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

5.1 Whom to Contact with Questions

If you have any questions relating to the submission of claims for services provided to Members for processing, please see Sections 5.4.1 and 5.4.2 below.

5.2 Methods of Claims Submission

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.

KP is no longer accepting submissions of claims that are handwritten, faxed or photocopied.

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

5.3 Claims Filing Requirements

5.3.1 Record Authorization Number

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

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

5.3.2 One Member and One Provider per Claim Form

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

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

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

CMS 1500 (0212)

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

UB04

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

5.3.4 Billing for Claims That Span Different Years

5.3.4.1 Billing Inpatient Claims That Span Different Years

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

5.3.4.2 Billing Outpatient Claims That Span Different Years

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

5.3.5 Interim Inpatient Bills

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

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

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

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

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

5.3.6 Psychiatric and Recovery Services Provided to Medi-Cal Members

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

5.4 Paper Claims

5.4.1 Submission of Paper Claims -Referred Services

Unless otherwise indicated on the written Authorization for Medical Care or Patient Transfer Referral form, claims for referred services and professional services to which Members have direct access without a prior authorization should be sent to:

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

Phone: 1-800-390-3510

Claims for **DME, SNF, CBAS, ICF/DD, ICF/DD-H, ICF/DD-N, Home Health, and Hospice** Services should be sent to:

Kaiser Foundation Health Plan, Inc.
National Claims Administration
P.O. Box 12923
Oakland, CA 94604-2923

Phone: 1-800-390-3510

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

Kaiser Permanente
Transplant Claims Processing Unit
1950 Franklin St., 7th Floor
Oakland, CA 94612

5.4.1.1 Contacting KP Regarding Referred Services Claims

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

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

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

5.4.2 Submission of Paper Claims – Emergency Services

Claims for emergency services for Members should be sent to:

Kaiser Foundation Health Plan, Inc.
National Claims Administration
P.O. Box 12923
Oakland, CA 94604-2923

Claims for emergency services provided to Members may be physically delivered (e.g., by courier) to:

Kaiser Foundation Health Plan, Inc.
National Claims Administration
1800 Harrison Street, 12th Floor
Oakland, CA 94612

5.4.2.1 Calling KP Regarding Emergency Claims

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

5.4.3 Supporting Documentation for Paper Claims

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

- Admitting face sheet
- Discharge summary
- Operative report(s)
- Emergency room records with respect to all emergency services
- Treatment and visit notes as reasonably relevant and necessary to determine payment
- A physician report relating to any claim under which a physician is billing a CPT-4 code with a modifier, demonstrating the need for the modifier
- A physician report relating to any claim under which a physician is billing an "Unlisted Procedure", a procedure or service that is not listed in the current edition of the CPT codebook
- Physical status codes and anesthesia start and stop times whenever necessary for anesthesia services
- Therapy logs showing frequency and duration of therapies provided for SNF services

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

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

5.4.4 Ambulance Services

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

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

Customer Claims Service Department
Monday through Friday 8:00 am to 5:00 pm Pacific
1-888-505-0468
EDI Payor ID: 59299

5.5 Submission of Electronic Claims

5.5.1 Electronic Data Interchange (EDI)

KP encourages Providers to submit electronic claims (837I/P transaction). Electronic claim transactions eliminate the need for paper claims. Electronic Data Interchange (EDI) is an electronic exchange of information in a standardized format that adheres to all Health Insurance Portability and Accountability Act (HIPAA) requirements. KP requires all EDI claims be HIPAA compliant.

For information or questions regarding EDI with KP, send an email to:

EDISupport@kp.org

5.5.2 Where to Submit Electronic Claims

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

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

Clearinghouse	NCAL Payer IDs
Emdeon	**94135**
Office Ally	**94135**
Relay Health	**RH009**

SSI	NKAISERCA

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

5.5.3 EDI Claims Acknowledgement

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

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

5.5.4 Supporting Documentation for Electronic Claims

If supporting documentation is required to process an EDI claim, KP will request the supporting documentation and let you know where to send the information. Note, this additional information can be submitted via KP's **Online Affiliate** tool. Providers are invited and encouraged to request access to KP's Online Affiliate tool. These and other functions are available on a self-serve basis, 24/7. Please see the Northern California Community Provider Portal (CPP) for more information at:

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

5.5.5 HIPAA Requirements

All electronic claim submissions must adhere to all HIPAA requirements. The following websites (listed in alphabetical order) include additional information on HIPAA and electronic loops and segments. HIPAA Implementation Guides can also be ordered by calling Washington Publishing Company (WPC) at **(301) 949-9740**.

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

5.6 Complete Claim

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

- Correct Form: All professional claims should be submitted using preprinted red OCR CMS-1500 or the EDI 837P file, and all facility claims (or appropriate ancillary services) should be submitted using preprinted red OCR UB-04 or EDI 837I file based on CMS guidelines.
- Standard Coding: All fields should be completed using industry standard coding, including the use of ICD-10 code sets.
- Applicable Attachments: Attachments should be included in the submission when circumstances require additional information, or this additional information can be submitted via KP's **Online Affiliate** tool. Providers are invited and encouraged to request access to KP's Online Affiliate tool. These and other functions are available on a self-serve basis, 24/7. Please see the Northern California Community Provider Portal (CPP) for more information.
- Completed Field Elements for CMS-1500 or UB-04: All applicable data elements of CMS forms, including correct loops and segments on electronic submission, should be completed.

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

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

- The format used in the completion or submission of the claim is missing required fields or codes are not active
- The eligibility of a Member cannot be verified
- The service from and to dates are missing
- The rendering Provider information is missing, and/or the applicable NPI is missing
- The billing Provider is missing, and/or the applicable NPI is missing
- The diagnosis is missing or invalid
- The place of service is missing or invalid, and/or the applicable NPI is missing
- A claim submitted without a National Drug Code (NDC), as applicable
- The procedures/services are missing or invalid
- The amount billed is missing or invalid
- The number of units/quantity is missing or invalid

- The type of bill, when applicable, is missing or invalid
- The responsibility of another payor for all or part of the claim is not included or sent with the claim
- Other coverage has not been verified
- Additional information is required for processing such as COB information, operative report or medical notes (these will be requested upon denial or pending of claim)
- The claim was submitted fraudulently

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

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

5.7 Claims Submission Timeframes

KP requests that Providers submit claims for services provided to Members within 90 Calendar Days of such service. However, all EDI or paper claims and encounter data must be sent to the appropriate address no later than 180 Calendar Days (or any longer period specified in your Agreement or required by law) after the date of service or date of discharge, as applicable.

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

5.8 Proof of Timely Claims Submission

Claims submitted for consideration or reconsideration of timely filing must be reviewed with information that indicates the claim was initially submitted within the appropriate time frames. KP will consider system generated reports that indicate the original date of claim submission. Please note that handwritten or typed documentation is not acceptable proof of timely filing.

5.9 Claims Receipt Verification and Status

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

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

Providers are invited and encouraged to request access to KP's **Online Affiliate** tool. Many functions, including but not limited to obtaining information on benefits and eligibility, Member Cost Share and claim status are available on a self-serve basis 24 hours per day, 7 days per week. For more information and to initiate the provisioning process, please visit KP's Northern California Community Provider Portal at:

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

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

5.10 Claim Corrections

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

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

Electronic Replacement/Corrected Claim Submissions

The KP claims system recognizes claim submission types on electronic claims by the frequency code submitted. The ANSI X12 837 claim format allows providers to submit changes to claims which were not included on the original claim adjudication. Claims submitted without the original claim number will be rejected. The DCN/original claim

number can be obtained from the 835 Electronic Remittance Advice (ERA) or the Provider's Explanation of Payment (EOP).

Claim Frequency Codes

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

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

Providers may contact **EDISupport@kp.org** to review requirements for corrected claim electronic submission.

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

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

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

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

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

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

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

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

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

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

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

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

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

5.11 Incorrect Claims Payments

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

5.11.1 Underpayments

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

5.11.2 Overpayments

5.11.2.1 Overpayment Identified by Provider

If you receive an overpayment directly from KP or as a result of coordination of benefits, you must notify KP promptly upon discovery and return the overpayment to the appropriate address below as soon as possible.

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

Please include the following information when returning uncontested overpayments:

- Name of each Member who received care for which an overpayment was received
- Copy of each applicable remittance advice
- Each applicable Member's MRN
- Authorization number(s) for all applicable non-emergency services

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

Kaiser Permanente
TPMG Payment Integrity
1950 Franklin St, 7th Floor
Oakland, CA 94612

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

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

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

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

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

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

5.11.2.2 Overpayment Identified by KP

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

5.11.2.3 Contested Notice

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

5.11.2.4 No Contest

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

5.11.2.5 Offset to Payments

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

5.11.3 Inconsistent Payments

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

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

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

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

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

5.12 Member Cost Share

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

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

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

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

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

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

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

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

5.13 Billing for Service Provided to Visiting Members

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

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

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

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

5.14 Coding for Claims

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

5.15 Coding Standards

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

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

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

ICD-10
To code diagnoses and hospital procedures on inpatient claims, use the International Classification of Diseases- 10th Revision-Clinical Modification (ICD-10-CM) and International Classification of Diseases – 10th Revision – Procedure Coding System (ICD-10-PCS) maintained by the ICD-10-CM and ICD-10-PCS Coordination and Maintenance Committee which includes the 4 cooperating parties: the American Hospital Association (AHA), the CMS, the National Center for Health Statistics (NCHS) and the American Health Information Management Association (AHIMA), ICD-10-CM codes appear as three-, four-, five-, six-, or seven-digit codes, depending on the specific disease or injury being described. ICD-10-PCS hospital inpatient procedure codes appear as seven-digit codes.

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

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

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

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

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

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

5.16 Modifiers Used in Conjunction with CPT and HCPCS Codes

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

5.17 Modifier Review

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

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

5.18 Claims Review and Adjustments; Coding and Billing Validation

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

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

5.18.1 Compensation Methodologies

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

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

5.18.2 Code Review and Editing

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

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

We do not allow code unbundling for procedures for which all-inclusive codes should be used, and we will re-bundle the procedures and pay according to the appropriate all-inclusive codes. KP will not reimburse for any professional component of clinical diagnostic laboratory services, such as automated laboratory tests, billed with a Modifier 26, whether performed inside or outside of the hospital setting, provided that, consistent with CMS payment practices, reimbursement for such services, if any, is included in the payment to the applicable facility responsible for providing the laboratory services.

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

5.18.3 Coding Edit Rules

The table below identifies common edit rules.

Edit Category	Description	Edit
Rebundling	Recoding a claim featuring two (2) or more component codes billed for a group of procedures which are covered by a single comprehensive code	Deny component codes, replace with a comprehensive code
Incidental	Procedure performed at the same time as a more complex primary procedure	Deny if procedure deemed to be incidental
	Procedure is clinically integral component of a global service	Deny if procedure deemed to be incidental
	Procedure is needed to accomplish the primary procedure	Deny if procedure deemed to be incidental
Mutually Exclusive	Procedures that differ in technique or approach but lead to the same outcome	Deny procedure that is deemed to be mutually exclusive
Duplicate Procedures	Category I--Bilateral: Shown twice on submitted claim	Allow one procedure per date of service; second procedure denied
	Category II- Unilateral/Bilateral shown twice on submitted claim	Allow only one procedure per date of service; second procedure denied
	Category III- Unilateral/single CPT shown twice	Replace with corresponding Bilateral or multiple code
	Category IV- Limited by date of service, lifetime or place of service	Allow/deny based on Plan's Allowable Limits
	Category V--Not addressed by Category I-IV	Pend for Review
Medical Visits/Pre- & Post-Op Visits	Based on Surgical Package guidelines; Audits across dates	Deny E&M services within Pre- and Post-op Timeframe
Cosmetic	Identifies procedures requiring review to determine if they were performed for cosmetic reasons only	Review for appropriateness and indication
Experimental	Codes defined by CMS and AMA in CPT and HCPCS manuals to be experimental	Pend for Review
Obsolete	Procedures no longer performed under prevailing medical standards	Review for appropriateness and indication

5.18.4 Clinical Review

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

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

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

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

KP does not reimburse for items or services that are considered inclusive of, or an integral part of, another procedure or service. The standards applied by KP to determine whether billed items or services are payable are described in POL-020, "Clinical Review Payment Determination Policy." A copy of POL-020 is attached hereto as Appendix A.

5.18.5 Do Not Bill Events (DNBE)

Depending on the terms of your Agreement, you may not be compensated for Services directly related to any Do Not Bill Event (as defined below) and may be required to waive copayments, co-insurance and/or deductibles (Member Cost Share) associated with, and hold Members harmless from, any liability for services directly related to any DNBE. KP expects you to report every DNBE as set forth in Section 9.6 of this Provider Manual. KP will reduce compensation for services directly related to a DNBE when the value of such services can be separately quantified in accordance with the applicable payment methodology. DNBE shall mean the following:

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

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

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

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

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

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

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[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).

5.18.6 Claims for Do Not Bill Events

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

- **CMS 1500** – If you submit a CMS 1500 Claim (or its successor) or an 837P for any inpatient or outpatient professional Services provided to a Member wherein a SE or RFO-HAC has occurred, you must include the applicable ICD-10 codes and modifiers as set forth in the following table and as otherwise required for the Medicare fee-for-service program.
- **UB-04** – If you submit a UB-04 Claim (or its successor) or an 837I for inpatient or outpatient facility Services provided to a Member wherein a HAC (Including an RFO-HAC) has occurred, you must include the following information:
  - **DRG.** If, under the terms of your Agreement, such Services are reimbursed on a DRG basis, you must include the applicable ICD-10 codes, present on admission indicators, and modifiers as set forth in the following table and as otherwise required for the Medicare fee-for-service program.
  - **Other Payment Methodologies.** If, under the terms of your Agreement, such Services are reimbursed on a payment methodology other than a DRG and the terms of your Agreement state that you will not be compensated for Services directly related to a DNBE, you must split the Claim and submit both a Type of Bill (TOB) '110' (no-pay bill) setting forth all Services directly related to the DNBE including the applicable ICD-10 codes, present on admission indicators, and modifiers as set forth in the following table and as otherwise required for the Medicare fee-for-service program, and a TOB '11X (with the exception of 110)' setting forth all covered services not directly related to the DNBE.
  - **Present on Admission (POA)**. This field is required on all primary and secondary diagnoses for inpatient Services for all bill types. Any condition labeled with a POA indicator other than 'Y'[5] shall be deemed hospital acquired.[6] All claims must utilize the applicable HCPCS modifiers with the associated charges on all lines related to the surgical error, as applicable.

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

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

5.19 Coordination of Benefits (COB)

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

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

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

5.19.1 How to Determine the Primary Payor

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

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

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

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

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

- Medicare Fee For Service or a Medicare Advantage plan is primary for beneficiaries who are covered by an EGHP and whose subscriber is a retiree of the EGHP when the CMS Working Aged or Disabled Beneficiaries provisions apply.
- Medicare Fee For Service or a Medicare Advantage plan is primary to EGHP for individuals eligible for or entitled to Medicare benefits based on an End Stage Renal Disease (ESRD) diagnosis after the coordination period as stipulated the Medicare Secondary Payer Provisions for ESRD Beneficiaries.
- In cases of work-related injuries, Workers Compensation is primary unless coverage for the injury has been denied
- In cases of services for injuries sustained in vehicle accidents or other types of accidents, primary payor status is determined on a jurisdictional basis. Submit the claim as if the benefit plan is the primary payor

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

5.19.2 Description of COB Payment Methodology

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

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

When KP is secondary to another payor, KP will coordinate benefits and determine the amount payable to the Provider in accordance with the applicable Agreement.

5.19.3 COB Claims Submission Requirements and Procedures

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

Secondary claims can be submitted to KP via EDI.

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

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

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

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

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

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

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

Contact your clearinghouse for assistance sending COB claims electronically.

5.19.4 Direct Patient Billing

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

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

5.20 Medi-Cal Cost Avoidance

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

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

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

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

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

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

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

5.21 Third Party Liability (TPL)

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 vendor, Optum.

5.21.1 First and Third Party Liability Definitions

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

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

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

5.21.2 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.

5.22 Workers' Compensation

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

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

If the Member's Workers' Compensation carrier/plan ultimately denies the Workers' Compensation claim, you may submit the claim for covered services to 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.

5.23 Prohibited Member Billing Practices

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

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

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

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

5.24 Explanation of Payment and Remittance Advice

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

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

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

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

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

5.25 Invoices

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

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

Following are the billing requirements for submitting invoices for payment:

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

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

5.25.1 Other Contracted Functions Related to Professional Services

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

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

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

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

To submit paper invoices, please direct mail to:

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

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

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

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

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

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

KP-AP-Invoice@kp.org

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

To submit paper invoices, please direct mail to:

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

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

5.25.3 1099 Tax Documents

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

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

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