistance Program does not prohibit adult family members from serving as interpreters for Members; however, using family members to interpret is discouraged. 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.

10.3.5 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."

10.3.6 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 mode

11. Additional Service Specific Information

11.1 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

11.2 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 2.5, KP Facility Listing.

11.2.1 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 Department as indicated in the table in Section 12.1 above. KP will work with you to determine the most appropriate provider and venue for providing the requested ancillary service to the Member.

11.2.2. 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.

11.2.3 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.

11.3 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 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 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 non-medical 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 recently discharged from an inpatient hospital who are at risk for re-hospitalization.

11.4 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 and Recovery Services. Residential Recovery Services are authorized through Addiction Medicine and Recovery Services department 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 hours/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 hours/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, typically14-21 days in length, providing therapy and educational services 6-8 hours each day.
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.

Service	Description
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 outside KP by 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, the patient 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.

11.5 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.

11.6 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 as required by California Health and Safety Code Section 1374.73(c)(1)(D) available upon request.